

Calendar No. 338

103D CONGRESS
1ST SESSION

S. 1770

A BILL

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

NOVEMBER 23, 1993

Read the second time and placed on the calendar

Calendar No. 338103^D CONGRESS
1ST SESSION**S. 1770**

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

IN THE SENATE OF THE UNITED STATES

NOVEMBER 22, 1993

Mr. CHAFEE (for himself, Mr. DOLE, Mr. BOND, Mr. HATFIELD, Mr. BENNETT, Mr. HATCH, Mr. DANFORTH, Mr. BROWN, Mr. GORTON, Mr. SIMPSON, Mr. STEVENS, Mr. COHEN, Mrs. KASSEBAUM, Mr. WARNER, Mr. SPECTER, Mr. FAIRCLOTH, Mr. DOMENICI, Mr. LUGAR, Mr. GRASSLEY, Mr. DURENBERGER Mr. BOREN, and Mr. KERREY) introduced the following bill; which was read the first time

NOVEMBER 23, 1993

Read the second time and placed on the calendar

A BILL

To provide comprehensive reform of the health care system of the United States, 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 “Health Equity and Access Reform Today Act of 1993”.

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

**TITLE I—BASIC REFORMS TO EXPAND ACCESS TO
 HEALTH INSURANCE COVERAGE AND TO ENSURE UNI-
 VERSAL COVERAGE**

Subtitle A—Universal Access

- Sec. 1001. Access for each individual.
- Sec. 1002. Promotion of coverage through expanded tax deductibility.
- Sec. 1003. Low-income assistance with qualified health plan premiums.
- Sec. 1004. Expanded access to employer plans.

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

PART I—STANDARDS FOR GENERAL ACCESS PLANS

SUBPART A—ESTABLISHMENT AND APPLICATION OF STANDARDS

- Sec. 1101. Qualified general access plans.
- Sec. 1102. Establishment of standards.
- Sec. 1103. Application of interim requirements.

SUBPART B—STANDARDS

- Sec. 1111. Guaranteed eligibility, availability, and renewability.
- Sec. 1112. Nondiscrimination based on health status.
- Sec. 1113. Benefits offered.
- Sec. 1114. Financial solvency requirements.
- Sec. 1115. Enrollment.
- Sec. 1116. Rating limitations.
- Sec. 1117. Risk adjustment.
- Sec. 1118. Collection and provision of standardized information.
- Sec. 1119. Quality assurance.
- Sec. 1120. Mediation procedures relating to malpractice claims.
- Sec. 1121. Service to designated underserved areas.
- Sec. 1122. Additional requirements.

PART II—INDIVIDUAL AND SMALL EMPLOYER PURCHASING GROUPS

- Sec. 1141. Establishment and organization.
- Sec. 1142. Agreements with qualified general access plans.
- Sec. 1143. Provision of information.
- Sec. 1144. Enrolling eligible employees and eligible individuals in qualified gen-
 eral access plans through a purchasing group.
- Sec. 1145. Restriction on charges.

PART III—CONSUMER PROTECTION AND MARKET REFORMS

- Sec. 1161. Requirement for provision of information by brokers.
- Sec. 1162. Prohibition of improper incentives.

**Subtitle C—Qualified Health Plans in the Large Employer
 Marketplace**

PART I—REQUIREMENTS ON LARGE EMPLOYER PLANS

- Sec. 1201. Standards applied to large employer plans.
- Sec. 1202. Establishment of standards applicable to large employer plans.
- Sec. 1203. Offer of different benefit packages required.
- Sec. 1204. Enrollment in large employer plans in satisfaction of enrollment requirement.
- Sec. 1205. Development of large or multiple employer purchasing groups.
- Sec. 1207. Corrective actions.

PART II—AMENDMENTS TO ERISA

- Sec. 1221. Limitation on coverage of group health plans under title I of ERISA.

PART III—REVISION OF COBRA CONTINUATION COVERAGE REQUIREMENTS

- Sec. 1231. Amendments to the Employee Retirement Income Security Act of 1974
- Sec. 1232. Amendment to Public Health Service Act.
- Sec. 1233. Additional revisions.

Subtitle D—Benefits; Benefits Commission

PART I—BENEFITS

- Sec. 1301. Offering of benefit packages.

PART II—BENEFITS COMMISSION

- Sec. 1311. Establishment.
- Sec. 1312. Duties.
- Sec. 1313. Operation of the Commission.
- Sec. 1314. Congressional consideration of Commission proposals.
- Sec. 1315. Implementation.

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

PART I—STATE RESPONSIBILITIES

SUBPART A—GENERAL RESPONSIBILITIES

- Sec. 1401. Establishment of State insurance market reform programs.
- Sec. 1402. Certification of insured health plans.
- Sec. 1403. Establishment of health care coverage areas.
- Sec. 1404. Procedures for purchasing groups.
- Sec. 1405. Preparation of information concerning plans and purchasing groups.
- Sec. 1406. Risk adjustment program.
- Sec. 1407. Development of binding arbitration process.
- Sec. 1408. Specification of annual general enrollment period.

SUBPART B—WAIVER OF REQUIREMENTS.

- Sec. 1421. Alternate State systems allowed.
- Sec. 1422. State opt-out.
- Sec. 1423. Waiver of certain medicare requirements.

SUBPART C—PREEMPTION OF CERTAIN STATE LAWS

- Sec. 1431. Preemption from State benefit mandates.
- Sec. 1432. Preemption of State law restrictions on network plans.

PART II—FEDERAL RESPONSIBILITIES

- Sec. 1441. Federal role with respect to multi-State employer plans.
- Sec. 1442. Federal role in the case of a default by a State.
- Sec. 1443. Establishment of residency rules.
- Sec. 1444. Rules determining separate employer status.

Subtitle F—Universal Coverage

- Sec. 1501. Requirement of coverage.

Subtitle G—Definitions

- Sec. 1601. Definitions.

TITLE II—TAX AND ENFORCEMENT PROVISIONS

- Sec. 2000. Amendment of 1986 Code.

Subtitle A—General Tax Provisions

- Sec. 2001. Certain employer health plan contributions included in income.
- Sec. 2002. Deductions for costs of qualified health plans.
- Sec. 2003. Medical savings accounts.
- Sec. 2004. Eliminating commonality of interest or geographic location requirement for tax exempt trust status.
- Sec. 2005. Revision of COBRA continuation coverage requirements.

Subtitle B—Provisions Relating to Acceleration of Death Benefits

- Sec. 2101. Tax treatment of payments under life insurance contracts for terminally ill individuals.
- Sec. 2102. Tax treatment of companies issuing qualified terminal illness riders.

Subtitle C—Long-Term Care Tax Provisions

PART I—GENERAL PROVISIONS

- Sec. 2201. Qualified long-term care services treated as medical care.
- Sec. 2202. Treatment of long-term care insurance or plans.
- Sec. 2203. Effective dates.

PART II—CONSUMER PROTECTION PROVISIONS

- Sec. 2301. Policy requirements.
- Sec. 2302. Additional requirements for issuers of long-term care insurance policies.
- Sec. 2303. Coordination with State requirements.
- Sec. 2304. Uniform language and definitions.
- Sec. 2305. Effective dates.

Subtitle D—Enforcement Provisions

PART I—GENERAL PROVISIONS

- Sec. 2401. Universal coverage.
- Sec. 2402. Role of employers and large employer plans.
- Sec. 2403. Enforcement before State certification programs or standards in place.
- Sec. 2404. Disclosure of information regarding reconciliation of assistance.

PART II—OTHER ENFORCEMENT PROVISIONS

- Sec. 2411. Conforming ERISA changes regarding enforcement of employer failures.
- Sec. 2412. Equitable relief regarding insurers failing to comply with qualified health plan standards.

TITLE III—QUALITY ASSURANCE AND SIMPLIFICATION

Subtitle A—Quality Assurance

PART I—STANDARDS AND MEASUREMENTS OF QUALITY

- Sec. 3001. Standards for quality assurance and performance measures programs.
- Sec. 3002. National health data system.
- Sec. 3003. Measures of quality of care of specialized centers of care.
- Sec. 3004. Clinical evaluations.
- Sec. 3005. Report and recommendations on achieving universal coverage.
- Sec. 3006. Monitoring reinsurance market.
- Sec. 3007. Authorization of appropriations.

PART II—AGENCY FOR HEALTH CARE POLICY AND RESEARCH

- Sec. 3101. Agency for Health Care Policy and Research.

PART III—NATIONAL FUND FOR MEDICAL RESEARCH

- Sec. 3201. National Fund for Medical Research.

Subtitle B—Administrative Simplification

- Sec. 3301. Establishment of health care data interchange system.
- Sec. 3302. Development of proposed regulations by Panel.
- Sec. 3303. Promulgation and implementation of proposed regulations by OMB.
- Sec. 3304. Selection and establishment of data and transaction standards, conventions, and requirements for the data interchange system.
- Sec. 3305. Standards for operation of a uniform working file.
- Sec. 3306. Code sets for system.
- Sec. 3307. Establishment of unique identifiers.
- Sec. 3308. Privacy and confidentiality standards.
- Sec. 3309. Transfer of information between health plans.
- Sec. 3310. Fines and penalties for failure to comply.
- Sec. 3311. Oversight of uniform working file, health care information clearinghouses, and value-added networks.
- Sec. 3312. Annual reports to Congress.
- Sec. 3313. Health Care Data Panel.
- Sec. 3314. National Health Informatics Commission.
- Sec. 3315. Definitions.

TITLE IV—JUDICIAL REFORMS

Subtitle A—Medical Liability Reform

Sec. 4001. Definitions.

PART I—MEDIATION AND ALTERNATIVE DISPUTE RESOLUTION

- Sec. 4011. Mediation.
- Sec. 4012. Failure of mediation.
- Sec. 4013. Alternative dispute resolution.
- Sec. 4014. Court actions.

PART II—LIABILITY REFORM

- Sec. 4021. Applicability.
- Sec. 4022. Limitation on amount of attorney's contingency fees.
- Sec. 4023. Reform of damages.
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- Sec. 4025. Practice guidelines.
- Sec. 4026. Drugs and devices.
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Subtitle B—Anti-Fraud and Abuse Control Program

PART I—ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM

- Sec. 4101. All-payer fraud and abuse control program.
- Sec. 4102. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health care plan.
- Sec. 4103. Reporting of fraudulent actions under medicare.

PART II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

- Sec. 4111. Mandatory exclusion from participation in Medicare and State health care programs.
- Sec. 4112. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from Medicare and State health care programs.
- Sec. 4113. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
- Sec. 4114. Civil monetary penalties.
- Sec. 4115. Actions subject to criminal penalties.
- Sec. 4116. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 4117. Intermediate sanctions for Medicare health maintenance organizations.
- Sec. 4118. Effective date.

PART III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

- Sec. 4121. Establishment of the health care fraud and abuse data collection program.
- Sec. 4122. Quarterly publication of adverse actions taken.

PART IV—AMENDMENTS TO CRIMINAL LAW

- Sec. 4131. Health care fraud.
- Sec. 4132. Forfeitures for Federal health care offenses.
- Sec. 4133. Injunctive relief relating to Federal health care offenses.

Sec. 4134. Racketeering activity relating to Federal health care offenses.

PART V—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

Sec. 4141. Amendments to Civil False Claims Act.

**Subtitle C—Treatment of Certain Activities Under the
Antitrust Laws**

Sec. 4201. Exemption from antitrust laws for certain competitive and collaborative activities.

Sec. 4202. Safe harbors.

Sec. 4203. Designation of additional safe harbors.

Sec. 4204. Certificates of review.

Sec. 4205. Notifications providing reduction in certain penalties under antitrust law for health care cooperative ventures.

Sec. 4206. Review and reports on safe harbors and certificates of review.

Sec. 4207. Rules, regulations, and guidelines.

Sec. 4208. Establishment of HHS office of health care competition policy.

Sec. 4209. Definitions.

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

Subtitle A—Frontier, Rural, and Urban Underserved Areas

Sec. 5001. Establishment of grant program.

Sec. 5002. Establishment of new program to provide funds to allow federally qualified health centers and other entities or organizations to provide expanded services to medically underserved individuals.

Sec. 5003. Tax incentives for practice in frontier, rural, and urban underserved areas.

Sec. 5004. Rural emergency access care hospitals.

Sec. 5005. Grants to States regarding aircraft for transporting rural victims of medical emergencies.

Sec. 5006. Demonstration projects to encourage the development and operation of rural health networks.

Sec. 5007. Study on expanding benefits under qualified health plans for individuals residing in rural areas.

Subtitle B—Primary Care Provider Education

Sec. 5101. Graduate medical education demonstration projects.

Sec. 5102. Funding under medicare for training in nonhospital-owned facilities.

Sec. 5103. Increase in National Health Service Corps funding.

Sec. 5104. Increase in health professions funding for primary care physicians.

Sec. 5105. Health professions funding for nurse practitioners and physician assistants programs.

Sec. 5106. State grants to increase the number of primary care providers.

**Subtitle C—Programs Relating to Primary and Preventive
Care Services**

Sec. 5201. Maternal and infant care coordination.

Sec. 5202. Comprehensive school health education program.

Sec. 5203. Frontier States.

TITLE VI—TREATMENT OF EXISTING FEDERAL PROGRAMS

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Subtitle A—Medicaid Program

PART I—OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS

Sec. 6001. Optional coverage under qualified health plans.

PART II—LIMITATION ON CERTAIN FEDERAL MEDICAID PAYMENTS

Sec. 6011. Cap on Federal payments made for acute medical services furnished under the medicaid program.

PART III—STATE FLEXIBILITY TO CONTRACT FOR COORDINATED CARE SERVICES

Sec. 6021. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under medicaid.

PART IV—OTHER PROVISIONS

Sec. 6031. Phased-in elimination of medicaid hospital disproportionate share adjustment payments.

Subtitle B—Medicare

PART I—ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS

Sec. 6101. Legislative proposal on enrolling medicare beneficiaries in qualified health plans.

Sec. 6102. Interim enrollment of medicare beneficiaries in qualified health plans.

PART II—ENHANCEMENT OF MEDICARE RISK CONTRACTS

Sec. 6111. Revisions in the payment methodology for risk contractors.

Sec. 6112. Adjustment in medicare capitation payments to take into account secondary payer status.

Sec. 6113. Establishment of outlier pool.

PART III—MEDICARE SELECT

Sec. 6121. Medicare select.

PART IV—OTHER PROVISIONS

Sec. 6131. Medicare part B premium.

Sec. 6132. Increase in medicare part B premium for individuals with high income.

Sec. 6133. Permanent 10-percent reduction in payments for capital-related costs of outpatient hospital services.

Sec. 6134. Permanent reduction in payments for other costs of outpatient hospital services.

Sec. 6135. Imposition of coinsurance on laboratory services.

Sec. 6136. Imposition of copayment for certain home health visits.

- Sec. 6137. Phased-in elimination of medicare hospital disproportionate share adjustment payments.
 Sec. 6138. Elimination of bad debt recognition for hospital services.
 Sec. 6139. Medicare as secondary payer.

**TITLE VII—PATIENT’S RIGHT TO SELF-DETERMINATION
REGARDING HEALTH CARE**

- Sec. 7001. Treatment of advance directives.
 Sec. 7002. Effect on other laws.
 Sec. 7003. Information provided to certain individuals.
 Sec. 7004. Recommendations to the Congress on issues relating to a patient’s right of self-determination.
 Sec. 7005. Effective date.

1 **TITLE I—BASIC REFORMS TO EX-**
 2 **PAND ACCESS TO HEALTH IN-**
 3 **SURANCE COVERAGE AND TO**
 4 **ENSURE UNIVERSAL COV-**
 5 **ERAGE**

6 **Subtitle A—Universal Access**

7 **SEC. 1001. ACCESS FOR EACH INDIVIDUAL.**

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

12 **SEC. 1002. PROMOTION OF COVERAGE THROUGH EX-**
 13 **PANDED TAX DEDUCTIBILITY.**

14 For provisions expanding health insurance tax de-
 15 ductibility, see section 2002.

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

18 (a) **PREMIUM ASSISTANCE TO QUALIFIED INDIVID-**
 19 **UALS AND FAMILIES.**—With respect to each calendar

1 year, in the case of a qualified family (as defined in sub-
 2 section (b)), the Secretary shall provide for payment
 3 through a voucher of the voucher amount (specified in
 4 subsection (c)), which may be applied against the cost of
 5 the premium for a qualified health plan under this title.

6 (b) QUALIFIED FAMILY.—For purposes of this sec-
 7 tion—

8 (1) IN GENERAL.—Subject to paragraph (3),
 9 the term “qualified family” means a family (as de-
 10 fined in section 1601(8)) the family income of which
 11 does not exceed the phase-in eligibility percentage
 12 (specified in paragraph (2)) of the poverty line for
 13 a family of the size involved.

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

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

18 (3) NOT QUALIFIED DURING PERIOD OF COV-
 19 ERAGE UNDER MEDICAID.—No family is eligible for
 20 a voucher if such family is a member of a class or

1 category described in 1902(a)(64) of the Social Se-
2 curity Act (as added by section 6011(b)).

3 (c) AMOUNT OF VOUCHER.—

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

7 (A) the annual premium paid the individ-
8 ual or family for such year for coverage under
9 a qualified health plan in which the family is
10 enrolled, or

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

17 (2) VOUCHER PERCENTAGE.—For purposes of
18 paragraph (1), the term “voucher percentage”
19 means, for a family, 100 percent reduced (but not
20 below zero percent) by the ratio of 100 to 140 for
21 each 1 percentage point (or portion thereof) such
22 family’s income equals or exceeds 100 percent of the
23 income official poverty line (as defined by the Office
24 of Management and Budget, and revised annually in
25 accordance with section 673(2) of the Omnibus

1 Budget Reconciliation Act of 1981) applicable to a
2 family of the size involved.

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

4 (1) ESTIMATION OF TOTAL EXPENDITURES.—

5 Between July 15 and August 1 of each calendar
6 year (beginning with 1997), the Director of the Of-
7 fice of Management and Budget (in this subsection
8 referred to as the “Director”) shall estimate the sum
9 of—

10 (A) the expenditures under titles XVIII
11 and XIX of the Social Security Act for the fis-
12 cal year beginning in such year, and

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

15 (2) COMPARISON WITH BASELINE.—

16 (A) MORE SAVINGS THAN ANTICIPATED.—

17 If the sum estimated under paragraph (1) for
18 a fiscal year is less than the baseline amount
19 under paragraph (3) for the fiscal year, then
20 paragraph (4) shall apply for the fiscal year.

21 (B) LESS SAVINGS THAN ANTICIPATED.—

22 If the sum estimated under paragraph (1) for
23 a fiscal year is more than the baseline amount
24 under paragraph (3), then paragraph (5)(B)

1 shall apply for the fiscal year (except as pro-
2 vided in paragraph (5)(A)).

3 (C) REPORT TO CONGRESS.—The Director
4 shall promptly report to Congress on determina-
5 tions under subparagraph (A).

6 (3) BASELINE.—For purposes of this sub-
7 section, the baseline amount under this paragraph
8 for fiscal year—

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

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

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

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

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

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

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

16 (H) 2004 and any succeeding fiscal year,
17 is the baseline under this paragraph for the
18 previous fiscal year increased by the percentage
19 increase in the per capita Gross Domestic Prod-
20 uct for the previous fiscal year.

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

23 (A) IN GENERAL.—If this paragraph ap-
24 plies for a year (before 2005), subject to sub-
25 paragraph (B), the applicable percentage under

1 subsection (b)(2) for the year shall be increased
2 by such whole number of percentage points as
3 the Director estimates will result in aggregate
4 additional expenditures in the year that do not
5 exceed the amount by which the baseline
6 amount under paragraph (3) for the fiscal year
7 will exceed the sum estimated under paragraph
8 (1) for the fiscal year. Such increase shall only
9 apply to that calendar year involved.

10 (B) LIMITATION.—In no case shall the in-
11 crease under subparagraph (A) for a year result
12 in an applicable percentage exceeding the appli-
13 cable percentage specified in the table in sub-
14 section (b)(2) for the following year.

15 (5) RECOVERY OF DEFICIT THROUGH ADJUST-
16 MENT MECHANISM.—

17 (A) IN GENERAL.—In the case described in
18 paragraph (2)(B), the Director shall submit to
19 the Benefits Commission a report on the deficit
20 for the year. With respect to a fiscal year in
21 which subparagraph (B)(i) applies, the Com-
22 mission may submit recommended modifications
23 under section 1312(c)(2) in response to such a
24 deficit. With respect to a fiscal year in which
25 subparagraph (B)(ii) applies, the Commission

1 shall submit recommended modifications under
2 section 1312(c)(2) in response to such a deficit.
3 If Congress adopts the modifications rec-
4 ommended by the Commission under such sec-
5 tion, then subparagraph (B) shall not apply for
6 such year.

7 (B) ADJUSTMENT MECHANISM.—

8 (i) BEFORE FULL PHASE-IN.—If this
9 subparagraph applies for a year (up to the
10 full phase-in year) (as defined in clause
11 (iii)), then for the following year the
12 phase-in eligibility percentage under sub-
13 section (b)(2) shall be decreased by such
14 whole number of percentage points as the
15 Director estimates will result in aggregate
16 decrease in expenditures that are equal to
17 the amount by which the sum estimated
18 under paragraph (1) for the fiscal year will
19 exceed the baseline amount under para-
20 graph (3) for the fiscal year. Such decrease
21 shall only apply to the year involved.

22 (ii) AFTER FULL PHASE-IN.—If this
23 subparagraph applies for a year (after the
24 full phase-in year), then for the following
25 year the phase-in eligibility percentage

1 under subsection (b)(2) shall be decreased
2 by such whole number of percentage points
3 as the Director estimates will result in ag-
4 gregate decrease in expenditures that are
5 equal to the amount by which the sum esti-
6 mated under paragraph (1) for the fiscal
7 year will exceed the baseline amount under
8 paragraph (3) for the fiscal year. Such de-
9 crease shall only apply to the year involved.

10 (iii) FULL PHASE-IN DEFINED.—In
11 this subparagraph, the term “full phase-in
12 year” means the first year in which the
13 phase-in eligibility percentage under sub-
14 section (b)(2) has equaled 240 percent.

15 (C) REPORT TO CONGRESS.—The Director
16 shall submit to Congress a report on any deter-
17 minations and any adjustments under this
18 paragraph.

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

1 (7) NO ADMINISTRATIVE OR JUDICIAL RE-
2 VIEW.—There shall be no administrative or judicial
3 review of any determination under this subsection.

4 (e) APPLICATION FOR ASSISTANCE.—

5 (1) IN GENERAL.—Any family may file an ap-
6 plication for a voucher under this section at any
7 time in accordance with this subsection.

8 (2) USE OF SIMPLE FORM.—The Secretary
9 shall use an application which shall be as simple in
10 form as possible and understandable to the average
11 individual. The application may require attachment
12 of such documentation as deemed necessary by the
13 Secretary in order to ensure eligibility for assistance.
14 The Secretary shall use, as deemed practicable by
15 the Secretary, any existing forms employed for Fed-
16 eral income tax filings as an application for assist-
17 ance.

18 (3) AVAILABILITY OF FORMS.—The Secretary
19 shall make application forms available through
20 health care providers and plans, public assistance of-
21 fices, public libraries, and at other locations (includ-
22 ing post offices) accessible to a broad cross-section
23 of families.

24 (4) SUBMISSION OF APPLICATION FORM.—An
25 application form under this subsection may be sub-

1 mitted in such manner as the Secretary shall pro-
2 vide.

3 (5) PERMITTING SUBMISSION OF REVISED AP-
4 PLICATION.—During a year, a family may submit a
5 revised application to reflect changes in the esti-
6 mated income of the family, including changes in
7 employment status of family members, during the
8 year. The voucher amount shall be revised to reflect
9 such a revised application.

10 (6) ENROLLMENT AT POINT OF APPLICA-
11 TION.—To the extent practicable, the Secretary shall
12 provide for the option of enrollment in a qualified
13 health plan as part of the application and approval
14 process for assistance under this section. In provid-
15 ing for such an option, the Secretary may require
16 the State of residence to provide such information
17 and assistance regarding qualified health plans and
18 purchasing groups as may be necessary.

19 (f) DETERMINATION OF ELIGIBILITY.—

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

22 (A) a determination of eligibility on each
23 application for a voucher submitted under sub-
24 section (e), and

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

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

7 (A) by multiplying by a factor of 4 the in-
8 come for the 3-month period immediately pre-
9 ceding the month in which the application is
10 made, or

11 (B) based upon estimated income for the
12 entire year in which the application is submit-
13 ted.

14 (g) USE OF VOUCHER.—A voucher provided to a
15 family under this section shall be remitted by any individ-
16 ual in such family to the qualified health plan, the pur-
17 chasing group, or, in the case of an employment-related
18 qualified health plan, to the employee's employer, as the
19 case may be, for payment by the Secretary. The qualified
20 health plan, purchasing group, or employer shall make
21 proper adjustments in billing statements to reflect such
22 family's remaining premium obligations (if any).

23 (h) RECONCILIATION.—

24 (1) NOTICE OF VOUCHER AMOUNT BY SEC-
25 RETARY.—In the case of a qualified family that has

1 received a voucher under this section for any month
2 in a year, the Secretary shall, not later than Janu-
3 ary 31 of the following year, notify such family of
4 the total amount of the vouchers that such family
5 received during the year.

6 (2) FILING OF NOTICE.—A family that receives
7 a notice under paragraph (1) shall attach such no-
8 tice to the tax return filed by such family for the
9 year involved. The Secretary of the Treasury shall
10 establish a procedure to enable a family that is not
11 required to file a tax return for the year involved to
12 file the notice received under paragraph (1).

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

15 (A) IN GENERAL.—Based on and using the
16 information contained in the notice filed under
17 paragraph (2) with respect to a family, the Sec-
18 retary of the Treasury shall compute the
19 amount of the voucher that should have been
20 provided under this section with respect to the
21 family in the year involved.

22 (B) OVERPAYMENT OF VOUCHER.—If the
23 amount of the voucher provided was greater
24 than the amount computed under subparagraph
25 (A), the excess amount shall be treated as an

1 underpayment of a tax imposed by chapter 1 of
2 the Internal Revenue Code of 1986 and paid by
3 the Secretary of the Treasury to the family in-
4 volved.

5 (C) UNDERPAYMENT OF VOUCHER.—If the
6 amount computed under subparagraph (A) is
7 greater than the amount of the voucher pro-
8 vided, the amount of the difference shall be
9 treated as an overpayment of tax imposed by
10 such chapter, or in the event such family is en-
11 titled to a refund of such a tax, subject to the
12 provisions of section 6402(d) of such Code.

13 (4) FAILURE TO FILE.—In the case of any fam-
14 ily that is required to file a notice under paragraph
15 (2) for a year and that fails to file such a notice by
16 the deadline specified by the Secretary, the entire
17 amount of the voucher provided in such year shall
18 be considered the excess amount under paragraph
19 (3)(B). The Secretary shall waive the application of
20 this paragraph if the family establishes, to the satis-
21 faction of the Secretary, good cause for the failure
22 to file the notice on a timely basis.

23 (5) PENALTIES FOR FALSE INFORMATION.—
24 Any individual who knowingly makes a material mis-
25 representation of information in an application for

1 assistance under this section, shall be liable to the
2 Federal Government for excess payments made
3 based on such misrepresentation and interest on
4 such excess payments at a rate specified by the Sec-
5 retary, and, in addition, shall be liable to the Fed-
6 eral Government for \$1,000 or, if greater, 3 times
7 the excess payments made based on such misrepre-
8 sentation.

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

14 (i) ADMINISTRATION BY A STATE.—Upon application
15 of a State, the Secretary may provide for the administra-
16 tion of this section in a State through an appropriate
17 State agency.

18 (j) DEFINITIONS AND DETERMINATION OF IN-
19 COME.—For purposes of this section:

20 (1) POVERTY LINE.—The term “poverty line”
21 means the income official poverty line (as defined by
22 the Office of Management and Budget, and revised
23 annually in accordance with section 673(2) of the
24 Omnibus Budget Reconciliation Act of 1981) appli-
25 cable to a family of the size involved.

1 (2) DETERMINATIONS OF INCOME.—

2 (A) IN GENERAL.—The term “income”
3 means adjusted gross income (as defined in sec-
4 tion 62(a) of the Internal Revenue Code of
5 1986)—

6 (i) determined without regard to sec-
7 tions 135, 162(l), 911, 931, and 933 of
8 such Code; and

9 (ii) increased by—

10 (I) the amount of interest re-
11 ceived or accrued which is exempt
12 from tax, plus

13 (II) the amount of social security
14 benefits (described in section 86(d) of
15 such Code) which is not includible in
16 gross income under section 86 of such
17 Code.

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

1 (C) FAMILY SIZE.—The family size to be
2 applied under this section, with respect to fam-
3 ily income, is the number of individuals in-
4 cluded in the family for purposes of coverage
5 under a qualified health plan.

6 **SEC. 1004. EXPANDED ACCESS TO EMPLOYER PLANS.**

7 (a) QUALIFIED HEALTH PLANS MADE AVAIL-
8 ABLE.—Each employer shall make available, either di-
9 rectly, through a purchasing group, or otherwise, enroll-
10 ment in a qualified health plan to each eligible employee
11 of such employer. A small employer may meet the require-
12 ment of the previous sentence only through a qualified in-
13 sured health plan.

14 (b) FORWARDING INFORMATION.—

15 (1) INFORMATION REGARDING PLANS.—An em-
16 ployer must provide each employee of such employer
17 (including any part-time or seasonal employee) with
18 information provided by the State under section
19 1405 regarding all qualified health plans offered in
20 the health care coverage area (in this title referred
21 to as a “HCCA”) in which the employer is located
22 and, if the employee resides in another HCCA, infor-
23 mation regarding how to obtain information on
24 qualified health plans offered to residents of such
25 other HCCA.

1 (2) INFORMATION REGARDING EMPLOYEES.—

2 An employer must forward the name and address
3 (and any other necessary identifying information
4 specified by the Secretary) of each eligible em-
5 ployee—

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

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

10 (c) PAYROLL DEDUCTION.—

11 (1) IN GENERAL.—If any employer is advised
12 by a qualified health plan (or by a purchasing group
13 on behalf of a qualified insured health plan) that an
14 eligible employee is enrolled in such a plan, the em-
15 ployer, upon authorization by the employee, shall
16 provide for the deduction, from the employee's wages
17 or other compensation, of the premium amount due
18 (less any employer contribution) to the plan or pur-
19 chasing group.

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

24 (d) LIMITED EMPLOYER OBLIGATION.—Nothing in
25 this section shall be construed as requiring an employer

1 to make, or preventing such employer from making, an
2 employer contribution toward coverage of employees (and
3 their dependents) under a qualified health plan.

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

9 (1) in any qualified health plan offered in the
10 HCCA in which the employee works or in which the
11 employee resides (including qualified health plans of-
12 fered through purchasing groups serving such
13 HCCA), or

14 (2) in a plan offered by an association which is
15 organized for purposes other than to offer health
16 plan coverage to the association's members and
17 which is offering such coverage as of the date of the
18 enactment of this Act.

1 **Subtitle B—Qualified General Ac-**
2 **cess Plans in the Small Em-**
3 **ployer and Individual Market-**
4 **place**

5 **PART I—STANDARDS FOR GENERAL ACCESS**
6 **PLANS**

7 **Subpart A—Establishment and Application of**
8 **Standards**

9 **SEC. 1101. QUALIFIED GENERAL ACCESS PLANS.**

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

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

18 (c) **CONSTRUCTION.**—Whenever in this title a re-
19 quirement or standard is imposed on a health plan, the
20 requirement or standard is deemed to have been imposed
21 on the insurer or health plan sponsor of the plan in rela-
22 tion to that plan.

1 **SEC. 1102. ESTABLISHMENT OF STANDARDS.**

2 (a) **ROLE OF THE NAIC.**—The Secretary shall re-
3 quest that the National Association of Insurance Commis-
4 sioners—

5 (1) develop specific standards, in the form of a
6 model Act and model regulations, to implement the
7 requirements of sections 1111 through 1117 and
8 1122 of subpart B; and

9 (2) report to the Secretary on such standards,
10 within 6 months after the date of the enactment of
11 this Act. If such Association develops such standards
12 within such period and the Secretary finds that such
13 standards implement the requirements of such sec-
14 tion, such standards shall be applicable under this
15 part.

16 (b) **ROLE OF THE SECRETARY.**—If the National As-
17 sociation of Insurance Commissioners Association fails to
18 develop and report on the standards described in sub-
19 section (a) by the date specified in such subsection or the
20 Secretary finds that such standards do not implement the
21 requirements of sections 1111 through 1117 and 1122,
22 the Secretary shall develop and publish such standards,
23 by not later than the date that is 1 year after the date
24 of enactment of this Act, and such standards shall be ap-
25 plicable under this part.

1 (c) REFERENCE TO INSURANCE REFORM STAND-
2 ARDS.—For purposes of this subtitle, the term “insurance
3 reform standards” means the standards developed under
4 this section and applicable under this part and includes
5 the requirements under sections 1118 through 1122 of
6 subpart B.

7 **SEC. 1103. APPLICATION OF INTERIM REQUIREMENTS.**

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

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

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

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

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

4 (A) any reference to 3 months in section
5 1112(b)(1)(A) is deemed a reference to 6
6 months,

7 (B) any reference to 6 months in section
8 1112(b)(1)(B) is deemed a reference to 9
9 months, and

10 (C) any reference to 3-month period in sec-
11 tion 1112(b)(3)(B) is deemed a reference to 6-
12 month period.

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

15 (4) Section 1116(d) (relating to rating limita-
16 tions).

17 (5) Section 1120 (relating to mediation proce-
18 dures).

19 **Subpart B—Standards**

20 **SEC. 1111. GUARANTEED ELIGIBILITY, AVAILABILITY, AND**
21 **RENEWABILITY.**

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

1 (b) STANDARDS.—The insurance reform standards
2 shall prohibit marketing or other practices by an insurer
3 intended to discourage or limit the issuance of a qualified
4 general access plan to an eligible employee or eligible indi-
5 vidual on the basis of health status, employer size or in-
6 dustry, geographic area, or other risk factors.

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

10 (d) GEOGRAPHIC LIMITATIONS.—A qualified general
11 access plan may deny coverage under the plan to an eligi-
12 ble employee or eligible individual who resides outside the
13 HCCA in which such plan is offered, but only if such de-
14 nial is applied uniformly, without regard to health status
15 or insurability of individuals.

16 (e) APPLICATION OF CAPACITY LIMITS.—

17 (1) IN GENERAL.—Subject to paragraph (2), a
18 qualified general access plan may apply to the ap-
19 propriate certifying authority (as defined in section
20 1601(1)) to cease enrolling eligible employees and el-
21 igible individuals under the plan if—

22 (A) the plan ceases to enroll any new eligi-
23 ble employees and eligible individuals; and

24 (B) the plan can demonstrate to the appli-
25 cable certifying authority that its financial or

1 provider capacity to serve previously covered
2 groups or individuals (and additional individ-
3 uals who will be expected to enroll because of
4 affiliation with such previously covered groups
5 or individuals) will be impaired if it is required
6 to enroll other eligible employees and eligible in-
7 dividuals.

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

15 (f) RENEWABILITY.—

16 (1) IN GENERAL.—A qualified general access
17 plan that is issued to a small employer, eligible em-
18 ployee, or eligible individual shall be renewed, at the
19 option of the employer, employee, or individual, un-
20 less the plan is terminated for a reason specified in
21 paragraph (2) or (3).

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

- 1 (A) nonpayment of premiums;
2 (B) fraud or misrepresentation; or
3 (C) change in residence to a HCCA not
4 served under the plan.

5 (3) TERMINATION.—

6 (A) IN GENERAL.—An insurer is not re-
7 quired to renew or make available a qualified
8 general access plan through a particular type of
9 delivery system (as defined in section 1601)
10 with respect to a small employer, eligible em-
11 ployee, or eligible individual, is the insurer—

12 (i) elects not to renew all of its quali-
13 fied general access plans using such deliv-
14 ery system issued to small employers, eligi-
15 ble employees, and eligible individuals in a
16 HCCA; and

17 (ii) provides notice to the appropriate
18 certifying authority and to each small em-
19 ployer and eligible individual covered under
20 the plan of such termination at least 180
21 days before the date of expiration of the
22 plan.

23 (B) PROHIBITION ON MARKET REENTRY.—

24 In the case of such a termination, the insurer
25 may not provide for issuance of any qualified

1 general access plan using such a delivery sys-
2 tem to an eligible employer, eligible employee,
3 or eligible individual in the State during the 5-
4 year period beginning on the date of the termi-
5 nation of the last plan not so renewed.

6 (g) EXCEPTION DURING TRANSITION.—

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

11 (2) CLARIFICATION OF TIMELY ENROLL-
12 MENT.—

13 (A) GENERAL INITIAL ENROLLMENT RE-
14 QUIREMENT.—Except as provided in this para-
15 graph, an insurer may consider enrollment of
16 an eligible employee or eligible individual in a
17 plan not to be timely if such employee or indi-
18 vidual fails to enroll in the plan during an ini-
19 tial enrollment period, if such period is at least
20 30 days long.

21 (B) ENROLLMENT DUE TO LOSS OF PRE-
22 VIOUS EMPLOYER COVERAGE.—Enrollment in a
23 qualified general access plan is considered to be
24 timely in the case of an eligible employee or eli-
25 gible individual who—

1 (i) was covered under another health
2 plan at the time of the individual's initial
3 enrollment period;

4 (ii) stated at the time of the initial en-
5 rollment period that coverage under a
6 health plan was the reason for declining
7 enrollment;

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

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

15 (C) REQUIREMENT APPLIES DURING OPEN
16 ENROLLMENT PERIODS.—Each qualified gen-
17 eral access plan shall provide for at least one
18 period (of not less than 30 days) each year dur-
19 ing which enrollment under the plan shall be
20 considered to be timely.

21 (D) EXCEPTION FOR COURT ORDERS.—
22 Enrollment of a spouse or minor child of an eli-
23 gible employee or eligible individual shall be
24 considered to be timely if—

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

5 (ii) a request for enrollment is made
6 within 30 days after the date the court is-
7 sues the order.

8 (E) ENROLLMENT OF SPOUSES AND DE-
9 PENDENTS.—

10 (i) IN GENERAL.—Enrollment of the
11 spouse (including a child of the spouse)
12 and any dependent child of an eligible em-
13 ployee or eligible individual shall be consid-
14 ered to be timely if a request for enroll-
15 ment is made either—

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

21 (II) within 30 days of the date
22 family coverage is first made avail-
23 able.

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

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

7 **SEC. 1112. NONDISCRIMINATION BASED ON HEALTH STA-**
8 **TUS.**

9 (a) IN GENERAL.—Except as provided under sub-
10 section (b), a qualified health plan may not deny, limit,
11 or condition the coverage under (or benefits of) the plan
12 based on the health status, claims experience, receipt of
13 health care, execution of an advance directive, medical his-
14 tory, or lack of evidence of insurability, of an individual.

15 (b) TREATMENT OF PREEXISTING CONDITION EX-
16 CLUSIONS FOR ALL SERVICES.—

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

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

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

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

11 (D) the limitation or exclusion relates to
12 pregnancy.

13 In the case of an individual who is eligible for cov-
14 erage under a qualified health plan but for a waiting
15 period imposed by an employer, in applying subpara-
16 graphs (A) and (B), the individual shall be treated
17 as having been covered under the plan as of the ear-
18 liest date of the beginning of the waiting period.

19 (2) CREDITING OF PREVIOUS COVERAGE.—A
20 qualified health plan shall provide that if an individ-
21 ual under such plan is in a period of continuous cov-
22 erage with respect to particular services as of the
23 date of initial coverage under such plan, any period
24 of exclusion of coverage with respect to a preexisting
25 condition for such services or type of services shall

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

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

4 (A) PERIOD OF CONTINUOUS COVERAGE.—

5 The term “period of continuous coverage”
6 means, with respect to particular services, the
7 period beginning on the date an individual is
8 enrolled under a qualified health plan or an
9 equivalent health care program which provides
10 benefits with respect to such services and ends
11 on the date the individual is not so enrolled for
12 a continuous period of more than 3 months.

13 (B) PREEXISTING CONDITION.—The term

14 “preexisting condition” means, with respect to
15 coverage under a qualified health plan, a condi-
16 tion the diagnosis of which was known or which
17 was treated, within the 3-month period ending
18 on the day before the first date of such cov-
19 erage (without regard to any waiting period).

20 **SEC. 1113. BENEFITS OFFERED.**

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

23 (1) offer to all enrollees in the plan coverage for
24 the covered items and services specified under sub-
25 title D;

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

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

7 (4) covers the routine medical costs of certain
8 investigational treatments referred to in section
9 1301(d)(3).

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

12 (b) AVAILABILITY OF SERVICES IN ENTIRE COV-
13 ERAGE AREA.—Each qualified general access plan offered
14 in a HCCA shall provide assurances to the appropriate
15 certifying authority that it has the capacity to deliver the
16 full range of covered items and services to potential enroll-
17 ees who reside within the HCCA served by the plan.

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

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

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

6 (3) coverage of such additional items and serv-
7 ices is offered to individuals who are not enrolled in
8 such plan.

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

13 **SEC. 1114. FINANCIAL SOLVENCY REQUIREMENTS.**

14 (a) SOLVENCY PROTECTION.—Each insurer offering
15 a qualified general access plan shall meet financial sol-
16 vency requirements to assure protection of enrollees with
17 respect to potential insolvency.

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

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

3 **SEC. 1115. ENROLLMENT.**

4 (a) ENROLLMENT PROCESS.—

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

8 (2) INITIAL ENROLLMENT PERIOD.—Each eligi-
9 ble employee or eligible individual, at the time the
10 individual first becomes an eligible employee or eligi-
11 ble individual in the HCCA in which a qualified gen-
12 eral access plan is offered, shall have an initial en-
13 rollment period (of not less than 30 days) in which
14 to enroll in the plan.

15 (3) GENERAL ENROLLMENT PERIOD.—Each
16 qualified general access plan shall permit eligible
17 employees and eligible individuals to enroll (or
18 change enrollment) in the plan during each general
19 annual enrollment period specified by the appro-
20 priate certifying authority under section 1408.

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

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

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

7 (C) changes residence to another HCCA;

8 each qualified general access plan shall provide for
9 a special enrollment period in which the employee or
10 individual is permitted to change the individual or
11 family basis of coverage or the plan in which the em-
12 ployee or individual is enrolled. The circumstances
13 under which such special enrollment periods are re-
14 quired and the duration of such periods shall be
15 specified in the insurance reform standards.

16 (5) TRANSITIONAL ENROLLMENT PERIOD.—
17 Each qualified general access plan that will be of-
18 fered at the beginning of the first certification year
19 (as defined in section 1601(9)) shall provide for a
20 special transitional enrollment period (during a pe-
21 riod beginning in the months of October through
22 December of the previous year) during which eligible
23 employees and eligible individuals may first enroll.

24 (b) PERIOD OF COVERAGE.—

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

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

15 (3) SPECIAL ENROLLMENT PERIODS.—

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

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

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

10 (4) MINIMUM PERIOD OF ENROLLMENT.—

11 (A) IN GENERAL.—In order to avoid ad-
12 verse selection, each qualified general access
13 plan may require, consistent with the insurance
14 reform standards, that enrollments with the
15 plan be for not less than a specified minimum
16 enrollment period (with exceptions permitted
17 for such exceptional circumstances as the stand-
18 ards may recognize).

19 (B) SUNSET.—Subparagraph (A) shall not
20 apply on and after the date that the universal
21 coverage requirement of section 1501 first ap-
22 plies.

23 **SEC. 1116. RATING LIMITATIONS.**

24 (a) LIMIT ON VARIATION OF PREMIUMS FOR EN-
25 ROLLEES UNDER AGE 65.—

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

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

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

13 (C) 10 percent for each succeeding year
14 thereafter.

15 (2) ADJUSTMENT BASED ON DIFFERENCES IN
16 ADMINISTRATIVE COSTS.—In accordance with the in-
17 surance reform standards, an insurer may vary the
18 premiums based on identifiable differences in mar-
19 keting and other legitimate administrative costs (as
20 defined in such standards), except that such pre-
21 miums may not vary under this paragraph with re-
22 spect to enrollees within a particular purchasing
23 group.

24 (b) ESTABLISHMENT OF CLASSES OF FAMILY EN-
25 ROLLMENT AND AGE BANDS.—

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

4 (A) Enrollment of an individual without
5 dependents (in this section referred to as “indi-
6 vidual enrollment”).

7 (B) Enrollment of an individual with de-
8 pendents.

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

15 (c) STANDARD PREMIUMS WITH RESPECT TO ELIGI-
16 BLE EMPLOYEES AND ELIGIBLE INDIVIDUALS.—

17 (1) IN GENERAL.—Each qualified general ac-
18 cess plan to be offered to an eligible employee or eli-
19 gible individual which provides for—

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

22 (B) the catastrophic package, shall estab-
23 lish a standard premium for such package,,
24 for individual enrollment within each HCCA in
25 which the plan is offered. Subject to paragraph (2),

1 within a HCCA for eligible employees and eligible in-
2 dividuals, the standard premium for each such pack-
3 age for all such employees and individuals shall be
4 the same.

5 (2) APPLICATION TO INDIVIDUALS.—The pre-
6 mium charged for coverage in a qualified general ac-
7 cess plan shall be the product of—

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

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

13 (C) the age factor (specified under para-
14 graph (4)) for the age band in which the enroll-
15 ment is classified.

16 (3) FAMILY ADJUSTMENT FACTOR.—The insur-
17 ance reform standards shall specify a family adjust-
18 ment factor that reflects the relative actuarial costs
19 of benefit packages based on a family enrollment (as
20 compared with such costs for individual enrollment).
21 Such factor may be different for the standard pack-
22 age and the catastrophic package, but may not differ
23 based on the geographic area in which the plan is
24 offered.

25 (4) AGE ADJUSTMENT FACTOR.—

1 (A) IN GENERAL.—The insurance reform
2 standards shall specify, for each age band es-
3 tablished under subsection (b)(2), an age ad-
4 justment factor that reflects the relative actuar-
5 ial costs of benefit packages among enrollees
6 classified in the different age bands. Such fac-
7 tors may be different for the standard package
8 and the catastrophic package.

9 (B) LIMIT ON VARIATION IN AGE ADJUST-
10 MENT FACTORS.—The highest age adjustment
11 factor may not exceed twice the lowest age ad-
12 justment factor.

13 (d) FULL DISCLOSURE OF RATING PRACTICES.—

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

17 (2) NOTICE ON EXPIRATION.—An insurer pro-
18 viding a qualified general access plan shall provide
19 for notice, at least 60 days before the date of expira-
20 tion of the plan, of the terms for renewal of the
21 plan. Such notice shall include an explanation of the
22 extent to which any increase in premiums is due to
23 actual or expected claims experience of the individ-
24 uals covered under the plan contract.

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

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

16 (1) the insurer is in compliance with the appli-
17 cable provisions of this section; and

18 (2) the rating methods are actuarially sound.

19 Each insurer shall retain a copy of such statement for ex-
20 amination by any individual at its principal place of busi-
21 ness.

22 (g) PAYMENT OF PREMIUMS.—

23 (1) IN GENERAL.—With respect to a new en-
24 rollee in a qualified general access plan, the plan
25 may require advanced payment of an amount equal

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

3 (2) REQUIREMENT FOR PAYROLL DEDUC-
4 TIONS.—

5 (A) IN GENERAL.—Subject to subpara-
6 graph (C)(ii), a qualified general access plan
7 may require, in the case of an individual en-
8 rolled under the plan as an eligible employee,
9 that payment of premiums with respect to the
10 individual be made through payroll deduction.

11 (B) FREQUENCY.—In the case of an eligi-
12 ble employee who is paid wages or other com-
13 pensation—

14 (i) on a monthly or more frequent
15 basis, a qualified general access plan may
16 not require the employer to provide for
17 payment of such an amount other than at
18 the same time at which such an amount is
19 deducted from such wages or other com-
20 pensation, or

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

25 (C) EMPLOYEE PROTECTIONS.—

1 (i) WITHHOLDING CONSTITUTES SAT-
2 ISFACTION OF OBLIGATION.—Withholding
3 of an amount by an employer under this
4 paragraph shall constitute satisfaction of
5 the employee’s obligation to pay the quali-
6 fied general access plan with respect to
7 such amount.

8 (ii) DIRECT PAYMENT ALLOWED IN
9 CASE OF NONPAYMENT.—In the case of
10 the nonpayment to a qualified general ac-
11 cess plan of any amount withheld by an
12 employer, the plan shall notify such em-
13 ployee of such nonpayment and shall allow
14 the employee to make direct payments to
15 the plan effective with the next succeeding
16 payment period.

17 **SEC. 1117. RISK ADJUSTMENT.**

18 (a) IN GENERAL.—Each qualified general access plan
19 shall participate in a risk adjustment program of the State
20 (or the Secretary if the Secretary is the appropriate cer-
21 tifying authority) described in section 1406.

22 (b) RISK ADJUSTMENT PROCESS AND FACTORS.—

23 (1) IN GENERAL.—The insurance reform stand-
24 ards shall specify the risk adjustment process and

1 factors to be used under such risk adjustment pro-
2 grams.

3 (2) FACTORS.—

4 (A) IN GENERAL.—Such risk-adjustment
5 factors shall be established for each class of
6 family enrollment in a qualified general access
7 plan based on all individuals in such class en-
8 rolled in the plan. Each factor shall be cor-
9 related with increased or diminished risk for
10 consumption of the type of health services in-
11 cluded in the covered items and services under
12 section 1301. To the maximum extent prac-
13 ticable, such factors shall be determined with-
14 out regard to the delivery system used by indi-
15 vidual qualified general access plans in the pro-
16 vision of such items and services.

17 (B) RULES.—In determining such a factor
18 for a class, in the case of a qualified general ac-
19 cess plan that—

20 (i) on average has a lower-than-aver-
21 age risk for consumption of the covered
22 items and services, the factor shall be a
23 number, less than zero, reflecting the de-
24 gree of such lower risk;

1 (ii) has an average risk for consump-
2 tion of such items and services, the factor
3 shall be zero; or

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

9 **SEC. 1118. COLLECTION AND PROVISION OF STANDARD-**
10 **IZED INFORMATION.**

11 (a) IN GENERAL.—A qualified health plan shall pro-
12 vide the State (at a time, not less frequently than annu-
13 ally) such information as the Secretary shall prescribe by
14 regulation as necessary, consistent with this section and
15 sections 1405 and 3301, to evaluate the performance of
16 the qualified health plan and to prepare the comparative
17 materials described in section 1405. A qualified general
18 access plan shall provide each State with such additional
19 information as such State may determine to be necessary
20 with respect to qualified general access plans. The data
21 collection standards shall specify the standardized format
22 for such information (including model forms) for use by
23 qualified health plans in providing information under this
24 subsection. Such standards shall be consistent with sub-
25 title B of title III.

1 (b) USE OF UNIFORM CLAIMS FORMS.—Each quali-
2 fied health plan shall use standardized forms, including
3 uniform claims forms, identified by the insurance reform
4 standards.

5 (c) CONDITIONING CERTAIN PROVIDER PAY-
6 MENTS.—

7 (1) IN GENERAL.—In order to assure the collec-
8 tion of all information required from the direct pro-
9 viders of services for which benefits are available
10 through a qualified general access plan, a qualified
11 general access plan may not provide payment for
12 services (other than emergency services) furnished
13 under a benefits package unless the provider has
14 given the plan standard information (specified in or
15 pursuant to the insurance reform standards) re-
16 specting the services.

17 (2) FORWARDING INFORMATION.—If informa-
18 tion under paragraph (1) is given to the qualified
19 general access plan, the plan is responsible for for-
20 warding the information to the State (or the Sec-
21 retary) under subsection (a).

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

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

9 **SEC. 1119. QUALITY ASSURANCE.**

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

13 **SEC. 1120. MEDIATION PROCEDURES RELATING TO MAL-**
14 **PRACTICE CLAIMS.**

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

18 **SEC. 1121. SERVICE TO DESIGNATED UNDERSERVED**
19 **AREAS.**

20 Each qualified general access plan shall contain as-
21 surances of compliance with any requirements relating to
22 the provision of covered items and services in designated
23 underserved areas as determined by the appropriate cer-
24 tifying authority.

1 **SEC. 1122. ADDITIONAL REQUIREMENTS.**

2 Each qualified general access plan shall comply with
3 the requirements of part III and meet such other require-
4 ments as may be imposed under the insurance reform
5 standards or by the appropriate certifying authority. If
6 such authority is a State, the authority may require such
7 a plan to enter into an agreement under section
8 1933(b)(3) of the Social Security Act, as added by section
9 6021(a) of this Act, for the provision of items and services
10 on a capitated basis under the medicaid program.

11 **PART II—INDIVIDUAL AND SMALL EMPLOYER**
12 **PURCHASING GROUPS**

13 **SEC. 1141. ESTABLISHMENT AND ORGANIZATION.**

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

21 (b) BOARD OF DIRECTORS.—

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

1 with paragraph (3). Such Board shall be composed
2 of individuals who are small employers (or represent-
3 atives of small employers), eligible employees of
4 small employers (or representatives of such employ-
5 ees), and eligible individuals in the HCCA in which
6 the group operates.

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

12 (3) VOTING.—Members of a purchasing group
13 shall have voting rights consistent with the rules es-
14 tablished under section 1404(b).

15 (c) DUTIES OF PURCHASING GROUPS.—

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

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

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

23 (C) enter into agreements with small em-
24 ployers under section 1143;

1 (D) enroll individuals in qualified general
2 access plans, only in accordance with section
3 1144; and

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

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

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

11 (B) perform any activity (including certifi-
12 cation or enforcement) relating to compliance of
13 general access plans with the requirements of
14 part 1 of this subtitle;

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

17 (D) perform other activities identified by
18 the State as being inconsistent with the per-
19 formance of its duties under paragraph (1).

20 (d) RULES OF CONSTRUCTION.—

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

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

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

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

8 **SEC. 1142. AGREEMENTS WITH QUALIFIED GENERAL AC-**
9 **CESS PLANS.**

10 (a) AGREEMENTS.—

11 (1) IN GENERAL.—Except as provided in para-
12 graph (3), each purchasing group for a HCCA shall
13 enter into an agreement under this section with each
14 qualified general access plan that desires to be made
15 available through the purchasing group in accord-
16 ance with procedures under section 1404.

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 group
20 may terminate an agreement under paragraph (1) if
21 the qualified general access plan's certification under
22 section 1402 is terminated or for other good cause
23 shown.

1 (3) LIMITATION ON RENEWAL OF AGREE-
2 MENTS.—Subsequent to the 12-month period de-
3 scribed in paragraph (2), a purchasing group may—

4 (A) refuse to enter into a subsequent
5 agreement with a qualified general access plan
6 if the group determines that the plan enroll-
7 ment or plan premium is too low, and

8 (B) if a previous agreement with a quali-
9 fied general access plan was terminated for
10 good cause and the group determines appro-
11 priate actions have not been taken to correct
12 the problems, refuse to enter into a subsequent
13 agreement with the plan.

14 (4) NO PROHIBITION ON OFFERING OF
15 PLANS.—Nothing in this subsection shall be con-
16 strued as prohibiting a qualified general access plan
17 that does not enter into an agreement under para-
18 graph (1) from being offered to small employers and
19 eligible individuals within a HCCA.

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

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

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

3 (2) TIMING OF PAYMENT OF PREMIUMS.—Pre-
4 miums may be payable on a monthly basis (or, at
5 the option of an eligible employee or individual, on
6 a quarterly basis). The purchasing group may pro-
7 vide for reasonable penalties and grace periods for
8 late payment.

9 (3) QUALIFIED GENERAL ACCESS PLANS RE-
10 TAIN RISK OF NONPAYMENT.—Nothing in this sub-
11 section shall be construed as placing upon a pur-
12 chasing group any risk associated with the failure of
13 individuals and employers to make prompt payment
14 of premiums (other than the portion of the premium
15 representing the purchasing group administrative fee
16 under section 1145). Each small employer and eligi-
17 ble individual who enrolls with a qualified general
18 access plan through the purchasing group is liable to
19 the plan for premiums.

20 (c) FORWARDING OF PREMIUMS.—

21 (1) IN GENERAL.—If, under an agreement
22 under subsection (a), premium payments under a
23 qualified general access plan are made to the pur-
24 chasing group, the purchasing group shall forward
25 to the plan the amount of the premiums.

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

7 **SEC. 1143. PROVISION OF INFORMATION.**

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

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

15 (2) the opportunity to enter into an agreement
16 with the group for the purchase of a qualified gen-
17 eral access plan.

18 (b) FORWARDING INFORMATION AND PAYROLL DE-
19 DUCTIONS.—As part of an agreement entered into under
20 this section, a small employer shall forward the informa-
21 tion and make the payroll deductions required under sec-
22 tion 1004.

1 **SEC. 1144. ENROLLING ELIGIBLE EMPLOYEES AND ELIGI-**
2 **BLE INDIVIDUALS IN QUALIFIED GENERAL**
3 **ACCESS PLANS THROUGH A PURCHASING**
4 **GROUP.**

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

10 (1) all eligible employees employed by small em-
11 ployers in the HCCA served by the purchasing
12 group; and

13 (2) all eligible individuals residing in such
14 HCCA.

15 **SEC. 1145. RESTRICTION ON CHARGES.**

16 (a) **IN GENERAL.**—A purchasing group may impose
17 an administrative fee with respect to an eligible employee
18 or eligible individual enrolled under a qualified general ac-
19 cess plan offered through the purchasing group.

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

1 **PART III—CONSUMER PROTECTION AND MARKET**
2 **REFORMS**

3 **SEC. 1161. REQUIREMENT FOR PROVISION OF INFORMA-**
4 **TION BY BROKERS.**

5 Brokers or insurers who offer coverage under a quali-
6 fied general access plan to small employers (or eligible em-
7 ployees of small employers) or eligible individuals must
8 disclose to such prospective enrollees the information de-
9 veloped by the State under section 1405.

10 **SEC. 1162. PROHIBITION OF IMPROPER INCENTIVES.**

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

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

21 **SEC. 1163. PROHIBITION OF SALE OF DUPLICATE COV-**
22 **ERAGE OR SALE TO CERTAIN POPULATIONS.**

23 (a) DUPLICATE COVERAGE PROHIBITION.—It is un-
24 lawful for a person to sell or issue a qualified insured gen-
25 eral access plan to an individual—

1 (1) with knowledge that the individual is cov-
2 ered under a qualified health plan or under an
3 equivalent health care program, or

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

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

13 (c) ENFORCEMENT.—Any person who violates sub-
14 section (a) is subject to a civil money penalty not to exceed
15 \$10,000 for each such violation. The provisions of section
16 1128A of the Social Security Act (other than subsections
17 (a) and (b)) shall apply to civil money penalties under this
18 subsection in the same manner as they apply to a penalty
19 or proceeding under section 1128A(a) of such Act.

1 **Subtitle C—Qualified Health Plans**
2 **in the Large Employer Market-**
3 **place**

4 **PART I—REQUIREMENTS ON LARGE EMPLOYER**
5 **PLANS**

6 **SEC. 1201. STANDARDS APPLIED TO LARGE EMPLOYER**
7 **PLANS.**

8 Each large employer plan (as defined in section
9 1601(16)) shall meet the applicable standards developed
10 under section 1202.

11 **SEC. 1202. ESTABLISHMENT OF STANDARDS APPLICABLE**
12 **TO LARGE EMPLOYER PLANS.**

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

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services, in consultation with the Secretary
17 of Labor, shall develop and publish standards appli-
18 cable to large employer plans relating to the require-
19 ments described in paragraph (2). The Secretary
20 shall develop and publish such standards by not
21 later than the date that is 6 months after the date
22 of enactment of this Act. Such standards shall be
23 the insurance standards applicable under this part.

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

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

3 (A) Subsection (a) of section 1111 (relat-
4 ing to guaranteed eligibility), subject to sub-
5 sections (d) and (e) of such section, except that
6 such subsection shall be applied (for purposes
7 of this subsection) only with respect to eligible
8 employees of the large employer.

9 (B) Section 1112 (relating to non-
10 discrimination based on health status).

11 (C) Section 1113 (relating to benefits).

12 (D) Section 1115 (relating to enrollment)
13 or establish such comparable enrollment proce-
14 dures as the Secretary of Labor specifies, other
15 than the requirement for a general enrollment
16 period under subsection (a)(3) of such section.

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

19 (F) Section 1119 (relating to quality as-
20 surance).

21 (3) COLLECTIVE BARGAINING EXCEPTION.—

22 Paragraph (2)(A) shall not apply to a large em-
23 ployer plan that is providing benefits pursuant to a
24 collective bargaining agreement.

1 (4) REFERENCE TO ENFORCEMENT.—For pro-
2 vision enforcing requirements of this subsection, see
3 the amendments made by sections 2402, 2411, and
4 2412.

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

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

17 (2) REQUIREMENTS SPECIFIED.—Subject to
18 paragraph (3), the requirements referred to in para-
19 graph (1) are requirements specified in the following
20 provisions:

21 (A) Section 1114 (relating to financial sol-
22 vency) or such standards similar to the stand-
23 ards established under such section as the Sec-
24 retary of Labor specifies, except that such
25 standards shall be consistent with the applicable

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

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

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

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

9 (c) CONSIDERATION OF NAIC STANDARDS.—In es-
10 tablishing standards under this section, the Secretary of
11 Health and Human Services and the Secretary of Labor
12 shall take into account standards established under sub-
13 title B relating to comparable requirements.

14 (d) APPLICATION OF STANDARDS TO HEALTH PLANS
15 OFFERED UNDER FEHBP.—Notwithstanding any other
16 provision of law, each health plan offered under chapter
17 89 of title 5, United States Code, shall meet the standards
18 applicable to large employer plans under this subtitle, in
19 the same manner and as of the same date such standards
20 first apply to such plans.

21 **SEC. 1203. OFFER OF DIFFERENT BENEFIT PACKAGES RE-**
22 **QUIRED.**

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

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

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

5 (b) SELECTION OF PLANS BY MAJORITY OF EMPLOY-
6 EES.—

7 (1) IN GENERAL.—The large employer shall
8 make the selections of qualified large employer plans
9 under paragraphs (1) and (2) of subsection (a) on
10 an annual basis. In making each such selection, the
11 large employer shall comply with any selection of a
12 qualified large employer plan made by at least 50
13 percent of the eligible employees of the large em-
14 ployer. The Secretary of Labor shall prescribe rules
15 which shall govern the manner in which employees
16 may make such a selection. Nothing in this sub-
17 section shall be construed to require an employer to
18 make any financial contribution towards the cost of
19 such a qualified large employer plan or for such an
20 employer to refuse to offer such a plan for good
21 cause.

22 (2) LIMITATION.—Paragraph (1) shall not
23 apply in the case of a large employer that contrib-
24 utes to the cost of the qualified large employer plan.

1 (c) ENFORCEMENT.—For enforcement of the require-
2 ment of this section, see amendment made by section
3 2402(b) of this Act.

4 **SEC. 1204. ENROLLMENT IN LARGE EMPLOYER PLANS IN**
5 **SATISFACTION OF ENROLLMENT REQUIRE-**
6 **MENT.**

7 In the case of an individual who qualifies for coverage
8 under large employer plan (and is not eligible for coverage
9 under an equivalent health care program or under a quali-
10 fied health plan that is not a large employer plan), the
11 individual shall satisfy the requirement of section 1501
12 through enrollment in the large employer plan.

13 **SEC. 1205. DEVELOPMENT OF LARGE OR MULTIPLE EM-**
14 **PLOYER PURCHASING GROUPS.**

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

19 (b) NO USE OF INDIVIDUAL AND SMALL EMPLOYER
20 PURCHASING GROUPS.—A large employer shall be ineli-
21 gible to purchase health insurance through an individual
22 and small employer purchasing group.

23 **SEC. 1207. CORRECTIVE ACTIONS.**

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

1 requirements of this part are met. In any case in which
2 the plan sponsor determines that there is reason to believe
3 that there is or will be a failure to meet such requirements,
4 or the Secretary or the Secretary of Labor makes such
5 a determination and so notifies the plan sponsor, the plan
6 sponsor shall, within 90 days after making such deter-
7 mination or receiving such notification, notify such Sec-
8 retary (in such form and manner as such Secretary may
9 prescribe by regulation) of a description of the corrective
10 actions (if any) that the plan sponsor has taken or plans
11 to take in response to such recommendations. The plan
12 sponsor shall thereafter report to such Secretary, in such
13 form and frequency as such Secretary may specify to the
14 plan sponsor, regarding corrective action taken by the plan
15 sponsor until such requirements are met. Either such Sec-
16 retary may make a determination that a large employer
17 plan has ceased to be a qualified large employer plan only
18 if such Secretary is satisfied that the necessary corrective
19 action cannot reasonably be expected to occur on a timely
20 basis necessary to avoid failure to provide benefits for
21 which the plan is obligated.

22 (b) DISQUALIFIED OR TERMINATION OF PLAN.—

23 (1) IN GENERAL.—In any case in which the
24 plan sponsor of a large employer plan determines
25 that there is reason to believe that the plan will

1 cease to be a qualified large employer plan or will
2 terminate, the plan sponsor shall so inform the Sec-
3 retary and the Secretary of Labor, shall develop a
4 plan for winding up the affairs of the plan in con-
5 nection with such disqualification or termination in
6 a manner which will result in timely payment of all
7 benefits for which the plan is obligated, and shall
8 submit such plan in writing to such Secretaries. Ac-
9 tions required under this subparagraph shall be
10 taken in such form and manner as may be pre-
11 scribed in regulations jointly prescribed by such Sec-
12 retaries.

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

15 (A) IN GENERAL.—In any case in which—

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

23 (ii) such Secretary determines, in con-
24 sultation with the other Secretary referred
25 to in clause (i), that the continuing failure

1 to meet such requirements can be reason-
2 ably expected to result in a continuing fail-
3 ure to pay benefits for which the plan is
4 obligated,

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

8 (B) ACTIONS BY PLAN SPONSOR.—Upon a
9 determination by the Secretary or the Secretary
10 of Labor under subparagraph (A)(ii), the plan
11 sponsor shall, at the direction of such Sec-
12 retary, terminate the plan and, in the course of
13 the termination, take such actions as such Sec-
14 retary, in consultation with the other Secretary
15 referred to in subparagraph (A)(i), may require
16 as necessary to ensure that the affairs of the
17 plan will be, to the maximum extent possible,
18 wound up in a manner which will result in time-
19 ly payment of all benefits for which the plan is
20 obligated.

21 (C) ACTIONS BY LARGE EMPLOYER.—
22 Upon a determination by the Secretary or the
23 Secretary of Labor under subparagraph (A)(ii),
24 the large employer shall provide for such con-
25 tingency coverage for all eligible employees of

1 the employer in accordance with regulations
 2 which shall be prescribed in joint regulations of
 3 such Secretaries. Such regulations may provide
 4 for temporary coverage of such employees under
 5 a plan provided by a purchasing group in the
 6 appropriate HCCA, a plan provided under
 7 chapter 89 of title 5, United States Code, or
 8 other appropriate means established in such
 9 regulations.”.

10 **PART II—AMENDMENTS TO ERISA**

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

13 (a) IN GENERAL.—Section 4 of the Employee Retire-
 14 ment Income Security Act of 1974 (29 U.S.C. 1003) is
 15 amended—

16 (1) in subsection (a), by striking “subsection
 17 (b)” and inserting “subsections (b) and (c)”;

18 (2) in subsection (b), by striking “The provi-
 19 sions” and inserting “Except as provided in sub-
 20 section (c), the provisions”; and

21 (3) by adding at the end the following new sub-
 22 section:

23 “(c) COVERAGE OF GROUP HEALTH PLANS.—

24 “(1) LIMITED INCLUSION.—This title shall
 25 apply to a group health plan to the extent provided

1 in this subsection. For purposes of this title, a plan,
2 fund, or program shall not be treated as a group
3 health plan solely because an employer makes the
4 plan available (and takes related actions) in compli-
5 ance with the applicable requirements of section
6 1004 or section 1203 of the Health Equity and Ac-
7 cess Reform Today Act of 1993.

8 “(2) COVERAGE UNDER CERTAIN PROVISIONS
9 WITH RESPECT TO LARGE EMPLOYER PLANS.—

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

13 “(B) INAPPLICABILITY WITH RESPECT TO
14 INSURED QUALIFIED HEALTH PLANS.—Sub-
15 paragraph (A) shall not apply with respect to
16 any employee welfare benefit plan to the extent
17 such plan provides for health benefits under or
18 through a qualified insured health plan (as de-
19 fined in section 1601 of the Health Equity and
20 Access Reform Today Act of 1993).

21 “(3) CLAIMS PROCEDURES.—Section 503 shall
22 apply in the case of any large employer plan.

23 “(4) CIVIL ACTIONS BY PARTICIPANTS, BENE-
24 FICIARIES, AND FIDUCIARIES AND BY THE SEC-
25 RETARY.—Section 502 shall apply in the case of any

1 large employer plan and any other group health plan
2 for which the plan sponsor makes a contribution.

3 “(5) DEFINITIONS AND ENFORCEMENT PROVI-
4 SIONS.—Sections 3, 501, 504, 505, 506, 510, and
5 511 and the preceding provisions of this section
6 shall apply to a group health plan to the extent nec-
7 essary to effectively carry out, and enforce the re-
8 quirements under, the provisions of this title as they
9 apply pursuant to this subsection.

10 “(6) APPLICABILITY OF PREEMPTION RULES.—
11 Section 514 shall apply in the case of any group
12 health plan to the extent that parts 1 and 4 of sub-
13 title B apply to such plan under paragraph (2).”.

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

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

18 (A) in the heading for section 110, by add-
19 ing “BY PENSION PLANS” at the end;

20 (B) by redesignating section 111 as section
21 112; and

22 (C) by inserting after section 110 the fol-
23 lowing new section:

24 “SPECIAL RULES FOR GROUP HEALTH PLANS

25 “SEC. 111. IN GENERAL.—The Secretary may by
26 regulation provide special rules for the application of this

1 part to group health plans which are consistent with the
2 purposes of this title and the Health Equity and Access
3 Reform Today Act of 1993 and which take into account
4 the special needs of participants, beneficiaries, and health
5 care providers under such plans.

6 “(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—

7 Such special rules may include rules providing for—

8 “(1) reductions in the periods of time referred
9 to in this part,

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

12 “(3) such other changes in the provisions of
13 this part as may result in more expeditious reporting
14 and disclosure of plan terms and changes in such
15 terms to the Secretary and to plan participants and
16 beneficiaries,

17 to the extent that the Secretary determines that the rules
18 described in this subsection are necessary to ensure timely
19 reporting and disclosure of information consistent with the
20 purposes of this part and the Health Equity and Access
21 Reform Today Act of 1993 as they relate to group health
22 plans.

23 “(c) ADDITIONAL REQUIREMENTS.—Such special
24 rules may include rules providing for reporting and disclo-
25 sure to the Secretary and to participants and beneficiaries

1 of additional information or at additional times with re-
 2 spect to group health plans to which this part applies
 3 under section 4(c)(2), if such reporting and disclosure
 4 would be comparable to and consistent with similar re-
 5 quirements applicable under the Health Equity and Access
 6 Reform Today Act of 1993 with respect to small employer
 7 plans and applicable regulations of the Secretary of
 8 Health and Human Services prescribed thereunder.”.

9 (2) CLERICAL AMENDMENT.—The table of con-
 10 tents in section 1 of such Act is amended by striking
 11 the items relating to sections 110 and 111 and in-
 12 serting the following new items:

“Sec. 110. Alternative methods of compliance by pension plans.

“Sec. 111. Special rules for group health plans.

“Sec. 112. Repeal and effective date.”.

13 (c) TREATMENT OF MULTIPLE EMPLOYER WELFARE
 14 ARRANGEMENTS.—

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

20 “This paragraph shall not apply in the case of a group
 21 health plan.”.

22 (2) SPECIAL RULES FOR MULTIPLE EMPLOYER
 23 WELFARE ARRANGEMENT PROVIDING HEALTH BEN-
 24 EFITS.—

1 (A) IN GENERAL.—Subject to subpara-
2 graph (B), any multiple employer welfare ar-
3 rangement with respect to which there is in ef-
4 fect a certification by the Secretary of Labor
5 under this paragraph shall be treated for pur-
6 poses of this title as a large employer plan.

7 (B) REQUIREMENTS.—Subparagraph (A)
8 shall apply to a multiple employer welfare ar-
9 rangement only if—

10 (i) the benefits provided under the ar-
11 rangement consist solely of medical care
12 (as defined in section 213(d) of the Inter-
13 nal Revenue Code of 1986),

14 (ii) such arrangement meets the re-
15 quirements of clause (i) of section
16 514(b)(6)(A) of the Employee Retirement
17 Income Security Act of 1974 (as in effect
18 immediately before the amendment made
19 by paragraph (1)), and

20 (iii) the sponsoring entity is organized
21 and maintained in good faith, with a con-
22 stitution and bylaws specifically stating its
23 purpose, as a trade association, an indus-
24 try association, a professional association,
25 or a chamber of commerce or other busi-

1 ness group, for substantial purposes other
2 than that of obtaining or providing medical
3 care described in section 213(d) of the In-
4 ternal Revenue Code of 1986, and the ap-
5 plicant demonstrates to the satisfaction of
6 the Secretary that the sponsoring entity is
7 established as a permanent entity which
8 receives the active support of its members.

9 (C) RESTRICTION ON COMMENCEMENT OF
10 NEW ARRANGEMENTS.—A multiple employer
11 welfare arrangement providing benefits which
12 consist of medical care (as defined in section
13 213(d) of the Internal Revenue Code of 1986)
14 which has not commenced operations as of Jan-
15 uary 1, 1994, may commence operations only if
16 a certification of the arrangement under this
17 paragraph is in effect.

18 (D) CERTIFICATION PROCEDURE.—The
19 Secretary of Labor shall certify a multiple em-
20 ployer welfare arrangement under this para-
21 graph if—

22 (i) an application for such certifi-
23 cation with respect to such arrangement,
24 identified individually or by class, has been
25 duly filed in complete form with the Sec-

1 retary of Labor in accordance with this
2 paragraph,

3 (ii) such application demonstrates
4 compliance with the requirements of sec-
5 tion 1202, and

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

8 (I) administratively feasible,

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

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

15 In the case of an arrangement which has com-
16 menced operations as of January 1, 1994, an
17 application under this paragraph must be filed
18 not later than January 1, 1996.

19 (E) DESIGNATION OF PLAN SPONSOR.—
20 The Secretary of Labor shall provide by regula-
21 tion for designation of the entities to be treated
22 as the plan sponsor.

23 (F) REVOCATION OF CERTIFICATION.—
24 The Secretary of Labor may revoke a certifi-
25 cation under this paragraph for any cause that

1 may serve as the basis for the denial of an ini-
2 tial application for such a certification under
3 this paragraph.

4 (G) REVIEW OF ACTIONS BY SECRETARY
5 OF LABOR.—Any decision by the Secretary of
6 Labor which involves the denial of an applica-
7 tion by a multiple employee welfare arrange-
8 ment for certification under this paragraph or
9 the revocation of such a certification shall con-
10 tain a statement of the specific reason or rea-
11 sons supporting the Secretary's action, includ-
12 ing reference to the specific terms of the certifi-
13 cation and the statutory provision or provisions
14 relevant to the determination. Any such denial
15 or revocation shall be subject to review as pro-
16 vided in section 502 of the Employee Retire-
17 ment Income Security Act of 1974.

18 **PART III—REVISION OF COBRA CONTINUATION**

19 **COVERAGE REQUIREMENTS**

20 **SEC. 1231. AMENDMENTS TO THE EMPLOYEE RETIREMENT**

21 **INCOME SECURITY ACT OF 1974.**

22 (A) PERIOD OF COVERAGE.—Subparagraph (D) of
23 section 602(2) of the Employee Retirement Income Secu-
24 rity Act of 1974 (29 U.S.C. 1161(2)) is amended—

1 (1) by striking “or” at the end of clause (i), by
2 striking the period at the end of clause (ii) and in-
3 sserting “, or”, and by adding at the end the follow-
4 ing new clause:

5 “(iii) eligible for coverage under a
6 qualified health plan in accordance with
7 title I of the Health Equity and Access Re-
8 form Today Act of 1993.”, and

9 (2) by striking “OR MEDICARE ENTITLEMENT”
10 in the heading and inserting “, MEDICARE ENTITL-
11 EMENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY”.

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

15 “(D) SPECIAL RULE FOR INDIVIDUALS
16 COVERED BY HEALTH EQUITY AND ACCESS RE-
17 FORM TODAY ACT OF 1993.—The term ‘qualified
18 beneficiary’ shall not include any individual
19 who, upon termination of coverage under a
20 group health plan, is eligible for coverage under
21 a qualified health plan in accordance with title
22 I of the Health Equity and Access Reform
23 Today Act of 1993.”

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

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

5 (2) CONFORMING AMENDMENTS.—

6 (A) Section 502(a)(7) of such Act (29
7 U.S.C. 1132(a)(7)) is amended by striking
8 “609(a)(2)(A)” and inserting “601(a)(2)(A)”.

9 (B) Section 502(c)(1) is amended by strik-
10 ing “paragraph (1) or (4) of section 606”.

11 (C) Section 514 of such Act (29 U.S.C.
12 1144) is amended by striking “609” each place
13 it appears in subsections (b)(7) and (b)(8) and
14 inserting “601”.

15 (D) The table of contents in section 1 of
16 such Act is amended by striking the items relat-
17 ing to sections 601 through 609 and inserting
18 the following new item:

“Sec. 601. Additional standards for group health plans.”

19 (d) EFFECTIVE DATE.—

20 (1) SUBSECTIONS (a) AND (b).—The amend-
21 ments made by subsections (a) and (b) shall take ef-
22 fect on the date of the enactment of this Act.

23 (2) SUBSECTION (c).—The amendments made
24 by subsection (c) shall take effect on the first Janu-

1 ary 1 following the deadline specified in section
2 1401(c)(2) of this Act.

3 **SEC. 1232. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.**

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

7 (1) by striking “or” at the end of clause (i), by
8 striking the period at the end of clause (ii) and in-
9 serting “, or”, and by adding at the end the follow-
10 ing new clause:

11 “(iii) eligible for coverage under a
12 qualified health plan in accordance with
13 title I of the Health Equity and Access Re-
14 form Today Act of 1993,” and

15 (2) by striking “OR MEDICARE ENTITLEMENT”
16 in the heading and inserting “, MEDICARE ENTITLE-
17 MENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY”.

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

21 “(C) SPECIAL RULE FOR INDIVIDUALS
22 COVERED BY THE HEALTH EQUITY AND ACCESS
23 REFORM TODAY ACT OF 1993.—The term ‘quali-
24 fied beneficiary’ shall not include any individual
25 who, upon termination of coverage under a

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

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

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

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

12 (d) EFFECTIVE DATE.—

13 (1) SUBSECTIONS (a) AND (b).—The amend-
14 ments made by subsections (a) and (b) shall take ef-
15 fect on the date of the enactment of this Act.

16 (2) SUBSECTION (c).—The amendments made
17 by subsection (c) shall take effect on the first Janu-
18 ary 1 following the deadline specified in section
19 1401(c)(2) of this Act.

20 **SEC. 1233. ADDITIONAL REVISIONS.**

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

1 **Subtitle D—Benefits; Benefits**
2 **Commission**

3 **PART I—BENEFITS**

4 **SEC. 1301. OFFERING OF BENEFIT PACKAGES.**

5 (a) **BENEFIT PACKAGES.**—Each qualified health plan
6 shall provide one (or both) of the following benefit pack-
7 ages:

8 (1) **STANDARD PACKAGE.**—The standard pack-
9 age consists of the covered items and services speci-
10 fied under subsection (b), subject to the applicable
11 cost sharing requirement specified under subsection
12 (c)(1) for such a package.

13 (2) **CATASTROPHIC PACKAGE.**—The cata-
14 strophic package consists of the covered items and
15 services (specified under subsection (b)), subject to
16 the applicable cost sharing requirement specified
17 under subsection (c)(2) for such a package.

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

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

25 (2) Medical equipment.

1 (3) Prescription drugs and biologicals.

2 (4) Preventive services.

3 (5) Rehabilitation and home health services re-
4 lated to an acute care episode.

5 (6) Services for severe mental illness.

6 (7) Substance abuse services.

7 (8) Hospice services.

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

11 (c) COST SHARING.—

12 (1) STANDARD PACKAGE.—The standard pack-
13 age shall include deductibles, copayments, coinsur-
14 ance, and out-of-pocket limits on cost sharing estab-
15 lished for such package pursuant to part II.

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

23 (3) LIMITATION.—In establishing cost sharing
24 requirements under part II, the Commission shall
25 establish a limit on the total amount of cost-sharing

1 that may be incurred by a family within a class of
2 family enrollment in a year.

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

5 (1) IN GENERAL.—A qualified health plan shall
6 provide for coverage of the items and services de-
7 scribed in subsection (b) only for treatments and di-
8 agnostic procedures that are medically necessary or
9 appropriate. In the case of dispute concerning a de-
10 termination of medical necessity or appropriateness
11 and subject to the succeeding provisions of this sub-
12 section, for purposes of this title, a treatment (as de-
13 fined in subparagraph (6)(A)) or diagnostic proce-
14 dure shall be considered to be “medically necessary
15 or appropriate” if the following criteria are met:

16 (A) TREATMENT OR DIAGNOSIS OF MEDI-
17 CAL CONDITION.—

18 (i) IN GENERAL.—The treatment or
19 diagnostic procedure is for a medical con-
20 dition.

21 (ii) MEDICAL CONDITION DEFINED.—
22 The term “medial condition” means a dis-
23 ease, illness, injury, or biological or psycho-
24 logical condition or status for which treat-
25 ment is indicated to improve, maintain, or

1 stabilize a health outcome (as defined in
2 paragraph (6)(B)) or which, in the absence
3 of treatment, could lead to an adverse
4 change in a health outcome.

5 (iii) ADVERSE CHANGE IN HEALTH
6 OUTCOME DEFINED.—In clause (ii), an ad-
7 verse change in a health outcome occurs if
8 there is a biological or psychological
9 decremental change in a health status.

10 (B) NOT INVESTIGATIONAL.—There must
11 be sufficient evidence on which to base conclu-
12 sions about the existence and magnitude of the
13 change in health outcome resulting from the
14 treatment or diagnostic procedure compared
15 with the best available alternative (or with no
16 treatment or diagnostic procedure if no alter-
17 native treatment or procedure is available).

18 (C) EFFECTIVE AND SAFE.—The evidence
19 must demonstrate that the treatment or diag-
20 nostic procedure can reasonably be expected to
21 produce the intended health result or provide
22 intended information and is safe and the treat-
23 ment or diagnostic procedure provides a clini-
24 cally meaningful benefit with respect to safety
25 and effectiveness in comparison to other avail-

1 able alternatives or the patients current health
2 status.

3 (2) RELATIONSHIP TO FDA REVIEW.—

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

6 (i) DRUGS.—A drug that has been
7 found to be safe and effective under sec-
8 tion 505 of the Federal Food, Drug, and
9 Cosmetic Act is deemed to meet the re-
10 quirements of paragraphs (1)(B) and
11 (1)(C) (relating to not investigational and
12 safety and effectiveness.)

13 (ii) BIOLOGICALS.—A biological that
14 has been found to be safe and effective
15 under section 351 of the Public Health
16 Service Act is deemed to meet the require-
17 ments of paragraphs (1)(B) and (1)(C)
18 (relating to not investigational and safety
19 and effectiveness).

20 (iii) MEDICAL DEVICES.—A medical
21 device that is marketed after the provision
22 of a notice under section 510(k) of the
23 Federal Food, Drug, and Cosmetic Act or
24 that has an application for premarket ap-
25 proval approved under section 515 of such

1 Act is deemed to meet the requirements of
2 paragraphs (1)(B) and (1)(C) (relating to
3 not investigational and safety and effec-
4 tiveness).

5 (B) OTHER DRUGS, BIOLOGICALS, AND DE-
6 VICES.—A drug, biological, or medical device
7 not described in subparagraph (A) shall be con-
8 sidered to be investigational. Nothing shall pro-
9 hibit a qualified health plan from covering (nor
10 as compelling such a plan to cover) such drugs,
11 biologicals, and medical devices, including treat-
12 ment investigational new drugs.

13 (3) COVERAGE OF INVESTIGATIONAL TREAT-
14 MENTS IN APPROVED RESEARCH TRIALS.—

15 (A) IN GENERAL.—Coverage of the routine
16 medial costs (as defined in subparagraph (C))
17 associated with the delivery of investigational
18 treatments (as defined in subparagraph (B))
19 shall be considered to be medically necessary or
20 appropriate only if the treatment is part of an
21 approved research trial (as defined in subpara-
22 graph (D)).

23 (B) INVESTIGATIONAL TREATMENT DE-
24 FINED.—In subparagraph (A), the term “inves-
25 tigational treatment” means a treatment for

1 which there is not sufficient evidence to deter-
2 mine the health outcome of the treatment com-
3 pared with the best available alternative treat-
4 ment (or with no treatment if there is no alter-
5 native treatment).

6 (C) ROUTINE MEDICAL COSTS DEFINED.—

7 In subparagraph (A), the term “routine medical
8 costs” means the cost of health services re-
9 quired to provide treatment according to the de-
10 sign of the trial, except those costs normally
11 paid for by other funding sources (as defined by
12 the Secretary). Such costs do not include the
13 cost of the investigational agent, devices or pro-
14 cedures themselves, the costs of any nonhealth
15 services that might be required for a person to
16 receive the treatment, or the costs of managing
17 the research.

18 (D) APPROVED RESEARCH TRIAL DE-

19 FINED.—In subparagraph (A), the term “ap-
20 proved research trial” means a trial—

21 (i) conducted for the primary purpose
22 of determining the safety, effectiveness, ef-
23 ficacy, or health outcomes of a treatment,
24 compared with the best available alter-
25 native treatment, and

1 (ii) approved by the Secretary.

2 A trial is deemed to be approved under clause
3 (ii) if it is approved by the National Institutes
4 of Health, the Food and Drug Administration
5 (through an investigational new drug exemp-
6 tion), the Department of Veterans Affairs, the
7 Department of Defense, or by a qualified non-
8 governmental research entity (as identified in
9 guidelines issued by one or more of the Na-
10 tional Institutes of Health).

11 (4) DOCUMENTATION.—

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

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

22 (5) BINDING ARBITRATION EVIDENCE.—The
23 evidence that may be used in making coverage deci-
24 sions under a binding arbitration process under this
25 section and section 1407 includes—

1 (A) published peer-reviewed literature,

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

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

6 (6) TREATMENT AND HEALTH OUTCOME DE-
7 FINED.—As used in this subsection:

8 (A) IN GENERAL.—The term “treatment”
9 means any health care intervention undertaken,
10 with respect to a specific indication, to improve,
11 maintain, or stabilize a health outcome or to
12 prevent or mitigate an adverse change in a
13 health outcome.

14 (B) HEALTH OUTCOME.—The term
15 “health outcome” means an outcome that af-
16 fects the length and quality of an enrollee’s life.

17 (e) APPLICATION IN BINDING ARBITRATION PROC-
18 ESS.—The criteria specified in subsection (d) shall be ap-
19 plied by arbitrators under the binding arbitration process
20 for disputes described in paragraphs (1)(C) and (2) of sec-
21 tion 1407.

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

1 **PART II—BENEFITS COMMISSION**

2 **SEC. 1311. ESTABLISHMENT.**

3 There is established a commission to be known as the
4 Benefits Commission (in this part referred to as the
5 “Commission”).

6 **SEC. 1312. DUTIES.**

7 (a) INITIAL PROPOSAL.—Not later than the termi-
8 nation of the 6-month period beginning on the date of the
9 enactment of this Act, the Commission shall develop and
10 submit to the Congress a proposal for legislation that in-
11 cludes the following:

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

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

19 (B) may not specify the categories of
20 health care providers who are authorized to de-
21 liver items or services;

22 (C) with respect to covered items and serv-
23 ices, may not specify (in this Act or by regula-
24 tions) particular procedures or treatments, or
25 classes thereof;

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

5 (E) with respect to section 1301(b)(9),
6 shall, after consultation with the Federal Avia-
7 tion Administration, provide for maximum flexi-
8 bility to air ambulance services, consistent with
9 basic public safety requirements, in order to
10 avoid an adverse change in health outcomes
11 (within the meaning of section 1301(d)(1)(A))
12 for persons using such services.

13 (2) SPECIFICATION OF COST SHARING.—A spec-
14 ification of the precise deductibles, copayments, coin-
15 insurance, and out-of-pocket limits on cost sharing
16 that are to apply to the standard package and the
17 catastrophic package under section 1301(c). Such
18 specification—

19 (A) shall establish multiple cost sharing
20 schedules that vary depending on the delivery
21 system by which health care is delivered to indi-
22 viduals enrolled in a qualified health plan; and

23 (B) shall provide that the general deduct-
24 ible amount described in section 1301(c)(2) is

1 greater than any general deductible amount ap-
2 plicable to the standard package.

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

6 (4) NO ADDITION OF BENEFITS.—A clarifica-
7 tion under this subsection may not add a new cat-
8 egory of items or services.

9 (b) RESUBMISSION OF INITIAL PROPOSAL.—If the
10 proposal described in subsection (a) is not approved by
11 the Congress, the Commission shall submit to the Con-
12 gress a second proposal conforming to the requirements
13 of subsection (a) not later than the termination of the 6-
14 month period beginning on the date an approval resolution
15 with respect to the first proposal is subject to a vote on
16 final passage in the last House to consider the resolution
17 under section 1314. If such second proposal is not ap-
18 proved, the Commission shall submit to the Congress a
19 third proposal in accordance with the procedure described
20 in the preceding sentence. If such third proposal is not
21 approved by the Congress, the members of the Commis-
22 sion shall vacate their positions, and new members shall
23 be appointed under section 1313 to fill such vacancies.
24 Such new members shall submit to the Congress not more
25 than three proposals conforming to the requirements of

1 subsection (a) in accordance with the procedure described
2 in this subsection.

3 (c) PROPOSED MODIFICATIONS.—

4 (1) IN GENERAL.—Not earlier than January 1
5 of the year that occurs 1 year after a legislative pro-
6 posal described in subsection (a) or (b) is enacted,
7 and not more frequently than annually, the Commis-
8 sion may submit to the Congress a proposal for leg-
9 islation containing recommended modifications to
10 such enactment. Such a proposal shall be treated as
11 an initial proposal under subsection (a) for purposes
12 of consideration in the Congress under section 1314
13 and implementation under section 1315. Subsection
14 (a)(4) shall not apply to such a proposal.

15 (2) SUBMISSION OF PROPOSAL IF DEFICIT.—If
16 the Commission receives a report concerning a defi-
17 cit under section 1003(d)(5)(A) for a year, within 60
18 days after receiving such report, the Commission
19 may submit under paragraph (1) a proposal to make
20 modifications (which may only include modifications
21 described in paragraph (3)) that will result in the
22 sum of—

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

1 (B) the amount of the increase in Federal
2 revenues,
3 for the next fiscal year being equal to the aggregate
4 amount of such deficit. The Commission shall sub-
5 mit such a proposal in the case of any year after the
6 full phase-in year (as defined in section
7 1003(d)(5)(B)(iii)).

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

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

12 (B) a reduction in the applicable phase-in
13 percentage (specified in the table under section
14 1003(b)(2));

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

18 (D) a reduction in the applicable dollar
19 limit determined under section 91(b)(2) of the
20 Internal Revenue Code of 1986, based on fam-
21 ily income.

22 **SEC. 1313. OPERATION OF THE COMMISSION.**

23 (a) MEMBERSHIP.—

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

1 (2) CONSULTATION.—In selecting individuals
2 for nominations for appointments for the Commis-
3 sion, the President should consult with—

4 (A) the Speaker of the House of Rep-
5 resentatives concerning the appointment of 1
6 member;

7 (B) the Majority Leader of the Senate con-
8 cerning the appointment of 1 member;

9 (C) the Minority Leader of the House of
10 Representatives concerning the appointment of
11 1 member; and

12 (D) the Minority Leader of the Senate con-
13 cerning the appointment of 1 member.

14 (3) CHAIRPERSON.—The President shall des-
15 ignate 1 individual described in paragraph (1) who
16 shall serve as Chairperson of the Commission.

17 (b) COMPOSITION.—The membership of the Commis-
18 sion shall include individuals with national recognition for
19 their expertise in health economics, hospital and health
20 plan management, health services, medical research and
21 effectiveness, and other related fields, who provide a mix
22 of different professions, broad geographic representation,
23 and a balance between urban and rural representatives,
24 including physicians and other providers of health care
25 services, employers, third party payors, individuals skilled

1 in the conduct and interpretation of biomedical, health
2 services, and health economics research, and individuals
3 having expertise in the research and development of tech-
4 nological and scientific advances in health care.

5 (c) TERMS.—The terms of members of the Commis-
6 sion shall be for 3 years, except that of the members first
7 appointed 2 shall be appointed for a term of 1 year and
8 2 shall be appointed for a term of 2 years.

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

14 (e) ADMINISTRATIVE PROVISIONS.—

15 (1) MEETINGS.—Each meeting of the Commis-
16 sion shall be open to the public.

17 (2) PAY AND TRAVEL EXPENSES.—

18 (A) IN GENERAL.—Each member, other
19 than the chairperson of the Commission, shall
20 be paid at a rate equal to the daily equivalent
21 of the minimum annual rate of basic pay pay-
22 able for level IV of the Executive Schedule
23 under section 5315 of title 5, United States
24 Code, for each day (including travel time) dur-
25 ing which the member is engaged in the actual

1 performance of duties vested in the Commis-
2 sion.

3 (B) CHAIRPERSON.—The chairperson of
4 the Commission shall be paid for each day re-
5 ferred to in subparagraph (A) at a rate equal
6 to the daily equivalent of the minimum annual
7 rate of basic pay payable for level III of the Ex-
8 ecutive Schedule under section 5314 of title 5,
9 United States Code.

10 (C) TRAVEL EXPENSES.—Members shall
11 receive travel expenses, including per diem in
12 lieu of subsistence, in accordance with sections
13 5702 and 5703 of title 5, United States Code.

14 (3) DIRECTOR OF STAFF.—

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

18 (B) PAY.—The Director shall be paid at
19 the rate of basic pay payable for level IV of the
20 Executive Schedule under section 5315 of title
21 5, United States Code.

22 (4) STAFF.—

23 (A) IN GENERAL.—Subject to subpara-
24 graphs (B) and (C), the Director, with the ap-

1 proval of the Commission, may appoint and fix
2 the pay of additional personnel.

3 (B) PAY.—The Director may make such
4 appointments without regard to the provisions
5 of title 5, United States Code, governing ap-
6 pointments in the competitive service, and any
7 personnel so appointed may be paid without re-
8 gard to the provisions of chapter 51 and sub-
9 chapter III of chapter 53 of such title, relating
10 to classification and General Schedule pay
11 rates, except that an individual so appointed
12 may not receive pay in excess of 120 percent of
13 the annual rate of basic pay payable for GS-15
14 of the General Schedule.

15 (C) DETAILED PERSONNEL.—

16 (i) IN GENERAL.—Upon request of
17 the Director, the head of any Federal de-
18 partment or agency may detail any of the
19 personnel of that department or agency to
20 the Commission to assist the Commission
21 in carrying out its duties under this Act.

22 (ii) AGREEMENT WITH COMPTROLLER
23 GENERAL.—The Comptroller General of
24 the United States shall provide assistance,
25 including the detailing of employees, to the

1 Commission in accordance with an agree-
2 ment entered into with the Commission.

3 (5) OTHER AUTHORITY.—

4 (A) CONTRACT SERVICES.—The Commis-
5 sion may procure by contract, to the extent
6 funds are available, the temporary or intermit-
7 tent services of experts or consultants pursuant
8 to section 3109 of title 5, United States Code.

9 (B) LEASES AND PROPERTY.—The Com-
10 mission may lease space and acquire personal
11 property to the extent funds are available.

12 **SEC. 1314. CONGRESSIONAL CONSIDERATION OF COMMIS-**
13 **SION PROPOSALS.**

14 (a) CONSIDERATION.—A legislative proposal submit-
15 ted to the Congress by the Commission (except in the case
16 of a proposal submitted pursuant to the second sentence
17 of section 1003(d)(5)(A)) shall be considered by the Con-
18 gress under the procedures described in this section.

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

21 (1) as an exercise of the rulemaking power of
22 the House of Representatives and the Senate, re-
23 spectively, and as such is deemed a part of the rules
24 of each House, respectively, but applicable only with
25 respect to the procedure to be followed in that

1 House in the case of approval resolutions described
2 in subsection (c), and supersedes other rules only to
3 the extent that such rules are inconsistent therewith;
4 and

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

10 (c) TERMS OF THE RESOLUTION.—For purposes of
11 this part, the term “approval resolution” means only a
12 joint resolution of the two Houses of the Congress, provid-
13 ing in—

14 (1) the matter after the resolving clause of
15 which is as follows: “That the Congress approves the
16 recommendations of the Benefits Commission as
17 submitted by the Commission on
18 _____”, the blank space
19 being filled in with the appropriate date; and

20 (2) the title of which is as follows: “Joint Reso-
21 lution approving the recommendation of the Benefits
22 Commission”.

23 (d) INTRODUCTION AND REFERRAL.—On the day on
24 which a recommendation of the Commission is transmitted
25 to the House of Representatives and the Senate, an ap-

1 proval resolution with respect to such recommendation
2 shall be introduced (by request) in the House of Rep-
3 resentatives by the majority leader of the House, for him-
4 self or herself and the minority leader of the House, or
5 by Members of the House designated by the majority lead-
6 er and minority leader of the House; and shall be intro-
7 duced (by request) in the Senate by the majority leader
8 of the Senate, for himself or herself and the minority lead-
9 er of the Senate, or by Members of the Senate designated
10 by the majority leader and minority leader of the Senate.
11 If either House is not in session on the day on which such
12 recommendation is transmitted, the approval resolution
13 with respect to such recommendation shall be introduced
14 in the House, as provided in the preceding sentence, on
15 the first day thereafter on which the House is in session.
16 The approval resolution introduced in the House of Rep-
17 resentatives and the Senate shall be referred to the appro-
18 priate committees of each House.

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

1 suspend the application of this subsection by unanimous
2 consent.

3 (f) PERIOD FOR COMMITTEE AND FLOOR CONSIDER-
4 ATION.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (2), if the committee or committees of either
7 House to which an approval resolution has been re-
8 ferred have not reported it at the close of the 30th
9 day after its introduction, such committee or com-
10 mittees shall be automatically discharged from fur-
11 ther consideration of the approval resolution and it
12 shall be placed on the appropriation calendar. A vote
13 on final passage of the approval resolution shall be
14 taken in each House on or before the close of the
15 30th day after the approval resolution is reported by
16 the committees or committee of that House to which
17 it was referred, or after such committee or commit-
18 tees have been discharged from further consideration
19 of the approval resolution. If prior to the passage by
20 one House of an approval resolution of that House,
21 that House receives the same approval resolution
22 from the other House then—

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

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

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

7 (g) FLOOR CONSIDERATION IN THE HOUSE OF REP-
8 RESENTATIVES.—

9 (1) MOTION TO PROCEED.—A motion in the
10 House of Representatives to proceed to the consider-
11 ation of an approval resolution shall be highly privi-
12 leged and not debatable. An amendment to the mo-
13 tion shall not be in order, nor shall it be in order
14 to move to reconsider the vote by which the motion
15 is agreed to or disagreed to.

16 (2) DEBATE.—Debate in the House of Rep-
17 resentatives on an approval resolution shall be lim-
18 ited to not more than 20 hours, which shall be di-
19 vided equally between those favoring and those op-
20 posing the bill or resolution. A motion further to
21 limit debate shall not be debatable. It shall not be
22 in order to move to recommit an approval resolution
23 or to move to reconsider the vote by which an ap-
24 proval resolution is agreed to or disagreed to.

1 (3) MOTION TO POSTPONE.—Motions to post-
2 pone, made in the House of Representatives with re-
3 spect to the consideration of an approval resolution,
4 and motions to proceed to the consideration of other
5 business, shall be decided without debate.

6 (4) APPEALS.—All appeals from the decisions
7 of the chairperson relating to the application of the
8 Rules of the House of Representatives to the proce-
9 dure relating to an approval resolution shall be de-
10 ecided without debate.

11 (5) GENERAL RULES APPLY.—Except to the ex-
12 tent specifically provided in the preceding provisions
13 of this subsection, consideration of an approval reso-
14 lution shall be governed by the Rules of the House
15 of Representatives applicable to other bills and reso-
16 lutions in similar circumstances.

17 (h) FLOOR CONSIDERATION IN THE SENATE.—

18 (1) MOTION TO PROCEED.—A motion in the
19 Senate to proceed to the consideration of an ap-
20 proval resolution shall be privileged and not debat-
21 able. An amendment to the motion shall not be in
22 order, nor shall it be in order to move to reconsider
23 the vote by which the motion is agreed to or dis-
24 agreed to.

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

7 (3) DEBATE OF MOTIONS AND APPEALS.—De-
8 bate in the Senate on any debatable motion or ap-
9 peal in connection with an approval resolution shall
10 be limited to not more than 1 hour, to be equally di-
11 vided between, and controlled by, the mover and the
12 manager of the approval resolution, except that in
13 the event the manager of the approval resolution is
14 in favor of any such motion or appeal, the time in
15 opposition thereto, shall be controlled by the Minor-
16 ity Leader or his designee. Such leaders, or either of
17 them, may, from time under their control on the
18 passage of an approval resolution, allot additional
19 time to any Senator during the consideration of any
20 debatable motion or appeal.

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

1 **SEC. 1315. IMPLEMENTATION.**

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

10 **Subtitle E—State and Federal Re-**
11 **sponsibilities in Relation to**
12 **Qualified Health Plans**

13 **PART I—STATE RESPONSIBILITIES**

14 **SEC. 1401. ESTABLISHMENT OF STATE INSURANCE MARKET**
15 **REFORM PROGRAMS.**

16 (a) **IN GENERAL.**—Each State shall establish a pro-
17 gram (in this part referred to as a “State program”) to
18 carry out State responsibilities specified in this part.

19 (b) **SUMMARY OF RESPONSIBILITIES.**—The State re-
20 sponsibilities under this subtitle include—

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

25 (2) dissemination of information under section
26 1403;

1 (3) establishment of procedures for establish-
2 ment and operation of purchasing groups under sec-
3 tion 1404;

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

6 (5) providing for a risk adjustment program
7 and adjustment for differences in nonpayments
8 among qualified insured health plans under section
9 1406;

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

12 (7) specification of an annual general enroll-
13 ment period under section 1408.

14 (c) DEADLINE.—

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

18 (2) DEADLINE.—The deadline specified in this
19 paragraph is the date that occurs 1 year after the
20 date of the insurance reform standards are estab-
21 lished under section 1102.

22 (d) PERIODIC SECRETARIAL REVIEW OF STATE PRO-
23 GRAMS.—

24 (1) IN GENERAL.—The Secretary may periodi-
25 cally review State programs established under sub-

1 section (a) to determine if such programs continue
2 to meet the requirements of subsection (b).

3 (2) REPORTING REQUIREMENTS OF STATES.—
4 For purposes of paragraph (1), each State shall sub-
5 mit to the Secretary, at intervals established by the
6 Secretary, a report on the compliance of the State
7 with the requirements of subsection (b).

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

17 **SEC. 1402. CERTIFICATION OF INSURED HEALTH PLANS.**

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

22 **SEC. 1403. ESTABLISHMENT OF HEALTH CARE COVERAGE**
23 **AREAS.**

24 (a) ESTABLISHMENT.—Each State program shall
25 provide, by not later than the deadline specified in section

1 1401(c)(2), for the division of the State into 1 or more
2 health care coverage areas or HCCAs. The program may
3 revise the boundaries of such areas from time to time con-
4 sistent with this section.

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

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

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

11 (3) no area incorporated in a HCCA may be in-
12 corporated into another HCCA.

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

18 **SEC. 1404. PROCEDURES FOR PURCHASING GROUPS.**

19 (a) PROCEDURES.—Consistent with part II of sub-
20 title B, each State program shall have procedures for the
21 establishment and operation of individual and small em-
22 ployer purchasing groups with respect to HCCAs within
23 such State.

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

1 **SEC. 1405. PREPARATION OF INFORMATION CONCERNING**
2 **PLANS AND PURCHASING GROUPS.**

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

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

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

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

17 (4) Any other information determined appro-
18 priate by the State.

19 **SEC. 1406. RISK ADJUSTMENT PROGRAM.**

20 (a) IN GENERAL.—Each State program under this
21 part shall provide for a risk adjustment program using
22 the risk adjustment process and factors described in sec-
23 tion 1117(b) to adjust the premiums of qualified general
24 access plans to reflect the relative actuarial risk of eligible
25 employees and eligible individuals enrolled in the qualified
26 general access plans participating in the program. The

1 program shall apply such risk-adjustment factors, in ac-
2 cordance with a methodology established under the stand-
3 ards under such section, so that the sum of such factors
4 is zero for all participating qualified general access plans,
5 within a class of family enrollment in each HCCA.

6 (b) ADJUSTMENT FOR DIFFERENCES IN
7 NONPAYMENT RATES.—In accordance with rules estab-
8 lished by the Secretary, each State program under this
9 part shall provide that if the rates of nonpayment of pre-
10 miums for qualified general access plans during grace pe-
11 riods (established under section 1142(b)(2) or otherwise)
12 vary appreciably among qualified general access plans, the
13 State program shall provide for such adjustments in the
14 payments made among such plans as will place each quali-
15 fied general access plan in the same position as if the rates
16 of nonpayment were the same.

17 **SEC. 1407. DEVELOPMENT OF BINDING ARBITRATION**
18 **PROCESS.**

19 Each State program shall establish an arbitration
20 process that—

21 (1) resolves in a timely manner disputes con-
22 cerning—

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

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

4 (C) decisions by a plan relating to the cov-
5 erage of a particular item or service for enroll-
6 ees generally; and

7 (2) with respect to disputes involving a deter-
8 mination by a plan that an item or service is not
9 medically necessary or appropriate with respect to a
10 specific enrollee, requires a person who contests such
11 determination to demonstrate to an arbitrator by a
12 preponderance of the evidence that the determina-
13 tion is inappropriate based on the available scientific
14 evidence.

15 **SEC. 1408. SPECIFICATION OF ANNUAL GENERAL ENROLL-**
16 **MENT PERIOD.**

17 Each State program shall specify an annual period,
18 of not less than 30 days, during which eligible employees
19 and eligible individuals in the State may enroll in qualified
20 insured health plans or change the qualified insured health
21 plan in which the individual is enrolled.

22 **Subpart B—Waiver of Requirements**

23 **SEC. 1421. ALTERNATE STATE SYSTEMS ALLOWED.**

24 (a) WAIVER AUTHORITY.—

1 (1) IN GENERAL.—In accordance with this sec-
2 tion, each State may submit an application to the
3 Secretary to waive the requirements specified in sub-
4 section (b) as they apply to the State (and to quali-
5 fied insured health plans and purchasing groups in
6 the State).

7 (2) ESTABLISHMENT OF CRITERIA.—The Sec-
8 retary shall establish criteria for the approval of
9 such waiver applications.

10 (3) EXPEDITED PROCEDURE.—The Secretary
11 shall establish an expedited procedure for the consid-
12 eration and disposition of waiver applications under
13 this subsection. The procedure established by the
14 Secretary shall provide that such consideration and
15 disposition shall be completed within 90 days.

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

18 (1) AVAILABILITY.—The requirements of sec-
19 tion 1111(c) (relating to availability of qualified
20 health plans).

21 (2) MSA BOUNDARIES.—Subject to subsection
22 (c)(1), the requirements of paragraphs (1) and (3)
23 of section 1403(b) (relating to the treatment of met-
24 ropolitan statistical areas in drawing the boundaries
25 of HCCAs).

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

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

10 (c) LIMITATIONS ON WAIVERS.—

11 (1) ANTI-REDLINING.—In establishing bound-
12 aries for HCCAs, a State may not discriminate on
13 the basis of or otherwise take into account race, reli-
14 gion, national origin, socio-economic status, disabil-
15 ity, or perceived health status.

16 (2) SUBSTITUTION OF ACTUARIALLY EQUIVA-
17 LENT BENEFITS.—A State may not waive the re-
18 quirement described in subsection (b)(4) unless the
19 State provides for the inclusion of benefits that are
20 actuarially equivalent to the benefits not included.

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

1 **SEC. 1422. STATE OPT-OUT.**

2 Any State that applies to the Secretary and dem-
3 onstrates to the satisfaction of the Secretary that, because
4 of unique geographic and related features that inhibit a
5 competitive market, no more than two qualified general
6 access plans are made available in the State, the Secretary
7 may waive such requirements of this title as may be nec-
8 essary to assure the provision of covered items and serv-
9 ices to all eligible employees and eligible individuals.

10 **SEC. 1423. WAIVER OF CERTAIN MEDICAID REQUIREMENTS.**

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

14 **Subpart C—Preemption of Certain State Laws**

15 **SEC. 1431. PREEMPTION FROM STATE BENEFIT MANDATES.**

16 Effective as of January 1, 1995, no State shall estab-
17 lish or enforce any law or regulation that—

18 (1) requires the offering, as part of a qualified
19 health plan, or any services, category of care, or
20 services of any class or type of provider that is dif-
21 ferent from the covered items and services specified
22 under subtitle C;

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

1 (3) requires a right of conversion from a group
2 health plan that is a qualified health plan to an indi-
3 vidual health plan.

4 **SEC. 1432. PREEMPTION OF STATE LAW RESTRICTIONS ON**
5 **NETWORK PLANS.**

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

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

11 (2) a State may not prohibit or limit a network
12 plan from limiting coverage of services to those pro-
13 vided by a participating provider;

14 (3) a State may not prohibit or limit the nego-
15 tiation of rates and forms of payments for providers
16 under a network plan;

17 (4) a State may not prohibit or limit a network
18 plan from limiting the number of participating pro-
19 viders;

20 (5) a State may not prohibit or limit a network
21 plan from requiring that services be provided (or au-
22 thorized) by a practitioner selected by the enrollee
23 from a list of available participating providers; and

24 (6) a State may not prohibit or limit the cor-
25 porate practice of medicine.

1 (b) DEFINITIONS.—In this section:

2 (1) NETWORK PLAN.—The term “network
3 plan” means a qualified health plan—

4 (A) which—

5 (i) limits coverage of covered items
6 and services to those provided by partici-
7 pating providers, or

8 (ii) provides, with respect to such
9 services provided by persons who are not
10 participating providers, for cost-sharing
11 which are in excess of those permitted
12 under the standard or catastrophic pack-
13 age for participating providers;

14 (B) which has a sufficient number and dis-
15 tribution of participating providers to assure
16 that the uniform set of effective benefits (i) is
17 available and accessible to each enrollee, within
18 the area served by the plan, with reasonable
19 promptness and in a manner which assures con-
20 tinuity, and (ii) when medically necessary, is
21 available and accessible twenty-four hours a day
22 and seven days a week; and

23 (C) which provides benefits for covered
24 items and services not furnished by participat-
25 ing providers if the services are medically nec-

1 essary and immediately required because of an
2 unforeseen illness, injury, or condition.

3 (2) PARTICIPATING PROVIDER.—The term
4 “participating provider” means an entity or individ-
5 ual which provides, sells, or leases health care serv-
6 ices under a contract with a network plan, which
7 contract does not permit—

8 (A) cost sharing in excess of the cost-shar-
9 ing permitted under a standard or catastrophic
10 package, and

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

13 **PART II—FEDERAL RESPONSIBILITIES**

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

16 In the case of an insured health plan offered by an
17 employer which has employees who are employed in 2 or
18 more States, the Secretary shall carry out activities under
19 this section in the same manner as a State program would
20 carry out activities under part I with respect to a health
21 plan subject to such part.

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

24 (a) FAILURE TO ESTABLISH STATE PROGRAM.—If a
25 State fails to establish a State program under part I or,

1 having established such a program, the program fails to
2 continue to meet the requirements of such part, the Sec-
3 retary shall, after notice and opportunity for correction,
4 terminate such program and shall carry out activities
5 under part I in the same manner as a State program
6 would carry out activities under such part.

7 (b) FAILURE OF STATE TO DESIGNATE HCCAs.—
8 If a State fails to designate 1 or more HCCAs under sec-
9 tion 1403(a) by the deadline specified in section
10 1401(c)(2), the Secretary shall make such designation.

11 **SEC. 1443. ESTABLISHMENT OF RESIDENCY RULES.**

12 The Secretary shall establish rules relating to identi-
13 fying the State (and HCCA) in which individuals reside.
14 Such rules shall be based on the principal residence of
15 such an individual.

16 **SEC. 1444. RULES DETERMINING SEPARATE EMPLOYER**
17 **STATUS.**

18 Under rules of the Secretary, employers that are re-
19 lated (as defined under such rules) shall be treated under
20 this title as a single employer if a reason for their separa-
21 tion relates to the health risk characteristics of eligible em-
22 ployees of such employers.

1 **Subtitle F—Universal Coverage**

2 **SEC. 1501. REQUIREMENT OF COVERAGE.**

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

6 (1) a qualified health plan, or

7 (2) an equivalent health care program (as de-
8 fined in section 1601(7)).

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

14 **Subtitle G—Definitions**

15 **SEC. 1601. DEFINITIONS.**

16 Unless specifically provided otherwise, as used in this
17 Act:

18 (1) APPROPRIATE CERTIFYING AUTHORITY.—

19 The term “appropriate certifying authority”
20 means—

21 (A) in the case of a health plan offered in
22 a State with a qualified health plan certification
23 program meeting the requirements of this Act,
24 the State commissioner or superintendent of in-

1 insurance or other State authority responsible for
2 regulation of health insurance; or

3 (B) in all other cases, the Secretary.

4 (2) COVERED ITEMS AND SERVICES.—The term
5 “covered items and services” means items and serv-
6 ices described in section 1301(b).

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

10 (A) Fee-for-service.

11 (B) Use of preferred providers.

12 (C) Staff or group model health mainte-
13 nance organizations.

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

16 (4) DEPENDENT.—The term “dependent”
17 means, with respect to any individual, any person
18 who is—

19 (A) the spouse of such individual, or

20 (B) under regulations of the Secretary, a
21 child (including an adopted child) of such indi-
22 vidual and who—

23 (i) is under 19 years of age,

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

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

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

10 (6) ELIGIBLE INDIVIDUAL.—The term “eligible
11 individual” means an individual who—

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

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

19 (7) EQUIVALENT HEALTH CARE PROGRAM.—
20 The term “equivalent health care program” means—

21 (A) part A or part B of the medicare pro-
22 gram under title XVIII of the Social Security
23 Act,

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

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

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

7 (E) the Civilian Health and Medical Pro-
8 gram of the Uniformed Services (CHAMPUS),
9 as defined in section 1073(4) of title 10, United
10 States Code,

11 (F) the Indian health service program
12 under the Indian Health Care Improvement Act
13 (25 U.S.C. 1601 et seq.), and

14 (G) any other plan recognized by the Sec-
15 retary the purpose of which is to provide retiree
16 health benefits.

17 (8) FAMILY.—The term “family” means as in-
18 dividual and includes the individual’s dependents (if
19 any), as defined in paragraph (4), but only if such
20 an individual or dependent is a citizen or lawful per-
21 manent resident of the United States.

22 (9) FIRST CERTIFICATION YEAR.—The term
23 “first certification year” means, with respect to a
24 qualified health plan in a State, the first year in
25 which the State has in effect a State program under

1 part I of subtitle E as of January 1 of such year,
2 but not later than the first January 1 following the
3 deadline specified in section 1401(c)(2).

4 (10) GENERAL ACCESS PLAN.—The term “gen-
5 eral access plan” means an insured health plan of-
6 fered with respect to eligible employees of small em-
7 ployers and eligible individuals under subtitle B.

8 (11) HCCA.—The term “HCCA” means a
9 health care coverage area established under section
10 1403.

11 (12) HEALTH PLAN.—the term “health plan”
12 means an insured health plan and a self-insured
13 health plan.

14 (13) HEALTH PLAN SPONSOR.—The term
15 “health plan sponsor” means, with respect to an in-
16 sured health plan or self-insured health plan, the in-
17 surer offering the plan or the self-insured sponsor
18 for the plan, respectively.

19 (14) INSURED HEALTH PLAN.—

20 (A) IN GENERAL.—Except as provided in
21 subparagraph (B), the term “insured health
22 plan” means any hospital or medical service
23 policy or certificate, hospital or medical service
24 plan contract, or health maintenance organiza-
25 tion group contract offered by an insurer.

1 (B) EXCEPTION.—Such term does not in-
2 clude any of the following—

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

6 (ii) medicare supplemental health in-
7 surance,

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

10 (iv) worker’s compensation or similar
11 insurance,

12 (v) automobile medical-payment insur-
13 ance,

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

16 (vii) a hospital or fixed indemnity pol-
17 icy (unless the Secretary determines that
18 such a policy provides sufficiently com-
19 prehensive coverage of a benefit so that it
20 should be treated as an insured health
21 plan),

22 or any combination thereof.

23 (15) INSURER.—The term “insurer” means—

24 (A) a licensed insurance company,

1 (B) a prepaid hospital or medical service
2 plan,

3 (C) a health maintenance organization, or

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

6 with respect to which State regulation is not pre-
7 empted by reason of section 514(b)(2) of the Em-
8 ployee Retirement Income Security Act of 1974.

9 (16) LARGE EMPLOYER.—The term “large em-
10 ployer” means an employer that is not a small em-
11 ployer.

12 (17) LARGE EMPLOYER PLAN.—The term
13 “large employer plan” means a qualified health plan
14 which is made available by a large employer, wheth-
15 er the plan is insured or self-insured.

16 (18) MULTIPLE EMPLOYER WELFARE AR-
17 RANGEMENT.—The term “multiple employer welfare
18 arrangement” has the meaning given such term in
19 section 3(40) of the Employee Retirement Income
20 Security Act of 1974.

21 (19) PURCHASING GROUP.—The term “pur-
22 chasing group” means an individual and small em-
23 ployer purchasing group established under section
24 1141.

1 (20) QUALIFIED HEALTH PLAN.—The term
2 “qualified” means—

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

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

9 (21) SECRETARY.—The term “Secretary”
10 means the Secretary of Health and Human Services.

11 (22) SELF-INSURED HEALTH PLAN.—The term
12 “self-insured health plan”—

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

19 (B) does not include any coverage or insur-
20 ance described in paragraph (14)(B).

21 (23) SELF-INSURED SPONSOR.—The term “self-
22 insured sponsor” includes, with respect to a self-in-
23 sured plan, any entity which establishes or main-
24 tains the plan.

25 (24) SMALL EMPLOYER.—

1 (A) IN GENERAL.—The term “small em-
 2 ployer” means, with respect to a calendar year,
 3 an employer that normally employs 1 or more
 4 but less than 101 eligible employees on a typi-
 5 cal business day.

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

9 (C) TREATMENT OF LINES OF BUSINESS,
 10 ETC.—For purposes of making a determination
 11 under subparagraph (A), an employer may treat
 12 each line of business or each geographic loca-
 13 tion as a separate employer.

14 (25) STATE.—The term “State” means each of
 15 the several States, the District of Columbia, the
 16 Commonwealth of Puerto Rico, the United States
 17 Virgin Islands, Guam, American Samoa, and the
 18 Commonwealth of the Northern Mariana Islands.

19 **TITLE II—TAX AND** 20 **ENFORCEMENT PROVISIONS**

21 **SEC. 2000. AMENDMENT OF 1986 CODE.**

22 Except as otherwise expressly provided, whenever in
 23 this title an amendment or repeal is expressed in terms
 24 of an amendment to, or repeal of, a section or other provi-
 25 sion, the reference shall be considered to be made to a

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

3 **Subtitle A—General Tax Provisions**

4 **SEC. 2001. CERTAIN EMPLOYER HEALTH PLAN CONTRIBU-** 5 **TIONS INCLUDED IN INCOME.**

6 (a) EXCLUSION FOR EMPLOYER HEALTH PLAN CON-
7 TRIBUTIONS LIMITED TO CONTRIBUTIONS TO QUALIFIED
8 HEALTH PLANS.—

9 (1) IN GENERAL.—Section 106 (relating to con-
10 tributions by employer to accident and health plans)
11 is amended to read as follows:

12 **“SEC. 106. CONTRIBUTIONS BY EMPLOYER TO QUALIFIED** 13 **HEALTH PLANS.**

14 “Except as provided in section 91, gross income of
15 an employee does not include employer-provided coverage
16 under a qualified health plan (as defined in section
17 1601(20) of the Health Equity and Access Reform Today
18 Act of 1993) or employer-provided contributions to such
19 employee’s medical savings account”.

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

“Sec. 106. Contributions by employer to qualified health plans.”

24 (b) INCLUSION IN INCOME.—

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

5 **“SEC. 91. EXCESS EMPLOYER CONTRIBUTIONS TO QUALI-**
6 **FIED HEALTH PLANS.**

7 “(a) GENERAL RULE.—Notwithstanding section 106,
8 if—

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

11 “(2) there is an excess employer contribution
12 with respect to the employee to such plan for such
13 month,

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

17 “(b) EXCESS EMPLOYER CONTRIBUTION DE-
18 FINED.—

19 “(1) IN GENERAL.—For purposes of this sec-
20 tion, the term ‘excess employer contribution’ means,
21 with respect to an employee enrolled in a qualified
22 health plan for any month, the excess of—

23 “(A) the employer contribution to such
24 plan for such month, over

1 “(B) the applicable dollar limit for such
2 employee for such month.

3 “(2) APPLICABLE DOLLAR LIMIT.—For pur-
4 poses of paragraph (1)—

5 “(A) IN GENERAL.—The applicable dollar
6 limit for an employee for any month is equal to
7 $\frac{1}{12}$ of the average premium cost for the cal-
8 endar year of the lowest priced $\frac{1}{2}$ of standard
9 packages (within the meaning of section
10 1301(a)(1) of the Health Equity and Access
11 Reform Today Act of 1993) of qualified health
12 plans offered in such year in the HCCA (as de-
13 fined in section 1601(11) of such Act) within
14 which is offered the qualified health plan in
15 which the employee is enrolled.

16 “(B) DETERMINATION OF LIMIT.—

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

23 “(ii) DETERMINATION BASED ON EN-
24 ROLLMENT AND AGE STATUS.—

1 “(I) IN GENERAL.—The applica-
2 ble dollar limit shall be determined
3 with respect to individual and family
4 enrollments, and within each such en-
5 rollment status, determined with re-
6 spect to the age of the principal en-
7 rollee.

8 “(II) AGE BANDS ESTAB-
9 LISHED.—In carrying out subclause
10 (I), the Secretary shall establish rea-
11 sonable age bands (consistent with
12 such bands established under section
13 1116 of the Health Equity and Access
14 Reform Today Act of 1993) within
15 which premium amounts will not vary
16 for a type of enrollment.

17 “(c) SPECIAL RULE FOR MULTIEMPLOYER HEALTH
18 PLANS.—In the case of employer contributions with re-
19 spect to any employee made to a multiemployer health
20 plan on a basis other than per employee per month, the
21 Secretary may by regulations prescribe the method of de-
22 termining that portion of such contributions that is not
23 included in gross income of the employee.

24 “(d) OTHER DEFINITIONS AND SPECIAL RULES.—
25 For purposes of this section—

1 “(1) QUALIFIED HEALTH PLAN.—The term
2 ‘qualified health plan’ shall have the meaning given
3 to such term by section 1601(20) of the Health Eq-
4 uity and Access Reform Today Act of 1993.

5 “(2) EMPLOYEE INCLUDES FORMER EM-
6 PLOYEE.—The term ‘employee’ includes a former
7 employee.

8 “(3) DETERMINATION OF EMPLOYER CON-
9 TRIBUTION.—

10 “(A) IN GENERAL.—The employer con-
11 tribution to any qualified health plan for any
12 month shall be that portion of the cost of such
13 plan for such month which is incurred by the
14 employer.

15 “(B) SELF-INSURED PLAN MAY USE AN-
16 NUAL ESTIMATES.—An employer who maintains
17 a self-insured health plan may elect (in such
18 manner and at such time as may be provided
19 in regulations) to determine the actual employer
20 contribution under subsection (b)(1)(A) for any
21 period of not more than 12 months on the basis
22 of a reasonable estimate of the cost of providing
23 coverage for such month. To the extent prac-
24 ticable, such estimate shall be made on an actu-
25 arial basis, and in the making of any such esti-

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

3 “(C) EMPLOYEES ONLY TAKEN INTO AC-
4 COUNT FOR PERIODS COVERED.—For purposes
5 of determining the employer contribution,
6 amounts shall be taken into account with re-
7 spect to an employee only for periods during
8 which such employee is covered by the plan.

9 “(4) COVERAGE FOR ONLY PART OF MONTH.—
10 If an employee is covered under a qualified health
11 plan for only a portion of a month, the amount re-
12 quired to be included under subsection (a) in the
13 gross income of such employee with respect to such
14 month shall be an amount which bears the same
15 ratio to the excess employer contribution for such
16 month as such portion bears to the entire month.

17 “(5) CERTAIN RELATED EMPLOYERS TREATED
18 AS 1 EMPLOYER.—Rules similar to the rules pro-
19 vided by subsections (b) and (c) of section 414 shall
20 apply.

21 “(6) MONTH.—The term ‘month’ means a cal-
22 endar month.

23 “(7) MULTIEMPLOYER HEALTH PLAN.—The
24 term ‘multiemployer health plan’ means a qualified
25 health plan which is part of an employee welfare

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

4 “(A) to which more than 1 employer is re-
 5 quired to contribute, and

6 “(B) which is maintained pursuant to 1 or
 7 more collective bargaining agreements between
 8 1 or more employee organizations and more
 9 than 1 employer.”.

10 (2) CLERICAL AMENDMENT.—The table of sec-
 11 tions for part II of subchapter B of chapter 1 is
 12 amended by adding at the end the following:

“Sec. 91. Excess employer contributions to qualified health plans.”

13 (c) EMPLOYMENT TAX AMENDMENTS.—

14 (1) GENERAL RULE.—Chapter 25 (relating to
 15 general provisions relating to employment taxes) is
 16 amended by adding at the end the following new sec-
 17 tion:

18 **“SEC. 3510. TREATMENT OF EXCESS EMPLOYER CONTRIBU-**
 19 **TIONS.**

20 “(a) IN GENERAL.—For purposes of this subtitle and
 21 section 209 of the Social Security Act, any amount re-
 22 quired to be included in the gross income of an employee
 23 under section 91(a) with respect to any month—

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

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

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

7 “(b) SPECIAL RULES IN THE CASE OF SELF-IN-
8 SURED PLANS.—

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

14 “(A) the actual employer contributions de-
15 termined under section 91 with respect to all
16 employees for such year, over

17 “(B) the amount estimated by the em-
18 ployer under section 91(d)(3)(B) as the em-
19 ployer contributions with respect to all employ-
20 ees for such year,

21 is not greater than 5 percent of the amount deter-
22 mined under subparagraph (A) then, except as pro-
23 vided in paragraph (2), no penalty shall be imposed
24 under section 6672 on the employer for failure to

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

3 “(2) EMPLOYER MUST PAY CERTAIN TAXES ON
4 EXCESS.—Paragraph (1) shall not apply to any tax
5 imposed, or required to be deducted and withheld,
6 under sections 3111, 3221, 3301, and 3402 on the
7 excess described in paragraph (1) unless the em-
8 ployer pays any such tax within the time prescribed
9 by the Secretary under regulations.

10 “(3) SPECIAL RULES FOR EMPLOYEE’S SOCIAL
11 SECURITY TAX AND CREDIT.—In the case of the ex-
12 cess described in paragraph (1)—

13 “(A) no tax shall be imposed by section
14 3101, and

15 “(B) the amount of such excess shall not
16 be taken into account for purposes of section
17 209 of the Social Security Act.

18 “(c) LIABILITY FOR WITHHOLDING AND PAYMENT
19 OF TAX.—

20 “(1) IN GENERAL.—Except as provided in para-
21 graph (2), the applicable payor shall withhold, and
22 be liable for, payment of any tax required to be
23 withheld or paid under this subtitle on any amount
24 described in subsection (a).

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

8 “(d) DEFINITIONS.—For purposes of this section—

9 “(1) APPLICABLE PAYOR.—The term ‘applica-
10 ble payor’ means the payor of remuneration for serv-
11 ices which qualifies the employee for coverage under
12 a multiemployer health plan.

13 “(2) EMPLOYEE.—The term ‘employee’ does
14 not include a former employee.

15 “(3) MULTIEMPLOYER HEALTH PLAN.—The
16 term ‘multiemployer health plan’ has the meaning
17 given such term by section 91(d)(7).”.

18 (2) CLERICAL AMENDMENT.—The table of sec-
19 tions for chapter 25 is amended by adding at the
20 end the following new item:

“Sec. 3510. Treatment of excess employer contributions.”.

21 (d) EFFECTIVE DATES.—

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

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

5 **SEC. 2002. DEDUCTIONS FOR COSTS OF QUALIFIED HEALTH**
6 **PLANS.**

7 (a) BUSINESS EXPENSE DEDUCTION FOR HEALTH
8 INSURANCE.—Section 162 (relating to trade or business
9 expenses) is amended by redesignating subsection (m) as
10 subsection (n) and by inserting after subsection (l) the fol-
11 lowing new subsection:

12 “(m) GROUP HEALTH PLANS.—The amount of ex-
13 penses paid or incurred by an employer for a group health
14 plan or as contributions to an employee’s medical savings
15 account shall not be allowed as a deduction under this sec-
16 tion—

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

20 “(2) with respect to each employee, to the ex-
21 tent such amount exceeds the applicable dollar limit
22 for such employee (within the meaning of section
23 91(b)(2) and determined on an annual basis).”.

1 (b) PERMANENT EXTENSION AND INCREASE IN
2 HEALTH INSURANCE TAX DEDUCTION FOR SELF-EM-
3 PLOYED INDIVIDUALS.—

4 (1) PERMANENT EXTENSION OF DEDUCTION.—

5 (A) IN GENERAL.—Subsection (l) of sec-
6 tion 162 (relating to special rules for health in-
7 surance costs of self-employed individuals) is
8 amended by striking paragraph (6).

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

12 (2) INCREASE IN AMOUNT OF DEDUCTION; IN-
13 SURANCE PURCHASED MUST MEET CERTAIN STAND-
14 ARDS.—

15 (A) INCREASE IN AMOUNT OF DEDUC-
16 TION.—Paragraph (1) of section 162(l) is
17 amended—

18 (i) by striking “25 percent of” and in-
19 serting “100 percent of”, and

20 (ii) by striking “dependents.” and in-
21 serting “dependents, and only to the extent
22 such amount does not exceed the applica-
23 ble dollar limit for such taxpayer (within
24 the meaning of section 91(b)(2) and deter-
25 mined on an annual basis).”

1 (B) INSURANCE PURCHASED MUST MEET
2 CERTAIN STANDARDS.—Paragraph (2) of sec-
3 tion 162(l) is amended by adding at the end the
4 following new subparagraph:

5 “(C) INSURANCE MUST MEET CERTAIN
6 STANDARDS.—Paragraph (1) shall apply only to
7 insurance which is a qualified health plan (as
8 defined in section 1601(20) of the Health Eq-
9 uity and Access Reform Today Act of 1993).”.

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

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

19 (c) RULES RELATING TO DEDUCTIONS FOR INDIVID-
20 UALS.—

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

1 of the Health Equity and Access Reform Today Act
2 of 1993).”

3 (2) DEDUCTION NOT SUBJECT TO AGI LIMITA-
4 TION.—Section 213 (relating to medical, dental, etc.,
5 expenses) is amended by adding at the end the fol-
6 lowing new subsection:

7 “(f) SPECIAL RULES FOR QUALIFIED HEALTH CARE
8 PREMIUM EXPENSES.—

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

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

19 “(B) no deduction shall be allowed to the
20 extent such amounts exceed the applicable dol-
21 lar limit for the taxpayer (within the meaning
22 of section 91(b)(2) and determined on an an-
23 nual basis).

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

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

5 “(A) the Secretary of Health and Human
6 Services under section 1003 of the Health Equity
7 and Access Reform Today Act of 1993,
8 and

9 “(B) all other entities (including any employer
10 or governmental agency),

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

13 (3) DEDUCTION ALLOWED AGAINST GROSS IN-
14 COME.—Section 62(a) (defining adjusted gross in-
15 come) is amended by inserting after paragraph (15)
16 the following new paragraph:

17 “(16) DEDUCTION FOR QUALIFIED HEALTH
18 PLAN PREMIUMS.—The deduction allowed under section
19 213(f).”.

20 (d) EFFECTIVE DATE.—Except as provided in sub-
21 section (b)(1)(B), the amendments made by this section
22 shall apply to taxable years beginning after the first De-
23 cember 31 following the deadline specified in section
24 1401(c)(2) of this Act.

1 **SEC. 2003. MEDICAL SAVINGS ACCOUNTS.**

2 (a) IN GENERAL.—Part VII of subchapter B of chap-
3 ter 1 (relating to additional itemized deductions for indi-
4 viduals) is amended by redesignating section 220 as sec-
5 tion 221 and by inserting after section 219 the following
6 new section:

7 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

8 “(a) DEDUCTION ALLOWED.—In the case of an eligi-
9 ble individual, there shall be allowed as a deduction the
10 amounts paid in cash during the taxable year by such indi-
11 vidual to a medical savings account for the benefit of such
12 individual or for the benefit of any spouse or dependent
13 of such individual who is an eligible individual.

14 “(b) LIMITATIONS.—

15 “(1) ONLY 1 ACCOUNT PER FAMILY.—Except as
16 provided in regulations prescribed by the Secretary,
17 no deduction shall be allowed under subsection (a)
18 for amounts paid to any medical savings account for
19 the benefit of an individual, such individual’s spouse,
20 or any dependent of such individual if such individ-
21 ual, spouse, or dependent is a beneficiary of any
22 other medical savings account.

23 “(2) DOLLAR LIMITATION.—The amount allow-
24 able as a deduction under subsection (a) with re-
25 spect to any individual for the taxable year shall not
26 exceed the excess of—

1 “(A) the applicable dollar limit with re-
2 spect to such individual (within the meaning of
3 section 91(b)(2) and determined on an annual
4 basis), over

5 “(B) the sum of—

6 “(i) the aggregate amount paid by, or
7 on behalf of such individual, as a premium
8 for a catastrophic health plan covering
9 such eligible individual for such taxable
10 year, plus

11 “(ii) the aggregate amount contrib-
12 uted to the eligible individual’s medical
13 savings account by persons other than the
14 eligible individual.

15 “(c) DEFINITIONS.—For purposes of this section—

16 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
17 individual’ means any individual who is covered
18 under a catastrophic health plan during any portion
19 of the calendar year with or within which the taxable
20 year begins.

21 “(2) CATASTROPHIC HEALTH PLAN.—For pur-
22 poses of paragraph (1), the term ‘catastrophic health
23 plan’ means a qualified health plan providing health
24 plan coverage through a catastrophic package. For
25 purposes of the preceding sentence, the terms ‘quali-

1 fied health plan’ and ‘catastrophic package’ have the
2 meanings given to such terms by sections 1601(20)
3 and 1301(a)(2) of the Health Equity and Access Re-
4 form Today Act of 1993.

5 “(d) MEDICAL SAVINGS ACCOUNTS.—For purposes
6 of this section—

7 “(1) MEDICAL SAVINGS ACCOUNT.—

8 “(A) IN GENERAL.—The term ‘medical
9 savings account’ means a trust created or orga-
10 nized in the United States exclusively for the
11 purpose of paying the medical expenses of the
12 beneficiaries of such trust, but only if the writ-
13 ten governing instrument creating the trust
14 meets the following requirements:

15 “(i) Except in the case of a rollover
16 contribution described in subsection (e)(4),
17 no contribution will be accepted unless it is
18 in cash, and, subject to subsection (e)(2),
19 contributions will not be accepted in excess
20 of the amount allowed as a deduction
21 under this section for the taxable year.

22 “(ii) The trustee is a bank (as defined
23 in section 408(n)) or another person who
24 demonstrates to the satisfaction of the Sec-
25 retary that the manner in which such per-

1 son will administer the trust will be con-
2 sistent with the requirements of this sec-
3 tion.

4 “(iii) No part of the trust assets will
5 be invested in life insurance contracts.

6 “(iv) The assets of the trust will not
7 be commingled with other property except
8 in a common trust fund or common invest-
9 ment fund.

10 “(v) The interest of an individual in
11 the balance in his account is nonforfeit-
12 able.

13 “(vi) Under regulations prescribed by
14 the Secretary, rules similar to the rules of
15 section 401(a)(9) shall apply to the dis-
16 tribution of the entire interest of bene-
17 ficiaries of such trust.

18 “(B) TREATMENT OF COMPARABLE AC-
19 COUNTS HELD BY INSURANCE COMPANIES.—
20 For purposes of this section, an account held by
21 an insurance company in the United States
22 shall be treated as a medical savings account
23 (and such company shall be treated as a bank)
24 if—

1 “(i) such account is part of a health
2 insurance plan that includes a catastrophic
3 health plan (as defined in subsection
4 (c)(2)),

5 “(ii) such account is exclusively for
6 the purpose of paying the medical expenses
7 of the beneficiaries of such account who
8 are covered under such catastrophic health
9 plan, and

10 “(iii) the written instrument govern-
11 ing the account meets the requirements of
12 clauses (i), (v), and (vi) of subparagraph
13 (A).

14 “(2) MEDICAL EXPENSES.—

15 “(A) IN GENERAL.—The term ‘medical ex-
16 penses’ means, with respect to an individual,
17 amounts paid or incurred by such individual
18 for—

19 “(i) medical care (as defined in sec-
20 tion 213), or

21 “(ii) long-term care (as defined in
22 paragraph (3)),

23 for such individual, the spouse of such individ-
24 ual, and any dependent (as defined in section
25 152) of such individual, but only to the extent

1 such amounts are not compensated for by in-
2 surance or otherwise.

3 “(B) HEALTH PLAN COVERAGE MAY NOT
4 BE PURCHASED FROM ACCOUNT.—

5 “(i) IN GENERAL.—Such term shall
6 not include any amount paid for coverage
7 under a health plan.

8 “(ii) EXCEPTION.—Clause (i) shall
9 not apply—

10 “(I) in the case of coverage of an
11 individual under 65 years of age
12 under a catastrophic health plan or
13 under a long-term care insurance
14 plan, or

15 “(II) in the case of coverage of
16 an individual 65 years of age or older
17 under a medicare supplemental policy
18 or under a long-term care insurance
19 plan or for payment of premiums
20 under part A or part B of title XVIII
21 of the Social Security Act.

22 “(3) LONG-TERM CARE.—

23 “(A) IN GENERAL.—The term ‘long-term
24 care’ means diagnostic, preventive, therapeutic,
25 rehabilitative, maintenance, or personal care

1 services which are required by, and provided to,
2 a functionally impaired individual, which have
3 as their primary purpose the direct provision of
4 needed assistance with 1 or more activities of
5 daily living (or the alleviation of the conditions
6 necessitating such assistance) that the individ-
7 ual is certified under subparagraph (B) as
8 being unable to perform, and which are pro-
9 vided in a setting other than an acute care unit
10 of a hospital pursuant to a continuing plan of
11 care prescribed by a physician or registered pro-
12 fessional nurse. Such term does not include
13 food or lodging provided in an institutional or
14 other setting, or basic living services associated
15 with the maintenance of a household or partici-
16 pation in community life, such as case manage-
17 ment, transportation or legal services, or the
18 performance of home maintenance or household
19 chores.

20 “(B) FUNCTIONALLY IMPAIRED INDIVID-
21 UAL.—The term ‘functionally impaired individ-
22 ual’ means an individual who is certified by a
23 physician or registered professional nurse as
24 being unable to perform at least 3 activities of
25 daily living without substantial assistance from

1 another individual. For purposes of this para-
2 graph, the term ‘activities of daily living’ means
3 bathing, dressing, eating, toileting, transferring,
4 and walking.

5 “(4) TIME WHEN CONTRIBUTIONS DEEMED
6 MADE.—A contribution shall be deemed to be made
7 on the last day of the preceding taxable year if the
8 contribution is made on account of such taxable year
9 and is made not later than the time prescribed by
10 law for filing the return for such taxable year (not
11 including extensions thereof).

12 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

13 “(1) IN GENERAL.—Any amount paid or dis-
14 tributed out of a medical savings account shall be in-
15 cluded in the gross income of the individual for
16 whose benefit such account was established unless
17 such amount is used exclusively to pay the medical
18 expenses of such individual or the spouse or any de-
19 pendent of such individual.

20 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
21 FORE DUE DATE OF RETURN.—Paragraph (1) shall
22 not apply to the distribution of any contribution paid
23 during a taxable year to a medical savings account
24 to the extent that such contribution exceeds the

1 amount allowable as a deduction under subsection
2 (a) if—

3 “(A) such distribution is received by the
4 individual on or before the last day prescribed
5 by law (including extensions of time) for filing
6 such individual’s return for such taxable year,
7 and

8 “(B) such distribution is accompanied by
9 the amount of net income attributable to such
10 excess contribution.

11 Any net income described in subparagraph (B) shall
12 be included in the gross income of the individual for
13 the taxable year in which it is received.

14 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
15 FOR MEDICAL EXPENSES.—

16 “(A) IN GENERAL.—The tax imposed by
17 this chapter for any taxable year in which there
18 is a payment or distribution from a medical
19 savings account which is not used to pay the
20 medical expenses of the individual for whose
21 benefit the account was established, shall be in-
22 creased by 10 percent of the amount of such
23 payment or distribution which is includible in
24 gross income under paragraph (1).

1 “(B) ACCOUNT BALANCE LIMITATION.—

2 If—

3 “(i) the tax imposed by this chapter is
4 required to be increased under subpara-
5 graph (A) by reason of a distribution, and

6 “(ii) after such distribution, the bal-
7 ance of the medical savings account estab-
8 lished for the benefit of the individual, is
9 less than the amount of the deductible
10 under the catastrophic health plan covering
11 such individual,

12 subparagraph (A) shall be applied by substitut-
13 ing ‘50 percent’ for ‘10 percent’.

14 “(4) ROLLOVERS.—Paragraph (1) shall not
15 apply to any amount paid or distributed out of a
16 medical savings account to the individual for whose
17 benefit the account is maintained, if the entire
18 amount received (including money and any other
19 property) is paid into another medical savings ac-
20 count for the benefit of such individual not later
21 than the 60th day after the day on which the indi-
22 vidual received the payment or distribution.

23 “(5) PENALTY FOR MANDATORY DISTRIBU-
24 TIONS NOT MADE FROM ACCOUNT.—

1 “(A) IN GENERAL.—If during any taxable
2 year—

3 “(i) there is a payment of a manda-
4 tory distribution expense incurred by a
5 beneficiary of a medical savings account,
6 and

7 “(ii) the person making such payment
8 is not reimbursed for such payment with a
9 distribution from such account before the
10 60th day after such payment,

11 the taxpayer’s tax imposed by this chapter for
12 such taxable year shall be increased by 100 per-
13 cent of the excess of the amount of such pay-
14 ment over the amount of reimbursement made
15 before such 60th day.

16 “(B) MANDATORY DISTRIBUTION EX-
17 PENSE.—For purposes of subparagraph (A),
18 the term ‘mandatory distribution expense’
19 means—

20 “(i) any expense incurred which may
21 be counted toward a deductible, or for a
22 copayment or coinsurance, under the cata-
23 strophic health plan covering such bene-
24 ficiary, and

1 “(ii) in the case of a beneficiary who
2 has attained age 65, any expense for cov-
3 erage described in subsection
4 (d)(2)(B)(ii)(II) and any expense incurred
5 which may be counted toward a deductible,
6 or for a copayment or coinsurance, under
7 title XVIII of the Social Security Act.

8 “(f) TAX TREATMENT OF ACCOUNTS.—

9 “(1) EXEMPTION FROM TAX.—Any medical sav-
10 ings account is exempt from taxation under this sub-
11 title unless such account has ceased to be a medical
12 savings account by reason of paragraph (2) or (3).
13 Notwithstanding the preceding sentence, any such
14 account shall be subject to the taxes imposed by sec-
15 tion 511 (relating to imposition of tax on unrelated
16 business income of charitable, etc. organizations).

17 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-
18 GAGES IN PROHIBITED TRANSACTION.—

19 “(A) IN GENERAL.—If, during any taxable
20 year of the individual for whose benefit the
21 medical savings account was established, such
22 individual engages in any transaction prohibited
23 by section 4975 with respect to the account, the
24 account ceases to be a medical savings account
25 as of the first day of that taxable year.

1 “(B) ACCOUNT TREATED AS DISTRIBUTING
2 ALL ITS ASSETS.—In any case in which any ac-
3 count ceases to be a medical savings account by
4 reason of subparagraph (A) on the first day of
5 any taxable year, paragraph (1) of subsection
6 (e) shall be applied as if there were a distribu-
7 tion on such first day in an amount equal to
8 the fair market value (on such first day) of all
9 assets in the account (on such first day) and no
10 portion of such distribution were used to pay
11 medical expenses.

12 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
13 RITY.—If, during any taxable year, the individual for
14 whose benefit a medical savings account was estab-
15 lished uses the account or any portion thereof as se-
16 curity for a loan, the portion so used is treated as
17 distributed to that individual and not used to pay
18 medical expenses.

19 “(g) CUSTODIAL ACCOUNTS.—For purposes of this
20 section, a custodial account shall be treated as a trust if—

21 “(1) the assets of such account are held by a
22 bank (as defined in section 408(n)) or another per-
23 son who demonstrates to the satisfaction of the Sec-
24 retary that the manner in which he will administer

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

3 “(2) the custodial account would, except for the
4 fact that it is not a trust, constitute a medical sav-
5 ings account described in subsection (d).

6 For purposes of this title, in the case of a custodial ac-
7 count treated as a trust by reason of the preceding sen-
8 tence, the custodian of such account shall be treated as
9 the trustee thereof.

10 “(h) REPORTS.—The trustee of a medical savings ac-
11 count shall make such reports regarding such account to
12 the Secretary and to the individual for whose benefit the
13 account is maintained with respect to contributions, dis-
14 tributions, and such other matters as the Secretary may
15 require under regulations. The reports required by this
16 subsection shall be filed at such time and in such manner
17 and furnished to such individuals at such time and in such
18 manner as may be required by those regulations.”.

19 (b) DEDUCTION ALLOWED WHETHER OR NOT INDI-
20 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
21 of section 62 (defining adjusted gross income), as amend-
22 ed by section 2002(c)(3), is amended by inserting after
23 paragraph (16) the following new paragraph:

24 “(17) MEDICAL SAVINGS ACCOUNTS.—The de-
25 duction allowed by section 220.”.

1 (c) DISTRIBUTIONS FROM MEDICAL SAVINGS AC-
2 COUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUC-
3 TION.—Section 213 (relating to medical, dental, etc., ex-
4 penses), as amended by section 2002(c)(2), is amended
5 by adding at the end the following new subsection:

6 “(g) COORDINATION WITH MEDICAL SAVINGS AC-
7 COUNTS.—The amount otherwise taken into account
8 under subsection (a) as expenses paid for medical care
9 shall be reduced by the amount (if any) of the distribu-
10 tions from any medical savings account of the taxpayer
11 during the taxable year which is not includible in gross
12 income by reason of being used for medical care.”.

13 (d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO
14 MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT
15 TAXES.—

16 (1) SOCIAL SECURITY TAXES.—

17 (A) Subsection (a) of section 3121 (defin-
18 ing wages) is amended by striking “or” at the
19 end of paragraph (20), by striking the period at
20 the end of paragraph (21) and inserting “; or”,
21 and by inserting after paragraph (21) the fol-
22 lowing new paragraph:

23 “(22) remuneration paid to or on behalf of an
24 employee if (and to the extent that) at the time of
25 payment of such remuneration it is reasonable to be-

1 lieve that a corresponding deduction is allowable
2 under section 220.”.

3 (B) Subsection (a) of section 209 of the
4 Social Security Act (42 U.S.C. 409) is amended
5 by striking “or” at the end of paragraph (17),
6 by striking the period at the end of paragraph
7 (18) and inserting “; or”, and by inserting after
8 paragraph (18) the following new paragraph:

9 “(19) remuneration paid to or on behalf of an
10 employee if (and to the extent that) at the time of
11 payment of such remuneration it is reasonable to be-
12 lieve that a corresponding deduction is allowable
13 under section 220 of the Internal Revenue Code of
14 1986.”.

15 (2) RAILROAD RETIREMENT TAX.—Subsection
16 (e) of section 3231 (defining compensation) is
17 amended by adding at the end the following new
18 paragraph:

19 “(10) EMPLOYER CONTRIBUTIONS TO MEDICAL
20 SAVINGS ACCOUNTS.—The term ‘compensation’ shall
21 not include any payment made to or on behalf of an
22 employee if (and to the extent that) at the time of
23 payment of such remuneration it is reasonable to be-
24 lieve that a corresponding deduction is allowable
25 under section 220.”.

1 (3) UNEMPLOYMENT TAX.—Subsection (b) of
2 section 3306 (defining wages) is amended by strik-
3 ing “or” at the end of paragraph (15), by striking
4 the period at the end of paragraph (16) and insert-
5 ing “; or”, and by inserting after paragraph (16) the
6 following new paragraph:

7 “(17) remuneration paid to or on behalf of an
8 employee if (and to the extent that) at the time of
9 payment of such remuneration it is reasonable to be-
10 lieve that a corresponding deduction is allowable
11 under section 220.”.

12 (4) WITHHOLDING TAX.—Subsection (a) of sec-
13 tion 3401 (defining wages) is amended by striking
14 “or” at the end of paragraph (19), by striking the
15 period at the end of paragraph (20) and inserting “;
16 or”, and by inserting after paragraph (20) the fol-
17 lowing new paragraph:

18 “(21) 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 be-
21 lieve that a corresponding deduction is allowable
22 under section 220.”.

23 (e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
24 (relating to tax on excess contributions to individual re-

1 tirement accounts, certain section 403(b) contracts, and
2 certain individual retirement annuities) is amended—

3 (1) by inserting “**MEDICAL SAVINGS AC-**
4 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
5 such section,

6 (2) by striking “or” at the end of paragraph
7 (1) of subsection (a),

8 (3) by redesignating paragraph (2) of sub-
9 section (a) as paragraph (3) and by inserting after
10 paragraph (1) the following:

11 “(2) a medical savings account (within the
12 meaning of section 220(d)), or”, and

13 (4) by adding at the end the following new sub-
14 section:

15 “(d) **EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS**
16 **ACCOUNTS.**—For purposes of this section, in the case of
17 a medical savings account (within the meaning of section
18 220(d)), the term ‘excess contributions’ means the amount
19 by which the amount contributed for the taxable year to
20 the account exceeds the amount deductible under section
21 220 for such taxable year. For purposes of this subsection,
22 any contribution which is distributed out of the medical
23 savings account in a distribution to which section
24 220(e)(2) applies shall be treated as an amount not con-
25 tributed.”.

1 (f) TAX ON PROHIBITED TRANSACTIONS.—Section
2 4975 (relating to prohibited transactions) is amended—

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

5 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
6 COUNTS.—An individual for whose benefit a medical
7 savings account (within the meaning of section
8 220(d)) is established shall be exempt from the tax
9 imposed by this section with respect to any trans-
10 action concerning such account (which would other-
11 wise be taxable under this section) if, with respect
12 to such transaction, the account ceases to be a medi-
13 cal savings account by reason of the application of
14 section 220(f)(2)(A) to such account.”, and

15 (2) by inserting “or a medical savings account
16 described in section 220(d)” in subsection (e)(1)
17 after “described in section 408(a)”.

18 (g) FAILURE TO PROVIDE REPORTS ON MEDICAL
19 SAVINGS ACCOUNTS.—Section 6693 (relating to failure to
20 provide reports on individual retirement accounts or annu-
21 ities) is amended—

22 (1) by inserting “**OR ON MEDICAL SAVINGS**
23 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
24 such section, and

1 (2) by adding at the end of subsection (a) the
2 following: “The person required by section 220(h) to
3 file a report regarding a medical savings account at
4 the time and in the manner required by such section
5 shall pay a penalty of \$50 for each failure unless it
6 is shown that such failure is due to reasonable
7 cause.”.

8 (h) CLERICAL AMENDMENTS.—

9 (1) The table of sections for part VII of sub-
10 chapter B of chapter 1 is amended by striking the
11 last item and inserting the following:

“Sec. 220. Medical savings accounts.
“Sec. 221. Cross reference.”

12 (2) The table of sections for chapter 43 is
13 amended by striking the item relating to section
14 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.”

15 (3) The table of sections for subchapter B of
16 chapter 68 is amended by inserting “or on medical
17 savings accounts” after “annuities” in the item re-
18 lating to section 6693.

19 (i) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years beginning after
21 the first December 31 following the deadline specified in
22 section 1401(c)(2) of this Act.

1 **SEC. 2004. ELIMINATING COMMONALITY OF INTEREST OR**
2 **GEOGRAPHIC LOCATION REQUIREMENT FOR**
3 **TAX EXEMPT TRUST STATUS.**

4 (a) IN GENERAL.—Paragraph (9) of section 501(c)
5 (relating to exempt organizations) is amended—

6 (1) by inserting “(A)” after “(9)”; and

7 (2) by adding at the end the following:

8 “(B) Any determination of whether a health
9 plan maintained by one or more large employers
10 (within the meaning of section 1601(16) of the
11 Health Equity and Access Reform Today Act of
12 1993) is a voluntary employees’ beneficiary associa-
13 tion meeting the requirements of this paragraph
14 shall be made without regard to any determination
15 of commonality of interest or geographic location if
16 the plan is a qualified health plan (as defined in
17 such section).”.

18 (b) EFFECTIVE DATE.—The amendments made by
19 subsection (a) shall apply with respect to determinations
20 made on or after January 1, 1994.

21 **SEC. 2005. REVISION OF COBRA CONTINUATION COVERAGE**
22 **REQUIREMENTS.**

23 (a) PERIOD OF COVERAGE.—Clause (iv) of section
24 4980B(f)(2)(B) (defining period of coverage) is amend-
25 ed—

1 (1) by striking “or” at the end of subclause (I),
2 by striking the period at the end of subclause (II)
3 and inserting “, or”, and by adding at the end the
4 following new subclause:

5 “(III) eligible for coverage under a qualified
6 health plan in accordance with title I of the Health
7 Equity and Access Reform Today Act of 1993.”,
8 and

9 (2) by striking “OR MEDICARE ENTITLEMENT”
10 in the heading and inserting “, MEDICARE ENTITLE-
11 MENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY”.

12 (b) QUALIFIED BENEFICIARY.—Section 4980B(g)(1)
13 (defining qualified beneficiary) is amended by adding at
14 the end the following new subparagraph:

15 “(E) SPECIAL RULE FOR INDIVIDUALS
16 COVERED BY HEALTH EQUITY AND ACCESS RE-
17 FORM TODAY ACT OF 1993.—The term ‘qualified
18 beneficiary’ shall not include any individual
19 who, upon termination of coverage under a
20 group health plan, is eligible coverage under a
21 qualified health plan in accordance with title I
22 of the Health Equity and Access Reform Today
23 Act of 1993.”

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

1 (1) IN GENERAL.—Section 4980B (relating to
2 failure to satisfy continuation coverage requirements
3 of group health care plans) is hereby repealed.

4 (2) CONFORMING AMENDMENTS.—

5 (A) Section 414(n)(3)(C) is amended by
6 striking “505, and 4980B” and inserting “and
7 505”.

8 (B) Section 414(t)(2) is amended by strik-
9 ing “505, or 4980B” and inserting “or 505”.

10 (C) The table of sections for chapter 43 is
11 amended by striking the item relating to section
12 4980B.

13 (d) EFFECTIVE DATE.—

14 (1) SUBSECTIONS (a) AND (b).—The amend-
15 ments made by subsections (a) and (b) shall take ef-
16 fect on the date of the enactment of this Act.

17 (2) SUBSECTION (c).—The amendments made
18 by subsection (c) shall take effect on the first Janu-
19 ary 1 following the deadline specified in section
20 1401(c)(2) of this Act.

1 **Subtitle B—Provisions Relating to**
2 **Acceleration of Death Benefits**

3 **SEC. 2101. TAX TREATMENT OF PAYMENTS UNDER LIFE IN-**
4 **SURANCE CONTRACTS FOR TERMINALLY ILL**
5 **INDIVIDUALS .**

6 (a) GENERAL RULE.—Section 101 (relating to cer-
7 tain death benefits) is amended by adding at the end the
8 following new subsection:

9 “(g) TREATMENT OF AMOUNTS PAID WITH RESPECT
10 TO TERMINALLY ILL INDIVIDUALS.—

11 “(1) IN GENERAL.—For purposes of this sec-
12 tion, any amount paid to an individual under a life
13 insurance contract on the life of an insured who is
14 a terminally ill individual shall be treated as an
15 amount paid by reason of the death of such insured.

16 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
17 poses of this subsection, the term ‘terminally ill indi-
18 vidual’ means an individual who has been certified
19 by a licensed physician as having an illness or phys-
20 ical condition which can reasonably be expected to
21 result in death in 12 months or less.”

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to taxable years beginning after
24 December 31, 1993.

1 **SEC. 2102. TAX TREATMENT OF COMPANIES ISSUING**
2 **QUALIFIED TERMINAL ILLNESS RIDERS.**

3 (a) QUALIFIED TERMINAL ILLNESS RIDER TREATED
4 AS LIFE INSURANCE.—Section 818 (relating to other defi-
5 nitions and special rules) is amended by adding at the end
6 the following new subsection:

7 “(g) QUALIFIED TERMINAL ILLNESS RIDER TREAT-
8 ED AS LIFE INSURANCE.—For purposes of this part—

9 “(1) IN GENERAL.—Any reference to life insur-
10 ance shall be treated as including a reference to a
11 qualified terminal illness rider.

12 “(2) QUALIFIED TERMINAL ILLNESS RIDER.—
13 For purposes of this subsection, the term ‘qualified
14 terminal illness rider’ means any rider or addendum
15 on, or other provision of, a life insurance contract
16 which provides for payments to an individual upon
17 the insured becoming a terminally ill individual (as
18 defined in section 101(g)(2)).”

19 (b) DEFINITIONS OF LIFE INSURANCE AND MODI-
20 FIED ENDOWMENT CONTRACTS.—

21 (1) RIDER TREATED AS QUALIFIED ADDI-
22 TIONAL BENEFIT.—Paragraph (5)(A) of section
23 7702(f) is amended by striking “or” at the end of
24 clause (iv), by redesignating clause (v) as clause (vi),
25 and by inserting after clause (iv) the following new
26 clause:

1 “(v) any qualified terminal illness
2 rider (as defined in section 818(g)(2)), or”.

3 (2) TRANSITIONAL RULE.—For purposes of ap-
4 plying section 7702 or 7702A of the Internal Reve-
5 nue Code of 1986 to any contract (or determining
6 whether either such section applies to such con-
7 tract), the issuance of a qualified terminal illness
8 rider (as defined in section 818(g)(2) of such Code)
9 with respect to any contract shall not be treated as
10 a modification or material change of such contract.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to taxable years beginning before,
13 on, or after December 31, 1993.

14 **Subtitle C—Long-Term Care Tax** 15 **Provisions**

16 **PART I—GENERAL PROVISIONS**

17 **SEC. 2201. QUALIFIED LONG-TERM CARE SERVICES TREAT-** 18 **ED AS MEDICAL CARE.**

19 (a) GENERAL RULE.—Paragraph (1) of section
20 213(d) (defining medical care), as amended by section
21 2002(c)(1), is amended by striking “or” at the end of sub-
22 paragraph (B), by redesignating subparagraph (C) as sub-
23 paragraph (D), and by inserting after subparagraph (B)
24 the following new subparagraph:

1 “(C) for qualified long-term care services
2 (as defined in subsection (g)), or”.

3 (b) QUALIFIED LONG-TERM CARE SERVICES DE-
4 FINED.—Section 213 (relating to deduction for medical,
5 dental, etc. expenses), as amended by section 2002(c)(2),
6 is amended by adding at the end the following new sub-
7 section:

8 “(g) QUALIFIED LONG-TERM CARE SERVICES.—For
9 purposes of this section—

10 “(1) IN GENERAL.—The term ‘qualified long-
11 term care services’ means necessary diagnostic, pre-
12 ventive, therapeutic, rehabilitative, and maintenance
13 (including personal care) services—

14 “(A) which are required by an individual
15 during any period during which such individual
16 is a functionally impaired individual,

17 “(B) which have as their primary purpose
18 the provision of needed assistance with 1 or
19 more activities of daily living which a function-
20 ally impaired individual is certified as being un-
21 able to perform under paragraph (2)(A), and

22 “(C) which are provided pursuant to a con-
23 tinuing plan of care prescribed by a licensed
24 health care practitioner (other than a relative of
25 such individual).

1 “(2) FUNCTIONALLY IMPAIRED INDIVIDUAL.—

2 “(A) IN GENERAL.—The term ‘functionally
3 impaired individual’ means any individual who
4 is certified by a licensed health care practitioner
5 (other than a relative of such individual) as
6 being unable to perform, without substantial as-
7 sistance from another individual (including as-
8 sistance involving verbal reminding, physical
9 cueing, or substantial supervision), at least 3
10 activities of daily living described in paragraph
11 (3).

12 “(B) SPECIAL RULE FOR HOME HEALTH
13 CARE SERVICES.—In the case of services which
14 are provided during any period during which an
15 individual is residing within the individual’s
16 home (whether or not the services are provided
17 within the home), subparagraph (A) shall be
18 applied by substituting ‘2’ for ‘3’. For purposes
19 of this subparagraph, a nursing home or similar
20 facility shall not be treated as a home.

21 “(3) ACTIVITIES OF DAILY LIVING.—Each of
22 the following is an activity of daily living:

23 “(A) Eating.

24 “(B) Transferring.

25 “(C) Toileting.

1 “(D) Dressing.

2 “(E) Bathing.

3 “(4) LICENSED HEALTH CARE PRACTI-
4 TIONER.—

5 “(A) IN GENERAL.—The term ‘licensed
6 health care practitioner’ means—

7 “(i) a physician or registered profes-
8 sional nurse,

9 “(ii) a qualified community care case
10 manager (as defined in subparagraph (B)),
11 or

12 “(iii) any other individual who meets
13 such requirements as may be prescribed by
14 the Secretary after consultation with the
15 Secretary of Health and Human Services.

16 “(B) QUALIFIED COMMUNITY CARE CASE
17 MANAGER.—The term ‘qualified community
18 care case manager’ means an individual or en-
19 tity which—

20 “(i) has experience or has been
21 trained in providing case management
22 services and in preparing individual care
23 plans;

1 “(ii) has experience in assessing indi-
2 viduals to determine their functional and
3 cognitive impairment;

4 “(iii) is not a relative of the individual
5 receiving case management services; and

6 “(iv) meets such requirements as may
7 be prescribed by the Secretary after con-
8 sultation with the Secretary of Health and
9 Human Services.

10 “(5) RELATIVE.—The term ‘relative’ means an
11 individual bearing a relationship to another individ-
12 ual which is described in paragraphs (1) through (8)
13 of section 152(a).”.

14 (c) TECHNICAL AMENDMENTS.—

15 (1) Subparagraph (D) of section 213(d)(1) (as
16 redesignated by subsection (a)) is amended to read
17 as follows:

18 “(D) for a qualified health plan (as defined
19 in section 1601(20) of the Health Equity and
20 Access Reform Today Act of 1993) (including
21 amounts paid as premiums under part B of
22 title XVIII of the Social Security Act, relating
23 to supplementary medical insurance for the
24 aged)—

1 “(i) covering medical care referred to
2 in subparagraphs (A) and (B), or

3 “(ii) covering medical care referred to
4 in subparagraph (C), but only if such cov-
5 erage is provided under a qualified long-
6 term care insurance contract (as defined in
7 section 7702B(b)).”

8 (2) Paragraph (6) of section 213(d) is amend-
9 ed—

10 (A) by striking “subparagraphs (A) and
11 (B)” in the matter preceding subparagraph (A)
12 and inserting “subparagraphs (A), (B), and
13 (C)”, and

14 (B) by striking “paragraph (1)(C)” in sub-
15 paragraph (A) and inserting “paragraph
16 (1)(D)”.

17 (3) Paragraph (7) of section 213(d) is amended
18 by striking “subparagraphs (A) and (B)” and insert-
19 ing “subparagraphs (A), (B), and (C)”.

20 **SEC. 2202. TREATMENT OF LONG-TERM CARE INSURANCE**
21 **OR PLANS.**

22 (a) GENERAL RULE.—Chapter 79 (relating to defini-
23 tions) is amended by inserting after section 7702A the fol-
24 lowing new section:

1 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE**
2 **OR PLANS.**

3 “(a) GENERAL RULE.—For purposes of this title—

4 “(1) a qualified long-term care insurance con-
5 tract shall be treated as an accident or health insur-
6 ance contract,

7 “(2) any plan of an employer providing cov-
8 erage of qualified long-term care services shall be
9 treated as an accident or health plan with respect to
10 such services,

11 “(3) amounts received under such a contract or
12 plan with respect to qualified long-term care services
13 shall be treated as amounts received for personal in-
14 juries or sickness, and

15 “(4) payments described in subsection (b)(5)
16 shall be treated as payments made with respect to
17 qualified long-term care services.

18 “(b) QUALIFIED LONG-TERM CARE INSURANCE
19 CONTRACT.—

20 “(1) IN GENERAL.—For purposes of this title,
21 the term ‘qualified long-term care insurance con-
22 tract’ means any insurance contract if—

23 “(A) the only insurance protection pro-
24 vided under such contract is coverage of quali-
25 fied long-term care services,

1 “(B) such contract meets the requirements
2 of paragraphs (2), (3), and (4), and

3 “(C) such contract is issued by a qualified
4 issuer.

5 “(2) PREMIUM REQUIREMENTS.—

6 “(A) IN GENERAL.—The requirements of
7 this paragraph are met with respect to a con-
8 tract if such contract provides that—

9 “(i) premium payments may not be
10 made earlier than the date such payments
11 would have been made if the contract pro-
12 vided for level annual payments over the
13 life of the contract (or, if shorter, 20
14 years), and

15 “(ii) all refunds of premiums, and all
16 policyholder dividends or similar amounts,
17 under such contract are to be applied as a
18 reduction in future premiums or to in-
19 crease future benefits.

20 A contract shall not be treated as failing to
21 meet the requirements of clause (i) solely by
22 reason of a provision providing for a waiver of
23 premiums if the policyholder becomes a func-
24 tionally impaired individual.

1 “(B) REFUNDS UPON DEATH OR COM-
2 PLETE SURRENDER OR CANCELLATION.—Sub-
3 paragraph (A)(ii) shall not apply to any refund
4 on the death of the policyholder, or on any com-
5 plete surrender or cancellation of the contract,
6 if, under the contract, the amount refunded
7 may not exceed the amount of the premiums
8 paid under the contract. For purposes of this
9 title, any refund described in the preceding sen-
10 tence shall be includible in gross income to the
11 extent that any deduction or exclusion was al-
12 lowed with respect to the refund.

13 “(3) BORROWING, PLEDGING, OR ASSIGNING
14 PROHIBITED.—The requirements of this paragraph
15 are met with respect to a contract if such contract
16 provides that no money may be borrowed under such
17 contract and that such contract (or any portion
18 thereof) may not be assigned or pledged as collateral
19 for a loan.

20 “(4) PROHIBITION OF DUPLICATE PAYMENT.—
21 The requirements of this paragraph are met with re-
22 spect to a contract if such contract does not cover
23 expenses incurred to the extent that such expenses
24 are reimbursable under title XVIII of the Social Se-
25 curity Act.

1 “(5) PER DIEM AND OTHER PERIODIC PAY-
2 MENTS PERMITTED.—

3 “(A) IN GENERAL.—For purposes of sub-
4 section (a)(4), and except as provided in sub-
5 paragraph (B), payments are described in this
6 paragraph for any calendar year if, under the
7 contract, such payments are made to (or on be-
8 half of) a functionally impaired individual on a
9 per diem or other periodic basis without regard
10 to the expenses incurred or services rendered
11 during the period to which the payments relate.

12 “(B) EXCEPTION WHERE AGGREGATE PAY-
13 MENTS EXCEED LIMIT.—If the aggregate pay-
14 ments under the contract for any period
15 (whether on a periodic basis or otherwise) ex-
16 ceed the dollar amount in effect for such pe-
17 riod—

18 “(i) subparagraph (A) shall not apply
19 for such period, and

20 “(ii) the requirements of paragraph
21 (1)(A) shall be met only if such payments
22 are made with respect to qualified long-
23 term care services provided during such
24 period.

1 “(C) DOLLAR AMOUNT.—The dollar
2 amount in effect under this paragraph shall be
3 \$100 per day (or the equivalent amount in the
4 case of payments on another periodic basis).

5 “(D) ADJUSTMENTS FOR INCREASED
6 COSTS.—

7 “(i) IN GENERAL.—In the case of any
8 calendar year after 1995, the dollar
9 amount in effect under subparagraph (C)
10 for any period occurring during such cal-
11 endar year shall be equal to the sum of—

12 “(I) the amount in effect under
13 subparagraph (C) for the preceding
14 calendar year (after application of this
15 subparagraph), plus

16 “(II) the applicable percentage of
17 the amount under subclause (I).

18 “(ii) APPLICABLE PERCENTAGE.—For
19 purposes of clause (i), the term ‘applicable
20 percentage’ means, with respect to any cal-
21 endar year, the greater of—

22 “(I) 5 percent, or

23 “(II) the cost-of-living adjust-
24 ment for such calendar year.

1 “(iii) COST-OF-LIVING ADJUST-
2 MENT.—For purposes of clause (ii), the
3 cost-of-living adjustment for any calendar
4 year is the percentage (if any) by which
5 the cost index under clause (iv) for the
6 preceding calendar year exceeds such index
7 for the second preceding calendar year. In
8 the case of any calendar year beginning be-
9 fore 1997, this clause shall be applied by
10 substituting the Consumer Price Index (as
11 defined in section 1(f)(5)) for the cost
12 index under clause (iv).

13 “(iv) COST INDEX.—The Secretary, in
14 consultation with the Secretary of Health
15 and Human Services, shall before January
16 1, 1997, establish a cost index to measure
17 increases in costs of nursing home and
18 similar facilities. The Secretary may from
19 time to time revise such index to the extent
20 necessary to accurately measure increases
21 or decreases in such costs.

22 “(E) AGGREGATION RULE.—For purposes
23 of this paragraph, all contracts issued with re-
24 spect to the same policyholder by the same
25 company shall be treated as 1 contract.

1 “(c) QUALIFIED ISSUER.—For purposes of this sec-
2 tion, the term ‘qualified issuer’ means any person which
3 at the time of the issuance of a long-term care insurance
4 contract—

5 “(1) uses a one year preliminary term method
6 for setting up reserves, and

7 “(2) maintains a capital ratio equal to not less
8 than 25 percent of long-term care insurance pre-
9 mium receivables.

10 “(d) SPECIAL RULES FOR TAX TREATMENT OF POL-
11 ICYHOLDERS.—For purposes of this title, solely with re-
12 spect to the policyholder under any qualified long-term
13 care insurance contract—

14 “(1) AGGREGATE PAYMENTS IN EXCESS OF
15 LIMITS.—If the aggregate payments under all quali-
16 fied long-term care insurance contracts with respect
17 to an policyholder for any period (whether on a peri-
18 odic basis or otherwise) exceed the dollar amount in
19 effect for such period under subsection (b)(5)—

20 “(A) subsection (b)(5) shall not apply for
21 such period, and

22 “(B) such payments shall be treated as
23 made for qualified long-term care services only
24 if made with respect to such services provided
25 during such period.

1 “(2) ASSIGNMENT OR PLEDGE.—Such contract
2 shall not be treated as a qualified long-term care in-
3 surance contract during any period on or after the
4 date on which the contract (or any portion thereof)
5 is assigned or pledged as collateral for a loan.

6 “(e) TREATMENT OF COVERAGE AS PART OF A LIFE
7 INSURANCE CONTRACT.—Except as provided in regula-
8 tions, in the case of coverage of qualified long-term care
9 services provided as part of a life insurance contract, the
10 requirements of this section shall apply as if the portion
11 of the contract providing such coverage was a separate
12 contract.

13 “(f) QUALIFIED LONG-TERM CARE SERVICES.—For
14 purposes of this section—

15 “(1) IN GENERAL.—The term ‘qualified long-
16 term care services’ has the meaning given such term
17 by section 213(g).

18 “(2) RECERTIFICATION.—If an individual has
19 been certified as a functionally impaired individual
20 under section 213(g)(2)(A), services shall not be
21 treated as qualified long-term care services with re-
22 spect to the individual unless such individual is
23 recertified no less frequently than annually as a
24 functionally impaired individual in the same manner
25 as under such section, except that such

1 recertification may be made by any licensed health
2 care practitioner (as defined in section 213(g)(4)),
3 other than a relative (as defined by section
4 213(g)(5)) of such individual.

5 “(g) CONTINUATION COVERAGE EXCISE TAX NOT
6 TO APPLY.—Section 4980B shall not apply to—

7 “(1) qualified long-term care insurance con-
8 tracts, or

9 “(2) plans described in subsection (a)(2).

10 “(h) REGULATIONS.—The Secretary shall prescribe
11 such regulations as may be necessary to carry out the re-
12 quirements of this section, including regulations to prevent
13 the avoidance of this section by providing qualified long-
14 term care services under a life insurance contract.”.

15 (b) CLERICAL AMENDMENT.—The table of sections
16 for chapter 79 is amended by inserting after the item re-
17 lating to section 7702A the following new item:

 “Sec. 7702B. Treatment of long-term care insurance or plans.”

18 **SEC. 2203. EFFECTIVE DATES.**

19 (a) SECTION 2201.—The amendments made by sec-
20 tion 2201 shall apply to taxable years beginning after De-
21 cember 31, 1994.

22 (b) SECTION 2202.—The amendments made by sec-
23 tion 2202 shall apply to contracts issued after December
24 31, 1994.

1 (c) TRANSITION RULE.—If, after the date of the en-
 2 actment of this Act and before January 1, 1995, a con-
 3 tract providing coverage for services which are similar to
 4 qualified long-term care services (as defined in section
 5 213(g) of the Internal Revenue Code of 1986) and issued
 6 on or before January 1, 1994, is exchanged for a qualified
 7 long-term care insurance contract (as defined in section
 8 7702B(b) of such Code), such exchange shall be treated
 9 as an exchange to which section 1035 of such Code ap-
 10 plies.

11 **PART II—CONSUMER PROTECTION PROVISIONS**

12 **SEC. 2301. POLICY REQUIREMENTS.**

13 (a) IN GENERAL.—Section 7702B (as added by sec-
 14 tion 2202) is amended by redesignating subsection (h) as
 15 subsection (i) and by inserting after subsection (g) the fol-
 16 lowing new subsection:

17 “(h) CONSUMER PROTECTION PROVISIONS.—

18 “(1) IN GENERAL.—The requirements of this
 19 subsection are met with respect to any contract if
 20 any long-term care insurance policy issued under the
 21 contract meets—

22 “(A) the requirements of the model regula-
 23 tion and model Act described in paragraph (2),

24 “(B) the disclosure requirement of para-
 25 graph (3),

1 “(C) the requirements relating to
2 nonforfeitability under paragraph (4), and

3 “(D) the requirements relating to rate sta-
4 bilization under paragraph (5).

5 “(2) REQUIREMENTS OF MODEL REGULATION
6 AND ACT.—

7 “(A) IN GENERAL.—The requirements of
8 this paragraph are met with respect to any pol-
9 icy if such policy meets—

10 “(i) MODEL REGULATION.—The fol-
11 lowing requirements of the model regula-
12 tion:

13 “(I) Section 7A (relating to guar-
14 anteed renewal or noncancellability),
15 and the requirements of section 6B of
16 the model Act relating to such section
17 7A.

18 “(II) Section 7B (relating to pro-
19 hibitions on limitations and exclu-
20 sions).

21 “(III) Section 7C (relating to ex-
22 tension of benefits).

23 “(IV) Section 7D (relating to
24 continuation or conversion of cov-
25 erage).

1 “(V) Section 7E (relating to dis-
2 continuance and replacement of poli-
3 cies).

4 “(VI) Section 8 (relating to unin-
5 tentional lapse).

6 “(VII) Section 9 (relating to dis-
7 closure), other than section 9F there-
8 of.

9 “(VIII) Section 10 (relating to
10 prohibitions against post-claims un-
11 derwriting).

12 “(IX) Section 11 (relating to
13 minimum standards).

14 “(X) Section 12 (relating to re-
15 quirement to offer inflation protec-
16 tion), except that any requirement for
17 a signature on a rejection of inflation
18 protection shall permit the signature
19 to be on an application or on a sepa-
20 rate form.

21 “(XI) Section 23 (relating to pro-
22 hibition against preexisting conditions
23 and probationary periods in replace-
24 ment policies or certificates).

1 “(ii) MODEL ACT.—The following re-
2 quirements of the model Act:

3 “(I) Section 6C (relating to pre-
4 existing conditions).

5 “(II) Section 6D (relating to
6 prior hospitalization).

7 “(B) DEFINITIONS.—For purposes of this
8 paragraph—

9 “(i) MODEL PROVISIONS.—The terms
10 ‘model regulation’ and ‘model Act’ mean
11 the long-term care insurance model regula-
12 tion, and the long-term care insurance
13 model Act, respectively, promulgated by
14 the National Association of Insurance
15 Commissioners (as adopted in January of
16 1993).

17 “(ii) COORDINATION.—Any provision
18 of the model regulation or model Act listed
19 under clause (i) or (ii) of subparagraph
20 (A) shall be treated as including any other
21 provision of such regulation or Act nec-
22 essary to implement the provision.

23 “(3) TAX DISCLOSURE REQUIREMENT.—The re-
24 quirement of this paragraph is met with respect to

1 any policy if such policy meets the requirements of
2 section 4980D(d)(1).

3 “(4) NONFORFEITURE REQUIREMENTS.—

4 “(A) IN GENERAL.—The requirements of
5 this paragraph are met with respect to any level
6 premium long-term care insurance policy, if the
7 issuer of such policy offers to the policyholder,
8 including any group policyholder, a
9 nonforfeiture provision.

10 “(B) REQUIREMENTS OF PROVISION.—The
11 nonforfeiture provision required under subpara-
12 graph (A) shall meet the following require-
13 ments:

14 “(i) The nonforfeiture provision shall
15 be appropriately captioned.

16 “(ii) The nonforfeiture provision shall
17 provide for a benefit available in the event
18 of a default in the payment of any pre-
19 miums and the amount of the benefit may
20 be adjusted subsequent to being initially
21 granted only as necessary to reflect
22 changes in claims, persistency, and interest
23 as reflected in changes in rates for pre-
24 mium paying policies approved by the Sec-
25 retary for the same policy form.

1 “(iii) The nonforfeiture provision shall
2 provide at least one of the following:

3 “(I) Reduced paid-up insurance.

4 “(II) Extended term insurance.

5 “(III) Shortened benefit period.

6 “(IV) Other similar offerings ap-
7 proved by the Secretary.

8 “(5) RATE STABILIZATION.—

9 “(A) IN GENERAL.—The requirements of
10 this paragraph are met with respect to any
11 long-term care insurance policy, including any
12 group master policy, if—

13 “(i) such policy contains the minimum
14 rate guarantees specified in subparagraph
15 (B), and

16 “(ii) the issuer of such policy meets
17 the requirements specified in subparagraph
18 (C).

19 “(B) MINIMUM RATE GUARANTEES.—The
20 minimum rate guarantees specified in this sub-
21 paragraph are as follows:

22 “(i) Rates under the policy shall be
23 guaranteed for a period of at least 3 years
24 from the date of issue of the policy.

1 “(ii) After the expiration of the 3-year
2 period required under clause (i), any rate
3 increase shall be guaranteed for a period of
4 at least 2 years from the effective date of
5 such rate increase.

6 “(iii) In the case of any individual age
7 75 or older who has maintained coverage
8 under a long-term care insurance policy for
9 10 years, rate increases under such policy
10 shall not exceed 10 percent in any 12-
11 month period.

12 “(C) INCREASES IN PREMIUMS.—The re-
13 quirements specified in this subparagraph are
14 as follows:

15 “(i) IN GENERAL.—If an issuer of any
16 long-term care insurance policy, including
17 any group master policy, plans to increase
18 the premium rates for a policy, such issuer
19 shall, at least 90 days before the effective
20 date of the rate increase, offer to each in-
21 dividual policyholder under such policy the
22 option to remain insured under the policy
23 at a reduced level of benefits which main-
24 tains the premium rate at the rate in effect

1 on the day before the effective date of the
2 rate increase.

3 “(ii) INCREASES OF MORE THAN 50
4 PERCENT.—

5 “(I) IN GENERAL.—If an issuer
6 of any long-term care insurance pol-
7 icy, including any group master pol-
8 icy, increases premium rates for a pol-
9 icy by more than 50 percent in any 3-
10 year period—

11 “(aa) in the case of a group
12 master long-term care insurance
13 policy, the issuer shall dis-
14 continue issuing all group master
15 long-term care insurance policies
16 in any State in which the issuer
17 issues such policy for a period of
18 2 years from the effective date of
19 such premium increase; and

20 “(bb) in the case of an indi-
21 vidual long-term care insurance
22 policy, the issuer shall dis-
23 continue issuing all individual
24 long-term care policies in any
25 State in which the issuer issues

1 such policy for a period of 2
2 years from the effective date of
3 such premium increase.

4 “(II) APPLICABILITY.—Subclause
5 (I) shall apply to any issuer of long-
6 term care insurance policies or any
7 other person that purchases or other-
8 wise acquires any long-term care in-
9 surance policies from another issuer
10 or person.

11 “(D) MODIFICATIONS OR WAIVERS OF RE-
12 QUIREMENTS.—The Secretary may modify or
13 waive any of the requirements under this para-
14 graph if—

15 “(i) such requirements will adversely
16 effect an issuer’s solvency;

17 “(ii) such modification or waiver is re-
18 quired for the issuer to meet other State or
19 Federal requirements;

20 “(iii) medical developments, new dis-
21 abling diseases, changes in long-term care
22 delivery, or a new method of financing
23 long-term care will result in changes to
24 mortality and morbidity patterns or as-
25 sumptions;

1 “(iv) judicial interpretation of a pol-
2 icy’s benefit features results in unintended
3 claim liabilities; or

4 “(v) in the case of a purchase or other
5 acquisition of long-term care insurance
6 policies of an issuer or other person, the
7 continued sale of other long-term care in-
8 surance policies by the purchasing issuer
9 or person is in the best interests of individ-
10 ual consumers.

11 “(6) LONG-TERM CARE INSURANCE POLICY DE-
12 FINED.—For purposes of this subsection, the term
13 ‘long-term care insurance policy’ has the meaning
14 given such term by section 4980D(e).”.

15 (b) CONFORMING AMENDMENT.—Section
16 7702B(b)(1)(B) (as added by section 2202) is amended
17 by inserting “and of subsection (h)” after “and (4)”.

18 **SEC. 2302. ADDITIONAL REQUIREMENTS FOR ISSUERS OF**
19 **LONG-TERM CARE INSURANCE POLICIES.**

20 (a) IN GENERAL.—Chapter 43, as amended by sec-
21 tion 2403, is amended by adding at the end the following
22 new section:

1 **“SEC. 4980D. FAILURE TO MEET REQUIREMENTS FOR**
2 **LONG-TERM CARE INSURANCE POLICIES.**

3 “(a) GENERAL RULE.—There is hereby imposed on
4 any person failing to meet the requirements of subsection
5 (c) or (d) a tax in the amount determined under sub-
6 section (b).

7 “(b) AMOUNT OF TAX.—

8 “(1) IN GENERAL.—The amount of the tax im-
9 posed by subsection (a) shall be \$100 per policy for
10 each day any requirements of subsection (c), (d), or
11 (e) are not met with respect to each long-term care
12 insurance policy.

13 “(2) WAIVER.—In the case of a failure which is
14 due to reasonable cause and not to willful neglect,
15 the Secretary may waive part or all of the tax im-
16 posed by subsection (a) to the extent that payment
17 of the tax would be excessive relative to the failure
18 involved.

19 “(c) ADDITIONAL RESPONSIBILITIES.—The require-
20 ments of this subsection are as follows:

21 “(1) REQUIREMENTS OF MODEL PROVISIONS.—

22 “(A) MODEL REGULATION.—The following
23 requirements of the model regulation must be
24 met:

25 “(i) Section 13 (relating to application
26 forms and replacement coverage).

1 “(ii) Section 14 (relating to reporting
2 requirements), except that the issuer shall
3 also report at least annually the number of
4 claims denied during the reporting period
5 for each class of business (expended as a
6 percentage of claims denied), other than
7 claims denied for failure to meet the wait-
8 ing period or because of any applicable
9 pre-existing condition.

10 “(iii) Section 20 (relating to filing re-
11 quirements for marketing).

12 “(iv) Section 21 (relating to standards
13 for marketing), including inaccurate com-
14 pletion of medical histories, other than sec-
15 tion 21C(1) and 21C(6) thereof, except
16 that—

17 “(I) in addition to such require-
18 ments, no person shall, in selling or
19 offering to sell a long-term care insur-
20 ance policy, misrepresent a material
21 fact; and

22 “(II) no such requirements shall
23 include a requirement to inquire or
24 identify whether a prospective appli-
25 cant or enrollee for long-term care in-

1 insurance has accident and sickness in-
2 surance.

3 “(v) Section 22 (relating to appro-
4 priateness of recommended purchase).

5 “(vi) Section 24 (relating to standard
6 format outline of coverage).

7 “(vii) Section 25 (relating to require-
8 ment to deliver shopper’s guide).

9 “(B) MODEL ACT.—The following require-
10 ments of the model Act must be met:

11 “(i) Section 6F (relating to right to
12 return), except that such section shall also
13 apply to denials of applications and any re-
14 fund shall be made within 30 days of the
15 return or denial.

16 “(ii) Section 6G (relating to outline of
17 coverage).

18 “(iii) Section 6H (relating to require-
19 ments for certificates under group plans).

20 “(iv) Section 6I (relating to policy
21 summary).

22 “(v) Section 6J (relating to monthly
23 reports on accelerated death benefits).

24 “(vi) Section 7 (relating to incontest-
25 ability period).

1 “(C) DEFINITIONS.—For purposes of this
2 paragraph, the terms ‘model regulation’ and
3 ‘model Act’ have the meanings given such terms
4 by section 7702B(h)(2)(B).

5 “(2) DELIVERY OF POLICY.—If an application
6 for a long-term care insurance policy (or for a cer-
7 tificate under a group long-term care insurance pol-
8 icy) is approved, the issuer shall deliver to the appli-
9 cant (or policyholder or certificate-holder) the policy
10 (or certificate) of insurance not later than 30 days
11 after the date of the approval.

12 “(3) INFORMATION ON DENIALS OF CLAIMS.—
13 If a claim under a long-term care insurance policy
14 is denied, the issuer shall, within 60 days of the date
15 of a written request by the policyholder or certifi-
16 cate-holder (or representative)—

17 “(A) provide a written explanation of the
18 reasons for the denial, and

19 “(B) make available all information di-
20 rectly relating to such denial.

21 “(d) DISCLOSURE.—The requirements of this sub-
22 section are met if either of the following statements,
23 whichever is applicable, is prominently displayed on the
24 front page of any long-term care insurance policy and in

1 the outline of coverage required under subsection
2 (c)(1)(B)(ii):

3 “(1) A statement that: ‘This policy is intended
4 to be a qualified long-term care insurance contract
5 under section 7702B(b) of the Internal Revenue
6 Code of 1986.’.

7 “(2) A statement that: ‘This policy is not in-
8 tended to be a qualified long-term care insurance
9 contract under section 7702B(b) of the Internal
10 Revenue Code of 1986.’.

11 “(e) LONG-TERM CARE INSURANCE POLICY DE-
12 FINED.—For purposes of this section, the term ‘long-term
13 care insurance policy’ means any product which is adver-
14 tised, marketed, or offered as long-term care insurance.”.

15 (b) CONFORMING AMENDMENT.—The table of sec-
16 tions for chapter 43, as amended by section 2403, is
17 amended by adding at the end the following new item:

“Sec. 4980D. Failure to meet requirements for long-term care in-
surance policies.”.

18 **SEC. 2303. COORDINATION WITH STATE REQUIREMENTS.**

19 Nothing in this subtitle shall be construed as prevent-
20 ing a State from applying standards that provide greater
21 protection of policyholders of long-term care insurance
22 policies (as defined in section 4980D(e) of the Internal
23 Revenue Code of 1986).

1 **SEC. 2304. UNIFORM LANGUAGE AND DEFINITIONS.**

2 (a) IN GENERAL.—The National Association of In-
3 surance Commissioners shall not later than January 1,
4 1995, promulgate standards for the use of uniform lan-
5 guage and definitions in long-term care insurance policies
6 (as defined in section 4980D(e) of the Internal Revenue
7 Code 1986).

8 (b) VARIATIONS.—Standards under subsection (a)
9 may permit the use of nonuniform language to the extent
10 required to take into account differences among States in
11 the licensing of nursing facilities and other providers of
12 long-term care.

13 **SEC. 2305. EFFECTIVE DATES.**

14 (a) SECTION 2301.—The amendments made by sec-
15 tion 2301 shall apply to contracts issued after December
16 31, 1994. The provisions of section 2203(c) of this Act
17 shall apply to such contracts.

18 (b) SECTION 2302.—The amendments made by sec-
19 tion 2302 shall apply to actions taken after December 31,
20 1994.

21 **Subtitle D—Enforcement**
22 **Provisions**

23 **PART I—GENERAL PROVISIONS**

24 **SEC. 2401. UNIVERSAL COVERAGE.**

25 (a) REQUIRED REPORTING.—

1 (1) IN GENERAL.—Section 1144 of the Social
2 Security Act (42 U.S.C. 1320b–14) is amended to
3 read as follows:

4 “HEALTH INSURANCE COVERAGE DATA BANK

5 “SEC. 1144. (a) ESTABLISHMENT OF DATA BANK.—

6 The Secretary shall establish a Health Insurance Coverage
7 Data Bank (hereafter in this section referred to as the
8 ‘Data Bank’) to—

9 “(1) further the purposes of subtitle F of title
10 I of the Health Equity and Access Reform Today
11 Act of 1993,

12 “(2) further the purposes of section 1862(b) in
13 the identification of, and collection from, third par-
14 ties responsible for payment for health care items
15 and services furnished to medicare beneficiaries, and

16 “(3) assist in the identification of, and the col-
17 lection from, third parties responsible for the reim-
18 bursement of costs incurred by any State plan under
19 title XIX with respect to medicaid beneficiaries,
20 upon request by the State agency described in sec-
21 tion 1902(a)(5) administering such plan.

22 “(b) INFORMATION IN DATA BANK.—

23 “(1) IN GENERAL.—The Data Bank shall con-
24 tain information obtained pursuant to section
25 6103(l)(12) of the Internal Revenue Code of 1986
26 and subsection (c).

1 “(2) DISCLOSURE OF INFORMATION IN DATA
2 BANK.—The Secretary is authorized until September
3 30, 1998—

4 “(A) (subject to the restriction in subpara-
5 graph (D)(i) of section 6103(l)(12) of the Inter-
6 nal Revenue Code of 1986) to disclose any in-
7 formation in the Data Bank obtained pursuant
8 to such section solely for the purposes of such
9 section,

10 “(B) (subject to the restriction in sub-
11 section (c)(5)) to disclose any other information
12 in the Data Bank to any State agency described
13 in section 1902(a)(5), employer, or qualified
14 health plan solely for the purposes described in
15 subsection (a), and

16 “(C) to disclose any other information in
17 the Data Bank to the Secretary of the Treasury
18 for the purpose of carrying out the purposes of
19 section 5000A of the Internal Revenue Code of
20 1986.

21 “(c) REQUIREMENT TO REPORT INFORMATION.—

22 “(1) REPORTING REQUIREMENT.—

23 “(A) IN GENERAL.—Any employer de-
24 scribed in paragraph (2), any qualified health
25 plan in the case of individuals enrolling in non-

1 employer-provided plans, and any governmental
2 or nongovernmental official responsible for any
3 equivalent health care program (as defined in
4 section 1601(7) of the Health Equity and Ac-
5 cess Reform Today Act of 1993 shall report to
6 the Secretary (in such form and manner as the
7 Secretary determines will minimize the burden
8 of such reporting) with respect to each individ-
9 ual the information required under paragraph
10 (3) for each applicable calendar year.

11 “(B) SPECIAL RULE.—To the extent a
12 qualified health plan provides information re-
13 quired under paragraph (3) in a form and man-
14 ner specified by the Secretary (in consultation
15 with the Secretary of Labor) on behalf of an
16 employer in accordance with section 101(f) of
17 the Employee Retirement Income Security Act
18 of 1974, the employer has complied with the re-
19 porting requirement under subparagraph (A)
20 with respect to the reporting of such informa-
21 tion.

22 “(C) APPLICABLE YEAR.—For purposes of
23 this paragraph, the term ‘applicable calendar
24 year’ means any calendar year beginning after
25 1994, and before the calendar year with respect

1 to which the Secretary makes a determination
2 that the health care data interchange system
3 established under subtitle B of title III of the
4 Health Equity and Access Reform Today Act of
5 1993 is providing the information necessary to
6 meet the purposes described in subsection (a).

7 “(2) EMPLOYER DESCRIBED.—

8 “(A) IN GENERAL.—An employer is de-
9 scribed in this paragraph if such employer has,
10 or contributes to, a qualified health plan, with
11 respect to which at least 1 employee of such
12 employer is an electing individual.

13 “(B) ELECTING INDIVIDUAL.—For pur-
14 poses of this paragraph, the term ‘electing indi-
15 vidual’ means an individual associated or for-
16 merly associated with the employer in a busi-
17 ness relationship who elects coverage under the
18 employer’s qualified health plan.

19 “(C) CERTAIN INDIVIDUALS EXCLUDED.—
20 For purposes of this paragraph, an individual
21 providing service referred to in section
22 3121(a)(7)(B) of the Internal Revenue Code of
23 1986 shall not be considered an employee or
24 electing individual with respect to an employer.

1 “(3) INFORMATION REQUIRED.—For purposes
2 of paragraph (1), each employer, qualified health
3 plan, or Secretary shall provide the following infor-
4 mation:

5 “(A) The name and TIN of the individual.

6 “(B) The type of qualified health plan cov-
7 erage (single or family) elected by the individ-
8 ual.

9 “(C) The name, address, and identifying
10 number of the qualified health plan elected by
11 such individual.

12 “(D) The name and TIN of each other in-
13 dividual covered under the qualified health plan
14 pursuant to such election.

15 “(E) The period during which such cov-
16 erage is elected.

17 “(F) The name, address, and TIN of the
18 employer or qualified health plan.

19 “(4) TIME OF FILING.—For purposes of deter-
20 mining the date for filing the report under para-
21 graph (1), such report shall be treated as a state-
22 ment described in section 6051(d) of the Internal
23 Revenue Code of 1986.

24 “(5) LIMITS ON DISCLOSURE OF INFORMATION
25 REPORTED.—

1 “(A) IN GENERAL.—The disclosure of the
2 information reported under paragraph (1) shall
3 be restricted by the Secretary under rules simi-
4 lar to the rules of subsections (a) and (p) of
5 section 6103 of the Internal Revenue Code of
6 1986.

7 “(B) PENALTY FOR UNAUTHORIZED WILL-
8 FUL DISCLOSURE OF INFORMATION.—The un-
9 authorized disclosure of any information re-
10 ported under paragraph (1) shall be subject to
11 the penalty described in paragraph (1), (2), (3),
12 or (4) of section 7213(a) of such Code.

13 “(6) PENALTY FOR FAILURE TO REPORT.—In
14 the case of the failure of an employer (other than a
15 Federal or other governmental entity) or a qualified
16 health plan to report under paragraph (1)(A) with
17 respect to each individual, the Secretary shall impose
18 a penalty as described in part II of subchapter B of
19 chapter 68 of the Internal Revenue Code of 1986.

20 “(d) FEES FOR DATA BANK SERVICES.—The Sec-
21 retary shall establish fees for services provided under this
22 section which shall remain available, without fiscal year
23 limitation, to the Secretary to cover the administrative
24 costs to the Data Bank of providing such services.

25 “(e) DEFINITIONS.—In this section:

1 “(1) MEDICARE BENEFICIARY.—The term
2 ‘medicare beneficiary’ means an individual entitled
3 to benefits under part A, or enrolled under part B,
4 of title XVIII, but does not include such an individ-
5 ual enrolled in part A under section 1818.

6 “(2) MEDICAID BENEFICIARY.—The term ‘med-
7 icaid beneficiary’ means an individual entitled to
8 benefits under a State plan for medical assistance
9 under title XIX (including a State plan operating
10 under a statewide waiver under section 1115).

11 “(3) QUALIFIED HEALTH PLAN.—The term
12 ‘qualified health plan’ shall have the meaning given
13 to such term by section 1601(20) of the Health Eq-
14 uity and Access Reform Today Act of 1993.

15 “(4) TIN.—The term ‘TIN’ shall have the
16 meaning given to such term by section 7701(a)(41)
17 of such Code.”.

18 (2) MEDICAID CONFORMING AMENDMENTS.—
19 Section 1902(a)(25)(A)(i) of the Social Security Act
20 (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by strik-
21 ing “Medicare and Medicaid Coverage Data Bank”
22 and inserting “Health Insurance Coverage Data
23 Bank”.

24 (3) CONFORMING AMENDMENTS TO ERISA.—
25 Section 101(f) of the Employee Retirement Income

1 Security Act of 1974 (29 U.S.C. 1021(f)) is amend-
2 ed—

3 (A) by striking “(as added by section
4 13581 of the Omnibus Budget Reconciliation
5 Act of 1993)” in paragraph (1)(A), and

6 (B) by striking “Medicare and Medicaid
7 Coverage Data Bank” in paragraph (1)(A)(i)
8 and inserting “Health Insurance Coverage Data
9 Bank”,

10 (4) EFFECTIVE DATE.—The amendments made
11 by this subsection shall take effect on and after the
12 first January 1 following the deadline specified in
13 section 1401(c)(2) of this Act.

14 (b) ENFORCEMENT.—

15 (1) IN GENERAL.—Chapter 47 (relating to ex-
16 cise taxes on qualified pension, etc. plans) is amend-
17 ed by inserting after section 5000 the following new
18 section:

19 **“SEC. 5000A. FAILURE OF INDIVIDUALS WITH RESPECT TO**
20 **HEALTH INSURANCE.**

21 “(a) GENERAL RULE.—There is hereby imposed a
22 tax on the failure of any individual to comply with the
23 requirements of section 1501 of the Health Equity and
24 Access Reform Today Act of 1993.

1 “(b) AMOUNT OF TAX.—The amount of tax imposed
2 by subsection (a) with respect to any calendar year shall
3 be equal to 120 percent of the applicable dollar limit for
4 such year for such individual (within the meaning of sec-
5 tion 91(b)(2) and determined on an annual basis).

6 “(c) LIMITATION ON TAX.—

7 “(1) TAX NOT TO APPLY WHERE FAILURES
8 CORRECTED WITHIN 30 DAYS.—No tax shall be im-
9 posed by subsection (a) with respect to any failure
10 if—

11 “(A) such failure was due to reasonable
12 cause and not to willful neglect, and

13 “(B) such failure is corrected during the
14 30-day period (or such period as the Secretary
15 may determine appropriate) beginning on the
16 1st date any of the individuals on whom the tax
17 is imposed knew, or exercising reasonable dili-
18 gence would have known, that such failure ex-
19 isted.

20 “(2) WAIVER BY SECRETARY.—In the case of a
21 failure which is due to reasonable cause and not to
22 willful neglect, the Secretary may waive part or all
23 of the tax imposed by subsection (a) to the extent
24 that the payment of such tax would be excessive rel-
25 ative to the failure involved.

1 “(3) LOW-ASSISTANCE EXEMPTION.—No tax
2 shall be imposed by subsection (a) on any individual
3 who would have received a voucher for the calendar
4 year under section 1003, but for a decrease in the
5 phase-in eligibility percentage provided under sub-
6 section (d)(5)(B) thereof.”.

7 (2) CLERICAL AMENDMENT.—The table of sec-
8 tions for such chapter 47 is amended by adding at
9 the end the following new item:

“Sec. 5000A. Failure of individuals with respect to health insur-
ance.”.

10 (3) EFFECTIVE DATE.—The amendments made
11 by this section shall take effect on January 1, 2005.

12 **SEC. 2402. ROLE OF EMPLOYERS AND LARGE EMPLOYER**
13 **PLANS.**

14 (a) IN GENERAL.—Chapter 47 (relating to excise
15 taxes on qualified pension, etc. plans), as amended by sec-
16 tion 2401(b)(1), is amended by inserting after section
17 5000A the following new section:

18 **“SEC. 5000B. FAILURE OF EMPLOYERS OR LARGE EM-**
19 **PLOYER PLANS WITH RESPECT TO HEALTH**
20 **INSURANCE.**

21 “(a) GENERAL RULE.—There is hereby imposed a
22 tax on the failure of any person or plan to comply with
23 the requirements of section 1004 or section 1201 of the
24 Health Equity and Access Reform Today Act of 1993 with

1 respect to any employee of the person or enrollee of the
2 plan.

3 “(b) AMOUNT OF TAX.—

4 “(1) IN GENERAL.—The amount of the tax im-
5 posed by subsection (a) on any failure with respect
6 to an employee or enrollee shall be \$100 for each
7 day in the noncompliance period with respect to such
8 failure.

9 “(2) NONCOMPLIANCE PERIOD.—For purposes
10 of this section, the term ‘noncompliance period’
11 means, with respect to any failure, the period—

12 “(A) beginning on the date such failure
13 first occurs, and

14 “(B) ending on the date such failure is
15 corrected.

16 “(3) CORRECTION.—A failure of a person or
17 plan to comply with the requirements of section
18 1004 or section 1201 of the Health Equity and Ac-
19 cess Reform Today Act of 1993 with respect to any
20 employee of the person or enrollee of the plan shall
21 be treated as corrected if—

22 “(A) such failure is retroactively undone to
23 the extent possible, and

24 “(B) the employee or enrollee is placed in
25 a financial position which is as good as such

1 employee or enrollee would have been in had
2 such failure not occurred.

3 “(c) LIMITATIONS ON AMOUNT OF TAX.—

4 “(1) TAX NOT TO APPLY TO FAILURES COR-
5 RECTED WITHIN 30 DAYS.—No tax shall be imposed
6 by subsection (a) on any failure if—

7 “(A) such failure was due to reasonable
8 cause and not to willful neglect, and

9 “(B) such failure is corrected during the
10 30-day period (or such period as the Secretary
11 may determine appropriate) beginning on the
12 first date any of the persons referred to in sub-
13 section (d) knew, or exercising reasonable dili-
14 gence would have known, that such failure ex-
15 isted.

16 “(2) WAIVER BY SECRETARY.—In the case of a
17 failure which is due to reasonable cause and not to
18 willful neglect, the Secretary may waive part or all
19 of the tax imposed by subsection (a) to the extent
20 that the payment of such tax would be excessive rel-
21 ative to the failure involved.

22 “(d) LIABILITY FOR TAX.—

23 “(1) IN GENERAL.—Except as otherwise pro-
24 vided in this subsection, the following shall be liable
25 for the tax imposed by subsection (a) on a failure:

1 “(A) In the case of a health plan other
2 than a multiemployer plan, the employer.

3 “(B) In the case of a multiemployer plan,
4 the plan.

5 “(C) Each person who is responsible (other
6 than in a capacity as an employee) for admin-
7 istering or providing benefits under the health
8 plan and whose act or failure to act caused (in
9 whole or in part) the failure.

10 “(2) SPECIAL RULES FOR PERSONS DESCRIBED
11 IN PARAGRAPH (1)(C).—A person described in sub-
12 paragraph (C) (and not in subparagraphs (A) and
13 (B)) of paragraph (1) shall be liable for the tax im-
14 posed by subsection (a) on any failure only if such
15 person assumed (under a legally enforceable written
16 agreement) responsibility for the performance of the
17 act to which the failure relates.”

18 (b) CLERICAL AMENDMENT.—The table of sections
19 for chapter 47, as amended by section 2401(b)(2), is
20 amended by adding at the end the following new item:

 “Sec. 5000B. Failure of employers and large employer plans with
 respect to health insurance.”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect on or after the first January
23 1 following the deadline specified in section 1401(c)(2).

1 **SEC. 2403. ENFORCEMENT BEFORE STATE CERTIFICATION**
2 **PROGRAMS OR STANDARDS IN PLACE.**

3 (a) ENFORCEMENT BY EXCISE TAX FOR INSUR-
4 ERS.—Chapter 43 (relating to qualified pension, etc.,
5 plans) is amended by adding at the end the following new
6 section:

7 **“SEC. 4980C. FAILURE OF INSURER OR LARGE EMPLOYER**
8 **PLAN TO COMPLY WITH CERTAIN PLAN**
9 **STANDARDS.**

10 “(a) IMPOSITION OF TAX.—

11 “(1) IN GENERAL.—There is hereby imposed a
12 tax on the failure of an insurer or of a sponsor of
13 a large employer plan to comply with the require-
14 ments applicable to such insurer or plan under sec-
15 tion 1103(c) or subparagraph (A) or (B) of section
16 1202(a)(2) of the Health Equity and Access Reform
17 Today Act of 1993.

18 “(2) EXCEPTION.—Paragraph (1) shall not
19 apply to a failure by an insurer in a State if the Sec-
20 retary of Health and Human Services determines
21 that the State has in effect a regulatory enforcement
22 mechanism that provides adequate sanctions with re-
23 spect to such a failure by such an insurer.

24 “(b) AMOUNT OF TAX.—

25 “(1) IN GENERAL.—Subject to paragraph (2),
26 the amount of the tax imposed by subsection (a)

1 shall be \$100 for each day during which such failure
2 persists for each individual to which such failure re-
3 lates. A rule similar to the rule of section
4 4980B(b)(3) shall apply for purposes of this section.

5 “(2) LIMITATION.—The amount of the tax im-
6 posed by subsection (a) for an insurer or plan spon-
7 sor with respect to a health plan shall not exceed 25
8 percent of the amounts received under the plan for
9 coverage during the period such failure persists.

10 “(c) LIABILITY FOR TAX.—The tax imposed by this
11 section shall be paid by the insurer or plan sponsor.

12 “(d) LIMITATIONS ON AMOUNT OF TAX.—

13 “(1) TAX NOT TO APPLY TO FAILURES COR-
14 RECTED WITHIN 30 DAYS.—No tax shall be imposed
15 by subsection (a) on any failure if—

16 “(A) such failure was due to reasonable
17 cause and not to willful neglect, and

18 “(B) such failure is corrected during the
19 30-day period (or such period as the Secretary
20 may determine appropriate) beginning on the
21 first date the insurer or plan sponsor knows, or
22 exercising reasonable diligence could have
23 known, that such failure existed.

24 “(2) WAIVER BY SECRETARY.—In the case of a
25 failure which is due to reasonable cause and not to

1 willful neglect, the Secretary may waive part or all
 2 of the tax imposed by subsection (a) to the extent
 3 that the payment of such tax would be excessive rel-
 4 ative to the failure involved.

5 “(e) DEFINITIONS.—For purposes of this section, the
 6 terms ‘health plan’, ‘insurer’, and ‘self-insured health
 7 plan’ have the meanings given such terms in section 1601
 8 of the Health Equity and Access Reform Today Act of
 9 1993.”.

10 (b) CLERICAL AMENDMENT.—The table of sections
 11 for chapter 43 is amended by adding at the end the follow-
 12 ing new item:

“Sec. 4980C. Failure of insurer or large employer plan to comply
 with certain plan standards.”.

13 (c) EFFECTIVE DATE.—The amendments made by
 14 this section shall take effect on the date of the enactment
 15 of this Act.

16 **SEC. 2404. DISCLOSURE OF INFORMATION REGARDING**
 17 **RECONCILIATION OF ASSISTANCE.**

18 Paragraph (7) of section 6103(l) (relating to disclo-
 19 sure of return information to Federal, State, and local
 20 agencies administering certain programs under the Social
 21 Security Act, the Food Stamp Act of 1977, or title 38,
 22 United States Code, or certain housing assistance pro-
 23 grams) is amended—

1 (1) by striking the semicolon at the end of
2 clauses (i), (ii), (iii), (iv), (v), and (vi) and inserting
3 a period,

4 (2) by striking “; and” at the end of the matter
5 following clause (viii) and inserting a period, and

6 (3) by adding at the end (following the matter
7 following clause (ix)) the following new clause:

8 “(x) voucher assistance provided
9 under section 1003 of the Health Equity
10 and Access Reform Today Act of 1993.”

11 **PART II—OTHER ENFORCEMENT PROVISIONS**

12 **SEC. 2411. CONFORMING ERISA CHANGES REGARDING EN-**
13 **FORCEMENT OF EMPLOYER FAILURES.**

14 (a) IN GENERAL.—Section 502(a) of the Employee
15 Retirement Income Security Act of 1974 (29 U.S.C.
16 1132(a)) is amended by striking “or” at the end of para-
17 graph (5), by striking the period at the end of paragraph
18 (6) and inserting “; or”, and by inserting at the end the
19 following new paragraph:

20 “(7) by an employee of any person, or by the
21 Secretary—

22 “(A) for the relief provided in subsection
23 (c)(4), or

24 “(B) to enjoin any act or practice which
25 violates section 1004 of the Health Equity and

1 Access Reform Today Act of 1993, or to obtain
2 other appropriate equitable relief to redress
3 such violation or to enforce the provisions of
4 such section.”.

5 (b) CIVIL PENALTY.—Section 502(c) of such Act (29
6 U.S.C. 1132(c)) is amended by adding at the end the fol-
7 lowing new paragraph:

8 “(4)(A) The Secretary may assess a civil pen-
9 alty against any employer who fails to meet the re-
10 quirements of section 1004 of the Health Equity
11 and Access Reform Today Act of 1993 in an amount
12 not to exceed \$100 per day from the date of the fail-
13 ure. Such penalty shall not be assessed if a tax has
14 been imposed under section 5000B with respect to
15 the failure.

16 “(B) No penalty shall be imposed under sub-
17 paragraph (A) on any failure during any period for
18 which it is established to the satisfaction of the Sec-
19 retary that the employer did not know, or exercising
20 reasonable diligence would not have known, that
21 such failure existed.

22 “(C) No penalty shall be imposed by subpara-
23 graph (A) on any failure if—

24 “(i) such failure was due to reasonable
25 cause and not to willful neglect, and

1 “(ii) such failure is corrected during the
2 30-day period beginning on the first date the
3 employer knew, or exercising reasonable dili-
4 gence would have known, that such failure ex-
5 isted.

6 “(D) In the case of a failure which is due to
7 reasonable cause and not to willful neglect, the Sec-
8 retary may waive part or all of the penalty imposed
9 by subparagraph (A) to the extent that the payment
10 of such penalty would be excessive relative to the
11 failure involved.”.

12 **SEC. 2412. EQUITABLE RELIEF REGARDING INSURERS FAIL-**
13 **ING TO COMPLY WITH QUALIFIED HEALTH**
14 **PLAN STANDARDS.**

15 (a) IN GENERAL.—The Secretary of Labor may—

16 (1) assess a civil penalty against any insurer
17 who fails to comply with the requirements applicable
18 to the insurer under subtitle B of title I of the
19 Health Equity and Access Reform Today Act of
20 1993 in an amount not to exceed \$100 for each day
21 during which the failure persists, except that the ag-
22 gregate amount of the penalty with respect to any
23 failure shall not exceed 25 percent of the amounts
24 received under the plan during the period during
25 which the failure persists, or

1 (2) bring a civil action—

2 (A) to enjoin an insurer from any such
3 failure, or

4 (B) to obtain other appropriate equitable
5 relief to address any such failure or to enforce
6 the provisions of such subtitle.

7 (b) EXCEPTIONS TO PENALTY.—

8 (1) IN GENERAL.—The provisions of subpara-
9 graphs (B), (C), and (D) of section 502(c)(4) of the
10 Employee Retirement Income Security Act of 1974
11 shall apply to any failure to which subsection (a)(1)
12 applies.

13 (2) EXCEPTION.—Subsection (a)(1) shall not
14 apply to a failure by an insurer in a State if the Sec-
15 retary of Health and Human Services determines
16 that the State has in effect a regulatory enforcement
17 mechanism that provides adequate sanctions with re-
18 spect to such a failure by such an insurer.

19 (3) COORDINATION WITH TAX.—No penalty
20 shall be assessed under subsection (a)(1) if a tax has
21 been imposed under section 5000C with respect to
22 the failure.

23 (c) APPLICABLE RULES.—The provisions of part 5
24 of title I of the Employee Retirement Income Security Act
25 of 1974 shall apply to the extent necessary to effectively

1 carry out, and enforce the requirements under, subsection
2 (a).

3 **TITLE III—QUALITY ASSURANCE**
4 **AND SIMPLIFICATION**

5 **Subtitle A—Quality Assurance**

6 **PART I—STANDARDS AND MEASUREMENTS OF**
7 **QUALITY**

8 **SEC. 3001. STANDARDS FOR QUALITY ASSURANCE AND**
9 **PERFORMANCE MEASURES PROGRAMS.**

10 (a) DEVELOPMENT.—The Secretary, in consultation
11 with relevant agencies (such as the Agency for Health
12 Care Policy and Research and other agencies determined
13 appropriate by the Secretary) and recognized private enti-
14 ties engaged in quality assurance activities related to
15 health insurance (such as the Joint Commission on Ac-
16 creditation of Health Care Organizations and the National
17 Committee for Quality Assurance), shall develop and pub-
18 lish in the Federal Register standards that quality assur-
19 ance programs must comply with. Such standards shall
20 apply to all facilities, including network providers. Such
21 standards may be annually modified if determined appro-
22 priate by the Secretary.

23 (b) QUALITY DATA.—

24 (1) REQUIREMENT.—The Secretary shall en-
25 sure that the standards developed under subsection

1 (a) contain a requirement that a qualified health
2 plan annually provide quality data, including infor-
3 mation concerning treatment outcomes and effective-
4 ness under the plan, to the Secretary, the relevant
5 HCCA and to individuals enrolled in a qualified
6 health plan.

7 (2) **FORMAT.**—The Secretary shall develop and
8 publish in the Federal Register a quality data for-
9 mat that a qualified health plan must adhere to in
10 providing quality data as required under paragraph
11 (1).

12 (c) **PERFORMANCE MEASURES.**—In developing the
13 standards under subsection (a), the Secretary shall ensure
14 that appropriate performance measures are established.
15 Such measures shall be utilized by the Health Care Data
16 Panel established under section 3214 as the basis upon
17 which the specifications and requirements for information
18 under subtitle B of this title will be developed.

19 (d) **PROVIDER RISK PROGRAMS.**—The Secretary
20 shall ensure that the standards developed under sub-
21 section (a) contain a requirement that a qualified health
22 plan provide for a provider risk program to prevent or pro-
23 vide early warning of practices that may result in injury.

24 **SEC. 3002. NATIONAL HEALTH DATA SYSTEM.**

25 (a) **STANDARDIZATION OF INFORMATION.**—

1 (1) IN GENERAL.—The Secretary, in consulta-
2 tion with the States, shall establish standards for
3 the periodic provision by qualified health plans of in-
4 formation under section 1118 to the States and the
5 auditing of the information so provided by the Sec-
6 retary.

7 (2) PATIENT CONFIDENTIALITY.—The stand-
8 ards developed under paragraph (1) shall be estab-
9 lished in a manner that protects the confidentiality
10 of individual enrollees, but may provide for the dis-
11 closure of information which discloses particular pro-
12 viders within a qualified health plan.

13 (b) ANALYSIS OF INFORMATION.—

14 (1) IN GENERAL.—The Secretary shall analyze
15 the information provided to the States under section
16 1118 with respect to qualified health plans.

17 (2) CENTRAL ACCESS.—The Secretary shall
18 make available, in a central location and consistent
19 with subsection (a)(2), all of such analyses.

20 (3) DISTRIBUTION OF ANALYSES.—The Sec-
21 retary shall distribute the analyses in a form, con-
22 sistent with subsection (a)(2), that reports, on a Na-
23 tional, State and community basis, the levels and
24 trends of health care expenditures, the rates and
25 trends in the provision of individual procedures, and

1 (to the extent such procedures are priced separately)
2 the price levels and rates of price change for such
3 procedures. The reports shall include both aggregate
4 and per capita measures for areas and shall include
5 comparative data for different areas.

6 (c) DISTRIBUTION OF INFORMATION.—

7 (1) ANNUAL REPORT ON EXPENDITURES.—The
8 Secretary shall publish annually (beginning with
9 1997) a report on expenditures for procedures, vol-
10 umes of procedures, and, to the extent such proce-
11 dures are priced separately, the prices of procedures.
12 Such report shall be distributed to each qualified
13 health plan, each purchasing group, each Governor,
14 and each State legislature.

15 (2) ANNUAL REPORTS.—The Secretary shall
16 publish an annual report, based on analyses under
17 this section, that identifies—

18 (A) procedures for which, as reflected in
19 variations in use or rates of increase, there ap-
20 pear to be the greatest need to develop valid
21 clinical protocols for clinical decision-making
22 and review,

23 (B) procedures for which, as reflected in
24 price variations and price inflation, there ap-

1 pear to be the greatest need for strengthening
2 competitive purchasing, and

3 (C) States and localities for which, as re-
4 flected in expenditure levels and rates of in-
5 crease, there appear to be the greatest need for
6 additional cost control measures.

7 (3) SPECIAL DISTRIBUTIONS.—The Secretary
8 may provide for the distribution to—

9 (A) a qualified health plan of such infor-
10 mation relating to the plan as may be appro-
11 priate in order to encourage the plan to improve
12 its delivery of care, and

13 (B) business, consumer, and other groups
14 and individuals of such information as may im-
15 prove their ability to effect improvements in the
16 outcomes, quality, and efficiency of health serv-
17 ices.

18 (4) ACCESS BY AGENCY FOR HEALTH CARE
19 POLICY AND RESEARCH.—The Secretary shall make
20 available to the Agency for Health Care Policy and
21 Research information obtained under this section in
22 a manner consistent with subsection (a)(2).

1 **SEC. 3003. MEASURES OF QUALITY OF CARE OF SPECIAL-**
2 **IZED CENTERS OF CARE.**

3 (a) COLLECTION OF INFORMATION.—The Secretary
4 shall provide a process whereby a specialized center of care
5 (as defined in subsection (d)) may submit to the Sec-
6 retary, or such independent entity as the Secretary may
7 designate, such clinical and other information bearing on
8 the quality of care provided with respect to the covered
9 items and services under section 1301 at the center as
10 the Secretary may specify. Such information shall include
11 sufficient information to take into account outcomes and
12 the risk factors associated with individuals receiving care
13 through the center. Such information shall be provided at
14 such frequency (not less often than annually) as the Sec-
15 retary specifies.

16 (b) MEASURES OF QUALITY.—Using information
17 submitted under subsection (a) and information reported
18 under section 3002, the Secretary shall—

19 (1) analyze the performance of such centers
20 with respect to the quality of care provided,

21 (2) rate the performance of such a center with
22 respect to a class of services relative to the perform-
23 ance of other specialized centers of care and relative
24 to the performance of qualified health plans gen-
25 erally, and

26 (3) publish such ratings.

1 (c) USE OF SERVICE MARK FOR SPECIALIZED CEN-
2 TERS OF CARE.—The Secretary may establish a service
3 mark for specialized centers of care the performance of
4 which has been rated under subsection (b). Such service
5 mark shall be treated as if registered under the Trade-
6 mark Act of 1946. For purposes of such Act, such service
7 mark shall be deemed to be used in commerce. For pur-
8 poses of this subsection, the “Trademark Act of 1946”
9 refers to the Act entitled “An Act to provide for the reg-
10 istration and protection of trademarks used in commerce,
11 to carry out the provisions of international conventions,
12 and for other purposes”, approved July 5, 1946 (15
13 U.S.C. 1051 et seq.).

14 (d) SPECIALIZED CENTER OF CARE DEFINED.—As
15 used in this section, the term “specialized center of care”
16 means an institution or other organized system for the
17 provision of specific services, which need not be multi-dis-
18 ciplinary, and does not include (except as the Secretary
19 may provide) individual practitioners.

20 **SEC. 3004. CLINICAL EVALUATIONS.**

21 (a) ESTABLISHMENT.—The Secretary shall examine
22 the feasibility of creating an Agency for Clinical Evalua-
23 tions (to be headed by an Administrator) under which the
24 following responsibilities will be consolidated:

1 (1) Responsibilities of the Administrator for
2 Health Care Policy and Research, under title IX of
3 the Public Health Service Act and under section
4 1142 of the Social Security Act.

5 (2) Responsibilities of the Director of the Na-
6 tional Center for Health Statistics (under section
7 306 of the Public Health Service Act).

8 (3) Responsibilities of the Director of the Office
9 of Medical Applications of Research at the National
10 Institutes of Health.

11 (4) Responsibilities of the Director of the Office
12 of Research and Demonstrations of the Health Care
13 Financing Administration, insofar as such respon-
14 sibilities relate to clinical evaluations.

15 (b) SPECIFIC DUTIES.—In addition to carrying out
16 subsection (a), the Secretary shall—

17 (1) set priorities for the research community to
18 strengthen the research base;

19 (2) support research and evaluation (both on a
20 contract and investigator-initiated basis) on medical
21 effectiveness through technology assessment, consen-
22 sus development, outcomes research practice guide-
23 lines, and other appropriate activities;

1 (3) conduct effectiveness trials in collaboration
2 with medical specialty societies, medical educators,
3 and qualified health plans;

4 (4) maintain a clearinghouse and other reg-
5 istries on clinical trials and outcomes research data;

6 (5) assure the systematic evaluation of existing
7 as well as new treatments and diagnostic tech-
8 nologies in a constant, continuous effort to upgrade
9 the knowledge base for clinical decisionmaking and
10 policy choice; and

11 (6) design a computerized dissemination system
12 for providers to provide an interactive system of in-
13 formation on outcomes research, practice guidelines,
14 and other information.

15 (c) ASSISTANCE.—The Secretary shall provide the
16 Benefits Commission established under subtitle D of title
17 I with such information, on evaluations related to the cov-
18 ered items and services under section 1301 and any other
19 information developed in the scope of carrying out the re-
20 sponsibilities of the Secretary, as may be appropriate.

21 (d) COOPERATION WITH OTHER AGENCIES.—In car-
22 rying out responsibilities under this section, the Secretary
23 shall cooperate and consult with the Director of the Na-
24 tional Institutes of Health, the Commissioner of Food and

1 Drugs, the Secretary of Veterans Affairs, and the heads
2 of any other interested Federal department or agency.

3 (e) ADDITIONAL AUTHORIZATION OF APPROPRIA-
4 TIONS.—For purposes of carrying out this section, there
5 are authorized to be appropriated \$250,000,000 for each
6 fiscal year (beginning with fiscal year 1995).

7 **SEC. 3005. REPORT AND RECOMMENDATIONS ON ACHIEV-**
8 **ING UNIVERSAL COVERAGE.**

9 (a) FACTORS AFFECTING COVERAGE.—

10 (1) COLLECTION OF INFORMATION.—The Sec-
11 retary, on a continuing basis, shall collect informa-
12 tion concerning, and analyze the number and char-
13 acteristics of, eligible individuals (as defined in sub-
14 section (c)) who are not enrolled with qualified
15 health plans compared to such number and charac-
16 teristics of individuals so enrolled. Such characteris-
17 tics shall include age, sex, race, ethnicity, family sta-
18 tus, employment status, whether the individual is an
19 eligible employee, income, health status, health risk
20 factors, geography, whether the individual resides in
21 a rural or medically underserved area, and such
22 other factors as may affect the election of an eligible
23 individual to obtain health insurance coverage.

24 (2) REPORT.—Not later than April 1 of each
25 year (beginning with 1997), the Secretary shall pre-

1 pare and submit to the appropriate committees of
2 Congress a report analyzing the information col-
3 lected under paragraph (1). Such report shall in-
4 clude an description of the primary factors contrib-
5 uting to lack of coverage of identifiable groups of eli-
6 gible individuals.

7 (b) RECOMMENDATIONS FOR INCREASING COV-
8 ERAGE.—

9 (1) IN GENERAL.—Not later than January 1,
10 1998, the Secretary shall prepare and submit to
11 Congress recommendations on the feasibility, cost-ef-
12 fectiveness, and the economic impact of using dif-
13 ferent voluntary and other methods for increasing
14 the coverage of eligible individuals.

15 (2) INDIVIDUAL MANDATE.—The Secretary
16 shall specifically make recommendations under para-
17 graph (1) regarding establishing a requirement that
18 all eligible individuals obtain health coverage
19 through enrollment with a qualified health plan.

20 (c) ELIGIBLE INDIVIDUAL DEFINED.—In this sec-
21 tion, the term “eligible individual” has the same meaning
22 given such term by section 1601(5).

23 **SEC. 3006. MONITORING REINSURANCE MARKET.**

24 (a) IN GENERAL.—The Secretary shall monitor the
25 reinsurance market for qualified health plans.

1 (b) PERIODIC REPORTS.—The Secretary shall peri-
2 odically report to Congress respecting the availability of
3 reinsurance for qualified health plans at reasonable rates
4 and the impact of such availability on the establishment
5 of new plans and on the financial solvency of current
6 plans.

7 **SEC. 3007. AUTHORIZATION OF APPROPRIATIONS.**

8 There are authorized to be appropriated to the Bene-
9 fits Commission established under subtitle D of title I for
10 each of fiscal years 1995 through 2001 such sums as may
11 be necessary to carry out activities under this Act.

12 **PART II—AGENCY FOR HEALTH CARE POLICY**
13 **AND RESEARCH**

14 **SEC. 3101. AGENCY FOR HEALTH CARE POLICY AND RE-**
15 **SEARCH.**

16 Title IX of the Public Health Service Act (42 U.S.C.
17 299 et seq.) is amended—

18 (1) in section 902(a) (42 U.S.C. 299a(a))—

19 (A) in the matter preceding paragraph (1),
20 by inserting after “guideline development,” the
21 following: “effectiveness trials (in collaboration
22 with medical speciality societies and qualified
23 health plans under the Health Equity and Ac-
24 cess Reform Today Act of 1993),”;

1 (B) in paragraph (7), by striking “and” at
2 the end thereof;

3 (C) in paragraph (8), by striking the pe-
4 riod and inserting “; and”; and

5 (D) by adding at the end thereof the fol-
6 lowing new paragraph:

7 “(9) priorities that would enable the research
8 community to strengthen and expand the health care
9 research base.”;

10 (2) in section 902, by adding at the end thereof
11 the following new subsections:

12 “(f) CLEARINGHOUSE.—The Administrator shall es-
13 tablish within the Agency a clearinghouse, and such other
14 registries as the Administrator determines are appro-
15 priate, to compile and make available information and re-
16 search data concerning clinical trials undertaken under
17 this title.

18 “(g) FUND INVESTIGATOR.—The Administrator shall
19 appoint an individual to serve as the fund investigator of
20 the Agency. The fund investigator shall be responsible for
21 initiating research, through grants or contracts under this
22 title, with respect to the relationship between health care
23 treatments and outcomes. The fund investigator shall be
24 compensated in accordance with section 925(a)(2).”; and

1 (3) in section 911(b)(2) (42 U.S.C. 299b-
 2 1(b)(2)), by striking “and medical review organiza-
 3 tions” and inserting “, medical review organizations,
 4 and qualified health plans under the Health Equity
 5 and Access Reform Today Act of 1993”.

6 **PART III—NATIONAL FUND FOR MEDICAL**
 7 **RESEARCH**

8 **SEC. 3201. NATIONAL FUND FOR MEDICAL RESEARCH.**

9 (a) DESIGNATION OF OVERPAYMENTS AND CON-
 10 TRIBUTIONS FOR THE NATIONAL FUND FOR MEDICAL
 11 RESEARCH.—

12 (1) IN GENERAL.—Subchapter A of chapter 61
 13 of the Internal Revenue Code of 1986 (relating to
 14 returns and records) is amended by adding at the
 15 end the following new part:

16 **“PART IX—DESIGNATION OF OVERPAYMENTS**
 17 **AND CONTRIBUTIONS FOR THE NATIONAL**
 18 **FUND FOR MEDICAL RESEARCH**

“Sec. 6097. Amounts for the National Fund for Medical Research.

19 **“SEC. 6097. AMOUNTS FOR THE NATIONAL FUND FOR MEDI-**
 20 **CAL RESEARCH.**

21 “(a) IN GENERAL.—Every individual (other than a
 22 nonresident alien) may designate that—

1 “(1) a portion (not less than \$1) of any over-
2 payment of the tax imposed by chapter 1 for the
3 taxable year, and

4 “(2) a cash contribution (not less than \$1),
5 be paid over to the National Fund for Medical Research.
6 In the case of a joint return of a husband and wife, each
7 spouse may designate one-half of any such overpayment
8 of tax (not less than \$2).

9 “(b) MANNER AND TIME OF DESIGNATION.—Any
10 designation under subsection (a) may be made with re-
11 spect to any taxable year only at the time of filing the
12 original return of the tax imposed by chapter 1 for such
13 taxable year. Such designation shall be made either on the
14 1st page of the return or on the page bearing the tax-
15 payer’s signature.

16 “(c) OVERPAYMENTS TREATED AS REFUNDED.—For
17 purposes of this section, any overpayment of tax des-
18 ignated under subsection (a) shall be treated as being re-
19 funded to the taxpayer as of the last day prescribed for
20 filing the return of tax imposed by chapter 1 (determined
21 with regard to extensions) or, if later, the date the return
22 is filed.

23 “(d) DESIGNATED AMOUNTS NOT DEDUCTIBLE.—
24 No amount designated pursuant to subsection (a) shall be

1 allowed as a deduction under section 170 or any other sec-
2 tion for any taxable year.

3 “(e) TERMINATION.—This section shall not apply to
4 taxable years beginning in a calendar year after a deter-
5 mination by the Secretary that the sum of all designations
6 under subsection (a) for taxable years beginning in the
7 second and third calendar years preceding the calendar
8 year is less than \$5,000,000.”.

9 (2) CLERICAL AMENDMENT.—The table of
10 parts for subchapter A of chapter 61 of such Code
11 is amended by adding at the end the following new
12 item:

“Part IX. Designation of overpayments and contributions for the
National Fund for Medical Research.”.

13 (3) EFFECTIVE DATE.—The amendments made
14 by this subsection shall apply to taxable years begin-
15 ning after December 31, 1993.

16 (b) ESTABLISHMENT OF THE NATIONAL FUND FOR
17 MEDICAL RESEARCH.—

18 (1) IN GENERAL.—Subchapter A of chapter 98
19 of the Internal Revenue Code of 1986 (relating to
20 the trust fund code) is amended by adding at the
21 end the following new section:

22 **“SEC. 9512. NATIONAL FUND FOR MEDICAL RESEARCH.**

23 “(a) CREATION OF FUND.—There is established in
24 the Treasury of the United States a fund to be known

1 as the 'National Fund for Medical Research', consisting
2 of such amounts as may be credited or paid to such Fund
3 as provided in this section or section 9602(b).

4 “(b) TRANSFERS TO FUND.—There is hereby trans-
5 ferred to the National Fund for Medical Research
6 amounts equivalent to—

7 “(1) the amounts designated under section
8 6097 (relating to designation of overpayments and
9 contributions to the Fund), and

10 “(2) amounts equivalent to the civil penalties
11 imposed under section 502(c)(4) of the Employee
12 Retirement Income Security Act of 1974 (29 U.S.C.
13 1132(c)) and section 2412 of the Health Equity and
14 Access Reform Today Act of 1993.

15 “(c) EXPENDITURES FROM FUND.—

16 “(1) IN GENERAL.—The Secretary shall pay an-
17 nually, within 30 days after the President signs an
18 appropriations Act for the Departments of Labor,
19 Health and Human Services, and Education, and re-
20 lated agencies, or by the end of the first quarter of
21 the fiscal year, to the Secretary of Health and
22 Human Services on behalf of the National Institutes
23 of Health, an amount equal to the amount in the
24 National Fund for Medical Research at the time of
25 such payment, to carry out the purposes of section

1 404F of the Public Health Service Act, less any ad-
2 ministrative expenses which may be paid under para-
3 graph (2).

4 “(2) ADMINISTRATIVE EXPENSES.—Amounts in
5 the National Fund for Medical Research shall be
6 available to pay the administrative expenses of the
7 Department of the Treasury directly allocable to—

8 “(A) modifying the individual income tax
9 return forms to carry out section 6097,

10 “(B) carrying out this chapter with respect
11 to such Fund, and

12 “(C) processing amounts received under
13 section 6097 and transferring such amounts to
14 such Fund.

15 “(d) BUDGET TREATMENT OF AMOUNTS IN FUND.—
16 The amounts in the National Fund for Medical Research
17 shall be excluded from, and shall not be taken into ac-
18 count, for purposes of any budget enforcement procedure
19 under the Congressional Budget Act of 1974 or the Bal-
20 anced Budget and Emergency Deficit Control Act of
21 1985.”.

22 (2) CLERICAL AMENDMENT.—The table of sec-
23 tions for subchapter A of chapter 98 of the Internal
24 Revenue Code of 1986 is amended by adding at the
25 end the following new item:

“Sec. 9512. National Fund for Medical Research.”.

1 (c) PURPOSES FOR EXPENDITURES FROM FUND.—
2 Part A of title IV of the Public Health Service Act is
3 amended by adding at the end the following new section:

4 **“SEC. 404F. EXPENDITURES FROM THE NATIONAL FUND**
5 **FOR MEDICAL RESEARCH.**

6 “(a) DISTRIBUTION OF AMOUNTS.—From amounts
7 received for any fiscal year from the National Fund for
8 Medical Research, the Secretary shall distribute—

9 “(1) 3 percent of such amounts to the Director
10 of NIH to be allocated at the Director’s discretion
11 for—

12 “(A) carrying out the responsibilities of the
13 Director of NIH, including the Office of Re-
14 search on Women’s Health, the Office of Re-
15 search on Minority Health, the Office on Alter-
16 native Medicine, and the Office of Rare Disease
17 Research;

18 “(B) construction of, and acquisition of
19 equipment for, facilities of or used by the Na-
20 tional Institutes of Health; and

21 “(C) transfer to the National Center for
22 Research Resources to carry out section 481A
23 concerning biomedical and behavioral research
24 facilities;

1 “(2) 1 percent of such amounts for carrying out
2 section 301 and part D of this title with respect to
3 health information communications; and

4 “(3) the remainder of such amounts to member
5 institutes and centers of the National Institutes of
6 Health in the same proportion to the total amount
7 received under this subsection, as the amount of an-
8 nual appropriations under appropriations Acts for
9 each member institute or center for the fiscal year
10 bears to the total amount of appropriations under
11 appropriations Acts for all member institutes and
12 centers of the National Institutes of Health for the
13 fiscal year.

14 “(b) PLANS OF ALLOCATION.—The amounts trans-
15 ferred under subsection (a) shall be allocated by the Direc-
16 tor of NIH or the various directors of the institutes and
17 centers, as the case may be, pursuant to allocation plans
18 developed by the various advisory councils to such direc-
19 tors, after consultation with such directors.

20 “(c) GRANTS AND CONTRACTS FULLY FUNDED IN
21 FIRST YEAR.—With respect to any grant or contract
22 funded by amounts distributed under subsection (a), the
23 full amount of the total obligation of such grant or con-
24 tract shall be funded in the first year of such grant or
25 contract, and shall remain available until expended.

1 “(d) MAINTENANCE OF EFFORT.—No amounts
2 transferred under subsection (a) shall replace or reduce
3 the amount of appropriations for the National Institutes
4 of Health under appropriations Acts.”.

5 **Subtitle B—Administrative**
6 **Simplification**

7 **SEC. 3301. ESTABLISHMENT OF HEALTH CARE DATA INTER-**
8 **CHANGE SYSTEM.**

9 (a) IN GENERAL.—In accordance with the procedures
10 provided in this subtitle, there shall be established a health
11 care data interchange system the purpose of which is to
12 make health care data available on a uniform basis to all
13 participants in the health care system.

14 (b) GENERAL REQUIREMENTS FOR SYSTEM.—The
15 system described in subsection (a) shall ensure—

16 (1) the integration of all participants in the
17 health care system;

18 (2) the use of uniform processes which will per-
19 mit participants in the health care system to com-
20 municate electronically for the submission and re-
21 ceipt of health care data;

22 (3) the privacy of individuals who are patients
23 receiving health care services and the confidentiality
24 of information in the data interchange system;

1 (4) that the data in the system is verifiable,
2 timely, accurate, reliable, useful, complete, relevant,
3 time and date stamped, and comparable; and

4 (5) an overall reduction in the administrative
5 burdens and costs of the health care system, an
6 overall increase in the productivity, effectiveness,
7 and efficiency of the system, and an overall increase
8 in the quality of care furnished by the system.

9 (c) GENERAL IMPLEMENTATION.—The system de-
10 scribed in subsection (a) shall be implemented through—

11 (1) the development of proposed regulations as
12 provided under section 3302 by the Health Care
13 Data Panel established under section 3313 (referred
14 to in this subtitle as the “Panel”); and

15 (2) the development of final regulations through
16 the Office of Management and Budget (referred to
17 in this subtitle as “OMB”) as provided under sec-
18 tion 3303.

19 **SEC. 3302. DEVELOPMENT OF PROPOSED REGULATIONS BY**
20 **PANEL.**

21 (a) IN GENERAL.—The Panel shall, in consultation
22 with the National Health Informatics Commission estab-
23 lished under section 3314, develop proposed regulations
24 for the implementation and ongoing operation of an inte-
25 grated electronic health care data interchange system that

1 are based on the operating standards, conventions, re-
2 quirements, and procedures for the system established, se-
3 lected, or developed by the Panel under sections 3304
4 through 3310.

5 (b) REQUIREMENTS RELATING TO PROPOSED REGU-
6 LATIONS.—The proposed regulations developed under sub-
7 section (a) shall—

8 (1) be submitted to OMB not later than 30
9 days after the date on which the Panel is required
10 to establish, select, or develop any of such operating
11 standards, conventions, requirements, and proce-
12 dures for the system; and

13 (2) provide that the general requirements for
14 the system referred to in section 3301(b) are met.

15 (c) MODIFICATIONS.—The Panel shall continuously
16 monitor the implementation of the regulations promul-
17 gated by OMB under section 3303 and shall submit to
18 OMB any proposed modifications to such regulations de-
19 termined appropriate by the Panel. The requirements of
20 section 3303 shall apply to any such proposed modifica-
21 tions in the same manner as such requirements apply to
22 the proposed regulations initially submitted by the Panel.

1 **SEC. 3303. PROMULGATION AND IMPLEMENTATION OF**
2 **PROPOSED REGULATIONS BY OMB.**

3 (a) PROMULGATION OF REGULATIONS.—OMB shall
4 promulgate regulations based on the proposed regulations
5 submitted under section 3302 within 90 days after the
6 date such proposed regulations are submitted.

7 (b) APPLICABILITY.—

8 (1) IN GENERAL.—The regulations promulgated
9 by OMB shall apply to all participants in the health
10 care system.

11 (2) SPECIAL RULE REGARDING THE MEDICARE
12 PROGRAM.—The Secretary may incorporate the ca-
13 pabilities of the common working file used in the
14 medicare program under title XVIII of the Social
15 Security Act into a uniform working file system de-
16 veloped and operated according to the regulations
17 referred to in subsection (a).

18 (c) COMPLIANCE WITH REGULATIONS.—

19 (1) IN GENERAL.—Not later than 1 year after
20 the date on which any regulations (other than the
21 regulations described in paragraph (2)) are promul-
22 gated by OMB, all participants in the health care
23 system shall be required to comply with such regula-
24 tions.

25 (2) COMPREHENSIVE QUALITY MEASUREMENT
26 DATA.—Not later than 2 years after the date on

1 which any regulations relating to standards, conven-
2 tions, and requirements for comprehensive quality
3 measurement data (as described in subsection
4 3304(e)(3)) are promulgated by OMB, all partici-
5 pants in the health care system shall be required to
6 comply with such regulations.

7 **SEC. 3304. SELECTION AND ESTABLISHMENT OF DATA AND**
8 **TRANSACTION STANDARDS, CONVENTIONS,**
9 **AND REQUIREMENTS FOR THE DATA INTER-**
10 **CHANGE SYSTEM.**

11 (a) IN GENERAL.—The Panel, in consultation with
12 the American National Standards Institute (referred to in
13 this subtitle as “ANSI”), shall select and establish data
14 and transaction standards, conventions, and requirements
15 that permit the electronic interchange of any health care
16 data the Panel determines necessary for the efficient and
17 effective administration of the health care system.

18 (b) MINIMUM REQUIREMENTS.—The data and trans-
19 action standards, conventions, and requirements selected
20 and established by the Panel under this section shall, at
21 a minimum—

22 (1) ensure that the data interchange system
23 shall have the capability to comply with such stand-
24 ards, conventions, and requirements; and

1 (2) be based on any standards that are in use
2 and generally accepted on the date of the enactment
3 of this subtitle or that are recommended by nation-
4 ally recognized standard setting groups, including
5 ANSI, the National Uniform Billing Committee, the
6 Uniform Claim Form Task Force, the National
7 Committee for Prescription Drug Programs, and the
8 Healthcare Informatics Standards Planning Panel.

9 (c) APPLICABILITY.—The proposed regulations devel-
10 oped by the Panel shall provide that—

11 (1) any participant in the health care system
12 who has the capability to interchange data through
13 a uniform working file developed by the Panel under
14 section 3305 shall be required to transmit and re-
15 ceive such data using the standards, conventions,
16 and requirements developed by the Panel under this
17 section; and

18 (2) any participant in the health care system
19 who does not have such capability shall be required
20 to transmit and receive data through a health care
21 information clearinghouse or a health care value-
22 added network that is certified under the procedure
23 established pursuant to 3311.

24 (d) ADDITIONAL REQUIREMENTS.—

1 (1) IN GENERAL.—The proposed regulations
2 developed by the Panel shall provide that no partici-
3 pant in the health care system shall be permitted to
4 establish data requirements in addition to such
5 standards, conventions, and requirements established
6 by the Panel and included in regulations promul-
7 gated by OMB—

8 (A) unless 2 or more participants volun-
9 tarily establish such additional requirements
10 and the requirements meet all of the privacy
11 and confidentiality standards developed by the
12 Panel under this subtitle and included in any
13 regulations promulgated by OMB; or

14 (B) unless a waiver is granted under para-
15 graph (2) to establish such additional require-
16 ments.

17 (2) CONDITIONS FOR WAIVERS.—

18 (A) IN GENERAL.—The proposed regula-
19 tions developed by the Panel shall provide that
20 any participant in the health care system may
21 request a waiver to establish additional data re-
22 quirements.

23 (B) CONSIDERATION OF WAIVER RE-
24 QUESTS.—The proposed regulations developed
25 by the Panel shall provide that no waiver shall

1 be granted under this paragraph unless the en-
2 tity granting such waiver considers the value of
3 the additional data to be exchanged for re-
4 search or other purposes determined appro-
5 priate by the Panel, the administrative cost of
6 the additional data requirements, the burden of
7 the additional data requirements, and the bur-
8 den of the timing of the imposition of the addi-
9 tional data requirements.

10 (C) CERTAIN REQUESTS FOR WAIVERS.—

11 The proposed regulations developed by the
12 Panel shall provide that if a participant in the
13 health care system attempts to impose addi-
14 tional data requirements on any other such par-
15 ticipant, the participant on which such require-
16 ments are being imposed may contact the Sec-
17 retary. The Panel shall develop a procedure
18 under which any participant in the health care
19 system contacting the Secretary under the pre-
20 ceeding sentence shall remain anonymous. The
21 Secretary shall notify the participant imposing
22 the additional data requirements that such re-
23 quirements may not be imposed on any other
24 participant unless such other participant volun-

1 tarily agrees to such requirements or a waiver
2 is obtained under this paragraph.

3 (e) TIMETABLE FOR STANDARDS, CONVENTIONS,
4 AND REQUIREMENTS.—

5 (1) STANDARDS, CONVENTIONS, AND REQUIRE-
6 MENTS RELATING TO FINANCIAL AND ADMINISTRA-
7 TIVE TRANSACTIONS.—Not later than 9 months
8 after the date of the enactment of this subtitle, the
9 Panel shall develop data and transaction standards,
10 conventions, and requirements for the following
11 items relating to the financing and administration of
12 health care:

13 (A) Enrollment.

14 (B) Eligibility.

15 (C) Payment and remittance advice.

16 (D) Claims.

17 (E) Claims status.

18 (F) Coordination of benefits.

19 (G) Crossover billing.

20 (H) First report of injury.

21 (I) Standardized claim attachments.

22 (J) Any other items relating to the financ-
23 ing and administration of health care delivery.

24 (2) STANDARDS, CONVENTIONS, AND REQUIRE-
25 MENTS RELATING TO INITIAL QUALITY MEASURE-

1 MENT INDICATORS.—Not later than 12 months after
2 the date of the enactment of this subtitle, the Panel
3 shall develop data and transaction standards, con-
4 ventions, and requirements for participants in the
5 health care system to transmit data derived from the
6 financial and administrative transactions data de-
7 scribed in paragraph (1) on quality measurement,
8 utilization monitoring, risk assessment, patient satis-
9 faction, outcomes, and access.

10 (3) STANDARDS, CONVENTIONS, AND REQUIRE-
11 MENTS RELATING TO COMPREHENSIVE QUALITY
12 MEASUREMENT DATA.—Not later than 24 months
13 after the date of the enactment of this subtitle, the
14 Panel shall develop standards, conventions, and re-
15 quirements for participants in the health care sys-
16 tem to transmit comprehensive data collected at the
17 site of care on quality measurement, utilization mon-
18 itoring, risk assessment, patient satisfaction, out-
19 comes, and access.

20 (4) STANDARDS, CONVENTIONS, AND REQUIRE-
21 MENTS RELATING TO DATA ON PATIENT CARE
22 RECORDS.—Not later than 36 months after the date
23 of the enactment of this subtitle, the Panel shall de-
24 velop standards, conventions, and requirements re-
25 lated to the inclusion of data from patient care

1 records into the health care data interchange sys-
2 tem, including standards, conventions, and require-
3 ments on the identification of the origin of any data
4 from such records that is included in such system.

5 (5) STANDARDS, CONVENTIONS, AND REQUIRE-
6 MENTS FOR THE CENTERS FOR DISEASE CONTROL
7 AND PREVENTION.—Not later than 36 months after
8 the date of the enactment of this subtitle, the Panel,
9 in collaboration with the Centers for Disease Control
10 and Prevention (referred to in this subtitle as the
11 “CDCP”) and in consultation with State depart-
12 ments of health, shall develop standards, conven-
13 tions, and requirements for the electronic inter-
14 change of data on vital health statistics collected by
15 CDCP or the States or any other such data as
16 CDCP determines appropriate.

17 (f) WAIVERS OF COMPLIANCE.—

18 (1) FINANCIAL AND ADMINISTRATIVE TRANS-
19 ACTIONS.—The proposed regulations developed by
20 the Panel shall provide that any of the data and
21 transaction standards, conventions, and require-
22 ments relating to financial and administrative trans-
23 actions developed by the Panel under subsection
24 (e)(1) may be waived until January 1, 1995, for a
25 health care provider that—

1 (A) does not have access to a health care
2 information clearinghouse or a health care
3 value-added network, is in the process of devel-
4 oping a system that complies with such stand-
5 ards, conventions, and requirements, and exe-
6 cutes an agreement with the appropriate regu-
7 latory entity that such provider will meet such
8 standards, conventions, and requirements by a
9 specified date (not later than January 1, 1995);
10 or

11 (B) is a small rural hospital (as defined by
12 the Panel and included in regulations promul-
13 gated by OMB).

14 (2) COMPREHENSIVE QUALITY MEASUREMENT
15 DATA.—The proposed regulations developed by the
16 Panel shall provide that any of the data and trans-
17 action standards, conventions, and requirements re-
18 lating to comprehensive quality measurement data
19 developed by the Panel under subsection (e)(3) may
20 be waived until January 1, 1998, for a health care
21 provider that—

22 (A) does not have access to a health care
23 information clearinghouse or a health care
24 value-added network, is in the process of devel-
25 oping a system that complies with such stand-

1 ards, conventions, and requirements, and exe-
2 cutes an agreement with the appropriate regu-
3 latory entity that such provider will meet such
4 standards and requirements by a specified date
5 (not later than January 1, 1998); or

6 (B) agrees to obtain from such provider's
7 records the data elements that are needed to
8 meet the standards and requirements developed
9 under subsection (e)(3) and agrees to subject
10 the provider's data transfer process to a quality
11 assurance program that is satisfactory to the
12 appropriate regulatory entity.

13 **SEC. 3305. STANDARDS FOR OPERATION OF A UNIFORM**
14 **WORKING FILE.**

15 Not later than 24 months after the date of the enact-
16 ment of this subtitle the Panel shall establish standards
17 for the development and operation of a uniform working
18 file system that is national in scope. Such standards shall
19 ensure—

20 (1) that all participants in the health care sys-
21 tem may be linked electronically (directly or indi-
22 rectly) to the uniform working file system;

23 (2) that any privacy and confidentiality stand-
24 ards established by the Panel under section 3308 are
25 satisfied;

1 (3) that the uniform working file system im-
2 proves the efficiency and effectiveness of the admin-
3 istration of the health care system, including health
4 care quality measurement;

5 (4) the interoperability of the uniform working
6 file system by—

7 (A) supporting the data and transaction
8 standards, conventions, and requirements se-
9 lected and established by the Panel; and

10 (B) making use of such standards, conven-
11 tions, and requirements; and

12 (5) the support of any other requirements se-
13 lected or established by the Panel.

14 **SEC. 3306. CODE SETS FOR SYSTEM.**

15 Not later than 9 months after the date of the enact-
16 ment of this subtitle, the Panel shall select and establish
17 code sets that are maintained by private and public enti-
18 ties as the Panel's official code sets for use in a national
19 uniform working file system. The proposed regulations de-
20 veloped by the Panel shall provide that any changes or
21 updates to such code sets that are established or requested
22 by the private or public entity which maintains the code
23 set—

24 (1) shall preserve the informational value of
25 data retained either within the uniform working file

1 system or within the information systems of parties
2 making use of the data and transactions standards,
3 conventions, and requirements;

4 (2) shall include instructions on how existing
5 data containing such codes is to be converted or
6 translated so as to preserve its value;

7 (3) shall be incorporated into the official code
8 set in such a manner as to minimize the disruption
9 to the national uniform working file system and min-
10 imize the cost to all entities within the system for
11 reprogramming to accommodate such changes or up-
12 dates; and

13 (4) shall be implemented—

14 (A) only after at least 90 days advance no-
15 tice has been provided to participants in the
16 health care system; and

17 (B) no more frequently than on an annual
18 basis.

19 **SEC. 3307. ESTABLISHMENT OF UNIQUE IDENTIFIERS.**

20 (a) IN GENERAL.—Not later than 9 months after the
21 date of the enactment of this subtitle, the Panel shall de-
22 velop unique identifiers for each participant in the health
23 care system.

24 (b) SPECIAL RULES.—

1 (1) INDIVIDUALS.—Each individual shall have a
2 unique identifier developed by the Panel.

3 (2) HEALTH PLANS OR PROVIDERS.—In devel-
4 oping unique identifiers for each health plan or pro-
5 vider, the Panel shall take into account multiple uses
6 for such identifiers and shall consider multiple phys-
7 ical locations and specialty classifications for provid-
8 ers. The unique identifiers for health plans or pro-
9 viders may be based on the system used under title
10 XVIII of the Social Security Act on the date of the
11 enactment of this subtitle.

12 **SEC. 3308. PRIVACY AND CONFIDENTIALITY STANDARDS.**

13 (a) IN GENERAL.—Not later than 9 months after the
14 date of the enactment of this subtitle, the Panel, after tak-
15 ing into consideration the Insurance Information and Pri-
16 vacy Protection Model Act of the National Association of
17 Insurance Commissioners, other model legislation, and
18 international guidelines, shall develop requirements that
19 protect the privacy of participants in the health care sys-
20 tem and ensure the confidentiality of information in the
21 data interchange system.

22 (b) PRINCIPLES CONSIDERED.—In developing the re-
23 quirements referred to in subsection (a), the Panel shall
24 take into consideration the following principles:

1 (1) Information relating to an identifiable or
2 identified individual should be collected only to the
3 extent necessary to carry out the purpose for which
4 the information is collected.

5 (2) Information relating to an identifiable or
6 identified individual collected for a particular pur-
7 pose should generally not be used for another pur-
8 pose without the individual's informed consent un-
9 less the pooling of information renders an individ-
10 ual's data unidentifiable.

11 (3) Information relating to an identifiable or
12 identified individual should be disposed of when no
13 longer necessary to carry out the purpose for which
14 it was collected, unless the pooling of information
15 renders an individual's data unidentifiable.

16 (4) Methods to ensure the verifiability, timeli-
17 ness, accuracy, reliability, utility, completeness, rel-
18 evance, and comparability of information relating to
19 an identifiable or identified individual should be in-
20 stituted.

21 (5) An individual should be notified in advance
22 of the collection of information relating to such indi-
23 vidual with regard to—

24 (A) whether the furnishing of information
25 is mandatory or voluntary;

1 (B) the recordkeeping practices with re-
2 spect to any information provided; and

3 (C) the uses to be made of any information
4 provided.

5 (6) If informed consent is necessary for the in-
6 tended primary or secondary use of information re-
7 lating to an identifiable or identified individual, the
8 individual should be provided the opportunity to re-
9 ject such uses at the time the information is col-
10 lected, except where such uses are necessary to com-
11 ply with law.

12 (7) An individual should be permitted to inspect
13 and correct any information which concerns such in-
14 dividual and should be able to obtain information on
15 how such information is being used.

16 **SEC. 3309. TRANSFER OF INFORMATION BETWEEN HEALTH**
17 **PLANS.**

18 Not later than 9 months after the date of the enact-
19 ment of this subtitle, the Panel shall develop rules and
20 procedures—

21 (1) for determining the financial liability of
22 health plans when health care benefits are payable
23 under two or more health plans; and

24 (2) concerning the transfer among health plans
25 of appropriate official data sets needed to carry out

1 the coordination of benefits, the sequential process-
2 ing of claims, and other health data as determined
3 necessary by the Panel for individuals who have
4 more than one health plan, according to the prior-
5 ities established under the rules and procedures es-
6 tablished under paragraph (1).

7 **SEC. 3310. FINES AND PENALTIES FOR FAILURE TO COM-**
8 **PLY.**

9 (a) DEVELOPMENT BY THE PANEL.—

10 (1) COMPLIANCE WITH STANDARDS FOR PRI-
11 VACY AND CONFIDENTIALITY.—Not later than 9
12 months after the date of the enactment of this sub-
13 title, the Panel shall develop civil fines and penalties,
14 as determined appropriate by the Panel, to enforce
15 any of the requirements developed by the Panel
16 under section 3308 relating to privacy and confiden-
17 tiality. The civil fines and penalties developed by the
18 Panel under this paragraph shall not be less than
19 \$1,000 for each violation.

20 (2) COMPLIANCE WITH OTHER REQUIRE-
21 MENTS.—

22 (A) IN GENERAL.—Not later than 9
23 months after the date of the enactment of this
24 subtitle, the Panel shall develop civil fines and
25 penalties, as determined appropriate by the

1 Panel, to enforce any of the requirements devel-
2 oped by the Panel under this subtitle other than
3 the requirements related to privacy and con-
4 fidentiality. The civil fines and penalties devel-
5 oped by the Panel under this paragraph shall
6 not exceed \$100 for each violation.

7 (B) LIMITATIONS.—

8 (i) PENALTIES NOT TO APPLY WHERE
9 NONCOMPLIANCE NOT DISCOVERED EXER-
10 CISING REASONABLE DILIGENCE.—No civil
11 fine or penalty developed by the Panel
12 under this paragraph shall be imposed if it
13 is established that the person liable for the
14 fine or penalty did not know, and by exer-
15 cising reasonable diligence would not have
16 known, that such person failed to comply
17 with any of the requirements described in
18 subparagraph (A).

19 (ii) PENALTIES NOT TO APPLY TO
20 COMPLIANCE FAILURES CORRECTED WITH-
21 IN 30 DAYS.—No civil fine or penalty devel-
22 oped by the Panel under this paragraph
23 shall be imposed if—

1 (I) the failure to comply was due
2 to reasonable cause and not to willful
3 neglect, and

4 (II) the failure to comply is cor-
5 rected during the 30-day period begin-
6 ning on the 1st date the person liable
7 for the fine or penalty knew, or by ex-
8 ercising reasonable diligence would
9 have known, that the failure to com-
10 ply occurred.

11 (iii) WAIVER.—In the case of a failure
12 to comply which is due to reasonable cause
13 and not to willful neglect, any civil fine or
14 penalty developed by the Panel under this
15 paragraph may be waived to the extent
16 that the payment of such fine or penalty
17 would be excessive relative to the compli-
18 ance failure involved.

19 (b) LEGISLATIVE PROPOSAL ON CERTAIN CRIMINAL
20 FINES AND PENALTIES.—Not later than 12 months after
21 the date of the enactment of this subtitle, the Panel shall
22 submit to Congress a legislative proposal relating to any
23 criminal fines and penalties determined appropriate by the
24 Panel to enforce any of the requirements developed by the

1 Panel under section 3308 relating to privacy and confiden-
2 tiality.

3 **SEC. 3311. OVERSIGHT OF UNIFORM WORKING FILE,**
4 **HEALTH CARE INFORMATION CLEARING-**
5 **HOUSES, AND VALUE-ADDED NETWORKS.**

6 (a) PERIODIC REVIEWS.—Not later than 9 months
7 after the date of the enactment of this subtitle, the Sec-
8 retary shall establish a procedure for the periodic review
9 of business practices, performance, and fees with respect
10 to the uniform working file and each health care informa-
11 tion clearinghouse and value-added network to ensure that
12 such entities are not taking unfair advantage of partici-
13 pants in the health care system through the application
14 of any regulations promulgated by OMB.

15 (b) CERTIFICATION PROCEDURE.—Not later than 12
16 months after the date of the enactment of this subtitle,
17 the Panel shall establish a certification procedure for the
18 uniform working file, health care information clearing-
19 houses, and value-added networks. The requirements for
20 certification shall include—

21 (1) adherence to the data and transaction
22 standards and requirements and the privacy and
23 confidentiality standards included in any regulations
24 promulgated by OMB;

1 (2) making public standardized indicators of
2 performance such as accessibility, transaction re-
3 sponsiveness, administrative efficiency, reliability,
4 dependability, and any other indicators determined
5 appropriate by the Secretary; and

6 (3) any other requirements determined appro-
7 priate by the Secretary.

8 **SEC. 3312. ANNUAL REPORTS TO CONGRESS.**

9 (a) IN GENERAL.—The Panel shall annually prepare
10 and submit to Congress a report on—

11 (1) the status of the data interchange system,
12 including the system’s ability to provide data on
13 cost, quality, and patient satisfaction;

14 (2) the savings and costs of implementing the
15 data interchange system; and

16 (3) any legislative recommendations related to
17 the data interchange system.

18 (b) AVAILABILITY TO THE PUBLIC.—Any informa-
19 tion in the report submitted to Congress under subsection
20 (a) shall be made available to the public unless such infor-
21 mation may not be disclosed by law.

22 **SEC. 3313. HEALTH CARE DATA PANEL.**

23 (a) ESTABLISHMENT.—There is established a panel
24 to be known as the Health Care Data Panel.

25 (b) MEMBERSHIP.—

1 (1) IN GENERAL.—The Panel shall be composed
2 of the following members:

3 (A) The Secretary.

4 (B) The Secretary of Defense.

5 (C) The Secretary of Veterans Affairs.

6 (D) A representative of the Agency for
7 Health Care Policy and Research.

8 (E) A representative of the National Insti-
9 tute of Standards and Technology.

10 (F) A representative of the National Tele-
11 communication and Information Administra-
12 tion.

13 (G) Six additional Federal officers deter-
14 mined appropriate by the Secretary.

15 (2) CHAIR.—The Secretary shall be the Chair
16 of the Panel.

17 (c) MEETINGS.—

18 (1) IN GENERAL.—Except as provided in para-
19 graph (2), the Panel shall meet at the call of the
20 Chair.

21 (2) INITIAL AND SUBSEQUENT MEETINGS.—
22 The Panel shall hold a meeting not later than 30
23 days after the date of the enactment of this section
24 and at least annually thereafter.

1 (3) QUORUM.—A majority of the members of
2 the Panel shall constitute a quorum, but a lesser
3 number of members may hold hearings.

4 (d) POWERS OF THE PANEL.—

5 (1) HEARINGS.—The Panel may hold such
6 hearings, sit and act at such times and places, take
7 such testimony, and receive such evidence as the
8 Panel considers advisable to carry out the purposes
9 of this section.

10 (2) INFORMATION FROM FEDERAL AGENCIES.—

11 The Panel may secure directly from any Federal de-
12 partment or agency such information as the Panel
13 considers necessary to carry out the provisions of
14 this section. Upon request of the Chair of the Panel,
15 the head of such department or agency shall furnish
16 such information to the Panel.

17 (3) POSTAL SERVICES.—The Panel may use the
18 United States mails in the same manner and under
19 the same conditions as other departments and agen-
20 cies of the Federal Government.

21 (4) GIFTS.—The Panel may accept, use, and
22 dispose of gifts or donations of services or property.

23 (e) PANEL PERSONNEL MATTERS.—

24 (1) COMPENSATION OF MEMBERS.—Members of
25 the Panel shall serve without compensation in addi-

1 tion to that received for their services as officers or
2 employees of the Federal Government.

3 (2) STAFF.—

4 (A) DETAIL OF GOVERNMENT EMPLOY-
5 EES.—Upon the request of the Chair, any Fed-
6 eral Government employee may be detailed to
7 the Panel without reimbursement, and such de-
8 tail shall be without interruption or loss of civil
9 service status or privilege.

10 (B) CONTRACTS.—The Chair may enter
11 into contracts or other arrangements that may
12 be necessary for the Panel to perform its du-
13 ties.

14 (C) INTERNAL ORGANIZATION.—The Chair
15 may prescribe such rules as the Chair deter-
16 mines necessary with respect to the internal or-
17 ganization of the Panel.

18 **SEC. 3314. NATIONAL HEALTH INFORMATICS COMMISSION.**

19 (a) APPOINTMENT.—The Panel shall provide for ap-
20 pointment of a National Health Informatics Commission
21 (referred to in this section as the “Commission”) to advise
22 the Panel on its activities.

23 (b) MEMBERSHIP.—

1 (1) IN GENERAL.—The Commission shall con-
2 sist of 15 members. The Panel shall designate 1
3 member of the Commission as the Chair.

4 (2) EXPERTISE.—Members of the Commission
5 shall be individuals who—

6 (A) represent different professions and dif-
7 ferent geographic areas, including urban and
8 rural areas;

9 (B) represent Federal or State government
10 health programs;

11 (C) represent applicable standard-setting
12 groups, including the National Uniform Billing
13 Committee, the Uniform Claim Form Task
14 Force, American National Standards Institute,
15 and the Healthcare Informatics Standards
16 Planning Panel;

17 (D) represent consumers of health care
18 services; and

19 (E) have expertise in—

20 (i) electronic data interchange of
21 health care information and computerized
22 information systems associated with the
23 operation and administration of matters
24 relating to health care;

1 (ii) the provision and financing of
2 health care;

3 (iii) conducting and interpreting
4 health economics research;

5 (iv) research and development of tech-
6 nological and scientific advances in health
7 care;

8 (v) health care eligibility, enrollment,
9 and claims administration;

10 (vi) health care financial management;

11 (vii) health care reimbursement; or

12 (viii) health care outcomes research.

13 (3) TERMS.—The Chair shall serve on the Com-
14 mission at the pleasure of the Panel. Each other
15 member of the Commission shall be appointed for a
16 term of 5 years, except with respect to the members
17 first appointed—

18 (A) 3 members shall be appointed for a
19 term of 1 year;

20 (B) 3 members shall be appointed for
21 terms of 2 years;

22 (C) 3 members shall be appointed for
23 terms of 3 years;

24 (D) 3 members shall be appointed for
25 terms of 4 years; and

1 (E) 2 members shall be appointed for
2 terms of 5 years.

3 (4) VACANCIES.—

4 (A) IN GENERAL.—A vacancy on the Com-
5 mission shall be filled in the manner in which
6 the 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 (c) MEETINGS.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the Commission shall meet at the call of
19 the Chair.

20 (2) INITIAL MEETING.—No later than 30 days
21 after the date on which all members of the Commis-
22 sion have been appointed, the Commission shall hold
23 its first meeting.

1 (3) QUORUM.—A majority of the members of
2 the Commission shall constitute a quorum, but a
3 lesser number of members may hold hearings.

4 (d) DUTIES.—

5 (1) IN GENERAL.—Not later than 60 days prior
6 to any date on which the Panel is required to select,
7 establish, or develop any requirements relating to
8 the data interchange system, the Commission shall
9 make recommendations to the Panel with respect to
10 the issues relating to such requirements.

11 (2) ADDITIONAL STUDIES AND PROJECTS.—As
12 directed by the Panel, the Commission shall under-
13 take such studies and projects as the Panel may
14 deem necessary.

15 (e) POWERS OF THE COMMISSION.—

16 (1) HEARINGS.—The Commission may hold
17 such hearings, sit and act at such times and places,
18 take such testimony, and receive such evidence as
19 the Commission considers advisable to carry out the
20 purposes of this section.

21 (2) INFORMATION FROM FEDERAL AGENCIES.—
22 The Commission may secure directly from any Fed-
23 eral department or agency such information as the
24 Commission considers necessary to carry out the
25 provisions of this section. Upon request of the Chair,

1 the head of such department or agency shall furnish
2 such information to the Commission.

3 (3) POSTAL SERVICES.—The Commission may
4 use the United States mails in the same manner and
5 under the same conditions as other departments and
6 agencies of the Federal Government.

7 (4) GIFTS.—The Commission may accept, use,
8 and dispose of gifts or donations of services or prop-
9 erty.

10 (f) COMMISSION PERSONNEL MATTERS.—

11 (1) COMPENSATION OF MEMBERS.—Each mem-
12 ber of the Commission who is not an officer or em-
13 ployee of the Federal Government shall be com-
14 pensated at a rate equal to the daily equivalent of
15 the annual rate of basic pay prescribed for level IV
16 of the Executive Schedule under section 5315 of title
17 5, United States Code, for each day (including travel
18 time) during which such member is engaged in the
19 performance of the duties of the Commission. All
20 members of the Commission who are officers or em-
21 ployees of the United States shall serve without com-
22 pensation in addition to that received for their serv-
23 ices as officers or employees of the United States.

24 (2) TRAVEL EXPENSES.—The members of the
25 Commission shall be allowed travel expenses, includ-

1 ing per diem in lieu of subsistence, at rates author-
2 ized for employees of agencies under subchapter I of
3 chapter 57 of title 5, United States Code, while
4 away from their homes or regular places of business
5 in the performance of services for the Commission.

6 (3) STAFF.—

7 (A) IN GENERAL.—The Chair may, with-
8 out regard to civil service laws and regulations,
9 appoint and terminate such personnel as may
10 be necessary to enable the Commission to per-
11 form its duties.

12 (B) COMPENSATION.—The Chair may fix
13 the compensation of personnel without regard
14 to the provisions of chapter 51 and subchapter
15 III of chapter 53 of title 5, United States Code,
16 relating to classification of positions and Gen-
17 eral Schedule pay rates, except that the rate of
18 pay for the personnel may not exceed the rate
19 payable for level V of the Executive Schedule
20 under section 5316 of such title.

21 (C) DETAIL OF GOVERNMENT EMPLOY-
22 EES.—Any Federal Government employee may
23 be detailed to the Commission without reim-
24 bursement, and such detail shall be without

1 interruption or loss of civil service status or
2 privilege.

3 (D) PROCUREMENT OF TEMPORARY AND
4 INTERMITTENT SERVICES.—The Chair may
5 procure temporary and intermittent services
6 under section 3109(b) of title 5, United States
7 Code, at rates for individuals which do not ex-
8 ceed the daily equivalent of the annual rate of
9 basic pay prescribed for level V of the Executive
10 Schedule under section 5316 of such title.

11 (E) CONTRACTS.—The Chair may enter
12 into contracts or other arrangements that may
13 be necessary for the Commission to perform its
14 duties.

15 (F) INTERNAL ORGANIZATION.—The Chair
16 may prescribe such rules as the Chair deter-
17 mines necessary with respect to the internal or-
18 ganization of the Commission. The Commission
19 shall create such committees (composed of
20 Commission members and others as appointed
21 by the Chair) as necessary to enable the Com-
22 mission to meet its responsibilities and func-
23 tions.

24 (g) REPORTS.—The Commission shall submit to the
25 Panel such reports as may be requested by the Panel on

1 each study or project conducted by the Commission. Such
2 reports shall contain such information as requested by the
3 Panel.

4 (h) TERMINATION OF COMMISSION.—The Commis-
5 sion shall terminate 20 years after the date of the enact-
6 ment of this title.

7 (i) AUTHORIZATION OF APPROPRIATIONS.—

8 (1) IN GENERAL.—There are authorized to be
9 appropriated such sums as may be necessary to
10 carry out the purposes of this section.

11 (2) AVAILABILITY.—Any sums appropriated
12 under the authorization contained in this subsection
13 shall remain available, without fiscal year limitation,
14 until expended.

15 **SEC. 3315. DEFINITIONS.**

16 For purposes of this subtitle:

17 (1) ADMINISTRATOR.—The term “adminis-
18 trator” has the meaning given that term in section
19 3(16)(A) of the Employee Retirement Income Secu-
20 rity Act of 1974.

21 (2) CODE SETS.—The term “code sets” means
22 any codes used for supplying specific data in a uni-
23 form data set, including tables of terms, medical di-
24 agnostic codes, medical procedure codes, identifica-
25 tion numbers, and any code sets of the National

1 Uniform Billing Committee, the Health Care Fi-
2 nancing Administration, or ANSI.

3 (3) EMPLOYEE WELFARE BENEFIT PLAN.—The
4 term “employee welfare benefit plan” has the mean-
5 ing given that term in section 3(1) of the Employee
6 Retirement Income Security Act of 1974.

7 (4) HEALTH CARE INFORMATION CLEARING-
8 HOUSE.—The term “health care information clear-
9 inghouse” means a public or private entity that—

10 (A) processes data that cannot be sent di-
11 rectly due to lack of proper formatting or edit-
12 ing; and

13 (B) facilitates the translation of data to
14 the standardized data set and code sets between
15 persons who normally would send or receive the
16 transaction;

17 but does not store information processed beyond the
18 time required to complete its task and communicate
19 the information.

20 (5) HEALTH CARE VALUE-ADDED NETWORK.—
21 The term “health care value-added network” means
22 any entity that provides additional services beyond
23 the transmission of data or value, such as the stor-
24 age of electronic data or value and the transfer of
25 such data or value between health care entities.

1 (6) INSURER.—The term “insurer” means any
2 entity that offers a health plan under which such en-
3 tity is at risk for all or part of the cost of benefits
4 under the plan, and includes any agent of such en-
5 tity.

6 (7) PARTICIPANT IN THE HEALTH CARE SYS-
7 TEM.—The term “participant in the health care sys-
8 tem” means any Federal health care program, State,
9 employee welfare benefit plan, health plan, adminis-
10 trator, insurer, or provider.

11 (8) PROVIDER.—The term “provider” means a
12 physician, hospital, pharmacy, laboratory, or other
13 person licensed or otherwise authorized under appli-
14 cable State laws to furnish health care items or serv-
15 ices.

16 **TITLE IV—JUDICIAL REFORMS**
17 **Subtitle A—Medical Liability**
18 **Reform**

19 **SEC. 4001. DEFINITIONS.**

20 For purposes of this subtitle:

21 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
22 TEM; ADR.—The term “alternative dispute resolution
23 system” or “ADR” means a system that provides
24 for the resolution of health care malpractice claims

1 in a manner other than through health care mal-
2 practice actions.

3 (2) CLAIMANT.—The term “claimant” means
4 any person who alleges a health care malpractice
5 claim, and any person on whose behalf such a claim
6 is alleged, including the decedent in the case of an
7 action brought through or on behalf of an estate.

8 (3) ECONOMIC LOSSES.—The term “economic
9 losses” means losses for hospital and medical ex-
10 penses, lost wages, lost employment, and other pecu-
11 niary losses incurred by an individual with respect to
12 which a health care malpractice claim or action is
13 pursued.

14 (4) HEALTH CARE PROFESSIONAL.—The term
15 “health care professional” means any individual who
16 provides health care services in a State and who is
17 required by State law or regulation to be licensed or
18 certified by the State to provide such services in the
19 State.

20 (5) HEALTH CARE PROVIDER.—The term
21 “health care provider” means any organization or
22 institution that is engaged in the delivery of health
23 care services in a State and that is required by State
24 or Federal law or regulation to be licensed or cer-

1 tified by the State or Federal Government to engage
2 in the delivery of such services in a State.

3 (6) HEALTH CARE NEGLIGENCE.—The term
4 “health care negligence” means an act or omission
5 by a health care provider or a health care profes-
6 sional which deviates from the applicable State
7 standard of care and causes an injury.

8 (7) HEALTH CARE MALPRACTICE ACTION.—The
9 term “health care malpractice action” means a civil
10 action brought in a State or Federal court against
11 a health care provider, health care professional, or
12 other defendant joined in the action (regardless of
13 the theory of liability on which the claim is based)
14 in which the claimant alleges a health care mal-
15 practice claim.

16 (8) HEALTH CARE MALPRACTICE CLAIM.—The
17 term “health care malpractice claim” means a claim
18 brought against a health care provider, health care
19 professional, or other defendant joined in a claim al-
20 leging that an injury was suffered by the claimant
21 as the result of health care negligence or gross neg-
22 ligence, breach of express or implied warranty or
23 contract, or failure to discharge a duty to warn or
24 instruction to obtain consent arising from the provi-
25 sion of (or failure to provide) health care services.

1 (9) INJURY.—The term “injury” means an in-
2 jury, illness, disease, or other harm suffered by an
3 individual as a result of the provision of health care
4 services by a health care provider or health care pro-
5 fessional.

6 (10) NONECONOMIC LOSSES.—The term “non-
7 economic losses” means losses for physical and emo-
8 tional pain, suffering, inconvenience, physical im-
9 pairment, mental anguish, disfigurement, loss of en-
10 joyment of life, and other nonpecuniary losses in-
11 curred by an individual with respect to which a
12 health care malpractice claim or action is pursued.

13 **PART I—MEDIATION AND ALTERNATIVE DISPUTE**
14 **RESOLUTION**

15 **SEC. 4011. MEDIATION.**

16 (a) REQUIREMENTS FOR QUALIFIED HEALTH
17 PLANS.—In accordance with section 1120, a qualified
18 health plan shall provide effective mediation procedures
19 for hearing and resolving health care malpractice claims.

20 (b) CERTIFICATION AND STANDARDS.—

21 (1) CERTIFICATION.—A qualified health plan
22 meets the requirement of subsection (a) if the medi-
23 ation procedures provided under the plan are cer-
24 tified by the State as being in compliance with the
25 standards developed under paragraph (2).

1 (2) STANDARDS.—

2 (A) IN GENERAL.—The standards devel-
3 oped under subpart B of part I of subtitle B of
4 title I shall contain minimum mediation stand-
5 ards that qualified health plans must meet in
6 order to be certified by the State under para-
7 graph (1).

8 (B) MEDIATION SERVICES.—The stand-
9 ards developed under subparagraph (A) shall
10 require a qualified health plan to provide medi-
11 ation services through—

12 (i) the Federal Mediation and Concil-
13 iation Service; or

14 (ii) a private mediation service that
15 has been certified by the State as being eli-
16 gible to mediate health care malpractice
17 claims.

18 (c) NOTIFICATION.—A qualified health plan shall
19 provide notice to enrollees and potential enrollees concern-
20 ing the mediation procedures available under the plan and
21 the procedures under which an enrollee commences the
22 mediation process.

23 (d) PARTICIPATION.—

24 (1) REQUIREMENT.—A party to a dispute
25 brought to mediation under this section shall be re-

1 required to participate in the mediation if requested by
2 another party.

3 (2) PRIVILEGE.—All information disclosed in a
4 mediation procedure under this section shall be priv-
5 ileged and may not be used in any other proceeding
6 unless such information is discovered independently
7 of such mediation procedure.

8 **SEC. 4012. FAILURE OF MEDIATION.**

9 With respect to a claim submitted to mediation as
10 provided for in section 4011, if the mediation process fails
11 to resolve the dispute from which such claim arose, the
12 parties to such claim shall participate in an applicable al-
13 ternative dispute resolution method under section 4013.

14 **SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.**

15 (a) APPLICATION TO HEALTH CARE MALPRACTICE
16 CLAIMS UNDER PLANS.—In the case of any health care
17 malpractice claim, no health care malpractice action may
18 be brought with respect to such claim until the final reso-
19 lution of the claim under the alternative dispute resolution
20 method adopted by the State under subsection (b).

21 (b) ADOPTION OF MECHANISM BY STATES.—Each
22 State shall—

23 (1) adopt at least one of the alternative dispute
24 resolution methods specified under this part for the

1 resolution of health care malpractice claims arising
2 from the provision of health care services; and

3 (2) require that health plans disclose to enroll-
4 ees (and potential enrollees), in accordance with
5 standards established by the Secretary, the availabil-
6 ity and procedures for consumer grievances under
7 the plan, including mediation and the alternative
8 dispute resolution method or methods adopted under
9 this section.

10 (c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE
11 DISPUTE RESOLUTION METHODS.—

12 (1) IN GENERAL.—The Secretary shall, by reg-
13 ulation, develop alternative dispute resolution meth-
14 ods for the use by States in resolving health care
15 malpractice claims under subsection (a). Such meth-
16 ods shall include at least the following:

17 (A) BINDING ARBITRATION.—The use of
18 binding arbitration.

19 (B) FAULT-BASED SYSTEMS.—The use of
20 fault-based administrative systems, expedited
21 review and dismissal of claims when not ade-
22 quately supported.

23 (C) EARLY OFFERS OF SETTLEMENT.—
24 The use of a process under which parties have
25 the option to make early offers of settlement.

1 (D) CATASTROPHIC SYSTEMS.—The use of
2 catastrophic injury compensation systems.

3 (2) STANDARDS FOR ESTABLISHING METH-
4 ODS.—In developing alternative dispute resolution
5 methods under paragraph (1), the Secretary shall
6 assure that the methods promote the resolution of
7 health care malpractice claims in a manner that—

8 (A) is affordable for the parties involved;

9 (B) provides for timely resolution of
10 claims;

11 (C) provides for the consistent and fair
12 resolution of claims; and

13 (D) provides for reasonably convenient ac-
14 cess to dispute resolution for individuals en-
15 rolled in qualified health plans.

16 (d) STATE INITIATED ALTERNATIVE.—A State will
17 be permitted to operate an alternative dispute resolution
18 method (other than a method described in subsection (c))
19 that otherwise complies with this part if such system—

20 (1) is determined by the Secretary to accom-
21 plish the purposes and otherwise meet the require-
22 ments of this part; and

23 (2) is certified by the Secretary as an appro-
24 priate alternative dispute resolution method.

1 (e) FAILURE TO ESTABLISH SYSTEM.—If a State
2 fails to establish an alternative resolution system that
3 meets the requirements of this part, the Secretary shall
4 provide for the operation of an approved alternative dis-
5 pute resolution method in such State until such time as
6 a system under this part is adopted.

7 **SEC. 4014. COURT ACTIONS.**

8 (a) IN GENERAL.—The extent to which any party
9 seeks further redress (subsequent to a decision of an alter-
10 native dispute resolution method) concerning a health care
11 malpractice claim or action in a Federal or State court
12 shall be dependent upon the methods of alternative dispute
13 resolution adopted by the State. With respect to such fur-
14 ther redress, if the party initiating such court action re-
15 ceives a worse result, with respect to liability or level of
16 damages, under the decision of the court than under the
17 State alternative dispute resolution method, such party
18 shall bear the costs, including legal fees, incurred in the
19 court action by the other party or parties to such action.

20 (b) REQUIREMENT FOR PERFORMANCE BOND.—The
21 court in a health care malpractice action may require the
22 party that contested the ruling of the alternative dispute
23 resolution method with respect to the health care mal-
24 practice claim that is the subject of the action to post a
25 performance bond (in such amount and consisting of such

1 funds and assets as the court determines to be appro-
2 priate), except that the court may waive the application
3 of such requirement to a party if the court determines that
4 the posting of such a bond is not necessary to ensure that
5 the party shall meet the requirements of this section to
6 pay the opposing party the costs incurred by the opposing
7 party under the action.

8 **PART II—LIABILITY REFORM**

9 **SEC. 4021. APPLICABILITY**

10 (a) IN GENERAL.—This part shall apply with respect
11 to any health care malpractice action brought in any State
12 or Federal court, except that this part shall not apply to
13 a claim or action for damages arising from a vaccine-relat-
14 ed injury or death to the extent that title XXI of the Pub-
15 lic Health Service Act applies to the claim or action.

16 (b) PREEMPTION.—The provisions of this part shall
17 preempt any State law to the extent such law is inconsis-
18 tent with the limitations contained in such provisions. The
19 provisions of this part shall not preempt any State law
20 that provides for liability defenses or places limitations on
21 a person’s liability for damages in addition to those con-
22 tained in this subtitle, places greater limitations on the
23 amount of attorneys’ fees that can be collected, or other-
24 wise imposes greater restrictions than those provided in
25 this part.

1 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
2 OF LAW OR VENUE.—Nothing in subsection (b) shall be
3 construed to—

4 (1) waive or affect any defense of sovereign im-
5 munity asserted by any State under any provision of
6 law;

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

9 (3) affect the applicability of any provision of
10 the Foreign Sovereign Immunities Act of 1976;

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

14 (5) affect the right of any court to transfer
15 venue or to apply the law of a foreign nation or to
16 dismiss a claim of a foreign nation or of a citizen
17 of a foreign nation on the ground of inconvenient
18 forum.

19 (d) FEDERAL COURT JURISDICTION NOT ESTAB-
20 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
21 this part shall be construed to establish any jurisdiction
22 in the district courts of the United States over health care
23 malpractice actions on the basis of section 1331 or 1337
24 of title 28, United States Code.

1 **SEC. 4022. LIMITATION ON AMOUNT OF ATTORNEY'S CON-**
2 **TINGENCY FEES.**

3 (a) IN GENERAL.—An attorney who represents, on
4 a contingency fee basis, a plaintiff in a health care mal-
5 practice claim or action may not charge, demand, receive,
6 or collect for services rendered in connection with such ac-
7 tion (including the resolution of the claim that is the sub-
8 ject of the action under any alternative dispute resolution)
9 in excess of 25 percent of the total amount recovered by
10 judgment or settlement in such action.

11 (b) CALCULATION OF FEES IN THE EVENT OF PERI-
12 ODIC PAYMENTS.—In the event that a judgment or settle-
13 ment includes periodic or future payments of damages, the
14 amount recovered for purposes of computing the limitation
15 on the contingency fee under subsection (a) shall be based
16 on the cost of the annuity or trust established to make
17 the payments. In any case in which an annuity or trust
18 is not established to make such payments, such amount
19 shall be based on the present value of the payments.

20 (c) CONTINGENCY FEE DEFINED.—As used in this
21 section, the term “contingency fee” means any fee for pro-
22 fessional legal services which is, in whole or in part, con-
23 tingent upon the recovery of any amount of damages,
24 whether through judgment or settlement.

1 **SEC. 4023. REFORM OF DAMAGES.**

2 (a) LIMITATION ON NONECONOMIC DAMAGES.—With
3 respect to a health care malpractice claim or action
4 brought in any forum, the total amount of damages that
5 may be awarded to an individual and the family members
6 of such individual for noneconomic losses resulting from
7 an injury alleged under such claim or action may not ex-
8 ceed \$250,000, regardless of the number of health care
9 professionals, health care providers and other defendants
10 against whom the action is brought or the number of ac-
11 tions brought with respect to the injury. With respect to
12 actions heard by a jury, the jury may not be informed
13 of limitation contained in this subsection, and if necessary,
14 a reduction in the jury’s damage award shall be made by
15 the court.

16 (b) MANDATORY OFFSETS FOR DAMAGES PAID BY
17 A COLLATERAL SOURCE.—

18 (1) IN GENERAL.—With respect to a health
19 care malpractice claim or action, the total amount of
20 damages received by an individual under such action
21 shall be reduced, in accordance with paragraph (2),
22 by any other payment that has been, or will be,
23 made to an individual to compensate such individual
24 for the injury that was the subject of such action.

25 (2) AMOUNT OF REDUCTION.—The amount by
26 which an award of damages to an individual for an

1 injury shall be reduced under paragraph (1) shall
2 be—

3 (A) the total amount of any payments
4 (other than such award) that have been made
5 or that will be made to such individual to pay
6 costs of or compensate such individual for the
7 injury that was the subject of the action; minus

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

12 (c) PERIODIC PAYMENTS.—With respect to a health
13 care malpractice action referred to in subsection (a), no
14 person may be required to pay more than \$100,000 for
15 future damages in a single payment of a damages award,
16 but a person shall be permitted to make such payments
17 of the award on a periodic basis. The periods for such
18 payments shall be determined by the adjudicating body,
19 based upon projections of future losses and shall be re-
20 duced to present value.

21 (d) PUNITIVE DAMAGES.—

22 (1) FUND.—Each State shall establish a health
23 care education and disciplinary program, to be ap-
24 proved by the Secretary, and a fund consisting of

1 such amounts as are transferred to the fund under
2 paragraph (2).

3 (2) TRANSFER OF AMOUNTS.—Each State shall
4 require that 75 percent of all awards of punitive
5 damages resulting from all health care malpractice
6 claims or actions in that State be transferred to the
7 fund established under paragraph (1) in the State.

8 (3) OBLIGATIONS FROM FUND.—The chief execu-
9 tive officer of a State shall obligate such sums as
10 are available in the fund established in that State
11 under paragraph (1) to provide additional resources
12 to State health care practitioner disciplinary boards
13 for the monitoring, education, and disciplining of
14 health care practitioners.

15 (e) ATTORNEY DISCLOSURE.—Attorneys hired to
16 represent any parties involved in a health care malpractice
17 action referred to in subsection (a) shall, at the time of
18 entering into the agreement with respect to such hiring,
19 disclose—

20 (1) the estimated probability of success on the
21 action;

22 (2) the number of hours the attorney estimates
23 will be needed to handle the action;

1 (3) an estimate of the attorney fee required
2 (and whether any costs will be assessed outside the
3 contingency fee arrangement); and

4 (4) an alternative fee type or rate (hourly or
5 contingency) if available.

6 At the close of the action, an attorney shall provide to
7 the client, and the court if the action was litigated, a full,
8 documented disclosure of the hours spent, a description
9 of the work conducted during those hours, the total com-
10 pensation received and the calculated hourly fee concern-
11 ing such action. Failure to provide the information re-
12 quired in this subsection will result in a fee limit of 10
13 percent of the award.

14 **SEC. 4024. REFORM OF PROCEDURES.**

15 (a) STATUTE OF LIMITATIONS.—

16 (1) IN GENERAL.—Except as provided in para-
17 graph (2), no health care malpractice claim or action
18 may be initiated after the expiration of the 2-year
19 period that begins on the date on which the alleged
20 injury and its cause should reasonably have been
21 discovered, but in no event later than 6 years after
22 the date of the alleged occurrence of the injury.

23 (2) EXCEPTION FOR MINORS.—In the case of
24 an alleged injury suffered by a minor who has not
25 attained 6 years of age, no health care malpractice

1 claim or action may be initiated after the expiration
2 of the 2-year period that begins on the date on
3 which the alleged injury and its cause should reason-
4 ably have been discovered, but in no event later than
5 6 years after the date of the alleged occurrence of
6 the injury and its cause or the date on which the
7 minor attains 12 years of age, whichever is later.

8 (b) JOINT AND SEVERAL LIABILITY.—

9 (1) IN GENERAL.—With respect to a health
10 care malpractice claim or action, the liability of each
11 defendant for noneconomic and punitive damages
12 shall be several only, and shall not be joint. Each de-
13 fendant shall be liable only for the amount of non-
14 economic and punitive damages allocated to such de-
15 fendant in direct proportion to such defendant's per-
16 centage of responsibility as determined under para-
17 graph (2).

18 (2) PROPORTION OF RESPONSIBILITY.—For
19 purposes of this subsection, the trier of fact shall de-
20 termine the proportion of responsibility of each
21 party for the claimant's harm.

22 (c) FRIVOLOUS ACTIONS.—

23 (1) BY ATTORNEY.—With respect to a health
24 care malpractice claim or action, if the court or the
25 adjudicating body determines that the claim or ac-

1 tion, or any part thereof, was pursued by an attor-
2 ney where the attorney does not have reasonable
3 grounds to believe that the action was well grounded
4 in fact and was warranted by existing law, the court
5 shall impose an appropriate sanction, including the
6 reasonable costs and attorneys fees attributable to
7 the frivolous claims.

8 (2) BY CLAIMANT.—Sanctions under paragraph
9 (1) may apply against a claimant if the court deter-
10 mines that the frivolous nature of the action was a
11 result of the misrepresentation of facts by the claim-
12 ant to the attorney.

13 **SEC. 4025. PRACTICE GUIDELINES.**

14 (a) REBUTTABLE PRESUMPTION.—

15 (1) DEVELOPMENT.—Each State shall develop,
16 for certification by the Secretary, a set of specialty
17 clinical practice guidelines, based on recommended
18 guidelines developed by the Agency for Health Care
19 Policy and Research.

20 (2) PROVISION OF HEALTH CARE UNDER
21 GUIDELINES.—Notwithstanding any other provision
22 of law, in any claim or action brought in a Federal
23 or State court or other forum arising from the provi-
24 sion of a health care service to an individual, if the
25 service was provided to the individual in accordance

1 with the guidelines developed by the State (that cer-
2 tified or regulates the health plan involved in the ac-
3 tion) and certified by the Secretary under paragraph
4 (1), the guidelines—

5 (A) may be introduced by a provider who
6 is a party to the claim or action;

7 (B) if introduced, shall establish a rebutta-
8 ble presumption that the service prescribed by
9 the guidelines is the appropriate standard of
10 medical care; and

11 (C) if used to establish a rebuttable pre-
12 sumption, may only be overcome by the presen-
13 tation of clear and convincing evidence on be-
14 half of the party against whom the presumption
15 operates.

16 (b) ABSOLUTE DEFENSE.—With respect to new or
17 experimental treatments that are part of approved re-
18 search trials (as defined in subsection (c)), no health care
19 provider may be required to provide or held liable for fail-
20 ing to provide such treatment until that treatment is
21 found to be safe and efficacious by the Agency for Health
22 Care Policy and Research.

23 (c) DEFINITIONS.—As used in this section—

24 (1) NEW OR EXPERIMENTAL TREATMENTS.—

25 The term “new or experimental treatments” means

1 a treatment for which there is not sufficient evidence
2 to determine the health outcome of the treatment
3 compared with the best available alternative treat-
4 ment (or with no treatment if there is no alternative
5 treatment).

6 (2) APPROVED RESEARCH TRIALS.—The term
7 “approved research trial” means a trial—

8 (A) conducted for the primary purpose of
9 determining the safety, effectiveness, efficacy,
10 or health outcomes of a treatment, compared
11 with the best available alternative treatment,
12 and

13 (B) approved by the Secretary.

14 A trial is deemed to be approved under subpara-
15 graph (B) if it is approved by the National Insti-
16 tutes of Health, the Food and Drug Administration
17 (through an investigational new drug exemption),
18 the Department of Defense, the Department of Vet-
19 erans Affairs, or by a qualified nongovernmental re-
20 search entity (as identified in guidelines issued by
21 one or more of the National Institutes of Health).

22 **SEC. 4026. DRUGS AND DEVICES.**

23 (a) DEFINITIONS.—For purposes of this section:

1 (1) DEVICE.—The term “device” has the mean-
2 ing given the term in section 201(h) of the Federal
3 Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

4 (2) DRUG.—The term “drug” has the meaning
5 given the term in section 201(g)(1) of the Federal
6 Food, Drug, and Cosmetic Act (21 U.S.C.
7 321(g)(1)).

8 (3) HEALTH CARE PRODUCER.—The term
9 “health care producer” means any firm or business
10 enterprise that designs, manufactures, produces, or
11 sells a drug or device that is the subject of a health
12 care malpractice claim or action.

13 (b) LIMITATION.—

14 (1) IN GENERAL.—Punitive damages otherwise
15 permitted by applicable law shall not be awarded in
16 a health care malpractice claim or action under this
17 Act against a health care producer of a drug or de-
18 vice (or other defendant joined in such claim or ac-
19 tion) that caused the harm complained of by the
20 claimant if—

21 (A) the drug or device—

22 (i) was subject to approval under sec-
23 tion 505 (21 U.S.C. 355) or premarket ap-
24 proval under section 515 (21 U.S.C. 360e),
25 respectively, of the Federal Food, Drug,

1 and Cosmetic Act, by the Food and Drug
2 Administration, with respect to—

3 (I) the safety of the formulation
4 or performance of the aspect of the
5 drug or device that caused the harm;
6 or

7 (II) the adequacy of the packag-
8 ing or labeling of the drug or device;
9 and

10 (ii) was approved by the Food and
11 Drug Administration; or

12 (B) the drug or device is generally recog-
13 nized as safe and effective pursuant to condi-
14 tions established by the Food and Drug Admin-
15 istration and applicable regulations, including
16 packaging and labeling regulations.

17 (2) WITHHELD INFORMATION; MISREPRESENTEN-
18 TATION; ILLEGAL PAYMENT.—The provisions of
19 paragraph (1) shall not apply in any case in which
20 the defendant—

21 (A) withheld from or misrepresented to the
22 Food and Drug Administration or any other
23 agency or official of the Federal Government,
24 information that is material and relevant to the
25 performance of the drug or device; or

1 (B) made an illegal payment to an official
2 of the Food and Drug Administration for the
3 purpose of securing approval of the drug or de-
4 vice.

5 (c) SEPARATE PROCEEDING.—

6 (1) CONSIDERATIONS.—At the request of the
7 health care producer, or other defendant joined, in
8 an action described in subsection (b), the trier of
9 fact shall consider in a separate proceeding—

10 (A) whether punitive damages are to be
11 awarded and the amount of the award; or

12 (B) the amount of punitive damages fol-
13 lowing a determination of punitive liability.

14 (2) EVIDENCE.—If a separate proceeding is re-
15 quested in accordance with paragraph (1), evidence
16 relevant only to the claim of punitive damages, as
17 determined by applicable State law, shall be inadmis-
18 sible in any proceeding to determine whether com-
19 pensatory damages are to be awarded.

20 (d) AMOUNT OF PUNITIVE DAMAGES.—In determin-
21 ing the amount of punitive damages in an action described
22 in subsection (b) or (c), the trier of fact shall consider
23 all relevant evidence, including—

24 (1) the financial condition of the health care
25 producer;

1 (2) the severity of the harm caused by the con-
2 duct of the health care producer;

3 (3) the duration of the conduct or any conceal-
4 ment of the conduct by the health care producer;

5 (4) the profitability of the conduct to the health
6 care producer;

7 (5) the number of products sold by the health
8 care producer of the kind causing the harm com-
9 plained of by the claimant;

10 (6) awards of punitive or exemplary damages to
11 persons similarly situated to the claimant;

12 (7) prospective awards of compensatory dam-
13 ages to persons similarly situated to the claimant;

14 (8) any criminal penalties imposed on the
15 health care producer as a result of the conduct com-
16 plained of by the claimant; and

17 (9) the amount of any civil fines assessed
18 against the defendant as a result of the conduct
19 complained of by the claimant.

20 (e) STRICT LIABILITY DEFENSE.—In a civil action
21 brought by a claimant in a Federal or State court under
22 which the claimant alleges that a health care producer of
23 a drug or device is strictly liable to such claimant for inju-
24 ries sustained from the use of such drug or device, a show-
25 ing by the defendant that such drug or devices was subject

1 to approval and was approved by the Food and Drug Ad-
2 ministration as described in subsection (b)(1)(A) shall be
3 an absolute defense to such strict liability claims.

4 **SEC. 4027. REPORT.**

5 The Secretary shall continuously monitor the oper-
6 ation of the provision of this subtitle. Not later than 3
7 years after the date of enactment of this Act, the Sec-
8 retary shall prepare and submit to the appropriate com-
9 mittees of Congress a report outlining the effects of this
10 subtitle on—

- 11 (1) access to health care;
- 12 (2) the costs of health care;
- 13 (3) the cost reductions passed on to the con-
14 sumers of health care;
- 15 (4) the number of health care malpractice ac-
16 tions filed;
- 17 (5) the time needed to resolve these claims;
- 18 (6) the numbers of claims resolved through al-
19 ternative dispute resolution; and
- 20 (7) the effect on the quality of health care.

1 **Subtitle B—Anti-Fraud and Abuse**
2 **Control Program**

3 **PART I—ALL-PAYER FRAUD AND ABUSE**

4 **CONTROL PROGRAM**

5 **SEC. 4101. ALL-PAYER FRAUD AND ABUSE CONTROL PRO-**
6 **GRAM.**

7 (a) ESTABLISHMENT OF PROGRAM.—

8 (1) IN GENERAL.—Not later than January 1,
9 1995, the Secretary shall establish in the Office of
10 the Inspector General of the Department of Health
11 and Human Services a program—

12 (A) to coordinate Federal, State, and local
13 law enforcement programs to control fraud and
14 abuse with respect to the delivery of and pay-
15 ment for health care in the United States,

16 (B) to conduct investigations, audits, eval-
17 uations, and inspections relating to the delivery
18 of and payment for health care in the United
19 States, and

20 (C) to facilitate the enforcement of the
21 provisions of sections 1128, 1128A, and 1128B
22 of the Social Security Act and other statutes
23 applicable to health care fraud and abuse.

24 (2) COORDINATION WITH HEALTH CARE
25 PLANS.—In carrying out the program established

1 under paragraph (1), the Secretary shall consult
2 with, and arrange for the sharing of data with, rep-
3 resentatives of health care plans.

4 (3) REGULATIONS.—

5 (A) IN GENERAL.—The Secretary shall by
6 regulation establish standards to carry out the
7 program under paragraph (1).

8 (B) INFORMATION STANDARDS.—

9 (i) IN GENERAL.—Such standards
10 shall include standards relating to the fur-
11 nishing of information by health care
12 plans, providers, and others to enable the
13 Secretary to carry out the program (in-
14 cluding coordination with health care plans
15 under paragraph (2)).

16 (ii) CONFIDENTIALITY.—Such stand-
17 ards shall include procedures to assure
18 that such information is provided and uti-
19 lized in a manner that appropriately pro-
20 tects the confidentiality of the information
21 and the privacy of individuals receiving
22 health care services and items.

23 (iii) QUALIFIED IMMUNITY FOR PRO-
24 VIDING INFORMATION.—The provisions of
25 section 1157(a) of the Social Security Act

1 (relating to limitation on liability) shall
2 apply to a person providing information to
3 the Secretary under the program under
4 this section, with respect to the Secretary's
5 performance of duties under the program,
6 in the same manner as such section applies
7 to information provided to organizations
8 with a contract under part B of title XI of
9 such Act, with respect to the performance
10 of such a contract.

11 (C) DISCLOSURE OF OWNERSHIP INFOR-
12 MATION.—

13 (i) IN GENERAL.—Such standards
14 shall include standards relating to the dis-
15 closure of ownership information described
16 in clause (ii) by any entity providing health
17 care services and items.

18 (ii) OWNERSHIP INFORMATION DE-
19 SCRIBED.—The ownership information de-
20 scribed in this clause includes—

21 (I) a description of such items
22 and services provided by such entity;

23 (II) the names and unique physi-
24 cian identification numbers of all phy-
25 sicians with a financial relationship

1 (as defined in section 1877(a)(2) of
2 the Social Security Act) with such
3 entity;

4 (III) the names of all other indi-
5 viduals with such an ownership or in-
6 vestment interest in such entity; and

7 (IV) any other ownership and re-
8 lated information required to be dis-
9 closed by such entity under section
10 1124 or section 1124A of the Social
11 Security Act.

12 (4) AUTHORIZATION OF APPROPRIATIONS FOR
13 INVESTIGATORS AND OTHER PERSONNEL.—In addi-
14 tion to any other amounts authorized to be appro-
15 priated to the Secretary for health care anti-fraud
16 and abuse activities for a fiscal year, there are au-
17 thorized to be appropriated additional amounts as
18 may be necessary to enable the Secretary to conduct
19 investigations and audits of allegations of health
20 care fraud and abuse and otherwise carry out the
21 program established under paragraph (1) in a fiscal
22 year.

23 (5) ENSURING ACCESS TO DOCUMENTATION.—

24 (A) IN GENERAL.—The Inspector General
25 of the Department of Health and Human Serv-

1 ices is authorized to exercise the authority de-
2 scribed in paragraphs (4) and (5) of section 6
3 of the Inspector General Act of 1978 (relating
4 to subpoenas and administration of oaths) with
5 respect to the activities under the all-payer
6 fraud and abuse control program established
7 under this subsection to the same extent as
8 such Inspector General may exercise such au-
9 thorities to perform the functions assigned by
10 such Act.

11 (B) PERMISSIVE EXCLUSION.—Section
12 1128(b) of the Social Security Act (42 U.S.C.
13 1320a–7(b)) is amended by adding at the end
14 the following new paragraph:

15 “(15) FAILURE TO SUPPLY REQUESTED INFOR-
16 MATION TO THE INSPECTOR GENERAL.—Any indi-
17 vidual or entity that fails fully and accurately to pro-
18 vide, upon request of the Inspector General of the
19 Department of Health and Human Services, records,
20 documents, and other information necessary for the
21 purposes of carrying out activities under the all-
22 payer fraud and abuse control program established
23 under section 4101 of the Health Equity and Access
24 Reform Today Act of 1993.”.

1 (6) HEALTH CARE PLAN DEFINED.—For the
2 purposes of this subsection, the term “health care
3 plan” shall have the meaning given such term in sec-
4 tion 1128(i) of the Social Security Act.

5 (b) ESTABLISHMENT OF ANTI-FRAUD AND ABUSE
6 TRUST FUND.—

7 (1) ESTABLISHMENT.—

8 (A) IN GENERAL.—There is hereby created
9 on the books of the Treasury of the United
10 States a trust fund to be known as the “Anti-
11 Fraud and Abuse Trust Fund” (in this section
12 referred to as the “Trust Fund”). The Trust
13 Fund shall consist of such gifts and bequests as
14 may be made as provided in subparagraph (B)
15 and such amounts as may be deposited in, or
16 appropriated to, such Trust Fund as provided
17 in subsection (a)(5), and title XI of the Social
18 Security Act.

19 (B) AUTHORIZATION TO ACCEPT GIFTS.—
20 The Managing Trustee of the Trust Fund is
21 authorized to accept on behalf of the United
22 States money gifts and bequests made uncondi-
23 tionally to the Trust Fund, for the benefit of
24 the Trust Fund, or any activity financed
25 through the Trust Fund.

1 (2) MANAGEMENT.—

2 (A) IN GENERAL.—The Trust Fund shall
3 be managed by the Secretary through a Manag-
4 ing Trustee designated by the Secretary.

5 (B) INVESTMENT OF FUNDS.—

6 (i) IN GENERAL.—It shall be the duty
7 of the Managing Trustee to invest such
8 portion of the Trust Fund as is not, in the
9 Managing Trustee's judgment, required to
10 meet current withdrawals.

11 (ii) GENERAL FORM OF INVEST-
12 MENT.—Investments described in clause (i)
13 may be made only in interest-bearing obli-
14 gations of the United States or in obliga-
15 tions guaranteed as to both principal and
16 interest by the United States. For such
17 purpose such obligations may be ac-
18 quired—

19 (I) on original issue at the issue
20 price, or

21 (II) by purchase of outstanding
22 obligations at market price.

23 (iii) ISSUANCE OF PUBLIC-DEBT OBLI-
24 GATIONS.—The purposes for which obliga-
25 tions of the United States may be issued

1 under chapter 31 of title 31, United States
2 Code, are hereby extended to authorize the
3 issuance at par of public-debt obligations
4 for purchase by the Trust Fund. Such obli-
5 gations issued for purchase by the Trust
6 Fund shall have maturities fixed with due
7 regard for the needs of the Trust Fund
8 and shall bear interest at a rate equal to
9 the average market yield (computed by the
10 Managing Trustee on the basis of market
11 quotations as of the end of the calendar
12 month next preceding the date of such
13 issue) on all marketable interest-bearing
14 obligations of the United States then form-
15 ing a part of the public debt which are not
16 due or callable until after the expiration of
17 4 years from the end of such calendar
18 month, except that where such average is
19 not a multiple of $\frac{1}{8}$ of 1 percent, the rate
20 of interest on such obligations shall be the
21 multiple of $\frac{1}{8}$ of 1 percent nearest such
22 market yield.

23 (iv) PURCHASES OF OTHER OBLIGA-
24 TIONS.—The Managing Trustee may pur-
25 chase other interest-bearing obligations of

1 the United States or obligations guaran-
2 teed as to both principal and interest by
3 the United States, on original issue or at
4 the market price, only where the Managing
5 Trustee determines that the purchase of
6 such other obligations is in the public
7 interest.

8 (C) SALE OF OBLIGATIONS.—Any obliga-
9 tions acquired by the Trust Fund (except pub-
10 lic-debt obligations issued exclusively to the
11 Trust Fund) may be sold by the Managing
12 Trustee at the market price, and such public-
13 debt obligations may be redeemed at par plus
14 accrued interest.

15 (D) INTEREST ON OBLIGATIONS AND PRO-
16 CEEDS FROM SALE OR REDEMPTION OF OBLI-
17 GATIONS.—The interest on, and the proceeds
18 from the sale or redemption of, any obligations
19 held in the Trust Fund shall be credited to and
20 form a part of the Trust Fund.

21 (E) RECEIPTS AND DISBURSEMENTS NOT
22 INCLUDED IN UNITED STATES GOVERNMENT
23 BUDGET TOTALS.—The receipts and disburse-
24 ments of the Secretary in the discharge of the
25 functions of the Secretary under the all-payer

1 fraud and abuse control program established
2 under subsection (a) shall not be included in
3 the totals of the budget of the United States
4 Government. For purposes of part C of the Bal-
5 anced Budget and Emergency Deficit Control
6 Act of 1985, the Secretary and the Trust Fund
7 shall be treated in the same manner as the
8 Federal Retirement Thrift Investment Board
9 and the Thrift Savings Fund, respectively. The
10 United States is not liable for any obligation or
11 liability incurred by the Trust Fund.

12 (3) USE OF FUNDS.—

13 (A) IN GENERAL.—Amounts in the Trust
14 Fund shall be used without regard to fiscal year
15 limitation to assist the Inspector General of the
16 Department of Health and Human Services in
17 carrying out the all-payer fraud and abuse con-
18 trol program established under subsection (a).

19 (B) OVERALL ADMINISTRATION.—The
20 Managing Trustee shall also pay from time to
21 time from the Trust Fund such amounts as the
22 Secretary certifies are necessary to carry out
23 the all-payer fraud and abuse control program
24 established under subsection (a).

1 (4) ANNUAL REPORT.—The Managing Trustee
2 shall be required to submit an annual report to Con-
3 gress on the amount of revenue which is generated
4 and disbursed by the Trust Fund in each fiscal year.
5 Such report shall include an estimate of the amount
6 of additional appropriations authorized under sub-
7 section (a)(5) necessary for the Secretary to conduct
8 the all-payer fraud and abuse program established
9 under subsection (a) in the next fiscal year.

10 **SEC. 4102. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**
11 **AND ABUSE SANCTIONS TO ALL FRAUD AND**
12 **ABUSE AGAINST ANY HEALTH CARE PLAN.**

13 (a) CIVIL MONETARY PENALTIES.—Section 1128A
14 of the Social Security Act (42 U.S.C. 1320a-7a) is
15 amended as follows:

16 (1) In subsection (a)(1), by inserting “or of any
17 health care plan (as defined in section 1128(i)),”
18 after “subsection (i)(1),”.

19 (2) In subsection (b)(1)(A), by inserting “or
20 under a health care plan” after “title XIX”.

21 (3) In subsection (f)—

22 (A) by redesignating paragraph (3) as
23 paragraph (4); and

24 (B) by inserting after paragraph (2) the
25 following new paragraph:

1 “(3) With respect to amounts recovered arising
2 out of a claim under a health care plan, the portion
3 of such amounts as is determined to have been paid
4 by the plan shall be repaid to the plan, and the por-
5 tion of such amounts attributable to the amounts re-
6 covered under this section by reason of the amend-
7 ments made by subtitle B of title IV of the Health
8 Equity and Access Reform Today Act of 1993 (as
9 estimated by the Secretary) shall be deposited into
10 the Anti-Fraud and Abuse Trust Fund.”.

11 (4) In subsection (i)—

12 (A) in paragraph (2), by inserting “or
13 under a health care plan” before the period at
14 the end, and

15 (B) in paragraph (5), by inserting “or
16 under a health care plan” after “or XX”.

17 (b) CRIMES.—

18 (1) SOCIAL SECURITY ACT.—Section 1128B of
19 such Act (42 U.S.C. 1320a-7b) is amended as
20 follows:

21 (A) In the heading, by adding at the end
22 the following: “OR HEALTH CARE PLANS”.

23 (B) In subsection (a)(1)—

24 (i) by striking “title XVIII or” and
25 inserting “title XVIII,”, and

1 (ii) by adding at the end the follow-
2 ing: “or a health care plan (as defined in
3 section 1128(i)),”.

4 (C) In subsection (a)(5), by striking “title
5 XVIII or a State health care program” and in-
6 serting “title XVIII, a State health care pro-
7 gram, or a health care plan”.

8 (D) In the second sentence of subsection
9 (a)—

10 (i) by inserting after “title XIX” the
11 following: “or a health care plan”, and

12 (ii) by inserting after “the State” the
13 following: “or the plan”.

14 (E) In subsection (b)(1), by striking “title
15 XVIII or a State health care program” each
16 place it appears and inserting “title XVIII, a
17 State health care program, or a health care
18 plan”.

19 (F) In subsection (b)(2), by striking “title
20 XVIII or a State health care program” each
21 place it appears and inserting “title XVIII, a
22 State health care program, or a health care
23 plan”.

24 (G) In subsection (b)(3), by striking “title
25 XVIII or a State health care program” each

1 place it appears in subparagraphs (A) and (C)
2 and inserting “title XVIII, a State health care
3 program, or a health care plan”.

4 (2) IDENTIFICATION OF COMMUNITY SERVICE
5 OPPORTUNITIES.—Section 1128B of such Act (42
6 U.S.C. 1320a–7b) is further amended by adding at
7 the end the following new subsection:

8 “(f) The Secretary may—

9 “(1) in consultation with State and local health
10 care officials, identify opportunities for the satisfac-
11 tion of community service obligations that a court
12 may impose upon the conviction of an offense under
13 this section, and

14 “(2) make information concerning such oppor-
15 tunities available to Federal and State law enforce-
16 ment officers and State and local health care
17 officials.”.

18 (c) HEALTH CARE PLAN DEFINED.—Section 1128 of
19 such Act (42 U.S.C. 1320a–7) is amended by redesignat-
20 ing subsection (i) as subsection (j) and by inserting after
21 subsection (h) the following new subsection:

22 “(i) HEALTH CARE PLAN DEFINED.—For purposes
23 of sections 1128A and 1128B, the term ‘health care plan’
24 means a public or private program for the delivery of or
25 payment for health care items or services other than the

1 medicare program, the medicaid program, or a State
2 health care program.”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 this section shall take effect on January 1, 1995.

5 **SEC. 4103. REPORTING OF FRAUDULENT ACTIONS UNDER**
6 **MEDICARE.**

7 Not later than 1 year after the date of the enactment
8 of this Act, the Secretary shall establish a program
9 through which individuals entitled to benefits under the
10 medicare program may report to the Secretary on a con-
11 fidential basis (at the individual’s request) instances of
12 suspected fraudulent actions arising under the program by
13 providers of items and services under the program.

14 **PART II—REVISIONS TO CURRENT SANCTIONS**
15 **FOR FRAUD AND ABUSE**

16 **SEC. 4111. MANDATORY EXCLUSION FROM PARTICIPATION**
17 **IN MEDICARE AND STATE HEALTH CARE PRO-**
18 **GRAMS.**

19 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
20 TO FRAUD.—

21 (1) IN GENERAL.—Section 1128(a) of the
22 Social Security Act (42 U.S.C. 1320a–7(a)) is
23 amended by adding at the end the following new
24 paragraph:

1 “(3) FELONY CONVICTION RELATING TO
2 FRAUD.—Any individual or entity that has been con-
3 victed, under Federal or State law, in connection
4 with the delivery of a health care item or service or
5 with respect to any act or omission in a program
6 (other than those specifically described in paragraph
7 (1)) operated by or financed in whole or in part by
8 any Federal, State, or local government agency, of
9 a criminal offense consisting of a felony relating to
10 fraud, theft, embezzlement, breach of fiduciary re-
11 sponsibility, or other financial misconduct.”.

12 (2) CONFORMING AMENDMENT.—Section
13 1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1))
14 is amended—

15 (A) in the heading, by striking “CONVIC-
16 TION” and inserting “MISDEMEANOR CONVIC-
17 TION”; and

18 (B) by striking “criminal offense” and in-
19 serting “criminal offense consisting of a mis-
20 demeanor”.

21 (b) INDIVIDUAL CONVICTED OF FELONY RELATING
22 TO CONTROLLED SUBSTANCE.—

23 (1) IN GENERAL.—Section 1128(a) of the So-
24 cial Security Act (42 U.S.C. 1320a-7(a)), as amend-

1 ed by subsection (a), is amended by adding at the
2 end the following new paragraph:

3 “(4) FELONY CONVICTION RELATING TO CON-
4 TROLLED SUBSTANCE.—Any individual or entity
5 that has been convicted, under Federal or State law,
6 of a criminal offense consisting of a felony relating
7 to the unlawful manufacture, distribution, prescrip-
8 tion, or dispensing of a controlled substance.”.

9 (2) CONFORMING AMENDMENT.—Section
10 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3))
11 is amended—

12 (A) in the heading, by striking “CONVIC-
13 TION” and inserting “MISDEMEANOR CONVIC-
14 TION”; and

15 (B) by striking “criminal offense” and in-
16 serting “criminal offense consisting of a mis-
17 demeanor”.

18 **SEC. 4112. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
19 **CLUSION FOR CERTAIN INDIVIDUALS AND**
20 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
21 **SION FROM MEDICARE AND STATE HEALTH**
22 **CARE PROGRAMS.**

23 Section 1128(c)(3) of the Social Security Act (42
24 U.S.C. 1320a–7(c)(3)) is amended by adding at the end
25 the following new subparagraphs:

1 “(D) In the case of an exclusion of an individual or
2 entity under paragraph (1), (2), or (3) of subsection (b),
3 the period of the exclusion shall be 3 years, unless the
4 Secretary determines in accordance with published regula-
5 tions that a shorter period is appropriate because of miti-
6 gating circumstances or that a longer period is appro-
7 priate because of aggravating circumstances.

8 “(E) In the case of an exclusion of an individual or
9 entity under subsection (b)(4) or (b)(5), the period of the
10 exclusion shall not be less than the period during which
11 the individual’s or entity’s license to provide health care
12 is revoked, suspended, or surrendered, or the individual
13 or the entity is excluded or suspended from a Federal or
14 State health care program.

15 “(F) In the case of an exclusion of an individual or
16 entity under subsection (b)(6)(B), the period of the exclu-
17 sion shall be not less than 1 year.”.

18 **SEC. 4113. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**
19 **OWNERSHIP OR CONTROL INTEREST IN**
20 **SANCTIONED ENTITIES.**

21 Section 1128(b) of the Social Security Act (42 U.S.C.
22 1320a-7(b)), as amended by section 4101(a)(6)(B), is fur-
23 ther amended by adding at the end the following new para-
24 graph:

1 “(16) INDIVIDUALS CONTROLLING A SANC-
2 TIONED ENTITY.—Any individual who has a direct
3 or indirect ownership or control interest of 5 percent
4 or more, or an ownership or control interest (as de-
5 fined in section 1124(a)(3)) in, or who is an officer,
6 director, agent, or managing employee (as defined in
7 section 1126(b)) of, an entity—

8 “(A) that has been convicted of any of-
9 fense described in subsection (a) or in para-
10 graph (1), (2), or (3) of this subsection;

11 “(B) against which a civil monetary pen-
12 alty has been assessed under section 1128A; or

13 “(C) that has been excluded from partici-
14 pation under a program under title XVIII or
15 under a State health care program.”.

16 **SEC. 4114. CIVIL MONETARY PENALTIES.**

17 (a) PROHIBITION AGAINST OFFERING INDUCEMENTS
18 TO INDIVIDUALS ENROLLED UNDER OR EMPLOYED BY
19 PROGRAMS OR PLANS.—

20 (1) INDUCEMENTS TO INDIVIDUALS ENROLLED
21 UNDER MEDICARE.—

22 (A) OFFER OF REMUNERATION.—Section
23 1128A(a) of the Social Security Act (42 U.S.C.
24 1320a-7a(a)) is amended—

1 (i) by striking “or” at the end of
2 paragraph (1)(D);

3 (ii) by striking “, or” at the end of
4 paragraph (2) and inserting a semicolon;

5 (iii) by striking the semicolon at the
6 end of paragraph (3) and inserting “; or”;
7 and

8 (iv) by inserting after paragraph (3)
9 the following new paragraph:

10 “(4) offers to or transfers remuneration to any
11 individual eligible for benefits under title XVIII of
12 this Act, or under a State health care program (as
13 defined in section 1128(h)) that such person knows
14 or should know is likely to influence such individual
15 to order or receive from a particular provider, practi-
16 tioner, or supplier any item or service for which pay-
17 ment may be made, in whole or in part, under title
18 XVIII, or a State health care program;”.

19 (B) REMUNERATION DEFINED.—Section
20 1128A(i) is amended by adding the following
21 new paragraph:

22 “(6) The term ‘remuneration’ includes the waiv-
23 er of coinsurance and deductible amounts (or any
24 part thereof), and transfers of items or services for
25 free or for other than fair market value. The term

1 'remuneration' does not include the waiver of coin-
2 surance and deductible amounts by a person, if—

3 “(A) the waiver is not offered as part of
4 any advertisement or solicitation;

5 “(B) the person does not routinely waive
6 coinsurance or deductible amounts; and

7 “(C) the person—

8 “(i) waives the coinsurance and de-
9 ductible amounts after determining in good
10 faith that the individual is in financial
11 need;

12 “(ii) fails to collect coinsurance or de-
13 ductible amounts after making reasonable
14 collection efforts; or

15 “(iii) provides for any permissible
16 waiver as specified in section 1128B(b)(3)
17 or in regulations issued by the Secretary.”.

18 (2) INDUCEMENTS TO EMPLOYEES.—Section
19 1128A(a) of such Act (42 U.S.C. 1320a-7a(a)), as
20 amended by paragraph (1), is further amended—

21 (A) by striking “or” at the end of para-
22 graph (3);

23 (B) by striking the semicolon at the end of
24 paragraph (4) and inserting “; or”; and

1 (C) by inserting after paragraph (4) the
2 following new paragraph:

3 “(5) pays a bonus, reward, or any other remuneration, directly or indirectly, to an employee to induce the employee to encourage individuals to seek
4 or obtain covered items or services for which payment may be made under the medicare program, or
5 a State health care program where the amount of the remuneration is determined in a manner that
6 takes into account (directly or indirectly) the value or volume of any referrals by the employee to the
7 employer for covered items or services;”.

8 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP
9 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—
10 Section 1128A(a) of such Act, as amended by subsection
11 (a), is further amended—

12 (1) by striking “or” at the end of paragraph
13 (4);

14 (2) by striking the semicolon at the end of
15 paragraph (5) and inserting “; or”; and

16 (3) by inserting after paragraph (5) the following new paragraph:

17 “(6) in the case of a person who is not an organization, agency, or other entity, is excluded from
18 participating in a program under title XVIII or a
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1 State health care program in accordance with this
2 subsection or under section 1128 and who, during
3 the period of exclusion, retains a direct or indirect
4 ownership or control interest of 5 percent or more,
5 or an ownership or control interest (as defined in
6 section 1124(a)(3)) in, or who is an officer, director,
7 agent, or managing employee (as defined in section
8 1126(b)) of, an entity that is participating in a pro-
9 gram under title XVIII or a State health care
10 program;”.

11 (c) MODIFICATIONS OF AMOUNTS OF PENALTIES
12 AND ASSESSMENTS.—Section 1128A(a) of such Act (42
13 U.S.C. 1320a–7a(a)), as amended by subsections (a) and
14 (b), is amended in the matter following paragraph (6)—

15 (1) by striking “\$2,000” and inserting
16 “\$10,000”;

17 (2) by inserting “; in cases under paragraph
18 (4), \$10,000 for each such offer or transfer; in cases
19 under paragraph (5), \$10,000 for each such pay-
20 ment; in cases under paragraph (6), \$10,000 for
21 each day the prohibited relationship occurs; in cases
22 under paragraph (7), \$10,000 per violation” after
23 “false or misleading information was given”;

24 (3) by striking “twice the amount” and insert-
25 ing “3 times the amount”; and

1 (4) by inserting “(or, in cases under paragraphs
2 (4), (5), and (7), 3 times the amount of the illegal
3 remuneration)” after “for each such item or serv-
4 ice”.

5 (d) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
6 RECT CODING OR MEDICALLY UNNECESSARY SERV-
7 ICES.—Section 1128A(a)(1) of such Act (42 U.S.C.
8 1320a-7a(a)(1)) is amended—

9 (1) in subparagraph (A) by striking “claimed,”
10 and inserting the following: “claimed, including any
11 person who presents or causes to be presented a
12 claim for an item or service that is based on a code
13 that the person knows or should know will result in
14 a greater payment to the person than the code the
15 person knows or should know is applicable to the
16 item or service actually provided,”;

17 (2) in subparagraph (C), by striking “or” at
18 the end;

19 (3) in subparagraph (D), by striking “; or” and
20 inserting “, or”; and

21 (4) by inserting after subparagraph (D) the
22 following new subparagraph:

23 “(E) is for a medical or other item or serv-
24 ice that a person knows or should know is not
25 medically necessary; or”.

1 (e) PERMITTING PARTIES TO BRING ACTIONS ON
2 OWN BEHALF.—Section 1128A of such Act (42 U.S.C.
3 1320a–7a) is amended by adding at the end the following
4 new subsection:

5 “(m)(1) Subject to paragraphs (2) and (3), any per-
6 son (including an organization, agency, or other entity,
7 but excluding a beneficiary, as defined in subsection
8 (i)(5)) that suffers harm or monetary loss as a result of
9 any activity of an individual or entity which makes the
10 individual or entity subject to a civil monetary penalty
11 under this section may, in a civil action against the indi-
12 vidual or entity in the United States District Court, obtain
13 treble damages and costs including attorneys’ fees against
14 the individual or entity and such equitable relief as is
15 appropriate.

16 “(2) A person may bring a civil action under this sub-
17 section only if—

18 “(A) the person provides the Secretary with
19 written notice of—

20 “(i) the person’s intent to bring an action
21 under this subsection,

22 “(ii) the identities of the individuals or en-
23 tities the person intends to name as defendants
24 to the action, and

1 “(iii) all information the person possesses
2 regarding the activity that is the subject of the
3 action that may materially affect the Sec-
4 retary’s decision to initiate a proceeding to im-
5 pose a civil monetary penalty under this section
6 against the defendants, and

7 “(B) one of the following conditions is met:

8 “(i) During the 60-day period that begins
9 on the date the Secretary receives the written
10 notice described in subparagraph (A), the Sec-
11 retary does not notify the person that the Sec-
12 retary intends to initiate an investigation to de-
13 termine whether to impose a civil monetary
14 penalty under this section against the defend-
15 ants.

16 “(ii) The Secretary notifies the person dur-
17 ing the 60-day period described in clause (i)
18 that the Secretary intends to initiate an inves-
19 tigation to determine whether to impose a civil
20 monetary penalty under this section against the
21 defendants, and the Secretary subsequently no-
22 tifies the person that the Secretary no longer
23 intends to initiate an investigation or proceed-
24 ing to impose a civil monetary penalty against
25 the defendants.

1 “(iii) After the expiration of the 2-year pe-
2 riod that begins on the date written notice is
3 provided to the Secretary, the Secretary has not
4 initiated a proceeding to impose a civil mone-
5 etary penalty against the defendants.

6 “(3) If a person is awarded any amounts in an action
7 brought under this subsection that are in excess of the
8 damages suffered by the person as a result of the defend-
9 ant’s activities, 20 percent of such amounts shall be with-
10 held from the person for payment into the Anti-Fraud and
11 Abuse Trust Fund established under section 4101(b) of
12 the Health Equity and Access Reform Act of 1993.

13 “(4) No action may be brought under this subsection
14 more than 6 years after the date of the activity with re-
15 spect to which the action is brought.”.

16 **SEC. 4115. ACTIONS SUBJECT TO CRIMINAL PENALTIES.**

17 (a) PERMITTING SECRETARY TO IMPOSE CIVIL MON-
18 ETARY PENALTY.—Section 1128A(b) of the Social Secu-
19 rity Act (42 U.S.C. 1320a–7a(a)) is amended by adding
20 the following new paragraph:

21 “(3) Any person (including any organization,
22 agency, or other entity, but excluding a beneficiary
23 as defined in subsection (i)(5)) who the Secretary
24 determines has violated section 1128(B)(b) of this
25 title shall be subject to a civil monetary penalty of

1 not more than \$10,000 for each such violation. In
2 addition, such person shall be subject to an assess-
3 ment of not more than twice the total amount of the
4 remuneration offered, paid, solicited, or received in
5 violation of section 1128B(b). The total amount of
6 remuneration subject to an assessment shall be cal-
7 culated without regard to whether some portion
8 thereof also may have been intended to serve a pur-
9 pose other than one proscribed by section
10 1128B(b).”.

11 (b) RESTRICTION ON APPLICATION OF EXCEPTION
12 FOR AMOUNTS PAID TO EMPLOYEES.—Section
13 1128B(b)(3)(B) of such Act (42 U.S.C. 1320a-
14 7b(b)(3)(B)) is amended by striking “services;” and in-
15 serting the following: “services, but only if the amount of
16 remuneration under the arrangement is (i) consistent with
17 fair market value; (ii) not determined in a manner that
18 takes into account (directly or indirectly) the volume or
19 value of any referrals by the employee to the employer for
20 the furnishing (or arranging for the furnishing) of such
21 items or services; and (iii) provided pursuant to an ar-
22 rangement that would be commercially reasonable even if
23 no referrals were made;”.

1 **SEC. 4116. SANCTIONS AGAINST PRACTITIONERS AND PER-**
2 **SONS FOR FAILURE TO COMPLY WITH STATU-**
3 **TORY OBLIGATIONS.**

4 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
5 TIONERS AND PERSONS FAILING TO MEET STATUTORY
6 OBLIGATIONS.—

7 (1) IN GENERAL.—The second sentence of sec-
8 tion 1156(b)(1) of the Social Security Act (42
9 U.S.C. 1320c-5(b)(1)) is amended by striking “may
10 prescribe)” and inserting “may prescribe, except
11 that such period may not be less than 1 year)”.

12 (2) CONFORMING AMENDMENT.—Section
13 1156(b)(2) of such Act (42 U.S.C. 1320c-5(b)(2)) is
14 amended by striking “shall remain” and inserting
15 “shall (subject to the minimum period specified in
16 the second sentence of paragraph (1)) remain”.

17 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-
18 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
19 of such Act (42 U.S.C. 1320c-5(b)(1)) is amended—

20 (1) in the second sentence, by striking “and de-
21 termines” and all that follows through “such obliga-
22 tions,”; and

23 (2) by striking the third sentence.

24 (c) AMOUNT OF CIVIL MONEY PENALTY.—Section
25 1156(b)(3) of such Act (42 U.S.C. 1320c-5(b)(3)) is

1 amended by striking “the actual or estimated cost” and
2 inserting the following: “up to \$10,000 for each instance”.

3 **SEC. 4117. INTERMEDIATE SANCTIONS FOR MEDICARE**
4 **HEALTH MAINTENANCE ORGANIZATIONS.**

5 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
6 ANY PROGRAM VIOLATIONS.—

7 (1) IN GENERAL.—Section 1876(i)(1) of the
8 Social Security Act (42 U.S.C. 1395mm(i)(1)) is
9 amended by striking “the Secretary may terminate”
10 and all that follows and inserting the following: “in
11 accordance with procedures established under para-
12 graph (9), the Secretary may at any time terminate
13 any such contract or may impose the intermediate
14 sanctions described in paragraph (6)(B) or (6)(C)
15 (whichever is applicable) on the eligible organization
16 if the Secretary determines that the organization—

17 “(A) has failed substantially to carry out
18 the contract;

19 “(B) is carrying out the contract in a man-
20 ner inconsistent with the efficient and effective
21 administration of this section;

22 “(C) is operating in a manner that is not
23 in the best interests of the individuals covered
24 under the contract; or

1 “(D) no longer substantially meets the ap-
2 plicable conditions of subsections (b), (c), (e),
3 and (f).”.

4 (2) OTHER INTERMEDIATE SANCTIONS FOR
5 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
6 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is
7 amended by adding at the end the following new
8 subparagraph:

9 “(C) In the case of an eligible organization for which
10 the Secretary makes a determination under paragraph (1)
11 the basis of which is not described in subparagraph (A),
12 the Secretary may apply the following intermediate sanc-
13 tions:

14 “(i) Civil money penalties of not more than
15 \$25,000 for each determination under paragraph (1)
16 if the deficiency that is the basis of the determina-
17 tion has directly adversely affected (or has the sub-
18 stantial likelihood of adversely affecting) an individ-
19 ual covered under the organization’s contract.

20 “(ii) Civil money penalties of not more than
21 \$10,000 for each week beginning after the initiation
22 of procedures by the Secretary under paragraph (9)
23 during which the deficiency that is the basis of a de-
24 termination under paragraph (1) exists.

1 “(iii) Suspension of enrollment of individuals
2 under this section after the date the Secretary noti-
3 fies the organization of a determination under para-
4 graph (1) and until the Secretary is satisfied that
5 the deficiency that is the basis for the determination
6 has been corrected and is not likely to recur.”.

7 (3) PROCEDURES FOR IMPOSING SANCTIONS.—
8 Section 1876(i) of such Act (42 U.S.C. 1395mm(i))
9 is amended by adding at the end the following new
10 paragraph:

11 “(9) The Secretary may terminate a contract with an
12 eligible organization under this section or may impose the
13 intermediate sanctions described in paragraph (6) on the
14 organization in accordance with formal investigation and
15 compliance procedures established by the Secretary under
16 which—

17 “(A) the Secretary provides the organization
18 with the opportunity to develop and implement a
19 corrective action plan to correct the deficiencies that
20 were the basis of the Secretary’s determination
21 under paragraph (1);

22 “(B) in deciding whether to impose sanctions,
23 the Secretary considers aggravating factors such as
24 whether an entity has a history of deficiencies or has

1 not taken action to correct deficiencies the Secretary
2 has brought to their attention;

3 “(C) there are no unreasonable or unnecessary
4 delays between the finding of a deficiency and the
5 imposition of sanctions; and

6 “(D) the Secretary provides the organization
7 with reasonable notice and opportunity for hearing
8 (including the right to appeal an initial decision) be-
9 fore imposing any sanction or terminating the con-
10 tract.”.

11 (4) CONFORMING AMENDMENTS.—

12 (A) IN GENERAL.—Section 1876(i)(6)(B)
13 of such Act (42 U.S.C. 1395mm(i)(6)(B)) is
14 amended by striking the second sentence.

15 (B) PROCEDURAL PROVISIONS.—Section
16 1876(i)(6) of such Act (42 U.S.C.
17 1395mm(i)(6)) is further amended by adding at
18 the end the following new subparagraph:

19 “(D) The provisions of section 1128A (other than
20 subsections (a) and (b)) shall apply to a civil money pen-
21 alty under subparagraph (A) or (B) in the same manner
22 as they apply to a civil money penalty or proceeding under
23 section 1128A(a).”.

24 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
25 TIONS.—

1 (1) REQUIREMENT FOR WRITTEN AGREE-
2 MENT.—Section 1876(i)(7)(A) of the Social Security
3 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by
4 striking “an agreement” and inserting “a written
5 agreement”.

6 (2) DEVELOPMENT OF MODEL AGREEMENT.—
7 Not later than July 1, 1995, the Secretary shall de-
8 velop a model of the agreement that an eligible orga-
9 nization with a risk-sharing contract under section
10 1876 of the Social Security Act must enter into with
11 an entity providing peer review services with respect
12 to services provided by the organization under sec-
13 tion 1876(i)(7)(A) of such Act.

14 (3) REPORT BY GAO.—

15 (A) STUDY.—The Comptroller General
16 shall conduct a study of the costs incurred by
17 eligible organizations with risk-sharing con-
18 tracts under section 1876(b) of such Act of
19 complying with the requirement of entering into
20 a written agreement with an entity providing
21 peer review services with respect to services pro-
22 vided by the organization, together with an
23 analysis of how information generated by such
24 entities is used by the Secretary to assess the

1 quality of services provided by such eligible or-
2 ganizations.

3 (B) REPORT TO CONGRESS.—Not later
4 than July 1, 1997, the Comptroller General
5 shall submit a report to the Committee on
6 Ways and Means and the Committee on Energy
7 and Commerce of the House of Representatives
8 and the Committee on Finance and the Special
9 Committee on Aging of the Senate on the study
10 conducted under subparagraph (A).

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply with respect to contract years be-
13 ginning on or after January 1, 1995.

14 **SEC. 4118. EFFECTIVE DATE.**

15 The amendments made by this part shall take effect
16 January 1, 1995.

17 **PART III—ADMINISTRATIVE AND**
18 **MISCELLANEOUS PROVISIONS**

19 **SEC. 4121. ESTABLISHMENT OF THE HEALTH CARE FRAUD**
20 **AND ABUSE DATA COLLECTION PROGRAM.**

21 (a) FINDINGS.—The Congress finds the following:

22 (1) Fraud and abuse with respect to the deliv-
23 ery of and payment for health care services is a sig-
24 nificant contributor to the growing costs of the
25 Nation's health care.

1 (2) Control of fraud and abuse in health care
2 services warrants greater efforts of coordination
3 than those that can be undertaken by individual
4 States or the various Federal, State, and local law
5 enforcement programs.

6 (3) There is a national need to coordinate infor-
7 mation about health care providers and entities that
8 have engaged in fraud and abuse in the delivery of
9 and payment for health care services.

10 (4) There is no comprehensive national data
11 collection program for the reporting of public infor-
12 mation about final adverse actions against health
13 care providers, suppliers, or licensed health care
14 practitioners that have engaged in fraud and abuse
15 in the deliver of and payment for health care
16 services.

17 (5) A comprehensive national data collection
18 program for the reporting of public information
19 about final adverse actions will facilitate the enforce-
20 ment of the provisions of the Social Security Act and
21 other statutes applicable to health care fraud and
22 abuse.

23 (b) GENERAL PURPOSE.—Not later than January 1,
24 1995, the Secretary shall establish a national health care
25 fraud and abuse data collection program for the reporting

1 of final adverse actions (not including settlements where
2 no finding of liability has been made) against health care
3 providers, suppliers, or practitioners as required by sub-
4 section (c), with access as set forth in subsection (d).

5 (c) REPORTING OF INFORMATION.—

6 (1) IN GENERAL.—Each government agency
7 and health care plan shall report any final adverse
8 action (not including settlements where no finding of
9 liability has been made) taken against a health care
10 provider, supplier, or practitioner.

11 (2) INFORMATION TO BE REPORTED.—The in-
12 formation to be reported under paragraph (1)
13 includes:

14 (A) The name of any health care provider,
15 supplier, or practitioner who is the subject of a
16 final adverse action.

17 (B) The name (if known) of any health
18 care entity with which a health care provider,
19 supplier, or practitioner is affiliated or associ-
20 ated.

21 (C) The nature of the final adverse action.

22 (D) A description of the acts or omissions
23 and injuries upon which the final adverse action
24 was based, and such other information as the
25 Secretary determines by regulation is required

1 for appropriate interpretation of information re-
2 ported under this section.

3 (3) CONFIDENTIALITY.—In determining what
4 information is required, the Secretary shall include
5 procedures to assure that the privacy of individuals
6 receiving health care services is appropriately pro-
7 tected.

8 (4) TIMING AND FORM OF REPORTING.—The
9 information required to be reported under this sub-
10 section shall be reported regularly (but not less often
11 than monthly) and in such form and manner as the
12 Secretary prescribes. Such information shall first be
13 required to be reported on a date specified by the
14 Secretary.

15 (5) TO WHOM REPORTED.—The information re-
16 quired to be reported under this subsection shall be
17 reported to the Secretary.

18 (d) DISCLOSURE AND CORRECTION OF INFORMA-
19 TION.—

20 (1) DISCLOSURE.—With respect to the informa-
21 tion about final adverse actions (not including settle-
22 ments where no findings of liability has been made)
23 reported to the Secretary under this section respect-
24 ing a health care provider, supplier, or practitioner,
25 the Secretary shall, by regulation, provide for—

1 (A) disclosure of the information, upon re-
2 quest, to the health care provider, supplier, or
3 licensed practitioner, and

4 (B) procedures in the case of disputed ac-
5 curacy of the information.

6 (2) CORRECTIONS.—Each Government agency
7 and health care plan shall report corrections of in-
8 formation already reported about any final adverse
9 action taken against a health care provider, supplier,
10 or practitioner, in such form and manner that the
11 Secretary prescribes by regulation.

12 (e) ACCESS TO REPORTED INFORMATION.—

13 (1) AVAILABILITY.—The information in this
14 database shall be available to the public, Federal
15 and State government agencies, and health care
16 plans pursuant to procedures that the Secretary
17 shall provide by regulation.

18 (2) FEES FOR DISCLOSURE.—The Secretary
19 may establish or approve reasonable fees for the dis-
20 closure of information in this database. The amount
21 of such a fee may not exceed the costs of processing
22 the requests for disclosure and of providing such in-
23 formation. Such fees shall be available to the Sec-
24 retary or, in the Secretary's discretion to the agency
25 designated under this section to cover such costs.

1 (f) PROTECTION FROM LIABILITY FOR REPORT-
2 ING.—No person or entity, including the agency des-
3 igned by the Secretary in subsection (c)(5) shall be held
4 liable in any civil action with respect to any report made
5 as required by this section, without knowledge of the fal-
6 sity of the information contained in the report.

7 (g) DEFINITIONS AND SPECIAL RULES.—For pur-
8 poses of this section:

9 (1) The term “final adverse action” includes:

10 (A) Civil judgments against a health care
11 provider in Federal or State court related to the
12 delivery of a health care item or service.

13 (B) Federal or State criminal convictions
14 related to the delivery of a health care item or
15 service.

16 (C) Actions by State or Federal agencies
17 responsible for the licensing and certification of
18 health care providers, suppliers, and licensed
19 health care practitioners, including—

20 (i) formal or official actions, such as
21 revocation or suspension of a license (and
22 the length of any such suspension), rep-
23 rimand, censure or probation,

1 (ii) any other loss of license of the
2 provider, supplier, or practitioner, by oper-
3 ation of law, or

4 (iii) any other negative action or find-
5 ing by such State or Federal agency that
6 is publicly available information.

7 (D) Exclusion from participation in Fed-
8 eral or State health care programs.

9 (E) Any other adjudicated actions or deci-
10 sions that the Secretary shall establish by regu-
11 lation.

12 (2) The terms “licensed health care practi-
13 tioner”, “licensed practitioner”, and “practitioner”
14 mean, with respect to a State, an individual who is
15 licensed or otherwise authorized by the State to pro-
16 vide health care services (or any individual who,
17 without authority holds himself or herself out to be
18 so licensed or authorized).

19 (3) The term “health care provider” means a
20 provider of services as defined in section 1861(u) of
21 the Social Security Act, and any entity, including a
22 health maintenance organization, group medical
23 practice, or any other entity listed by the Secretary
24 in regulation, that provides health care services.

1 (4) The term “supplier” means a supplier of
2 health care items and services described in sections
3 1819 (a) and (b), and section 1861 of the Social
4 Security Act.

5 (5) The term “Government agency” shall in-
6 clude:

7 (A) The Department of Justice.

8 (B) The Department of Health and
9 Human Services.

10 (C) Any other Federal agency that either
11 administers or provides payment for the deliv-
12 ery of health care services, including, but not
13 limited to the Department of Defense and the
14 Department of Veterans Affairs.

15 (D) State law enforcement agencies.

16 (E) State medicaid fraud and abuse units.

17 (F) State or Federal agencies responsible
18 for the licensing and certification of health care
19 providers and licensed health care practitioners.

20 (6) The term “health care plan” has the mean-
21 ing given to such term by section 1128(i) of the
22 Social Security Act.

23 (7) For purposes of paragraph (2), the exist-
24 ence of a conviction shall be determined under para-

1 graph (4) of section 1128(j) of the Social Security
2 Act.

3 (h) CONFORMING AMENDMENT.—Section 1921(d) of
4 the Social Security Act is amended by inserting “and sec-
5 tion 4121 of the Health Equity and Access Reform Today
6 Act of 1993” after “section 422 of the Health Care Qual-
7 ity Improvement Act of 1986”.

8 **SEC. 4122. QUARTERLY PUBLICATION OF ADVERSE AC-**
9 **TIONS TAKEN.**

10 (a) IN GENERAL.—Part A of title XI of the Social
11 Security Act (42 U.S.C. 1301 et seq.) is amended by
12 adding at the end the following new section:

13 “QUARTERLY PUBLICATION OF ADVERSE ACTIONS TAKEN
14 “SEC. 1144. Not later than 30 days after the end
15 of each calendar quarter, the Secretary shall publish in
16 the Federal Register a listing of all final adverse actions
17 taken during the quarter under this part (including pen-
18 alties imposed under section 1107, exclusions under sec-
19 tion 1128, the imposition of civil monetary penalties under
20 section 1128A, and the imposition of criminal penalties
21 under section 1128B) and under section 1156.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to calendar quarters beginning
24 on or after January 1, 1995.

1 **PART IV—AMENDMENTS TO CRIMINAL LAW**

2 **SEC. 4131. 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—

11 “(1) to defraud any health care plan or other
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
15 pretenses, representations, or promises, any of the
16 money or property owned by, or under the custody
17 or control of, any health care plan, or person in con-
18 nection with the delivery of or payment for health
19 care benefits, items, or services;

20 shall be fined under this title or imprisoned not more than
21 10 years, or both. If the violation results in serious bodily
22 injury (as defined in section 1365(g)(3) of this title), such
23 person shall be imprisoned for life or any term of years.

24 “(b) For purposes of this section, the term ‘health
25 care plan’ means a federally funded public program or pri-

1 vate program for the delivery of or payment for health
2 care items or services.”.

3 (2) CLERICAL AMENDMENT.—The table of sec-
4 tions at the beginning of chapter 63 of title 18,
5 United States Code, is amended by adding at the
6 end the following:

“1347. Health care fraud.”.

7 **SEC. 4132. FORFEITURES FOR FEDERAL HEALTH CARE OF-**
8 **FENSES.**

9 Section 982(a) of title 18, United States Code, is
10 amended by inserting after paragraph (5) the following:

11 “(6)(A) If the court determines that a Federal health
12 care offense is of a type that poses a serious threat to
13 the health of any person or has a significant detrimental
14 impact on the health care system, the court, in imposing
15 sentence on a person convicted of that offense, shall order
16 that person to forfeit property, real or personal, that—

17 “(i)(I) is used in the commission of the offense;

18 or

19 “(II) constitutes or is derived from proceeds
20 traceable to the commission of the offense; and

21 “(ii) is of a value proportionate to the serious-
22 ness of the offense.

23 “(B) For purposes of this paragraph, the term ‘Fed-
24 eral health care offense’ means a violation of, or a criminal
25 conspiracy to violate—

1 “(i) section 1347 of this title;

2 “(ii) section 1128B of the Social Security Act;

3 “(iii) sections 287, 371, 664, 666, 1001, 1027,
4 1341, 1343, or 1954 of this title if the violation or
5 conspiracy relates to health care fraud;

6 “(iv) section 501 or 511 of the Employee Re-
7 tirement Income Security Act of 1974, if the viola-
8 tion or conspiracy relates to health care fraud; and

9 “(v) section 301, 303(a)(2), or 303 (b) or (e)
10 of the Federal Food, Drug and Cosmetic Act, if the
11 violation or conspiracy relates to health care fraud.”.

12 **SEC. 4133. INJUNCTIVE RELIEF RELATING TO FEDERAL**
13 **HEALTH CARE OFFENSES.**

14 Section 1345(a)(1) of title 18, United States Code,
15 is amended—

16 (1) by striking “or” at the end of subparagraph
17 (A);

18 (2) by inserting “or” at the end of subpara-
19 graph (B); and

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

21 “(C) committing or about to commit a
22 Federal health care offense (as defined in sec-
23 tion 982(a)(6)(B) of this title);”.

1 **SEC. 4134. RACKETEERING ACTIVITY RELATING TO FED-**
2 **ERAL HEALTH CARE OFFENSES.**

3 Section 1961 of title 18, United States Code, is
4 amended by inserting “section 982(a)(6) (relating to Fed-
5 eral health care offenses),” after “sections 891–894 (relat-
6 ing to extortionate credit transactions),”.

7 **PART V—AMENDMENTS TO CIVIL FALSE CLAIMS**
8 **ACT**

9 **SEC. 4141. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.**

10 Section 3729 of title 31, United States Code, is
11 amended—

12 (1) in subsection (a)(7), by inserting “or to a
13 health care plan,” after “property to the Govern-
14 ment,”;

15 (2) in the matter following subsection (a)(7), by
16 inserting “or health care plan” before “sustains be-
17 cause of the act of that person,”;

18 (3) at the end of the first sentence of sub-
19 section (a), by inserting “or health care plan” before
20 “sustains because of the act of the person.”;

21 (4) in subsection (c)—

22 (A) by inserting “the term” after “sec-
23 tion,”; and

24 (B) by adding at the end the following:
25 “The term also includes any request or demand,
26 whether under contract or otherwise, for money

1 or property which is made or presented to a
2 health care plan.”; and

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

4 “(f) HEALTH CARE PLAN DEFINED.—For purposes
5 of this section, the term ‘health care plan’ means a feder-
6 ally funded public program for the delivery of or payment
7 for health care items or services.”.

8 **Subtitle C—Treatment of Certain**
9 **Activities Under the Antitrust**
10 **Laws**

11 **SEC. 4201. EXEMPTION FROM ANTITRUST LAWS FOR CER-**
12 **TAIN COMPETITIVE AND COLLABORATIVE**
13 **ACTIVITIES.**

14 (a) EXEMPTION DESCRIBED.—An activity relating to
15 the provision of health care services shall be exempt from
16 the antitrust laws if—

17 (1) the activity is within one of the categories
18 of safe harbors described in section 4202;

19 (2) the activity is within an additional safe har-
20 bor designated by the Attorney General under sec-
21 tion 4203; or

22 (3) the activity is specified in and in compliance
23 with the terms of a certificate of review issued by
24 the Attorney General under section 4204 and the ac-
25 tivity occurs—

1 (A) while the certificate is in effect, or

2 (B) in the case of a certificate issued dur-
3 ing the 2-year period beginning on the date of
4 the enactment of this Act, at any time on or
5 after the first day of the 2-year period that
6 ends on the date the certificate takes effect.

7 (b) AWARD OF ATTORNEY'S FEES AND COSTS OF
8 SUIT.—

9 (1) IN GENERAL.—If any person brings an ac-
10 tion alleging a claim under the antitrust laws and
11 the activity on which the claim is based is found by
12 the court to be exempt from such laws under sub-
13 section (a), the court shall, at the conclusion of the
14 action—

15 (A) award to a substantially prevailing
16 claimant the cost of suit attributable to such
17 claim, including a reasonable attorney's fee, or

18 (B) award to a substantially prevailing
19 party defending against such claim the cost of
20 such suit attributable to such claim, including
21 reasonable attorney's fee, if the claim, or the
22 claimant's conduct during litigation of the
23 claim, was frivolous, unreasonable, without
24 foundation, or in bad faith.

1 (2) OFFSET IN CASES OF BAD FAITH.—The
2 court may reduce an award made pursuant to para-
3 graph (1) in whole or in part by an award in favor
4 of another party for any part of the cost of suit (in-
5 cluding a reasonable attorney’s fee) attributable to
6 conduct during the litigation by any prevailing party
7 that the court finds to be frivolous, unreasonable,
8 without foundation, or in bad faith.

9 **SEC. 4202. SAFE HARBORS.**

10 The following activities are safe harbors for purposes
11 of section 4201(a)(1):

12 (1) COMBINATIONS WITH MARKET SHARE
13 BELOW THRESHOLD.—Activities relating to health
14 care services of any combination of health care pro-
15 viders if the number of each type or specialty of pro-
16 vider in question does not exceed 20 percent of the
17 total number of such type or specialty of provider in
18 the relevant market area.

19 (2) ACTIVITIES OF MEDICAL SELF-REGULATORY
20 ENTITIES.—

21 (A) IN GENERAL.—Subject to subpara-
22 graph (B), any activity of a medical self-regu-
23 latory entity relating to standard setting or
24 standard enforcement activities that are de-

1 signed to promote the quality of health care
2 provided to patients.

3 (B) EXCEPTION.—No activity of a medical
4 self-regulatory entity may be deemed to fall
5 under the safe harbor established under this
6 paragraph if the activity is conducted for pur-
7 poses of financial gain.

8 (3) PARTICIPATION IN SURVEYS.—The partici-
9 pation of a provider of health care services in a writ-
10 ten survey of the prices of services, reimbursement
11 levels, or the compensation and benefits of employ-
12 ees and personnel, but only if—

13 (A) the survey is conducted by a third
14 party, such as a purchaser of health care serv-
15 ices, governmental entity, institution of higher
16 education, or trade association;

17 (B) the information provided by partici-
18 pants in the survey is based on prices charged,
19 reimbursements received, or compensation and
20 benefits paid prior to the third month preceding
21 the month in which the information is provided;
22 and

23 (C) if the results of the survey are dissemi-
24 nated, the results are aggregated in a manner
25 that ensures that no recipient of the results

1 may identify the prices charged, reimbursement
2 received, or compensation and benefits paid by
3 any particular provider.

4 (4) JOINT VENTURES FOR HIGH TECHNOLOGY
5 AND COSTLY EQUIPMENT AND SERVICES.—Any ac-
6 tivity of a health care cooperative venture relating to
7 the purchase, operation, or marketing of high tech-
8 nology or other expensive medical equipment, or the
9 provision of high cost or complex services, but only
10 if the number of participants in the venture does not
11 exceed the lowest number needed to support the ven-
12 ture. Other providers may be included in the ven-
13 ture, but only if such other providers could not pur-
14 chase, operate, or market such equipment or provide
15 a competing service either alone or through the for-
16 mation of a competing venture.

17 (5) HOSPITAL MERGERS.—Activities relating to
18 a merger of 2 hospitals if, during the 3-year period
19 preceding the merger, one of the hospitals had an
20 average of 150 or fewer operational beds and an av-
21 erage daily inpatient census of less than 50 percent
22 of such beds.

23 (6) JOINT PURCHASING ARRANGEMENTS.—Any
24 joint purchasing arrangement among health care
25 providers if—

1 (A) the purchases under the arrangement
2 represent less than 35 percent of the total sales
3 of the product or service purchased in the rel-
4 evant market; and

5 (B) the cost of the products and services
6 purchased jointly accounts for less than 20 per-
7 cent of the total revenues from all products or
8 services sold by each participant in the joint
9 purchasing arrangement.

10 (7) NEGOTIATIONS.—Activities consisting of
11 good faith negotiations to carry out any activity—

12 (A) described in this section,

13 (B) within an additional safe harbor des-
14 ignated by the Attorney General under section
15 4203,

16 (C) that is the subject of an application for
17 a certificate of review under section 4204, or

18 (D) that is deemed a submission of a noti-
19 fication under section 4205(a)(2)(B),

20 without regard to whether such an activity is carried
21 out.

22 **SEC. 4203. DESIGNATION OF ADDITIONAL SAFE HARBORS.**

23 (a) IN GENERAL.—

24 (1) SOLICITATION OF PROPOSALS.—Not later
25 than 30 days after the date of the enactment of this

1 Act, the Attorney General shall publish a notice in
2 the Federal Register soliciting proposals for addi-
3 tional safe harbors.

4 (2) REVIEW AND REPORT ON PROPOSED SAFE
5 HARBORS.—Not later than 180 days after the date
6 of the enactment of this Act, the Attorney General
7 (in consultation with the Secretary of Health and
8 Human Services and the Chair of the Federal Trade
9 Commission) shall—

10 (A) review the proposed safe harbors sub-
11 mitted under paragraph (1); and

12 (B) submit a report to Congress describing
13 the proposals to be included in the publication
14 of additional safe harbors described in para-
15 graph (3) and the proposals that are not to be
16 so included, together with explanations there-
17 fore.

18 (3) PUBLICATION OF ADDITIONAL SAFE HAR-
19 BORS.—Not later than 180 days after the date of
20 the enactment of this Act, the Attorney General (in
21 consultation with the Secretary of Health and
22 Human Services and the Chair of the Federal Trade
23 Commission) shall publish in the Federal Register
24 proposed additional safe harbors for purposes of sec-
25 tion 4201(a)(2) for providers of health care services.

1 Not later than 180 days after publishing such pro-
2 posed safe harbors in the Federal Register, the At-
3 torney General shall issue final rules establishing
4 such safe harbors.

5 (b) CRITERIA FOR SAFE HARBORS.—In establishing
6 safe harbors under subsection (a), the Attorney General
7 shall take into account the following:

8 (1) The extent to which a competitive or col-
9 laborative activity will accomplish any of the follow-
10 ing:

11 (A) An increase in access to health care
12 services.

13 (B) The enhancement of the quality of
14 health care services.

15 (C) The establishment of cost efficiencies
16 that will be passed on to consumers, including
17 economies of scale and reduced transaction and
18 administrative costs.

19 (D) An increase in the ability of health
20 care facilities to provide services in medically
21 underserved areas or to medically underserved
22 populations.

23 (E) An improvement in the utilization of
24 health care resources or the reduction in the in-

1 efficient duplication of the use of such re-
2 sources.

3 (2) Whether the designation of an activity as a
4 safe harbor under subsection (a) will result in the
5 following outcomes:

6 (A) Health plans and other health care in-
7 surers, consumers of health care services, and
8 health care providers will be better able to ne-
9 gotiate payment and service arrangements
10 which will reduce costs to consumers.

11 (B) Taking into consideration the charac-
12 teristics of the particular purchasers and
13 providproviders involved, competition will not be
14 unduly restricted.

15 (C) Equally efficient and less restrictive al-
16 ternatives do not exist to meet the criteria de-
17 scribed in paragraph (1).

18 (D) The activity will not unreasonably
19 foreclose competition by denying competitors a
20 necessary element of competition.

21 **SEC. 4204. CERTIFICATES OF REVIEW.**

22 (a) ESTABLISHMENT OF PROGRAM.—In consultation
23 with the Secretary and the Chair, the Attorney General
24 shall (not later than 180 days after the date of the enact-
25 ment of this Act) issue certificates of review in accordance

1 with this section for providers of health care services and
2 advise and assist any person with respect to applying for
3 such a certificate of review.

4 (b) PROCEDURES FOR APPLICATION FOR CERTIFI-
5 CATE.—

6 (1) FORM; CONTENT.—To apply for a certifi-
7 cate of review, a person shall submit to the Attorney
8 General a written application which—

9 (A) specifies the activities relating to the
10 provision of health care services which satisfy
11 the criteria described in section 4203(b) and
12 which will be included in the certificate; and

13 (B) is in a form and contains any informa-
14 tion, including information pertaining to the
15 overall market in which the applicant operates,
16 required by rule or regulation promulgated
17 under section 4207.

18 (2) PUBLICATION OF NOTICE IN FEDERAL REG-
19 ISTER.—Within 10 days after an application submit-
20 ted under paragraph (1) is received by the Attorney
21 General, the Attorney General shall publish in the
22 Federal Register a notice that announces that an
23 application for a certificate of review has been sub-
24 mitted, identifies each person submitting the appli-

1 cation, and describes the conduct for which the ap-
2 plication is submitted.

3 (3) ESTABLISHMENT OF PROCEDURES FOR IS-
4 SUANCE OF CERTIFICATE.—In consultation with the
5 Chair and the Secretary, the Attorney General shall
6 establish procedures to be used in applying for and
7 in determining whether to approve an application for
8 a certificate of review under this subtitle. Under
9 such procedures the Attorney General shall approve
10 an application if the Attorney General determines
11 that the activities to be covered under the certificate
12 will satisfy the criteria described in section 4203(b)
13 for additional safe harbors designated under such
14 section and that the benefits of the issuance of the
15 certificate will outweigh any disadvantages that may
16 result from reduced competition.

17 (4) TIMING FOR DECISION ON APPLICATION.—

18 (A) IN GENERAL.—Within 90 days after
19 the Attorney General receives an application for
20 a certificate of review, the Attorney General
21 shall determine whether the applicant's health
22 care market activities are in accordance with
23 the procedures described in paragraph (3). If
24 the Attorney General, with the concurrence of
25 the Secretary, determines that such procedures

1 are met, the Attorney General shall issue to the
2 applicant a certificate of review. The certificate
3 of review shall specify—

4 (i) the health care market activities to
5 which the certificate applies,

6 (ii) the person to whom the certificate
7 of review is issued, and

8 (iii) any terms and conditions the At-
9 torney General or the Secretary deems nec-
10 essary to assure compliance with the appli-
11 cable procedures described in paragraph
12 (3).

13 (B) APPLICATIONS DEEMED APPROVED.—

14 If the Attorney General does not reject an ap-
15 plication before the expiration of the 90-period
16 beginning on the date the Attorney General re-
17 ceives the application, the Attorney General
18 shall be deemed to have approved the applica-
19 tion and to have issued a certificate of review
20 relating to the applicant's health care market
21 activities covered under the application.

22 (5) EXPEDITED ACTION.—If the applicant indi-
23 cates a special need for prompt disposition, the At-
24 torney General and the Secretary may expedite ac-
25 tion on the application, except that no certificate of

1 review may be issued within 30 days of publication
2 of notice in the Federal Register under subsection
3 (b)(2).

4 (6) ACTIONS UPON DENIAL.—

5 (A) NOTIFICATION.—If the Attorney Gen-
6 eral denies in whole or in part an application
7 for a certificate, the Attorney General shall no-
8 tify the applicant of the Attorney General's de-
9 termination and the reasons for it.

10 (B) REQUEST FOR RECONSIDERATION.—

11 An applicant may, within 30 days of receipt of
12 notification that the application has been denied
13 in whole or in part, request the Attorney Gen-
14 eral to reconsider the determination. The Attor-
15 ney General, with the concurrence of the Sec-
16 retary, shall notify the applicant of the deter-
17 mination upon reconsideration within 30 days
18 of receipt of the request.

19 (C) RETURN OF DOCUMENTS.—If the At-

20 torney General denies an application for the is-
21 suance of a certificate of review and thereafter
22 receives from the applicant a request for the re-
23 turn of documents submitted by the applicant
24 in connection with the application for the cer-
25 tificate, the Attorney General and the Secretary

1 shall return to the applicant, not later than 30
2 days after receipt of the request, the documents
3 and all copies of the documents available to the
4 Attorney General and the Secretary, except to
5 the extent that the information has been made
6 public under an exception to the rule against
7 public disclosure described in subsection
8 (g)(2)(B).

9 (7) FRAUDULENT PROCUREMENT.—A certifi-
10 cate of review shall be void ab initio with respect to
11 any health care market activities for which the cer-
12 tificate was procured by fraud.

13 (c) AMENDMENT AND REVOCATION OF CERTIFI-
14 CATES.—

15 (1) NOTIFICATION OF CHANGES.—Any appli-
16 cant who receives a certificate of review—

17 (A) shall promptly report to the Attorney
18 General any change relevant to the matters
19 specified in the certificate; and

20 (B) may submit to the Attorney General
21 an application to amend the certificate to re-
22 flect the effect of the change on the conduct
23 specified in the certificate.

24 (2) AMENDMENT TO CERTIFICATE.—An appli-
25 cation for an amendment to a certificate of review

1 shall be treated as an application for the issuance of
2 a certificate. The effective date of an amendment
3 shall be the date on which the application for the
4 amendment is submitted to the Attorney General.

5 (3) REVOCATION.—

6 (A) GROUNDS FOR REVOCATION.—In ac-
7 cordance with this paragraph, the Attorney
8 General may revoke in whole or in part a cer-
9 tificate of review issued under this section. The
10 following shall be considered grounds for the
11 revocation of a certificate:

12 (i) After the expiration of the 2-year
13 period beginning on the date a person's
14 certificate is issued, the activities of the
15 person have not substantially accomplished
16 the purposes for the issuance of the certifi-
17 cate.

18 (ii) The person has failed to comply
19 with any of the terms or conditions im-
20 posed under the certificate by the Attorney
21 General or the Secretary under subsection
22 (b)(4).

23 (iii) The activities covered under the
24 certificate no longer satisfy the criteria set
25 forth in section 4203(b).

1 (B) REQUEST FOR COMPLIANCE INFORMA-
2 TION.—If the Attorney General or Secretary
3 has reason to believe that any of the grounds
4 for revocation of a certificate of review de-
5 scribed in subparagraph (A) may apply to a
6 person holding the certificate, the Attorney
7 General shall request such information from
8 such person as the Attorney General or the Sec-
9 retary deems necessary to resolve the matter of
10 compliance. Failure to comply with such request
11 shall be grounds for revocation of the certificate
12 under this paragraph.

13 (C) PROCEDURES FOR REVOCATION.—If
14 the Attorney General or the Secretary deter-
15 mines that any of the grounds for revocation of
16 a certificate of review described in subpara-
17 graph (A) apply to a person holding the certifi-
18 cate, or that such person has failed to comply
19 with a request made under subparagraph (B),
20 the Attorney General shall give written notice of
21 the determination to such person. The notice
22 shall include a statement of the circumstances
23 underlying, and the reasons in support of, the
24 determination. In the 60-day period beginning
25 30 days after the notice is given, the Attorney

1 General shall revoke the certificate or modify it
2 as the Attorney General or the Secretary deems
3 necessary to cause the certificate to apply only
4 to activities that meet the procedures for the is-
5 suanance of certificates described in subsection
6 (b)(2).

7 (D) INVESTIGATION AUTHORITY.—For
8 purposes of carrying out this paragraph, the
9 Attorney General may conduct investigations in
10 the same manner as the Attorney General con-
11 ducts investigations under section 3 of the Anti-
12 trust Civil Process Act, except that no civil in-
13 vestigative demand may be issued to a person
14 to whom a certificate of review is issued if such
15 person is the target of such investigation.

16 (d) REVIEW OF DETERMINATIONS.—

17 (1) AVAILABILITY OF REVIEW FOR CERTAIN AC-
18 TIONS.—If the Attorney General denies, in whole or
19 in part, an application for a certificate of review or
20 for an amendment to a certificate, or revokes or
21 modifies a certificate pursuant to paragraph (3), the
22 applicant or certificate holder (as the case may be)
23 may, within 30 days of the denial or revocation,
24 bring an action in any appropriate district court of
25 the United States to set aside the determination on

1 the ground that such determination is erroneous
2 based on the preponderance of the evidence.

3 (2) NO OTHER REVIEW PERMITTED.—Except
4 as provided in paragraph (1), no action by the At-
5 torney General or the Secretary pursuant to this
6 subtitle shall be subject to judicial review.

7 (3) EFFECT OF REJECTED APPLICATION.—If
8 the Attorney General denies, in whole or in part, an
9 application for a certificate of review or for an
10 amendment to a certificate, or revokes or amends a
11 certificate, neither the negative determination nor
12 the statement of reasons therefore shall be admissi-
13 ble in evidence, in any administrative or judicial pro-
14 ceeding, concerning any claim under the antitrust
15 laws.

16 (e) PUBLICATION OF DECISIONS.—The Attorney
17 General shall publish a notice in the Federal Register on
18 a timely basis of each decision made with respect to an
19 application for a certificate of review under this section
20 or the amendment or revocation of such a certificate, in
21 a manner that protects the confidentiality of any propri-
22 etary information relating to the application.

23 (f) ANNUAL REPORTS.—Every person to whom a cer-
24 tificate of review is issued shall submit to the Attorney
25 General an annual report, in such form and at such time

1 as the Attorney General may require, that contains any
2 necessary updates to the information required under sub-
3 section (b) and a description of the activities of the holder
4 under the certificate during the preceding year.

5 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-
6 TION.—

7 (1) WAIVER OF DISCLOSURE REQUIREMENTS
8 UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-
9 mation submitted by any person in connection with
10 the issuance, amendment, or revocation of a certifi-
11 cate of review shall be exempt from disclosure under
12 section 552 of title 5, United States Code.

13 (2) RESTRICTIONS ON DISCLOSURE OF COM-
14 MERCIAL OR FINANCIAL INFORMATION.—

15 (A) IN GENERAL.—Except as provided in
16 subparagraph (B), no officer or employee of the
17 United States shall disclose commercial or fi-
18 nancial information submitted in connection
19 with the issuance, amendment, or revocation of
20 a certificate of review if the information is priv-
21 ileged or confidential and if disclosure of the in-
22 formation would cause harm to the person who
23 submitted the information.

1 (B) EXCEPTIONS.—Subparagraph (A)
2 shall not apply with respect to information dis-
3 closed—

4 (i) upon a request made by the Con-
5 gress or any committee of the Congress,

6 (ii) in a judicial or administrative pro-
7 ceeding, subject to appropriate protective
8 orders,

9 (iii) with the consent of the person
10 who submitted the information,

11 (iv) in the course of making a deter-
12 mination with respect to the issuance,
13 amendment, or revocation of a certificate
14 of review, if the Attorney General deems
15 disclosure of the information to be nec-
16 essary in connection with making the de-
17 termination,

18 (v) in accordance with any require-
19 ment imposed by a statute of the United
20 States, or

21 (vi) in accordance with any rule or
22 regulation promulgated under subsection
23 (i) permitting the disclosure of the infor-
24 mation to an agency of the United States
25 or of a State on the condition that the

1 agency will disclose the information only
2 under the circumstances specified in
3 clauses (i) through (v).

4 (3) PROHIBITION AGAINST USE OF INFORMA-
5 TION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-
6 TRUST LAWS.—Any information disclosed in an ap-
7 plication for a certificate of review under this section
8 shall only be admissible into evidence in a judicial or
9 administrative proceeding for the sole purpose of es-
10 tablishing that a person is entitled to the protections
11 provided by such a certificate.

12 **SEC. 4205. NOTIFICATIONS PROVIDING REDUCTION IN CER-**
13 **TAIN PENALTIES UNDER ANTITRUST LAW**
14 **FOR HEALTH CARE COOPERATIVE VEN-**
15 **TURES.**

16 (a) NOTIFICATIONS DESCRIBED.—

17 (1) SUBMISSION OF NOTIFICATION BY VEN-
18 TURE.—Any party to a health care cooperative ven-
19 ture, acting on such venture's behalf, may, not later
20 than 90 days after entering into a written agreement
21 to form such venture or not later than 90 days after
22 the date of the enactment of this Act, whichever is
23 later, file with the Attorney General a written notifi-
24 cation disclosing—

1 (A) the identities of the parties to such
2 venture,

3 (B) the nature and objectives of such ven-
4 ture, and

5 (C) such additional information as the At-
6 torney General may require by regulation.

7 (2) ACTIVITIES DEEMED SUBMISSION OF NOTI-
8 FICATION.—The following health care cooperative
9 ventures shall be deemed to have filed a written noti-
10 fication with respect to the venture under paragraph
11 (1):

12 (A) SUBMISSION OF APPLICATION FOR
13 CERTIFICATE OF REVIEW.—Any health care co-
14 operative venture for which an application for a
15 certificate of review is filed with the Attorney
16 General under section 4203.

17 (B) CERTAIN VENTURES.—Any health care
18 cooperative venture meeting the following re-
19 quirements:

20 (i) The venture consists of a network
21 of non-institutional providers not greater
22 than—

23 (I) in the case of a nonexclusive
24 network in which the participating
25 members are permitted to create or

1 join other competing networks, 50
2 percent of the providers of health care
3 services in the relevant geographic
4 area and 50 percent of the members
5 of the provider specialty group in the
6 relevant market; or

7 (II) in the case of an exclusive
8 network in which the participating
9 members are not permitted to create
10 or join other competing networks, 35
11 percent of the providers of health care
12 services in the relevant geographic
13 area and 35 percent of the members
14 of the provider specialty group in the
15 relevant market.

16 (ii) Each member of the venture as-
17 sumes substantial financial risk for the op-
18 eration of the venture through risk-sharing
19 arrangements, including (but not limited
20 to)—

21 (I) the acceptance of capitation
22 contracts;

23 (II) the acceptance of contracts
24 with fee withholding mechanisms re-
25 lating to the ability to meet estab-

1 lished goals for utilization review and
2 management; and

3 (III) the holding by members of
4 significant ownership or equity inter-
5 ests in the venture, where the capital
6 contributed by the members is used to
7 fund the operational costs of the ven-
8 ture such as administration, market-
9 ing, and computer-operated medical
10 information, if the venture develops
11 and operates comprehensive programs
12 for utilization management and qual-
13 ity assurance that include controls
14 over the use of institutional, special-
15 ized, and ancillary medical services.

16 (3) SUBMISSION OF ADDITIONAL INFORMA-
17 TION.—

18 (A) REQUEST OF ATTORNEY GENERAL.—

19 At any time after receiving a notification filed
20 under paragraph (1), the Attorney General may
21 require the submission of additional information
22 or documentary material relevant to the pro-
23 posed health care cooperative venture.

24 (B) PARTIES TO VENTURE.—Any party to
25 a health care cooperative venture may submit

1 such additional information on the venture's be-
2 half as may be appropriate to ensure that the
3 venture will receive the protections provided
4 under subsection (b).

5 (C) REQUIRED SUBMISSION OF INFORMA-
6 TION ON CHANGES TO VENTURE.—A health
7 care cooperative venture for which a notification
8 is in effect under this section shall submit infor-
9 mation on any change in the membership of the
10 venture not later than 90 days after such
11 change occurs.

12 (4) PUBLICATION OF NOTIFICATION.—

13 (A) INFORMATION MADE PUBLICLY AVAIL-
14 ABLE.—Not later than 30 days after receiving
15 a notification with respect to a venture under
16 paragraph (1), the Attorney General shall pub-
17 lish in the Federal Register a notice with re-
18 spect to the venture that identifies the parties
19 to the venture and generally describes the pur-
20 pose and planned activity of the venture. Prior
21 to its publication, the contents of the notice
22 shall be made available to the parties to the
23 venture.

24 (B) RESTRICTION ON DISCLOSURE OF
25 OTHER INFORMATION.—All information and

1 documentary material submitted pursuant to
2 this section and all information obtained by the
3 Attorney General in the course of any investiga-
4 tion or case with respect to a potential violation
5 of the antitrust laws by the health care coopera-
6 tive venture (other than information and mate-
7 rial described in subparagraph (A)) shall be ex-
8 empt from disclosure under section 552 of title
9 5, United States Code, and shall not be made
10 publicly available by any agency of the United
11 States to which such section applies except in
12 a judicial proceeding in which such information
13 and material is subject to any protective order.

14 (5) WITHDRAWAL OF NOTIFICATION.—Any per-
15 son who files a notification pursuant to this section
16 may withdraw such notification before a publication
17 by the Attorney General pursuant to paragraph (4).
18 Any person who is deemed to have filed a notifica-
19 tion under paragraph (2)(A) shall be deemed to have
20 withdrawn the notification if the certificate of review
21 in question is revoked or withdrawn under section
22 4204.

23 (6) NO JUDICIAL REVIEW PERMITTED.—Any
24 action taken or not taken by the Attorney General

1 with respect to notifications filed pursuant to this
2 subsection shall not be subject to judicial review.

3 (b) PROTECTIONS FOR VENTURES SUBJECT TO NO-
4 TIFICATION.—

5 (1) IN GENERAL.—

6 (A) PROTECTIONS DESCRIBED.—The pro-
7 visions of paragraphs (2), (3), (4), and (5) shall
8 apply with respect to any action under the anti-
9 trust laws challenging conduct within the scope
10 of a notification which is in effect pursuant to
11 subsection (a)(1).

12 (B) TIMING OF PROTECTIONS.—The pro-
13 tections described in this subsection shall apply
14 to the venture that is the subject of a notifica-
15 tion under subsection (a)(1) as of the earlier
16 of—

17 (i) the date of the publication in the
18 Federal Register of the notice published
19 with respect to the notification; or

20 (ii) if such notice is not published dur-
21 ing the period required under subsection
22 (a)(4), the expiration of the 30-day period
23 that begins on the date the Attorney Gen-
24 eral receives any necessary information re-
25 quired to be submitted under subsection

1 (a)(1) or any additional information re-
2 quired by the Attorney General under sub-
3 section (a)(3)(A).

4 (2) APPLICABILITY OF RULE OF REASON
5 STANDARD.—In any action under the antitrust laws,
6 the conduct of any person which is within the scope
7 of a notification filed under subsection (a) shall not
8 be deemed illegal per se, but shall be judged on the
9 basis of its reasonableness, taking into account all
10 relevant factors affecting competition, including, but
11 not limited to, effects on competition in relevant
12 markets.

13 (3) LIMITATION ON RECOVERY TO ACTUAL
14 DAMAGES AND INTEREST.—Notwithstanding section
15 4 of the Clayton Act, any person who is entitled to
16 recovery under the antitrust laws for conduct that is
17 within the scope of a notification filed under sub-
18 section (a) shall recover the actual damages sus-
19 tained by such person and interest calculated at the
20 rate specified in section 1961 of title 28, United
21 States Code, for the period beginning on the earliest
22 date for which injury can be established and ending
23 on the date of judgment, unless the court finds that
24 the award of all or part of such interest is unjust
25 under the circumstances.

1 (4) AWARD OF ATTORNEY'S FEES AND COSTS
2 OF SUIT.—

3 (A) IN GENERAL.—In any action under the
4 antitrust laws brought against a health care co-
5 operative venture for conduct that is within the
6 scope of a notification filed under subsection
7 (a), the court shall, at the conclusion of the ac-
8 tion—

9 (i) award to a substantially prevailing
10 claimant the cost of suit attributable to
11 such claim, including a reasonable attor-
12 ney's fee, or

13 (ii) award to a substantially prevailing
14 party defending against such claim the
15 cost of such suit attributable to such claim,
16 including reasonable attorney's fee, if the
17 claim, or the claimant's conduct during
18 litigation of the claim, was frivolous, un-
19 reasonable, without foundation, or in bad
20 faith.

21 (B) OFFSET IN CASES OF BAD FAITH.—

22 The court may reduce an award made pursuant
23 to subparagraph (A) in whole or in part by an
24 award in favor of another party for any part of
25 the cost of suit (including a reasonable attor-

1 ney's fee) attributable to conduct during the
2 litigation by any prevailing party that the court
3 finds to be frivolous, unreasonable, without
4 foundation, or in bad faith.

5 (5) RESTRICTIONS ON ADMISSIBILITY OF IN-
6 FORMATION.—

7 (A) IN GENERAL.—Any information dis-
8 closed in a notification submitted under sub-
9 section (a)(1) and the fact of the publication of
10 a notification by the Attorney General under
11 subsection (a)(4) shall only be admissible into
12 evidence in a judicial or administrative proceed-
13 ing for the sole purpose of establishing that a
14 party to a health care cooperative venture is en-
15 titled to the protections described in this sub-
16 section.

17 (B) ACTIONS OF ATTORNEY GENERAL.—
18 No action taken by the Attorney General pursu-
19 ant to this section shall be admissible into evi-
20 dence in any judicial or administrative proceed-
21 ing for the purpose of supporting or answering
22 any claim under the antitrust laws.

1 **SEC. 4206. REVIEW AND REPORTS ON SAFE HARBORS AND**
2 **CERTIFICATES OF REVIEW.**

3 (a) IN GENERAL.—The Attorney General (in con-
4 sultation with the Secretary and the Chair) shall periodi-
5 cally review the safe harbors described in section 4202,
6 the additional safe harbors designated under section 4203,
7 and the certificates of review issued under section 4204,
8 and—

9 (1) with respect to the safe harbors described in
10 section 4202, submit such recommendations to Con-
11 gress as the Attorney General considers appropriate
12 for modifications of such safe harbors;

13 (2) with respect to the additional safe harbors
14 under designated under section 4203, issue proposed
15 revisions to such activities and publish the revisions
16 in the Federal Register; and

17 (3) with respect to the certificates of review,
18 submit a report to Congress on the issuance of such
19 certificates, and shall include in the report a descrip-
20 tion of the effect of such certificates on increasing
21 access to high quality health care services at reduced
22 costs.

23 (b) RECOMMENDATIONS FOR LEGISLATION.—The
24 Attorney General shall include in the reports submitted
25 under subsection (a)(3) any recommendations of the At-
26 torney General for legislation to improve the program for

1 the issuance of certificates of review established under this
2 subtitle.

3 **SEC. 4207. RULES, REGULATIONS, AND GUIDELINES.**

4 (a) SAFE HARBORS, CERTIFICATES, AND NOTIFICA-
5 TIONS.—The Attorney General, with the concurrence of
6 the Secretary, shall promulgate such rules, regulations,
7 and guidelines as are necessary to carry out sections 4202,
8 4203, 4204, and 4205, including guidelines defining or re-
9 lating to relevant geographic and product markets for
10 health care services and providers of health care services.

11 (b) GUIDANCE FOR PROVIDERS.—

12 (1) IN GENERAL.—To promote greater cer-
13 tainty regarding the application of the antitrust laws
14 to activities in the health care market, the Attorney
15 General, in consultation with the Secretary and the
16 Chair, shall (not later than 1 year after the date of
17 the enactment of this Act), taking into account the
18 criteria used to designate additional safe harbors
19 under section 4203 and grant certificates of review
20 under section 4204, publish guidelines—

21 (A) to assist providers of health care serv-
22 ices in analyzing whether the activities of such
23 providers may be subject to a safe harbor under
24 sections 4202 or 4203; and

1 (B) describing specific types of activities
2 which would meet the requirements for a cer-
3 tificate of review under section 4204, and sum-
4 marizing the factual and legal bases on which
5 the activities would meet the requirements.

6 (2) PERIODIC UPDATE.—The Attorney General
7 shall periodically update the guidelines published
8 under paragraph (1) as the Attorney General consid-
9 ers appropriate.

10 (3) WAIVER OF ADMINISTRATIVE PROCEDURE
11 ACT.—Section 553 of title 5, United States Code,
12 shall not apply to the issuance of guidelines under
13 paragraph (1).

14 **SEC. 4208. ESTABLISHMENT OF HHS OFFICE OF HEALTH**
15 **CARE COMPETITION POLICY.**

16 (a) IN GENERAL.—There is established within the
17 Department of Health and Human Services an Office to
18 be known as the Office of Health Care Competition Policy
19 (hereafter in this section referred to as the “Office”). The
20 Office shall be headed by a director, who shall be ap-
21 pointed by the Secretary.

22 (b) DUTIES.—The Office shall coordinate the respon-
23 sibilities of the Secretary under this subtitle and otherwise
24 assist the Secretary in developing policies relating to the

1 competitive and collaborative activities of providers of
2 health care services.

3 **SEC. 4209. DEFINITIONS.**

4 In this subtitle, the following definitions shall apply:

5 (1) The term “antitrust laws”—

6 (A) has the meaning given it in subsection
7 (a) of the first section of the Clayton Act (15
8 U.S.C. 12(a)), except that such term includes
9 section 5 of the Federal Trade Commission Act
10 (15 U.S.C. 45) to the extent such section ap-
11 plies to unfair methods of competition; and

12 (B) includes any State law similar to the
13 laws referred to in subparagraph (A).

14 (2) The term “Chair” means the Chair of the
15 Federal Trade Commission.

16 (3) The term “health care cooperative venture”
17 means any activities, including attempts to enter
18 into or perform a contract or agreement, carried out
19 by 2 or more persons for the purpose of providing
20 health care services.

21 (4) The term “health care services” means any
22 services for which payment may be made under a
23 health plan, including services related to the delivery
24 or administration of such services.

1 (5) The term “medical self-regulatory entity”
2 means a medical society or association, a specialty
3 board, a recognized accrediting agency, or a hospital
4 medical staff, and includes the members, officers,
5 employees, consultants, and volunteers or commit-
6 tees of such an entity.

7 (6) The term “person” includes a State or unit
8 of local government.

9 (7) The term “provider of health care services”
10 means any individual or entity that is engaged in the
11 delivery of health care services in a State and that
12 is required by State law or regulation to be licensed
13 or certified by the State to engage in the delivery of
14 such services in the State.

15 (8) The term “specialty group” means a medi-
16 cal specialty or subspecialty in which a provider of
17 health care services may be licensed to practice by
18 a State (as determined by the Secretary in consulta-
19 tion with the certification boards for such specialties
20 and subspecialties).

21 (9) The term “standard setting and enforce-
22 ment activities” means—

23 (A) accreditation of health care practition-
24 ers, health care providers, medical education in-
25 stitutions, or medical education programs,

1 (B) technology assessment and risk man-
2 agement activities,

3 (C) the development and implementation of
4 practice guidelines or practice parameters, or

5 (D) official peer review proceedings under-
6 taken by a hospital medical staff (or committee
7 thereof) or a medical society or association for
8 purposes of evaluating the professional conduct
9 or quality of health care provided by a medical
10 professional.

11 **TITLE V—SPECIAL ASSISTANCE**
12 **FOR FRONTIER, RURAL, AND**
13 **URBAN UNDERSERVED AREAS**
14 **Subtitle A—Frontier, Rural, and**
15 **Urban Underserved Areas**

16 **SEC. 5001. ESTABLISHMENT OF GRANT PROGRAM.**

17 Subpart I of part D of title III of the Public Health
18 Service Act (42 U.S.C. 254b et seq.) is amended by adding
19 at the end the following new section:

20 **“SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE**
21 **GRANT PROGRAM.**

22 “(a) ESTABLISHMENT.—The Secretary shall estab-
23 lish and administer a program to provide allotments to
24 States to enable such States to provide grants for the cre-
25 ation or enhancement of community-based primary health

1 care entities that provide services to low-income or medi-
2 cally underserved populations.

3 “(b) ALLOTMENTS TO STATES.—

4 “(1) IN GENERAL.—From the amount available
5 for allotment under subsection (h) for a fiscal year,
6 the Secretary shall allot to each State an amount
7 equal to the product of the grant share of the State
8 (as determined under paragraph (2)) multiplied by
9 such amount available.

10 “(2) GRANT SHARE.—

11 “(A) IN GENERAL.—For purposes of para-
12 graph (1), the grant share of a State shall be
13 the product of the need-adjusted population of
14 the State (as determined under subparagraph
15 (B)) multiplied by the Federal matching per-
16 centage of the State (as determined under sub-
17 paragraph (C)), expressed as a percentage of
18 the sum of the products of such factors for all
19 States.

20 “(B) NEED-ADJUSTED POPULATION.—

21 “(i) IN GENERAL.—For purposes of
22 subparagraph (A), the need-adjusted popu-
23 lation of a State shall be the product of
24 the total population of the State (as esti-
25 mated by the Secretary of Commerce) mul-

1 multiplied by the need index of the State (as
2 determined under clause (ii)).

3 “(ii) NEED INDEX.—For purposes of
4 clause (i), the need index of a State shall
5 be the ratio of—

6 “(I) the weighted sum of the geo-
7 graphic percentage of the State (as
8 determined under clause (iii)), the
9 poverty percentage of the State (as
10 determined under clause (iv)), and the
11 multiple grant percentage of the State
12 (as determined under clause (v)); to

13 “(II) the general population per-
14 centage of the State (as determined
15 under clause (vi)).

16 “(iii) GEOGRAPHIC PERCENTAGE.—

17 “(I) IN GENERAL.—For purposes
18 of clause (ii)(I), the geographic per-
19 centage of the State shall be the esti-
20 mated population of the State that is
21 residing in nonurbanized areas (as de-
22 termined under subclause (II)) ex-
23 pressed as a percentage of the total
24 nonurbanized population of all States.

1 “(II) NONURBANIZED POPU-
2 LATION.—For purposes of subclause
3 (I), the estimated population of the
4 State that is residing in nonurbanized
5 areas shall be one minus the urban-
6 ized population of the State (as deter-
7 mined using the most recent decennial
8 census), expressed as a percentage of
9 the total population of the State (as
10 determined using the most recent de-
11 cennial census), multiplied by the cur-
12 rent estimated population of the
13 State.

14 “(III) STATE OF ALASKA.—Not-
15 withstanding subclause (I), the geo-
16 graphic percentage for the State of
17 Alaska shall be the relative population
18 density of the State expressed as the
19 ratio of—

20 “(aa) the average number of
21 individuals residing in Alaska per
22 square mile; to

23 “(bb) the average number of
24 individuals residing in the United
25 States per square mile.

1 “(iv) POVERTY PERCENTAGE.—For
2 purposes of clause (ii)(I), the poverty per-
3 centage of the State shall be the estimated
4 number of people residing in the State
5 with incomes below 200 percent of the in-
6 come official poverty line (as adjusted for
7 actual costs and incomes in each State and
8 as determined by the Office of Manage-
9 ment and Budget) expressed as a percent-
10 age of the total number of such people re-
11 siding in all States.

12 “(v) MULTIPLE GRANT PERCENT-
13 AGE.—For purposes of clause (ii)(I), the
14 multiple grant percentage of the State
15 shall be the amount of Federal funding re-
16 ceived by the State under grants awarded
17 under sections 329, 330, and 340, ex-
18 pressed as a percentage of the total
19 amounts received under such grants by all
20 States. With respect to a State, such per-
21 centage shall not exceed twice the general
22 population percentage of the State under
23 clause (vi) or be less than one-half of the
24 States general population percentage.

1 “(vi) GENERAL POPULATION PER-
2 CENTAGE.—For purposes of clause (ii)(II),
3 the general population percentage of the
4 State shall be the total population of the
5 State (as determined by the Secretary of
6 Commerce) expressed as a percentage of
7 the total population of all States.

8 “(C) FEDERAL MATCHING PERCENTAGE.—

9 “(i) IN GENERAL.—For purposes of
10 subparagraph (A), the Federal matching
11 percentage of the State shall be equal to
12 one, less the State matching percentage (as
13 determined under clause (ii)).

14 “(ii) STATE MATCHING PERCENT-
15 AGE.—For purposes of clause (i), the State
16 matching percentage of the State shall be
17 0.25 multiplied by the ratio of the total
18 taxable resource percentage (as determined
19 under clause (iii)) to the need-adjusted
20 population of the State (as determined
21 under subparagraph (B)).

22 “(iii) TOTAL TAXABLE RESOURCE
23 PERCENTAGE.—For purposes of clause (ii),
24 the total taxable resources percentage of
25 the State shall be the total taxable re-

1 sources of a State (as determined by the
2 Secretary of the Treasury) expressed as a
3 percentage of the sum of the total taxable
4 resources of all States.

5 “(3) ANNUAL ESTIMATES.—

6 “(A) IN GENERAL.—If the Secretary of
7 Commerce does not produce the annual esti-
8 mates required under paragraph (2)(B)(iv),
9 such estimates shall be determined by multiply-
10 ing the percentage of the population of the
11 State that is below 200 percent of the income
12 official poverty line as determined using the
13 most recent decennial census by the most recent
14 estimate of the total population of the State.
15 Except as provided in subparagraph (B), the
16 calculations required under this subparagraph
17 shall be made based on the most recent 3-year
18 average of the total taxable resources of individ-
19 uals within the State.

20 “(B) DISTRICT OF COLUMBIA.—Notwith-
21 standing subparagraph (A), the calculations re-
22 quired under such subparagraph with respect to
23 the District of Columbia shall be based on the
24 most recent 3-year average of the personal in-
25 come of individuals residing within the District

1 as a percentage of the personal income for all
2 individuals residing within the District, as de-
3 termined by the Secretary of Commerce.

4 “(C) STATE OF ALASKA.—Notwithstanding
5 subparagraph (A), the calculations required
6 under such subparagraph with respect to the
7 State of Alaska shall be based on the quotient
8 of—

9 “(i) the most recent 3-year average of
10 the per capita income of individuals resid-
11 ing in the State; divided by

12 “(ii) 1.25.

13 “(4) MATCHING REQUIREMENT.—A State that
14 receives an allotment under this section shall make
15 available State resources (either directly or indi-
16 rectly) to carry out this section in an amount that
17 shall equal the State matching percentage for the
18 State (as determined under paragraph (2)(C)(ii)) di-
19 vided by the Federal matching percentage (as deter-
20 mined under paragraph (2)(C)).

21 “(c) APPLICATION.—

22 “(1) IN GENERAL.—To be eligible to receive an
23 allotment under this section, a State shall prepare
24 and submit an application to the Secretary at such

1 time, in such manner, and containing such informa-
2 tion as the Secretary may by regulation require.

3 “(2) ASSURANCES.—A State application sub-
4 mitted under paragraph (1) shall contain an assur-
5 ance that—

6 “(A) the State will use amounts received
7 under its allotment consistent with the require-
8 ments of this section; and

9 “(B) the State will provide, from non-Fed-
10 eral sources, the amounts required under sub-
11 section (b)(4).

12 “(d) USE OF FUNDS.—

13 “(1) IN GENERAL.—The State shall use
14 amounts received under this section to award grants
15 to eligible public and nonprofit private entities, or
16 consortia of such entities, within the State to enable
17 such entities or consortia to provide services of the
18 type described in paragraph (2) of section 329(h) to
19 low-income or medically underserved populations.

20 “(2) ELIGIBILITY.—To be eligible to receive a
21 grant under paragraph (1), an entity or consortium
22 shall—

23 “(A) prepare and submit to the admin-
24 istering entity of the State, an application at
25 such time, in such manner, and containing such

1 information as such administering entity may
2 require, including a plan for the provision of
3 services of the type described in paragraph (3);

4 “(B) provide assurances that services will
5 be provided under the grant at fee rates estab-
6 lished or determined in accordance with section
7 330(e)(3)(F); and

8 “(C) provide assurances that in the case of
9 services provided to individuals with health in-
10 surance, such insurance shall be used as the
11 primary source of payment for such services.

12 “(3) SERVICES.—The services to be provided
13 under a grant awarded under paragraph (1) shall in-
14 clude—

15 “(A) one or more of the types of primary
16 health services described in section 330(b)(1);

17 “(B) one or more of the types of supple-
18 mental health services described in section
19 330(b)(2); and

20 “(C) any other services determined appro-
21 priate by the administering entity of the State.

22 “(4) TARGET POPULATIONS.—Entities or con-
23 sortia receiving grants under paragraph (1) shall, in
24 providing the services described in paragraph (3),
25 substantially target populations of low-income or

1 medically underserved populations within the State
2 who reside in medically underserved or health pro-
3 fessional shortage areas, areas certified as under-
4 served under the rural health clinic program, or
5 other areas determined appropriate by the admin-
6 istering entity of the State, within the State.

7 “(5) PRIORITY.—In awarding grants under
8 paragraph (1), the State shall—

9 “(A) give priority to entities or consortia
10 that can demonstrate through the plan submit-
11 ted under paragraph (2) that—

12 “(i) the services provided under the
13 grant will expand the availability of pri-
14 mary care services to the maximum num-
15 ber of low-income or medically underserved
16 populations who have no access to such
17 care on the date of the grant award; and

18 “(ii) the delivery of services under the
19 grant will be cost-effective; and

20 “(B) ensure that an equitable distribution
21 of funds is achieved among urban and rural en-
22 tities or consortia.

23 “(e) REPORTS AND AUDITS.—Each State shall pre-
24 pare and submit to the Secretary annual reports concern-
25 ing the State’s activities under this section which shall be

1 in such form and contain such information as the Sec-
2 retary determines appropriate. Each such State shall es-
3 tablish fiscal control and fund accounting procedures as
4 may be necessary to assure that amounts received under
5 this section are being disbursed properly and are ac-
6 counted for, and include the results of audits conducted
7 under such procedures in the reports submitted under this
8 subsection.

9 “(f) PAYMENTS.—

10 “(1) ENTITLEMENT.—Each State for which an
11 application has been approved by the Secretary
12 under this section shall be entitled to payments
13 under this section for each fiscal year in an amount
14 not to exceed the State’s allotment under subsection
15 (b) to be expended by the State in accordance with
16 the terms of the application for the fiscal year for
17 which the allotment is to be made.

18 “(2) METHOD OF PAYMENTS.—The Secretary
19 may make payments to a State in installments, and
20 in advance or by way of reimbursement, with nec-
21 essary adjustments on account of overpayments or
22 underpayments, as the Secretary may determine.

23 “(3) STATE SPENDING OF PAYMENTS.—Pay-
24 ments to a State from the allotment under sub-
25 section (b) for any fiscal year must be expended by

1 the State in that fiscal year or in the succeeding fis-
2 cal year.

3 “(g) DEFINITION.—As used in this section, the term
4 ‘administering entity of the State’ means the agency or
5 official designated by the chief executive officer of the
6 State to administer the amounts provided to the State
7 under this section.

8 “(h) FUNDING.—Notwithstanding any other provi-
9 sion of law, the Secretary shall use 50 percent of the
10 amounts that the Secretary is required to utilize under
11 section 330B(h) in each fiscal year to carry out this sec-
12 tion.”.

13 **SEC. 5002. ESTABLISHMENT OF NEW PROGRAM TO PRO-**
14 **VIDE FUNDS TO ALLOW FEDERALLY QUALI-**
15 **FIED HEALTH CENTERS AND OTHER ENTI-**
16 **TIES OR ORGANIZATIONS TO PROVIDE EX-**
17 **PANDED SERVICES TO MEDICALLY UNDER-**
18 **SERVED INDIVIDUALS.**

19 (a) IN GENERAL.—Subpart I of part D of title III
20 of the Public Health Service Act (42 U.S.C. 254b et seq.)
21 (as amended by section 5001) is amended by adding at
22 the end the following new section:

1 **“SEC. 330B. ESTABLISHMENT OF NEW PROGRAM TO PRO-**
2 **VIDE FUNDS TO ALLOW FEDERALLY QUALI-**
3 **FIED HEALTH CENTERS AND OTHER ENTI-**
4 **TIES OR ORGANIZATIONS TO PROVIDE EX-**
5 **PANDED SERVICES TO MEDICALLY UNDER-**
6 **SERVED INDIVIDUALS.**

7 “(a) ESTABLISHMENT OF HEALTH SERVICES AC-
8 CESS PROGRAM.—From amounts appropriated under this
9 section, the Secretary shall, acting through the Bureau of
10 Health Care Delivery Assistance, award grants under this
11 section to federally qualified health centers (hereinafter re-
12 ferred to in this section as ‘FQHC’s’) and other entities
13 and organizations submitting applications under this sec-
14 tion (as described in subsection (c)) for the purpose of
15 providing access to services for medically underserved pop-
16 ulations (as defined in section 330(b)(3)) or in high im-
17 pact areas (as defined in section 329(a)(5)) not currently
18 being served by a FQHC.

19 “(b) ELIGIBILITY FOR GRANTS.—

20 “(1) IN GENERAL.—The Secretary shall award
21 grants under this section to entities or organizations
22 described in this paragraph and paragraph (2) which
23 have submitted a proposal to the Secretary to ex-
24 pand such entities or organizations operations (in-
25 cluding expansions to new sites (as determined nec-
26 essary by the Secretary)) to serve medically under-

1 served populations or high impact areas not cur-
2 rently served by a FQHC and which—

3 “(A) have as of January 1, 1991, been cer-
4 tified by the Secretary as a FQHC under sec-
5 tion 1905(l)(2)(B) of the Social Security Act;
6 or

7 “(B) have submitted applications to the
8 Secretary to qualify as FQHC’s under such sec-
9 tion 1905(l)(2)(B); or

10 “(C) have submitted a plan to the Sec-
11 retary which provides that the entity will meet
12 the requirements to qualify as a FQHC when
13 operational.

14 “(2) NON FQHC ENTITIES.—

15 “(A) ELIGIBILITY.—The Secretary shall
16 also make grants under this section to public or
17 private nonprofit agencies, health care entities
18 or organizations which meet the requirements
19 necessary to qualify as a FQHC except, the re-
20 quirement that such entity have a consumer
21 majority governing board and which have sub-
22 mitted a proposal to the Secretary to provide
23 those services provided by a FQHC as defined
24 in section 1905(l)(2)(B) of the Social Security
25 Act and which are designed to promote access

1 to primary care services or to reduce reliance on
2 hospital emergency rooms or other high cost
3 providers of primary health care services, pro-
4 vided such proposal is developed by the entity
5 or organizations (or such entities or organiza-
6 tions acting in a consortium in a community)
7 with the review and approval of the Governor of
8 the State in which such entity or organization
9 is located.

10 “(B) LIMITATION.—The Secretary shall
11 provide in making grants to entities or organi-
12 zations described in this paragraph that no
13 more than 10 percent of the funds provided for
14 grants under this section shall be made avail-
15 able for grants to such entities or organizations.

16 “(c) APPLICATION REQUIREMENTS.—

17 “(1) IN GENERAL.—In order to be eligible to
18 receive a grant under this section, a FQHC or other
19 entity or organization must submit an application in
20 such form and at such time as the Secretary shall
21 prescribe and which meets the requirements of this
22 subsection.

23 “(2) REQUIREMENTS.—An application submit-
24 ted under this section must provide—

1 “(A)(i) for a schedule of fees or payments
2 for the provision of the services provided by the
3 entity designed to cover its reasonable costs of
4 operations; and

5 “(ii) for a corresponding schedule of dis-
6 counts to be applied to such fees or payments,
7 based upon the patient’s ability to pay (deter-
8 mined by using a sliding scale formula based on
9 the income of the patient);

10 “(B) assurances that the entity or organi-
11 zation provides services to persons who are eli-
12 gible for benefits under title XVIII of the Social
13 Security Act, for medical assistance under title
14 XIX of such Act or for assistance for medical
15 expenses under any other public assistance pro-
16 gram or private health insurance program; and

17 “(C) assurances that the entity or organi-
18 zation has made and will continue to make
19 every reasonable effort to collect reimbursement
20 for services—

21 “(i) from persons eligible for assist-
22 ance under any of the programs described
23 in subparagraph (B); and

24 “(ii) from patients not entitled to ben-
25 efits under any such programs.

1 “(d) LIMITATIONS ON USE OF FUNDS.—

2 “(1) IN GENERAL.—From the amounts award-
3 ed to an entity or organization under this section,
4 funds may be used for purposes of planning but may
5 only be expended for the costs of—

6 “(A) assessing the needs of the populations
7 or proposed areas to be served;

8 “(B) preparing a description of how the
9 needs identified will be met; and

10 “(C) development of an implementation
11 plan that addresses—

12 “(i) recruitment and training of per-
13 sonnel; and

14 “(ii) activities necessary to achieve
15 operational status in order to meet FQHC
16 requirements under 1905(l)(2)(B) of the
17 Social Security Act.

18 “(2) RECRUITING, TRAINING AND COMPENSA-
19 TION OF STAFF.—From the amounts awarded to an
20 entity or organization under this section, funds may
21 be used for the purposes of paying for the costs of
22 recruiting, training and compensating staff (clinical
23 and associated administrative personnel (to the ex-
24 tent such costs are not already reimbursed under
25 title XIX of the Social Security Act or any other

1 State or Federal program)) to the extent necessary
2 to allow the entity to operate at new or expended ex-
3 isting sites.

4 “(3) FACILITIES AND EQUIPMENT.—From the
5 amounts awarded to an entity or organization under
6 this section, funds may be expended for the purposes
7 of acquiring facilities and equipment but only for the
8 cost of—

9 “(A) construction of new buildings (to the
10 extent that new construction is found to be the
11 most cost-efficient approach by the Secretary);

12 “(B) acquiring, expanding, and moderniz-
13 ing of existing facilities;

14 “(C) purchasing essential (as determined
15 by the Secretary) equipment; and

16 “(D) amortization of principal and pay-
17 ment of interest on loans obtained for purposes
18 of site construction, acquisition, modernization,
19 or expansion, as well as necessary equipment.

20 “(4) SERVICES.—From the amounts awarded
21 to an entity or organization under this section, funds
22 may be expended for the payment of services but
23 only for the costs of—

24 “(A) providing or arranging for the provi-
25 sion of all services through the entity necessary

1 to qualify such entity as a FQHC under section
2 1905(l)(2)(B) of the Social Security Act;

3 “(B) providing or arranging for any other
4 service that a FQHC may provide and be reim-
5 bursed for under title XIX of such Act; and

6 “(C) providing any unreimbursed costs of
7 providing services as described in section 330(a)
8 to patients.

9 “(e) PRIORITIES IN THE AWARDING OF GRANTS.—

10 “(1) CERTIFIED FQHC’S.—The Secretary shall
11 give priority in awarding grants under this section
12 to entities which have, as of January 1, 1991, been
13 certified as a FQHC under section 1905(l)(2)(B) of
14 the Social Security Act and which have submitted a
15 proposal to the Secretary to expand their operations
16 (including expansion to new sites) to serve medically
17 underserved populations for high impact areas not
18 currently served by a FQHC. The Secretary shall
19 give first priority in awarding grants under this sec-
20 tion to those FQHCs or other entities which propose
21 to serve populations with the highest degree of
22 unmet need, and which can demonstrate the ability
23 to expand their operations in the most efficient man-
24 ner.

1 “(2) QUALIFIED FQHC’S.—The Secretary shall
2 give second priority in awarding grants to entities
3 which have submitted applications to the Secretary
4 which demonstrate that the entity will qualify as a
5 FQHC under section 1905(l)(2)(B) of the Social Se-
6 curity Act before it provides or arranges for the pro-
7 vision of services supported by funds awarded under
8 this section, and which are serving or proposing to
9 serve medically underserved populations or high im-
10 pact areas which are not currently served (or pro-
11 posed to be served) by a FQHC.

12 “(3) EXPANDED SERVICES AND PROJECTS.—
13 The Secretary shall give third priority in awarding
14 grants in subsequent years to those FQHCs or other
15 entities which have provided for expanded services
16 and project and are able to demonstrate that such
17 entity will incur significant unreimbursed costs in
18 providing such expanded services.

19 “(f) RETURN OF FUNDS TO SECRETARY FOR COSTS
20 REIMBURSED FROM OTHER SOURCES.—To the extent
21 that an entity or organization receiving funds under this
22 section is reimbursed from another source for the provi-
23 sion of services to an individual, and does not use such
24 increased reimbursement to expand services furnished,
25 areas served, to compensate for costs of unreimbursed

1 services provided to patients, or to promote recruitment,
2 training, or retention of personnel, such excess revenues
3 shall be returned to the Secretary.

4 “(g) TERMINATION OF GRANTS.—

5 “(1) FAILURE TO MEET FQHC REQUIRE-
6 MENTS.—

7 “(A) IN GENERAL.—With respect to any
8 entity that is receiving funds awarded under
9 this section and which subsequently fails to
10 meet the requirements to qualify as a FQHC
11 under section 1905(l)(2)(B) or is an entity that
12 is not required to meet the requirements to
13 qualify as a FQHC under section 1905(l)(2)(B)
14 of the Social Security Act but fails to meet the
15 requirements of this section, the Secretary shall
16 terminate the award of funds under this section
17 to such entity.

18 “(B) NOTICE.—Prior to any termination
19 of funds under this section to an entity, the en-
20 tities shall be entitled to 60 days prior notice of
21 termination and, as provided by the Secretary
22 in regulations, an opportunity to correct any de-
23 ficiencies in order to allow the entity to con-
24 tinue to receive funds under this section.

1 “(2) REQUIREMENTS.—Upon any termination
2 of funding under this section, the Secretary may (to
3 the extent practicable)—

4 “(A) sell any property (including equip-
5 ment) acquired or constructed by the entity
6 using funds made available under this section
7 or transfer such property to another FQHC,
8 provided, that the Secretary shall reimburse
9 any costs which were incurred by the entity in
10 acquiring or constructing such property (includ-
11 ing equipment) which were not supported by
12 grants under this section; and

13 “(B) recoup any funds provided to an en-
14 tity terminated under this section.

15 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section,
17 \$400,000,000 for fiscal year 1995, \$800,000,000 for fis-
18 cal year 1996, \$1,200,000,000 for fiscal year 1997,
19 \$1,600,000,000 for fiscal year 1998, and \$1,600,000,000
20 for fiscal year 1999.”.

21 (b) EFFECTIVE DATE.—The amendments made by
22 subsection (a) shall become effective with respect to serv-
23 ices furnished by a federally qualified health center or
24 other qualifying entity described in this section beginning
25 on or after October 1, 1995.

1 (c) STUDY AND REPORT ON SERVICES PROVIDED BY
2 COMMUNITY HEALTH CENTERS AND HOSPITALS.—

3 (1) IN GENERAL.—The Secretary of Health and
4 Human Services (hereinafter referred to in this sub-
5 section as the “Secretary”) shall provide for a study
6 to examine the relationship and interaction between
7 community health centers and hospitals in providing
8 services to individuals residing in medically under-
9 served areas. The Secretary shall ensure that the
10 National Rural Research Centers participate in such
11 study.

12 (2) REPORT.—The Secretary shall provide to
13 the appropriate committees of Congress a report
14 summarizing the findings of the study within 90
15 days of the end of each project year and shall in-
16 clude in such report recommendations on methods to
17 improve the coordination of and provision of services
18 in medically underserved areas by community health
19 centers and hospitals.

20 (3) AUTHORIZATION.—There are authorized to
21 be appropriated to carry out the study provided for
22 in this subsection \$150,000 for each of fiscal years
23 1995 and 1996.

1 **SEC. 5003. TAX INCENTIVES FOR PRACTICE IN FRONTIER,**
2 **RURAL, AND URBAN UNDERSERVED AREAS.**

3 (a) NONREFUNDABLE CREDIT FOR CERTAIN PRI-
4 MARY HEALTH SERVICES PROVIDERS.—

5 (1) IN GENERAL.—Subpart A of part IV of sub-
6 chapter A of chapter 1 of the Internal Revenue Code
7 of 1986 (relating to nonrefundable personal credits)
8 is amended by inserting after section 25 the follow-
9 ing new section:

10 **“SEC. 25A. PRIMARY HEALTH SERVICES PROVIDERS.**

11 “(a) ALLOWANCE OF CREDIT.—In the case of a
12 qualified primary health services provider, there is allowed
13 as a credit against the tax imposed by this chapter for
14 any taxable year in a mandatory service period an amount
15 equal to the product of—

16 “(1) the lesser of—

17 “(A) the number of months of such period
18 occurring in such taxable year, or

19 “(B) 36 months, reduced by the number of
20 months taken into account under this para-
21 graph with respect to such provider for all pre-
22 ceding taxable years (whether or not in the
23 same mandatory service period), multiplied by

24 “(2) \$1,000 (\$500 in the case of a qualified
25 primary health services provider who is a physician
26 assistant or a nurse practitioner).

1 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-
2 VIDER.—For purposes of this section, the term ‘qualified
3 primary health services provider’ means any physician,
4 physician assistant, or nurse practitioner who for any
5 month during a mandatory service period is certified by
6 the Bureau to be a primary health services provider who—

7 “(1) is providing primary health services—

8 “(A) full time, and

9 “(B) to individuals at least 80 percent of
10 whom reside in a health professional shortage
11 area (as defined in subsection (d)(2)),

12 “(2) is not receiving during such year a scholar-
13 ship under the National Health Service Corps Schol-
14 arship Program or a loan repayment under the Na-
15 tional Health Service Corps Loan Repayment Pro-
16 gram,

17 “(3) is not fulfilling service obligations under
18 such Programs, and

19 “(4) has not defaulted on such obligations.

20 “(c) MANDATORY SERVICE PERIOD.—For purposes
21 of this section, the term ‘mandatory service period’ means
22 the period of 60 consecutive calendar months beginning
23 with the first month the taxpayer is a qualified primary
24 health services provider.

1 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
2 poses of this section—

3 “(1) BUREAU.—The term ‘Bureau’ means the
4 Bureau of Health Care Delivery and Assistance,
5 Health Resources and Services Administration of the
6 United States Public Health Service.

7 “(2) HEALTH PROFESSIONAL SHORTAGE
8 AREA.—The term ‘health professional shortage area’
9 means—

10 “(A) a geographic area in which there are
11 6 or fewer individuals residing per square mile,

12 “(B) a health professional shortage area
13 (as defined in section 332(a)(1)(A) of the Pub-
14 lic Health Service Act),

15 “(C) an area which is determined by the
16 Secretary of Health and Human Services as
17 equivalent to an area described in subparagraph
18 (A) and which is designated by the Bureau of
19 the Census as not urbanized, or

20 “(D) a community that is certified as un-
21 derserved by the Secretary for purposes of par-
22 ticipation in the rural health clinic program
23 under title XVIII of the Social Security Act.

1 “(3) PHYSICIAN.—The term ‘physician’ has the
2 meaning given to such term by section 1861(r) or
3 the Social Security Act.

4 “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-
5 TIONER.—The terms ‘physician assistant’ and ‘nurse
6 practitioner’ have the meanings given to such terms
7 by section 1861(aa)(5) of the Social Security Act.

8 “(5) PRIMARY HEALTH SERVICES PROVIDER.—
9 The term ‘primary health services provider’ means a
10 provider of primary health services (as defined in
11 section 330(b)(1) of the Public Health Service Act).

12 “(e) RECAPTURE OF CREDIT.—

13 “(1) IN GENERAL.—If, during any taxable year,
14 there is a recapture event, then the tax of the tax-
15 payer under this chapter for such taxable year shall
16 be increased by an amount equal to the product of—

17 “(A) the applicable percentage, and

18 “(B) the aggregate unrecaptured credits
19 allowed to such taxpayer under this section for
20 all prior taxable years.

21 “(2) APPLICABLE RECAPTURE PERCENTAGE.—

22 “(A) IN GENERAL.—For purposes of this
23 subsection, the applicable recapture percentage
24 shall be determined from the following table:

| “If the recapture event occurs during: | The applicable recapture percentage is: |
|-----------------------------------------------|------------------------------------------------|
| Months 1–24 | 100 |
| Months 25–36 | 75 |
| Months 37–48 | 50 |
| Months 49–60 | 25 |
| Months 61 and thereafter | 0. |

1 “(B) TIMING.—For purposes of subpara-
2 graph (A), month 1 shall begin on the first day
3 of the mandatory service period.

4 “(3) RECAPTURE EVENT DEFINED.—

5 “(A) IN GENERAL.—For purposes of this
6 subsection, the term ‘recapture event’ means
7 the failure of the taxpayer to be a qualified pri-
8 mary health services provider for any month
9 during any mandatory service period.

10 “(B) CESSATION OF DESIGNATION.—The
11 cessation of the designation of any area as a
12 rural health professional shortage area after the
13 beginning of the mandatory service period for
14 any taxpayer shall not constitute a recapture
15 event.

16 “(C) SECRETARIAL WAIVER.—The Sec-
17 retary may waive any recapture event caused by
18 extraordinary circumstances.

19 “(4) NO CREDITS AGAINST TAX.—Any increase
20 in tax under this subsection shall not be treated as
21 a tax imposed by this chapter for purposes of deter-

1 mining the amount of any credit under subpart A,
2 B, or D of this part.”.

3 (2) CLERICAL AMENDMENT.—The table of sec-
4 tions for subpart A of part IV of subchapter A of
5 chapter 1 of such Code is amended by inserting
6 after the item relating to section 25 the following
7 new item:

“Sec. 25A. Primary health services providers.”.

8 (3) EFFECTIVE DATE.—The amendments made
9 by this subsection shall apply to taxable years begin-
10 ning after the date of the enactment of this Act.

11 (b) NATIONAL HEALTH SERVICE CORPS LOAN RE-
12 PAYMENTS EXCLUDED FROM GROSS INCOME.—

13 (1) IN GENERAL.—Part III of subchapter B of
14 chapter 1 of the Internal Revenue Code of 1986 (re-
15 lating to items specifically excluded from gross in-
16 come) is amended by redesignating section 137 as
17 section 138 and by inserting after section 136 the
18 following new section:

19 **“SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN RE-
20 PAYMENTS.**

21 “(a) GENERAL RULE.—Gross income shall not in-
22 clude any qualified loan repayment.

23 “(b) QUALIFIED LOAN REPAYMENT.—For purposes
24 of this section, the term ‘qualified loan repayment’ means
25 any payment made on behalf of the taxpayer by the Na-

1 tional Health Service Corps Loan Repayment Program
2 under section 338B(g) of the Public Health Service Act.”.

3 (2) CONFORMING AMENDMENT.—Paragraph (3)
4 of section 338B(g) of the Public Health Service Act
5 is amended by striking “Federal, State, or local”
6 and inserting “State or local”.

7 (3) CLERICAL AMENDMENT.—The table of sec-
8 tions for part III of subchapter B of chapter 1 of
9 the Internal Revenue Code of 1986 is amended by
10 striking the item relating to section 136 and insert-
11 ing the following:

“Sec. 137. National Health Service Corps loan repayments.
“Sec. 138. Cross references to other Acts.”.

12 (4) EFFECTIVE DATE.—The amendments made
13 by this subsection shall apply to payments made
14 under section 338B(g) of the Public Health Service
15 Act after the date of the enactment of this Act.

16 (c) EXPENSING OF MEDICAL EQUIPMENT.—

17 (1) IN GENERAL.—Section 179 of the Internal
18 Revenue Code of 1986 (relating to election to ex-
19 pense certain depreciable business assets) is amend-
20 ed—

21 (A) by striking paragraph (1) of subsection
22 (b) and inserting the following:

23 “(1) DOLLAR LIMITATION.—

1 “(A) GENERAL RULE.—The aggregate cost
2 which may be taken into account under sub-
3 section (a) for any taxable year shall not exceed
4 \$17,500.

5 “(B) RURAL HEALTH CARE PROPERTY.—
6 In the case of rural health care property, the
7 aggregate cost which may be taken into account
8 under subsection (a) for any taxable year shall
9 not exceed \$32,500, reduced by the amount
10 otherwise taken into account under subsection
11 (a) for such year.”; and

12 (B) by adding at the end of subsection (d)
13 the following new paragraph:

14 “(11) RURAL HEALTH CARE PROPERTY.—For
15 purposes of this section, the term ‘rural health care
16 property’ means section 179 property—

17 “(A) which is medical equipment used in
18 the screening, monitoring, observation, diag-
19 nosis, or treatment of patients in a laboratory,
20 medical, or hospital environment,

21 “(B) which is owned (directly or indirectly)
22 and used by a physician (as defined in section
23 1861(r) of the Social Security Act) in the active
24 conduct of such physician’s full-time trade or
25 business of providing primary health services

1 (as defined in section 330(b)(1) of the Public
2 Health Service Act) in a rural health profes-
3 sional shortage area (as defined in section
4 25A(d)(5)), and

5 “(C) substantially all the use of which is in
6 such area.”.

7 (2) EFFECTIVE DATE.—The amendments made
8 by this subsection shall apply to property placed in
9 service in taxable years beginning after the date of
10 enactment of this Act.

11 (d) DEDUCTION FOR STUDENT LOAN PAYMENTS BY
12 MEDICAL PROFESSIONALS PRACTICING IN RURAL
13 AREAS.—

14 (1) INTEREST ON STUDENT LOANS NOT TREAT-
15 ED AS PERSONAL INTEREST.—Section 163(h)92) of
16 the Internal Revenue Code of 1986 (defining per-
17 sonal interest) is amended by striking “and” at the
18 end of subparagraph (D), by striking the period at
19 the end of subparagraph (E) and inserting “, and”,
20 and by adding at the end thereof the following new
21 subparagraph:

22 “(F) any qualified medical education interest
23 (within the meaning of subsection (k)).”.

24 (2) QUALIFIED MEDICAL EDUCATION INTEREST
25 DEFINED.—Section 163 of such Code (relating to in-

1 interest expenses) is amended by redesignating sub-
2 section (k) as subsection (l) and by inserting after
3 subsection (j) the following new subsection:

4 “(k) QUALIFIED MEDICAL EDUCATION INTEREST OF
5 MEDICAL PROFESSIONALS PRACTICING IN RURAL
6 AREAS.—

7 “(1) IN GENERAL.—For purposes of subsection
8 (h)(2)(F), the term ‘qualified medical education in-
9 terest’ means an amount which bears the same ratio
10 to the interest paid on qualified educational loans
11 during the taxable year by an individual performing
12 services under a qualified rural medical practice
13 agreement as—

14 “(A) the number of months during the tax-
15 able year during which such services were per-
16 formed, bears to

17 “(B) the number of months in the taxable
18 year.

19 “(2) DOLLAR LIMITATION.—The aggregate
20 amount which may be treated as qualified medical
21 education interest for any taxable year with respect
22 to an individual shall not exceed \$5,000.

23 “(3) QUALIFIED RURAL MEDICAL PRACTICE
24 AGREEMENT.—For purposes of this subsection—

1 “(A) IN GENERAL.—The term ‘qualified
2 rural medical practice agreement’ means a writ-
3 ten agreement between an individual and an ap-
4 plicable rural community under which the indi-
5 vidual agrees—

6 “(i) in the case of a medical doctor,
7 upon completion of the individual’s resi-
8 dency (or internship if no residency is re-
9 quired), or

10 “(ii) in the case of a registered nurse,
11 nurse practitioner, or physician’s assistant,
12 upon completion of the education to which
13 the qualified education loan relates, to per-
14 form full-time services as such a medical
15 professional in the applicable rural commu-
16 nity for a period of 24 consecutive months.
17 An individual and an applicable rural com-
18 munity may elect to have the agreement
19 apply for 36 consecutive months rather
20 than 24 months.

21 “(B) SPECIAL RULE FOR COMPUTING PE-
22 RIODS.—An individual shall be treated as meet-
23 ing the 24- or 36-consecutive month require-
24 ment under subparagraph (A) if, during each
25 12-consecutive month period within either such

1 period, the individual performs full-time services
2 as a medical doctor, registered nurse, nurse
3 practitioner, or physician’s assistant, whichever
4 applies, in the applicable rural community dur-
5 ing 9 of the months in such 12-consecutive
6 month period. For purposes of this subsection,
7 an individual meeting the requirements of the
8 preceding sentence shall be treated as perform-
9 ing services during the entire 12-month period.

10 “(C) APPLICABLE RURAL COMMUNITY.—

11 The term ‘applicable rural community’ means—

12 “(i) any political subdivision of a
13 State which—

14 “(I) has a population of 5,000 or
15 less, and

16 “(II) has a per capita income of
17 \$15,000 or less, or

18 “(ii) an Indian reservation which has
19 a per capita income of \$15,000 or less.

20 “(4) QUALIFIED EDUCATIONAL LOAN.—The
21 term ‘qualified educational loan’ means any indebt-
22 edness to pay qualified higher education expenses
23 (within the meaning of section 135(c)(2)) and rea-
24 sonable living expenses—

25 “(A) which are paid or incurred—

1 “(i) as a candidate for a degree as a
2 medical doctor at an educational institu-
3 tion described in section 170(b)(1)(A)(ii),
4 or

5 “(ii) in connection with courses of in-
6 struction at such an institution necessary
7 for certification as a registered nurse,
8 nurse practitioner, or physician’s assistant,
9 and

10 “(B) which are paid or incurred within a
11 reasonable time before or after such indebted-
12 ness is incurred.

13 “(5) RECAPTURE.—If an individual fails to
14 carry out a qualified rural medical practice agree-
15 ment during any taxable year, then—

16 “(A) no deduction with respect to such
17 agreement shall be allowable by reason of sub-
18 section (h)(2)(F) for such taxable year and any
19 subsequent taxable year, and

20 “(B) there shall be included in gross in-
21 come for such taxable year the aggregate
22 amount of the deductions allowable under this
23 section (by reason of subsection (h)(2)(F)) for
24 all preceding taxable years.

1 “(6) DEFINITIONS.—For purposes of this sub-
2 section, the terms ‘registered nurse’, ‘nurse practi-
3 tioner’, and ‘physician’s assistant’ have the meaning
4 given such terms by section 1861 of the Social Secu-
5 rity Act.”.

6 (3) DEDUCTION ALLOWED IN COMPUTING AD-
7 JUSTED GROSS INCOME.—Section 62(a) of such
8 Code, as amended by sections 2002(c)(3) and
9 2003(b), is amended by inserting after paragraph
10 (17) the following new paragraph:

11 “(18) INTEREST ON STUDENT LOANS OF RURAL
12 HEALTH PROFESSIONALS.—The deduction allowable
13 by reason of section 163(h)(2)(F) (relating to stu-
14 dent loan payments of medical professionals practic-
15 ing in rural areas).”.

16 (4) EFFECTIVE DATE.—The amendments made
17 by this subsection shall apply to taxable years begin-
18 ning after the date of the enactment of this Act.

19 **SEC. 5004. RURAL EMERGENCY ACCESS CARE HOSPITALS.**

20 (a) RURAL EMERGENCY ACCESS CARE HOSPITALS
21 DESCRIBED.—Section 1861 of the Social Security Act (42
22 U.S.C. 1395x) is amended by adding at the end the follow-
23 ing new subsection:

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) an agreement with a hospital with a par-
18 ticipation agreement in effect under section 1866(a),
19 and under such agreement the hospital shall accept
20 patients transferred to the hospital from the facility
21 and receive data from and transmit data to the facil-
22 ity.

23 “(E) There is a practitioner who is qualified to
24 provide advanced cardiac life support services (as de-

1 terminated 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 dietician, 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

1 such paragraph, would meet the requirements if any
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
5 ‘nurse practitioners or nurses’), except that in deter-
6 mining whether a facility meets the requirements of
7 this subparagraph, subparagraphs (E) and (F) of
8 that paragraph shall be applied as if any reference
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
12 services’ means medical and other health services fur-
13 nished by a rural emergency access care hospital.”.

14 (b) COVERAGE OF AND PAYMENT FOR SERVICES.—
15 Section 1832(a)(2) of the Social Security Act (42 U.S.C.
16 1395k(a)(2)) is amended—

17 (1) by striking “and” at the end of subpara-
18 graph (I);

19 (2) by striking the period at the end of sub-
20 paragraph (J) and inserting “; and”; and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(K) rural emergency access care hospital
24 services (as defined in section 1861(oo)(2)).”.

1 (c) PAYMENT BASED ON PAYMENT FOR OUTPATIENT
2 RURAL PRIMARY CARE HOSPITAL SERVICES.—

3 (1) IN GENERAL.—Section 1833(a)(6) of the
4 Social Security Act (42 U.S.C. 1395l(a)(6)) is
5 amended by striking “services,” and inserting “serv-
6 ices and rural emergency access care hospital serv-
7 ices.”.

8 (2) PAYMENT METHODOLOGY DESCRIBED.—
9 Section 1834(g) of such Act (42 U.S.C. 1395m(g))
10 is amended—

11 (A) in the heading, by striking “SERV-
12 ICES” and inserting “SERVICES AND RURAL
13 EMERGENCY ACCESS CARE HOSPITAL SERV-
14 ICES”;

15 (B) in paragraph (1), by striking “during
16 a year before 1993” and inserting “during a
17 year before the prospective payment system de-
18 scribed in paragraph (2) is in effect”;

19 (C) in paragraph (1), by adding at the end
20 the following: “The amount of payment shall be
21 determined under either method without regard
22 to the amount of the customary or other
23 charge.”;

1 (D) in paragraph (2), by striking “Janu-
2 ary 1, 1993,” and inserting “January 1,
3 1996,”; and

4 (E) by adding at the end the following new
5 paragraph:

6 “(3) APPLICATION OF METHODS TO PAYMENT
7 FOR RURAL EMERGENCY ACCESS CARE HOSPITAL
8 SERVICES.—The amount of payment for rural emer-
9 gency access care hospital services provided during
10 a year shall be determined using the applicable
11 method provided under this subsection for determin-
12 ing payment for outpatient rural primary care hos-
13 pital services during the year.”.

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to fiscal years beginning on or
16 after October 1, 1994.

17 **SEC. 5005. GRANTS TO STATES REGARDING AIRCRAFT FOR**
18 **TRANSPORTING RURAL VICTIMS OF MEDICAL**
19 **EMERGENCIES.**

20 Part E of title XII of the Public Health Service Act
21 (42 U.S.C. 300d–51 et seq.) is amended by adding at the
22 end thereof the following new section:

1 **“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**
2 **VICTIMS OF MEDICAL EMERGENCIES.**

3 “(a) IN GENERAL.—The Secretary shall make grants
4 to States to assist such States in the creation or enhance-
5 ment of air medical transport systems that provide victims
6 of medical emergencies in rural areas with access to treat-
7 ments for the injuries or other conditions resulting from
8 such emergencies.

9 “(b) APPLICATION AND PLAN.—

10 “(1) APPLICATION.—To be eligible to receive a
11 grant under subsection (a), a State shall prepare
12 and submit to the Secretary an application in such
13 form, made in such manner, and containing such
14 agreements, assurances, and information, including
15 a State plan as required in paragraph (2), as the
16 Secretary determines to be necessary to carry out
17 this section.

18 “(2) STATE PLAN.—An application submitted
19 under paragraph (1) shall contain a State plan that
20 shall—

21 “(A) describe the intended uses of the
22 grant proceeds and the geographic areas to be
23 served;

24 “(B) demonstrate that the geographic
25 areas to be served, as described under subpara-
26 graph (A), are rural in nature;

1 “(C) demonstrate that there is a lack of
2 facilities available and equipped to deliver ad-
3 vanced levels of medical care in the geographic
4 areas to be served;

5 “(D) demonstrate that in utilizing the
6 grant proceeds for the establishment or en-
7 hancement of air medical services the State
8 would be making a cost-effective improvement
9 to existing ground-based or air emergency medi-
10 cal service systems;

11 “(E) demonstrate that the State will not
12 utilize the grant proceeds to duplicate the capa-
13 bilities of existing air medical systems that are
14 effectively meeting the emergency medical needs
15 of the populations they serve;

16 “(F) demonstrate that in utilizing the
17 grant proceeds the State is likely to achieve a
18 reduction in the morbidity and mortality rates
19 of the areas to be served, as determined by the
20 Secretary;

21 “(G) demonstrate that the State, in utiliz-
22 ing the grant proceeds, will—

23 “(i) maintain the expenditures of the
24 State for air and ground medical transport
25 systems at a level equal to not less than

1 the level of such expenditures maintained
2 by the State for the fiscal year preceding
3 the fiscal year for which the grant is re-
4 ceived; and

5 “(ii) ensure that recipients of direct
6 financial assistance from the State under
7 such grant will maintain expenditures of
8 such recipients for such systems at a level
9 at least equal to the level of such expendi-
10 tures maintained by such recipients for the
11 fiscal year preceding the fiscal year for
12 which the financial assistance is received;

13 “(H) demonstrate that persons experienced
14 in the field of air medical service delivery were
15 consulted in the preparation of the State plan;
16 and

17 “(I) contain such other information as the
18 Secretary may determine appropriate.

19 “(c) CONSIDERATIONS IN AWARDING GRANTS.—In
20 determining whether to award a grant to a State under
21 this section, the Secretary shall—

22 “(1) consider the rural nature of the areas to
23 be served with the grant proceeds and the services
24 to be provided with such proceeds, as identified in
25 the State plan submitted under subsection (b); and

1 “(2) give preference to States with State plans
2 that demonstrate an effective integration of the pro-
3 posed air medical transport systems into a com-
4 prehensive network or plan for regional or statewide
5 emergency medical service delivery.

6 “(d) STATE ADMINISTRATION AND USE OF
7 GRANT.—

8 “(1) IN GENERAL.—The Secretary may not
9 make a grant to a State under subsection (a) unless
10 the State agrees that such grant will be adminis-
11 tered by the State agency with principal responsibil-
12 ity for carrying out programs regarding the provi-
13 sion of medical services to victims of medical emer-
14 gencies or trauma.

15 “(2) PERMITTED USES.—A State may use
16 amounts received under a grant awarded under this
17 section to award subgrants to public and private en-
18 tities operating within the State.

19 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—
20 The Secretary may not make a grant to a State
21 under subsection (a) unless that State agrees that,
22 in developing and carrying out the State plan under
23 subsection (b)(2), the State will provide public notice
24 with respect to the plan (including any revisions

1 thereto) and facilitate comments from interested
2 persons.

3 “(e) NUMBER OF GRANTS.—The Secretary shall
4 award grants under this section to not less than 7 States.

5 “(f) REPORTS.—

6 “(1) REQUIREMENT.—A State that receives a
7 grant under this section shall annually (during each
8 year in which the grant proceeds are used) prepare
9 and submit to the Secretary a report that shall con-
10 tain—

11 “(A) a description of the manner in which
12 the grant proceeds were utilized;

13 “(B) a description of the effectiveness of
14 the air medical transport programs assisted
15 with grant proceeds; and

16 “(C) such other information as the Sec-
17 retary may require.

18 “(2) TERMINATION OF FUNDINGS.—In review-
19 ing reports submitted under paragraph (1), if the
20 Secretary determines that a State is not using
21 amounts provided under a grant awarded under this
22 section in accordance with the State plan submitted
23 by the State under subsection (b), the Secretary may
24 terminate the payment of amounts under such grant
25 to the State until such time as the Secretary deter-

1 mines that the State comes into compliance with
2 such plan.

3 “(g) DEFINITION.—As used in this section, the term
4 ‘rural areas’ means geographic areas that are located out-
5 side of standard metropolitan statistical areas, as identi-
6 fied by the Secretary.

7 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to make grants under
9 this section, \$15,000,000 for fiscal year 1995, and such
10 sums as may be necessary for each for fiscal years 1996
11 and 1997.”.

12 **SEC. 5006. DEMONSTRATION PROJECTS TO ENCOURAGE**
13 **THE DEVELOPMENT AND OPERATION OF**
14 **RURAL HEALTH NETWORKS.**

15 (a) IN GENERAL.—

16 (1) ESTABLISHMENT.—

17 (A) IN GENERAL.—The Secretary may
18 conduct a demonstration project under which
19 public and private entities may apply for waiv-
20 ers of any of the provisions of title XVIII and
21 XIX of the Social Security Act in order to oper-
22 ate rural health networks (as defined in sub-
23 section (d)(1)) which—

24 (i) improve the access of medicare
25 beneficiaries (as defined in subsection

1 (d)(2)) and medicaid beneficiaries (as de-
2 fined in subsection (d)(3)) to health care
3 services;

4 (ii) improve the quality of health care
5 services furnished to such beneficiaries;
6 and

7 (iii) improve the outcomes of health
8 care services furnished to such bene-
9 ficiaries.

10 (B) NUMBER OF WAIVERS.—The Secretary
11 may grant waivers to operate rural health net-
12 works under the demonstration project con-
13 ducted under this section to a number of public
14 and private entities determined appropriate by
15 the Secretary.

16 (2) APPLICATIONS.—

17 (A) IN GENERAL.—In order to participate
18 in the demonstration project conducted under
19 this subsection, a public or private entity desir-
20 ing to operate a rural health network shall sub-
21 mit an application to the Secretary which meets
22 the requirements of subparagraph (B). Such
23 application shall be submitted in such manner
24 and at such time as the Secretary shall require.

1 (B) REQUIREMENTS.—An application sub-
2 mitted by a public or private entity under this
3 subsection must provide—

4 (i) a description of the health care
5 providers participating in the rural health
6 network;

7 (ii) a description of the geographic
8 area served by the rural health networks;

9 (iii) information demonstrating that
10 the public or private entity has consulted
11 with interested parties with respect to the
12 operation of the rural health network, in-
13 cluding local government entities and com-
14 munity groups;

15 (iv) a description of the operational
16 structure of the rural health network, in-
17 cluding whether the network is a managed
18 care entity or a fee-for-service provider;

19 (v) a proposal for how payments
20 should be made to the rural health network
21 under titles XVIII and XIX of the Social
22 Security Act, including a statement as to
23 whether such payments should be made
24 pursuant to the provisions of such titles or

1 pursuant to an alternative payment meth-
2 odology described in the application;

3 (vi) assurances that medicare bene-
4 ficiaries served by the rural health network
5 will receive care and services of the same
6 quality as the care and services received by
7 other beneficiaries under title XVIII of the
8 Social Security Act;

9 (vii) assurances that medicaid bene-
10 ficiaries served by the rural health network
11 will receive care and services of the same
12 quality as the care and services received by
13 other beneficiaries under title XIX of the
14 Social Security Act;

15 (viii) a description of how the rural
16 health network plans to handle any situa-
17 tion in which a medicare beneficiary or
18 medicaid beneficiary served by the network
19 receives health care services from providers
20 outside the network;

21 (ix) assurances that the rural health
22 network is furnishing health care services
23 to a significant number of individuals who
24 are not receiving benefits under titles
25 XVIII and XIX of the Social Security Act;

1 (x) assurances that through sharing
2 of facilities, land, and equipment, the rural
3 health network will result in a reduction of
4 total capital costs for the area served by
5 the network;

6 (xi) a plan for cooperation in service
7 delivery by health care providers partici-
8 pating in the rural health network that
9 demonstrates the elimination of unneces-
10 sary duplication and, when appropriate,
11 the consolidation of specialized services
12 within the area served by the network;

13 (xii) evidence that the rural health
14 network furnishes services which address
15 the special access needs of the medicare
16 beneficiaries and medicaid beneficiaries
17 served by the network;

18 (xiii) evidence of capability and exper-
19 tise in network planning and management;
20 and

21 (xiv) such additional information as
22 the Secretary determines appropriate.

23 (C) APPROVAL OF APPLICATION.—

24 (i) INITIAL REVIEW.—Within 60 days
25 after an application is submitted by a pub-

1 lic or private entity under this subsection,
2 the Secretary shall review and approve
3 such application or provide the entity with
4 a list of the modifications that are nec-
5 essary for such application to be approved.

6 (ii) ADDITIONAL REVIEW.—Within 60
7 days after a public or private entity resub-
8 mits any application under this subsection,
9 the Secretary shall review and approve
10 such application or provide the entity with
11 a summary of which items included on the
12 list provided to the State under clause (i)
13 remain unsatisfied. An entity may resub-
14 mit an application under this subpara-
15 graph as many times as necessary to gain
16 approval.

17 (3) COORDINATION WITH OTHER PROGRAMS.—

18 The Secretary shall coordinate the demonstration
19 project conducted under this subsection with any
20 other relevant Federal or State programs in order to
21 prevent duplication and improve the quality and de-
22 livery of health care services to medicare bene-
23 ficiaries and medicaid beneficiaries.

24 (4) PAYMENTS TO NETWORKS.—

1 (A) IN GENERAL.—The Secretary shall de-
2 termine the amount of payments to be made
3 under titles XVIII and XIX to a rural health
4 network participating in a demonstration
5 project under this subsection based on historic
6 costs adjusted based on population and geo-
7 graphic area as the Secretary determines appro-
8 priate to take into account the costs of furnish-
9 ing health care services in the area served by
10 the network.

11 (B) BUDGET NEUTRALITY.—The Secretary
12 shall provide that in carrying out the dem-
13 onstration project under this section, the aggre-
14 gate payments under titles XVIII and XIX of
15 the Social Security Act to providers participat-
16 ing in a rural health network shall be no great-
17 er or lesser than what such payments would
18 have been if such providers were not participat-
19 ing in such network.

20 (5) DURATION OF WAIVERS.—Any waiver
21 granted under the demonstration project conducted
22 under this subsection shall be granted for a period
23 determined appropriate by the Secretary. The Sec-
24 retary may terminate such a waiver at any time if
25 the Secretary determines that the rural health net-

1 work has failed to furnish health care services in ac-
2 cordance with the terms of the waiver.

3 (6) REPORTS.—

4 (A) IN GENERAL.—Each public or private
5 entity receiving a wavier to operate a rural
6 health network under the demonstration project
7 conducted under this subsection shall, through
8 an independent entity, evaluate the network and
9 submit interim and final reports to the Sec-
10 retary at such times and containing such infor-
11 mation as the Secretary shall require.

12 (B) REPORT TO CONGRESS.—Not later
13 than 60 days after the receipt of a final report
14 by a rural health network under subparagraph
15 (A) the Secretary shall submit a report to Con-
16 gress.

17 (b) GRANTS FOR THE DEVELOPMENT OF RURAL
18 HEALTH NETWORKS.—

19 (1) IN GENERAL.—The Secretary shall award
20 grants to public and private entities which have re-
21 ceived a wavier under the demonstration project con-
22 ducted under subsection (a) for the purpose of plan-
23 ning and developing rural health networks.

24 (2) APPLICATION PROCESS.—

1 (A) SUBMISSION OF APPLICATION.—Each
2 public or private entity desiring to receive a
3 grant under this subsection shall submit an ap-
4 plication to the Secretary at such time and con-
5 taining such information as the Secretary deter-
6 mines appropriate.

7 (B) CONSIDERATION OF APPLICATIONS.—
8 The Secretary shall develop a system for deter-
9 mining the priority for distributing grants
10 under this subsection and such grants shall be
11 distributed in accordance with such system.

12 (3) USE OF GRANT FUNDS.—A State that is
13 awarded grant funds under this subsection may use
14 such funds for all costs associated with assisting
15 public or private entities in planning and developing
16 rural health networks.

17 (4) AUTHORIZATION OF APPROPRIATIONS.—
18 There are authorized to be appropriated such sums
19 as may be necessary for the purposes of awarding
20 grants under this subsection.

21 (c) GRANTS FOR THE OPERATION OF RURAL
22 HEALTH NETWORKS.—

23 (1) IN GENERAL.—The Secretary shall award
24 grants to public and private entities which have re-
25 ceived a waiver under the demonstration project con-

1 ducted under subsection (a) for the operation of
2 rural health networks.

3 (2) APPLICATION PROCESS.—

4 (A) SUBMISSION OF APPLICATION.—Any
5 public or private entity which desires to receive
6 a grant under this subsection shall submit an
7 application of the Secretary at such time and
8 containing such information as the Secretary
9 determines appropriate.

10 (B) CONSIDERATION OF APPLICATIONS.—

11 The Secretary shall develop a system for deter-
12 mining the priority for distributing grants
13 under this subsection and such grants shall be
14 distributed in accordance with such priority.

15 (3) USE OF GRANT FUNDS.—A public or pri-
16 vate entity that is awarded grant funds under this
17 subsection may use such funds for all costs associ-
18 ated with operating a rural health network.

19 (4) AUTHORIZATION OF APPROPRIATIONS.—

20 There are authorized to be appropriated such sums
21 as may be necessary for the purposes of awarding
22 grants under this subsection.

23 (d) DEFINITIONS.—For purposes of this section:

24 (1) RURAL HEALTH NETWORK.—The term
25 “rural health network” means a formal cooperative

1 arrangement between participating hospitals, physi-
2 cians, and other health care providers which—

3 (A) furnishes health care services to medi-
4 care beneficiaries and medicaid beneficiaries;

5 (B) is located in a rural area; and

6 (C) is governed by a board of directors se-
7 lected by participating health care providers.

8 (2) MEDICAID BENEFICIARY.—The term “med-
9 icaid beneficiary” means an individual receiving ben-
10 efits under this XIX of the Social Security Act who
11 resides in a rural area or who receives health care
12 services from a health care provider located in a
13 rural area.

14 (3) MEDICARE BENEFICIARY.—The term “med-
15 icare beneficiary” means an individual receiving ben-
16 efits under title XVIII of the Social Security Act
17 who resides in a rural area or who receives health
18 care services from a health care provider located in
19 a rural area.

20 (4) RURAL AREA.—The term “rural area”
21 means a rural area as described in section
22 1886(d)(2)(D).

1 **SEC. 5007. STUDY ON EXPANDING BENEFITS UNDER QUALI-**
2 **FIED HEALTH PLANS FOR INDIVIDUALS RE-**
3 **SIDING IN RURAL AREAS.**

4 (a) STUDY.—

5 (1) IN GENERAL.—The Secretary shall conduct
6 a study on the possible benefits of a program under
7 which issuers of qualified health plans covering indi-
8 viduals who reside in rural areas may—

9 (A) develop a package of benefits targeted
10 at improving access to health care services
11 which would supplement the benefits included
12 under such plan; and

13 (B) receive premium payments for such
14 package of benefits from the Secretary.

15 (2) CONSULTATION WITH CERTAIN ENTITIES.—
16 In conducting the study under paragraph (1), the
17 Secretary shall consult with the Office of Rural
18 Health Policy and private and public entities with
19 expertise in rural health issues.

20 (b) REPORT.—Not later than 1 year after the date
21 of the enactment of this Act the Secretary shall submit
22 a report to Congress containing the results of the study
23 conducted under subsection (a) and any legislative rec-
24 ommendations determined appropriate by the Secretary.

1 **Subtitle B—Primary Care Provider**
2 **Education**

3 **SEC. 5101. GRADUATE MEDICAL EDUCATION DEMONSTRATION PROJECTS.**
4

5 Part C of title VII of the Public Health Service Act
6 (42 U.S.C. 293j et seq.) is amended by adding at the end
7 the following new section:

8 **“SEC. 753. GRADUATE MEDICAL EDUCATION DEMONSTRATION PROJECTS.**
9

10 “(a) STATE DEMONSTRATION PROGRAM.—

11 “(1) IN GENERAL.—The Secretary of Health
12 and Human Services (hereafter referred to in this
13 section as the ‘Secretary’) acting through the Ad-
14 ministrator of the Health Resources and Services
15 Administration shall provide for the establishment of
16 demonstration projects in no more than 7 States for
17 the purpose of testing and evaluating mechanisms to
18 increase the number and percentage of medical stu-
19 dents entering primary care practice relative to those
20 entering nonprimary care practice through the use
21 of funds otherwise available for direct graduate med-
22 ical education costs under section 1886(h) of the So-
23 cial Security Act.

24 “(2) APPLICATIONS.—

1 “(A) IN GENERAL.—Each State desiring to
2 conduct a demonstration project under this sub-
3 section shall prepare and submit to the Sec-
4 retary an application, at such time, in such
5 manner, and containing such information as the
6 Secretary may require, including—

7 “(i) information demonstrating that
8 the State has consulted with interested
9 parties with respect to conducting a dem-
10 onstration project under this subsection,
11 including State medical associations, State
12 hospital associations, and medical schools
13 located in the State;

14 “(ii) an assurance that in conducting
15 a demonstration project under this sub-
16 section no single teaching hospital located
17 in the State will lose more than 10 percent
18 of such hospital’s approved medical resi-
19 dency positions in any year; and

20 “(iii) an explanation of a plan for
21 evaluating the project.

22 “(B) APPROVAL OF APPLICATIONS.—A
23 State that submits an application under sub-
24 paragraph (A) may begin a demonstration
25 project under this subsection—

1 “(i) upon approval of such application
2 by the Secretary; or

3 “(ii) at the end of the 60-day period
4 beginning on the date such application is
5 submitted, unless the Secretary denies the
6 application during such period.

7 “(C) NOTICE AND COMMENT.—A State
8 shall issue a public notice on the date it sub-
9 mits an application under subparagraph (A)
10 which contains a general description of the pro-
11 posed demonstration project. Any interested
12 party may comment on the proposed dem-
13 onstration project to the State or the Secretary
14 during the 30-day period beginning on the date
15 the public notice is issued.

16 “(3) FUNDING FOR DEMONSTRATION
17 PROJECTS.—

18 “(A) ALLOCATION OF GME FUNDS.—

19 “(i) IN GENERAL.—For each year a
20 State conducts a demonstration project
21 under this subsection the Secretary shall
22 pay to such State an amount equal to the
23 total amount available to hospitals located
24 in the State under section 1886(h) of the
25 Social Security Act. In the case of a State

1 which establishes any health care training
2 consortium under clause (ii)(II), the State
3 shall designate a teaching hospital for each
4 resident assigned to such a consortium
5 which the Secretary shall use to calculate
6 the State’s payment amount under such
7 section. Such teaching hospital shall be the
8 hospital where the resident receives the
9 majority of the resident’s hospital-based,
10 nonambulatory training experience.

11 “(ii) USE OF FUNDS.—Each State
12 that receives a payment under clause (i)
13 shall use such funds to conduct activities
14 which test and evaluate mechanisms to in-
15 crease the number and percentage of medi-
16 cal students entering primary care practice
17 relative to those entering nonprimary care
18 practice as follows:

19 “(I) The State may apply
20 weighting factors that are different
21 than the weighting factors set forth in
22 section 1886(h)(4)(C) of the Social
23 Security Act for the purpose of mak-
24 ing direct graduate medical education
25 payments. In applying different

1 weighting factors, the State may re-
2 quire entities receiving payments to
3 use a portion of such payments to in-
4 crease stipends paid to primary care
5 residents relative to nonprimary care
6 residents.

7 “(II) The State may use funds to
8 provide for the establishment and op-
9 eration of any health care training
10 consortium. The State shall make
11 payments to any such consortium
12 through an entity identified by the
13 consortium as appropriate for receiv-
14 ing payment on behalf of the consor-
15 tium. The consortium shall have dis-
16 cretion in determining the purposes
17 for which such payments may be used
18 and may direct such payments to con-
19 sortium medical schools for primary
20 care medical student education pro-
21 grams.

22 “(B) GRANTS FOR PLANNING AND EVAL-
23 UATIONS.—

24 “(i) IN GENERAL.—The Secretary
25 may award grants to States conducting

1 demonstration projects under this sub-
2 section for the purpose of developing and
3 evaluating such projects. A State may con-
4 duct such an evaluation or contract with a
5 private entity to conduct the evaluation.
6 Each State desiring to receive a grant
7 under this subparagraph shall prepare and
8 submit to the Secretary an application, at
9 such time, in such manner, and containing
10 such information as the Secretary may re-
11 quire.

12 “(ii) AUTHORIZATION OF APPROPRIA-
13 TIONS.—There are authorized to be appro-
14 priated such sums as may be necessary to
15 carry out the purposes of this subpara-
16 graph for fiscal years 1995 through 2003.

17 “(4) MAINTENANCE OF EFFORT.—Any funds
18 available for the activities covered by a demonstra-
19 tion project conducted under this subsection shall
20 supplement, and shall not supplant, funds that are
21 expended for similar purposes under any State, re-
22 gional, or local program.

23 “(b) CONSORTIUM DEMONSTRATION PROGRAM.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Administrator of the Health Resources

1 and Services Administration, shall provide for the
2 establishment of demonstration projects for no more
3 than 7 health care training consortia which are lo-
4 cated in States that are not conducting a demonstra-
5 tion project under subsection (a) for the purpose of
6 testing and evaluating mechanisms to increase the
7 number and percentage of medical students entering
8 primary care practice relative to those entering
9 nonprimary care practice through the use of funds
10 otherwise available for direct graduate medical edu-
11 cation costs under section 1886(h) of the Social Se-
12 curity Act.

13 “(2) APPLICATIONS.—

14 “(A) IN GENERAL.—Each health care
15 training consortium desiring to conduct a dem-
16 onstration project under this subsection shall
17 prepare and submit to the Secretary an applica-
18 tion, at such time, in such manner, and con-
19 taining such information as the Secretary may
20 require, including an explanation of a plan for
21 evaluating the project.

22 “(B) APPROVAL OF APPLICATIONS.—A
23 consortium that submits an application under
24 subparagraph (A) may begin a demonstration
25 project under this subsection—

1 “(i) upon approval of such application
2 by the Secretary; or

3 “(ii) at the end of the 60-day period
4 beginning on the date such application is
5 submitted, unless the Secretary denies the
6 application during such period.

7 “(3) FUNDING FOR DEMONSTRATION
8 PROJECTS.—

9 “(A) ALLOCATION OF GME FUNDS.—

10 “(i) IN GENERAL.—For each year a
11 consortium conducts a demonstration
12 project under this subsection the Secretary
13 shall pay to such consortium an amount
14 equal to the total amount available to hos-
15 pitals that are members of the consortium
16 under section 1886(h) of the Social Secu-
17 rity Act. The consortium shall designate a
18 teaching hospital for each resident as-
19 signed to the consortium which the Sec-
20 retary shall use to calculate the consor-
21 tium’s payment amount under such sec-
22 tion. Such teaching hospital shall be the
23 hospital where the resident receives the
24 majority of the resident’s hospital-based,
25 nonambulatory training experience.

1 “(ii) USE OF FUNDS.—

2 “(I) TESTING AND EVALUA-
3 TION.—Each consortium that receives
4 a payment under clause (i) shall use
5 such funds to conduct activities which
6 test and evaluate mechanisms to in-
7 crease the number and percentage of
8 medical students entering primary
9 care practice relative to those entering
10 nonprimary care practice.

11 “(II) ESTABLISHMENT AND OP-
12 ERATION.—Each consortium that re-
13 ceives a payment under clause (i) may
14 also use such funds for the establish-
15 ment and operation of the consortium.
16 The Secretary shall make payments to
17 the consortium through an entity
18 identified by the consortium as appro-
19 priate for receiving payment on behalf
20 of the consortium. The consortium
21 shall have discretion in determining
22 the purposes for which such payments
23 may be used and may direct such pay-
24 ments to consortium medical schools

1 for primary care medical student edu-
2 cation programs.

3 “(B) GRANTS FOR PLANNING AND EVAL-
4 UATIONS.—

5 “(i) IN GENERAL.—The Secretary
6 may award grants to consortia conducting
7 demonstration projects under this sub-
8 section for the purpose of developing and
9 evaluating such projects. Each consortium
10 desiring to receive a grant under this sub-
11 paragraph shall prepare and submit to the
12 Secretary an application, at such time, in
13 such manner, and containing such infor-
14 mation as the Secretary may require.

15 “(ii) AUTHORIZATION OF APPROPRIA-
16 TIONS.—There are authorized to be appro-
17 priated such sums as may be necessary to
18 carry out the purposes of this subpara-
19 graph for fiscal years 1995 through 2003.

20 “(4) MAINTENANCE OF EFFORT.—Any funds
21 available for the activities covered by a demonstra-
22 tion project conducted under this subsection shall
23 supplement, and shall not supplant, funds that are
24 expended for similar purposes under any State, re-
25 gional, or local program.

1 “(c) DURATION.—A demonstration project under this
2 section shall be conducted for a period not to exceed 8
3 years. The Secretary may terminate a project if the Sec-
4 retary determines that the State or consortium conducting
5 the project is not in substantial compliance with the terms
6 of the application approved by the Secretary under this
7 section.

8 “(d) EVALUATIONS AND REPORTS.—

9 “(1) EVALUATIONS.—Each State or consortium
10 that conducts a demonstration project under this
11 section shall submit to the Secretary a final evalua-
12 tion of such project within 360 days of the termi-
13 nation of such project and such interim evaluations
14 as the Secretary may require.

15 “(2) REPORTS TO CONGRESS.—Not later than
16 360 days after the first demonstration project under
17 this section begins, and annually thereafter for each
18 year in which a project is conducted under this sec-
19 tion, the Secretary shall submit a report to the ap-
20 propriate committees of the Congress which evalu-
21 ates the effectiveness of the demonstration projects
22 conducted under this section and includes any legis-
23 lative recommendations determined appropriate by
24 the Secretary.

25 “(e) DEFINITIONS.—For purposes of this section:

1 “(1) AMBULATORY TRAINING SITES.—The term
2 ‘ambulatory training sites’ includes, but is not lim-
3 ited to, health maintenance organizations, federally
4 qualified health centers, community health centers,
5 migrant health centers, rural health clinics, nursing
6 homes, hospice, and other community-based provid-
7 ers, including private practices.

8 “(2) HEALTH CARE TRAINING CONSORTIUM.—
9 The term ‘health care training consortium’ means a
10 State, regional, or local entity which—

11 “(A) includes teaching hospitals, ambula-
12 tory training sites, and one or more schools of
13 medicine located in the same geographic region;
14 and

15 “(B) is operated in a manner intended to
16 ensure that by the end of the 8-year demonstra-
17 tion project at least 50 percent of the graduates
18 of the schools included in the entity will become
19 primary care providers during the 1-year period
20 immediately following the date such graduates
21 complete their residency training.

22 “(3) PRIMARY CARE.—The term ‘primary care’
23 means family practice, general internal medicine,
24 and general pediatrics, and may also include obstet-
25 rics and gynecology if such care is person-centered,

1 comprehensive care that is not organ or problem
2 specific.”.

3 **SEC. 5102. FUNDING UNDER MEDICARE FOR TRAINING IN**
4 **NONHOSPITAL-OWNED FACILITIES.**

5 (a) RESIDENCY TRAINING TIME IN NONHOSPITAL-
6 OWNED FACILITIES COUNTED IN DETERMINING FULL-
7 TIME-EQUIVALENT RESIDENTS FOR DIRECT GRADUATE
8 MEDICAL EDUCATION PAYMENTS.—Section
9 1886(h)(4)(E) of the Social Security Act (42 U.S.C.
10 1395ww(h)(4)(E)) is amended by striking “, if the hos-
11 pital incurs all, or substantially all, of the costs for the
12 training program in that setting”.

13 (b) RESIDENCY TRAINING TIME IN NONHOSPITAL-
14 OWNED FACILITIES COUNTED IN DETERMINING FULL-
15 TIME-EQUIVALENT RESIDENTS FOR INDIRECT MEDICAL
16 EDUCATION PAYMENTS.—

17 (1) IN GENERAL.—Section 1886(d)(5)(B)(iv) of
18 the Social Security Act (42 U.S.C.
19 1395ww(d)(5)(B)(iv)) is amended to read as follows:

20 “(iv) In determining such adjustment,
21 the Secretary shall count interns and resi-
22 dents—

23 “(I) assigned to any patient serv-
24 ice environment which is part of the
25 hospital’s approved medical residency

1 training program (as defined in sec-
2 tion 1886(h)(5)(A)), or

3 “(II) providing services at any
4 entity receiving a grant under section
5 330 of the Public Health Service Act
6 that is under the ownership or control
7 of the hospital (if the hospital incurs
8 all, or substantially all, of the costs of
9 the services furnished by such interns
10 and residents),

11 as part of the calculation of the full-time-
12 equivalent number of interns and resi-
13 dents.”.

14 (2) ADJUSTMENT OF INDIRECT TEACHING AD-
15 JUSTMENT FACTOR TO ACHIEVE BUDGET NEUTRAL-
16 ITY.—Section 1886(d)(5)(B)(ii) of the Social Secu-
17 rity Act (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amend-
18 ed to read as follows:

19 “(ii)(I) For purposes of clause (i)(II),
20 the indirect teaching adjustment factor is
21 equal to $1.89 \times (((1+r \times t) \text{ to the } n\text{th}$
22 $\text{power}) - 1)$.

23 “(II) For purposes of subclause (i)—

1 “(aa) ‘r’ is the ratio of the hos-
2 pital’s full-time-equivalent interns and
3 residents to beds;

4 “(bb) ‘t’ is the ratio of the num-
5 ber of full-time-equivalent interns and
6 residents of all hospitals paid under
7 this paragraph and used in the cal-
8 culation of ‘r’ on June 1, 1993, to the
9 number of full-time-equivalent interns
10 and residents of all hospitals paid
11 under this paragraph and used in the
12 calculation of ‘r’ on June 1, 1994;
13 and

14 “(cc) ‘n’ equals .405.”.

15 **SEC. 5103. INCREASE IN NATIONAL HEALTH SERVICE**
16 **CORPS FUNDING.**

17 (a) GENERAL AUTHORIZATION.—Section 338H(b)(1)
18 of the Public Health Service Act (42 U.S.C. 254q(b)(1))
19 is amended—

20 (1) by striking “1991, and” and inserting
21 “1991,”; and

22 (2) by striking “through 2000” and inserting “,
23 1993, and 1994, \$120,000,000 for fiscal year 1995,
24 and such sums as may be necessary for each of the
25 fiscal years 1996 through 1998”.

1 (b) GRANTS FOR STATE LOAN REPAYMENT PRO-
2 GRAMS.—Section 338I(i)(1) of such Act (42 U.S.C. 254q-
3 1(i)(1)) is amended to read as follows:

4 “(1) IN GENERAL.—The Secretary shall ensure
5 that not less than one-third of the amounts appro-
6 priated under section 338H(b)(1) for each fiscal
7 year shall be made available for grants under this
8 section.”.

9 **SEC. 5104. INCREASE IN HEALTH PROFESSIONS FUNDING**
10 **FOR PRIMARY CARE PHYSICIANS.**

11 (a) FAMILY MEDICINE.—Section 747(d)(1) of the
12 Public Health Service Act (42 U.S.C. 293k(d)(1)) is
13 amended by striking “for each of” and all that follows
14 through “1995” and inserting “for each of the fiscal years
15 1993 and 1994, \$67,500,000 for fiscal year 1995, and
16 such sums as may be necessary for each of the fiscal years
17 1996 and 1997”.

18 (b) GENERAL INTERNAL MEDICINE AND PEDIAT-
19 RICS.—Section 748(c) of the Public Health Service Act
20 (42 U.S.C. 293l(c)) is amended by striking “for each of”
21 and all that follows through “1995” and inserting “for
22 each of the fiscal years 1993 and 1994, \$31,250,000 for
23 fiscal year 1995, and such sums as may be necessary for
24 each of the fiscal years 1996 and 1997”.

1 **SEC. 5105. HEALTH PROFESSIONS FUNDING FOR NURSE**
2 **PRACTITIONERS AND PHYSICIAN ASSISTANTS**
3 **PROGRAMS.**

4 (a) PHYSICIAN ASSISTANTS.—Section 750(d)(1) of
5 the Public Health Service Act (42 U.S.C. 293n(d)(1)) is
6 amended by striking “for each of the fiscal years 1993
7 through 1995” and inserting “for each of the fiscal years
8 1993 and 1994, \$11,250,000 for fiscal year 1995, and
9 such sums as may be necessary for each of the fiscal years
10 1996 and 1997.”.

11 (b) NURSE PRACTITIONERS.—Section 822(d) of such
12 Act (42 U.S.C. 296m(d)) is amended by striking “1994.”
13 and inserting “1994, \$25,000,000 for fiscal year 1995,
14 and such sums as may be necessary for each of the fiscal
15 years 1996 and 1997”.

16 (c) ADVANCED EDUCATION OR PROFESSIONAL
17 NURSES.—Section 830(f)(1) of the Public Health Service
18 Act (42 U.S.C. 297(f)(1)) is amended by striking “for
19 each of” and all that follows through “1995” and insert-
20 ing “for each of the fiscal years 1993 and 1994,
21 \$25,000,000 for fiscal year 1995, and such sums as may
22 be necessary for each of the fiscal years 1996 and 1997”.

23 (d) SCHOLARSHIP PROGRAM FOR PHYSICIAN ASSIST-
24 ANTS.—Part C of title VII of the Public Health Service
25 Act (42 U.S.C. 293j et seq.), as amended by section 511,

1 is further amended by adding at the end thereof the fol-
2 lowing new section:

3 **“SEC. 754. PHYSICIAN ASSISTANT SCHOLARSHIP PROGRAM.**

4 “(a) IN GENERAL.—The Secretary may award grants
5 to public and nonprofit private entities to enable such enti-
6 ties to meet the cost of providing traineeships for individ-
7 uals in baccalaureate and advanced-degree programs in
8 order to educate such individuals to serve in and prepare
9 for practice as physician assistants.

10 “(b) SPECIAL CONSIDERATION IN MAKING
11 GRANTS.—In awarding grants for traineeships under sub-
12 section (a), the Secretary shall give special consideration
13 to entities submitting applications for the conduct of
14 traineeship programs that conform to the guidelines estab-
15 lished by the Secretary under section 750(b)(2).

16 “(c) PREFERENCES IN AWARDING GRANTS.—The
17 Secretary may award a grant under subsection (a) only
18 if the grant applicant involved agrees that, in providing
19 traineeships under such grant, the applicant will give pref-
20 erence to individuals who are residents of health profes-
21 sional shortage areas designated under section 332.

22 “(d) USE OF GRANT.—The Secretary may award a
23 grant under subsection (a) only if the grant applicant in-
24 volved agrees that traineeships provided with amounts re-

1 ceived under the grant will pay all or part of the costs
2 of—

3 “(1) the tuition, books, and fees of the physi-
4 cian assistants’ program with respect to which the
5 traineeship is provided; and

6 “(2) amounts necessary to pay the reasonable
7 living expenses of the individual involved during the
8 period for which the traineeship is provided.

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
10 purpose of carrying out this section, there are authorized
11 to be appropriated \$25,000,000 for fiscal year 1995, and
12 such sums as may be necessary for each of the fiscal years
13 1996 and 1997.”.

14 **SEC. 5106. STATE GRANTS TO INCREASE THE NUMBER OF**
15 **PRIMARY CARE PROVIDERS.**

16 Part B of title III of the Public Health Service Act
17 (42 U.S.C. 243 et seq.) is amended by adding at the end
18 thereof the following new section:

19 **“SEC. 320A. PRIMARY CARE DEMONSTRATION GRANTS.**

20 “(a) AUTHORIZATION.—The Secretary, acting
21 through the Health Resources and Services Administra-
22 tion, shall award grants to States or nonprofit entities to
23 fund not less than 10 demonstration projects to enable
24 such States or entities to evaluate one or more of the fol-
25 lowing:

1 “(1) State mechanisms, including changes in
2 the scope of practice laws, to enhance the delivery of
3 primary care by nurse practitioners or physician as-
4 sistants.

5 “(2) The feasibility of, and the most effective
6 means to train subspecialists to deliver primary care
7 as primary care providers.

8 “(3) State mechanisms to increase the supply
9 or improve the distribution of primary care provid-
10 ers.

11 “(b) APPLICATION.—To be eligible to receive a grant
12 under this section a State or nonprofit entity shall prepare
13 and submit to the Secretary an application at such time,
14 in such manner, and containing such information as the
15 Secretary may require.

16 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section,
18 \$9,000,000 for fiscal year 1995, and such sums as may
19 be necessary for each of the fiscal years 1996 through
20 1998.”.

1 **Subtitle C—Programs Relating to**
2 **Primary and Preventive Care**
3 **Services**

4 **SEC. 5201. MATERNAL AND INFANT CARE COORDINATION.**

5 (a) PURPOSE.—It is the purpose of this section to
6 assist States in the development and implementation of
7 coordinated, multidisciplinary, and comprehensive primary
8 health care and social services, and health and nutrition
9 education programs, designed to improve maternal and
10 child health.

11 (b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

12 (1) AUTHORITY.—The Secretary of Health and
13 Human Services (hereafter referred to in this section
14 as the “Secretary”) is authorized to award grants to
15 States to enable such States to plan and implement
16 coordinated, multidisciplinary, and comprehensive
17 primary health care and social service programs tar-
18 geted to pregnant women and infants.

19 (2) ELIGIBILITY.—To be eligible to receive a
20 grant under this section, a State shall—

21 (A) prepare and submit to the Secretary
22 an application at such time, in such manner,
23 and containing such information as the Sec-
24 retary may require;

1 (B) as part of the State application, pro-
2 vide assurances that under the program estab-
3 lished with amounts received under a grant, in-
4 dividuals will have access to a broad range of
5 primary health care services, social services,
6 and health and nutrition programs designed to
7 improve maternal and child health and a de-
8 scription of how coordination of such services
9 will improve maternal and child health based
10 upon the goals of “Healthy People 2000: Na-
11 tional Health Promotion and Disease Preven-
12 tion Objectives”;

13 (C) as part of the State application, sub-
14 mit a plan for the coordination of existing and
15 proposed Federal and State resources, as ap-
16 propriate, including amounts provided under
17 the medicaid program under title XIX of the
18 Social Security Act, the special supplemental
19 food program under section 17 of the Child Nu-
20 trition Act of 1966, family planning programs,
21 substance abuse programs, State maternal and
22 child health programs funded under title V of
23 the Social Security Act, community and mi-
24 grant health center programs under the Public

1 Health Service Act, and other publicly, or where
2 practicable, privately supported programs;

3 (D) demonstrate that the major service
4 providers to be involved, including private non-
5 profit entities committed to improving maternal
6 and infant health, are committed to and in-
7 volved in the program to be funded with
8 amounts received under the grant;

9 (E) with respect to States with high infant
10 mortality rates among minority populations,
11 demonstrate the involvement of major health,
12 multiservice, professional, or civic group rep-
13 resentatives of such minority groups in the
14 planning and implementation of the State pro-
15 gram; and

16 (F) demonstrate that activities under the
17 State program are targeted to women of child-
18 bearing age, particularly those at risk for hav-
19 ing low birth weight babies.

20 (3) TERM OF GRANT.—A grant awarded under
21 this subsection shall be for a period of 5 years.

22 (4) USE OF AMOUNTS.—Amounts received by a
23 State under a grant awarded under this subsection
24 shall be used to establish a State program to provide
25 coordinated, multidisciplinary, and comprehensive

1 primary health care and social services, and health
2 and nutrition education program services, that are
3 designed to improve maternal and child health. Such
4 amounts shall not be used for the construction of
5 buildings or the purchase of medical equipment.

6 (5) MAINTENANCE OF EFFORT.—Any funds re-
7 ceived by a State under this subsection shall supple-
8 ment, and shall not supplant, funds that are ex-
9 pended for similar purposes by the State.

10 (6) AUTHORIZATION OF APPROPRIATIONS.—
11 There are authorized to be appropriated such sums
12 as may be necessary to carry out the purposes of
13 this subsection for fiscal years 1995 through 1998.

14 **SEC. 5202. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
15 **PROGRAM.**

16 Section 4605 of the Elementary and Secondary Edu-
17 cation Act of 1965 (20 U.S.C. 3155) is amended to read
18 as follows:

19 **“SEC. 4605. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
20 **PROGRAMS.**

21 “(a) PURPOSE.—It is the purpose of this section to
22 establish a comprehensive school health education and pre-
23 vention program for elementary and secondary school stu-
24 dents.

1 “(b) PROGRAM AUTHORIZED.—The Secretary,
2 through the Office of Comprehensive School Health Edu-
3 cation established in subsection (d), shall award grants to
4 States to enable such States to—

5 “(1) award grants to local or intermediate edu-
6 cational agencies, and consortia thereof, to enable
7 such agencies or consortia to establish, operate and
8 improve local programs of comprehensive health edu-
9 cation and prevention, early health intervention, and
10 health education, in elementary and secondary
11 schools (including preschool, kindergarten, inter-
12 mediate, and junior high schools); and

13 “(2) develop training, technical assistance and
14 coordination activities for the programs assisted pur-
15 suant to paragraph (1).

16 “(c) USE OF FUNDS.—Grant funds under this sec-
17 tion may be used to improve elementary and secondary
18 education in the areas of—

19 “(1) personal health and fitness;

20 “(2) prevention of chronic diseases;

21 “(3) prevention and control of communicable
22 diseases;

23 “(4) nutrition;

24 “(5) substance use and abuse;

25 “(6) accident prevention and safety;

1 “(7) community and environmental health;

2 “(8) mental and emotional health; and

3 “(9) the effective use of the health services de-
4 livery system.

5 “(d) OFFICE OF COMPREHENSIVE SCHOOL HEALTH
6 EDUCATION.—The Secretary shall establish within the Of-
7 fice of the Secretary an Office of Comprehensive School
8 Health Education which shall have the following respon-
9 sibilities:

10 “(1) To recommend mechanisms for the coordi-
11 nation of school health education programs con-
12 ducted by the various departments and agencies of
13 the Federal Government.

14 “(2) To advise the Secretary on formulation of
15 school health education policy within the Depart-
16 ment of Education.

17 “(3) To disseminate information on the benefits
18 to health education of utilizing a comprehensive
19 health curriculum in schools.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—

21 “(1) IN GENERAL.—There are authorized to be
22 appropriated such sums as may be necessary to
23 carry out the purposes of this subsection for fiscal
24 years 1995 through 1998.

1 “(2) AVAILABILITY.—Funds appropriated pur-
2 suant to the authority of paragraph (1) in any fiscal
3 year shall remain available for obligation and ex-
4 penditure until the end of the fiscal year succeeding
5 the fiscal year for which such funds were appro-
6 priated.”.

7 **SEC. 5203. FRONTIER STATES.**

8 (a) IN GENERAL.—Frontier States (including Alaska,
9 Wyoming and Montana) may implement proposals to offer
10 preventive services, including mobile preventive health cen-
11 ters which may include centers equipped with various pre-
12 ventive health services, such as mammography, eye care,
13 X-ray, and other advanced equipment, and which may be
14 located on aircraft, watercraft, or other forms of transpor-
15 tation.

16 (b) DEMONSTRATION PROJECTS.—Frontier States
17 may participate in demonstration projects under this or
18 any other Act to improve recruitment, retention, and
19 training of rural providers, including nurse practitioners
20 and physician assistants. Such demonstration projects
21 shall give special consideration to the diverse needs of
22 Frontier States, and shall involve cooperative agreements
23 with a range of service delivery systems and teaching hos-
24 pitals.

1 **TITLE VI—TREATMENT OF**
2 **EXISTING FEDERAL PROGRAMS**

3 **SEC. 6000. REFERENCES IN TITLE.**

4 Except as otherwise specifically provided, whenever in
5 this title an amendment is expressed in terms of an
6 amendment to or repeal of a section or other provision,
7 the reference shall be considered to be made to that sec-
8 tion or other provision of the Social Security Act.

9 **Subtitle A—Medicaid Program**

10 **PART I—OPTIONAL COVERAGE UNDER**
11 **QUALIFIED HEALTH PLANS**

12 **SEC. 6001. OPTIONAL COVERAGE UNDER QUALIFIED**
13 **HEALTH PLANS.**

14 (a) STATE OPTION.—Section 1902(a) (42 U.S.C.
15 1396a(a)) is amended—

16 (1) by striking “and” at the end of paragraph
17 (61);

18 (2) by striking the period at the end of para-
19 graph (62) and inserting “; and”; and

20 (3) by adding at the end the following new
21 paragraph:

22 “(63) at the option of the State, provide that
23 an individual eligible for medical assistance under
24 the State plan has the option to receive medical as-
25 sistance consisting of the items or services covered

1 under the standard benefit package required to be
2 offered by a qualified health plan (as defined in sec-
3 tion 1931(d)(2)) through enrollment with such a
4 qualified health plan offered in the health care cov-
5 erage area (as defined in section 1931(d)(1)) in
6 which such individual resides instead of through en-
7 rollment in the State plan, in accordance with the
8 requirements of section 1931.”.

9 (b) REQUIREMENTS DESCRIBED.—Title XIX (42
10 U.S.C. 1396 et seq.) is amended by redesignating section
11 1931 as section 1932 and by inserting after section 1930
12 the following new section:

13 “REQUIREMENTS FOR STATES PROVIDING OPTIONAL
14 COVERAGE UNDER QUALIFIED HEALTH PLANS

15 “SEC. 1931. (a) IN GENERAL.—For purposes of sec-
16 tion 1902(a)(63), a State meets the requirements of this
17 section with respect to individuals eligible for medical as-
18 sistance under the State plan if the State meets the follow-
19 ing requirements:

20 “(1) CHOICE OF PLANS.—The State may not
21 restrict the individual’s choice of a qualified health
22 plan under such section, except that nothing in this
23 paragraph may be construed to waive any limits on
24 the capacity of a qualified health plan applicable
25 under title I of the Health Equity and Access Re-
26 form Today Act of 1993.

1 “(2) INFORMED CHOICE.—The State shall en-
2 sure that each individual who is eligible for medical
3 assistance under the State plan is provided sufficient
4 information to make an informed choice about en-
5 rolling in a qualified health plan under such section
6 and selecting such a plan.

7 “(3) PAYMENTS TO QUALIFIED HEALTH PLANS
8 BY STATES.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (B), the State shall make all necessary
11 payments of premiums, copayments, and
12 deductibles applicable under a qualified health
13 plan on behalf of an individual who enrolls in
14 a qualified health plan under such section.

15 “(B) LIMITATION ON AMOUNT OF PRE-
16 MIUM PAYMENTS.—With respect to an individ-
17 ual who is enrolled in a qualified health plan in
18 a health care coverage area under such section,
19 the State is not required to pay more than the
20 applicable dollar limit for such area (as deter-
21 mined under section 2001 of the Health Equity
22 and Access Reform Today Act of 1993).

23 “(4) ANNUAL STUDIES AND REPORTS.—

24 “(A) ANNUAL STUDY.—The State shall
25 provide for an annual study focusing on the

1 health outcomes of individuals in the State who
2 have elected to enroll in qualified health plans
3 under such section.

4 “(B) ANNUAL REPORTS.—The results of
5 the studies conducted pursuant to paragraph
6 (1) shall be summarized in reports submitted to
7 the Secretary at such time and in such manner
8 as the Secretary determines appropriate.

9 “(b) TREATMENT OF PAYMENTS AS MEDICAL AS-
10 SISTANCE.—For purposes of determining the amount of
11 Federal financial participation for a State under section
12 1903 in a quarter, any payments made by a State under
13 subsection (a)(3) shall be treated as expenditures for med-
14 ical assistance under the State plan for such quarter.

15 “(c) LIMITATION ON NUMBER OF INDIVIDUALS PER-
16 MITTED TO MAKE ELECTION.—

17 “(1) IN GENERAL.—

18 “(A) LIMITATION.—The number of AFDC-
19 eligible and SSI-eligible individuals electing to
20 enroll in a qualified health plan under section
21 1902(a)(63) in a State during a year may not
22 exceed the applicable percentage of the Sec-
23 retary’s estimate of the number of such individ-
24 uals in the State who are eligible to enroll in

1 qualified health plans under such section during
2 the year.

3 “(B) APPLICABLE PERCENTAGE DE-
4 SCRIBED.—In subparagraph (A), the ‘applicable
5 percentage’ with respect to a State for a year—

6 “(i) for each of the first 3 years for
7 which the State exercises the option de-
8 scribed in such section, 15 percent; and

9 “(ii) for each succeeding year for
10 which the State exercises such option, the
11 applicable percentage under this subpara-
12 graph for the preceding year, increased by
13 10 percent.

14 “(2) WAIVER OF LIMITATION.—The limit on
15 the number of individuals provided in paragraph (1)
16 may be waived by the Secretary with respect to a
17 State if the Secretary determines that such a waiver
18 is appropriate.

19 “(3) DEFINITIONS.—

20 “(A) AFDC RECIPIENT.—The term
21 ‘AFDC recipient’ means an individual who is
22 receiving aid or assistance under any plan of
23 the State approved under title I, X, XIV, or
24 XVI, or part A or part E of title IV.

1 “(B) SSI RECIPIENT.—The term ‘SSI re-
2 cipient’ means an individual—

3 “(i) with respect to whom supple-
4 mental security income benefits are being
5 paid under title XVI,

6 “(ii) who is receiving a supplementary
7 payment under section 1616 or under sec-
8 tion 212 of Public Law 93–66, or

9 “(iii) who is receiving monthly bene-
10 fits under section 1619(a) (whether or not
11 pursuant to section 1616(c)(3)).

12 “(d) DEFINITIONS.—For purposes of this section:

13 “(1) HEALTH CARE COVERAGE AREA.—The
14 term ‘health care coverage area’ means a health care
15 coverage area established under section 1403 of the
16 Health Equity and Access Reform Today Act of
17 1993.

18 “(2) QUALIFIED HEALTH PLAN.—The term
19 ‘qualified health plan’ means a health plan that is
20 certified as a qualified health plan under section
21 1402 of the Health Equity and Access Reform
22 Today Act of 1993.’”.

1 **PART II—LIMITATION ON CERTAIN FEDERAL**
2 **MEDICAID PAYMENTS.**
3 **SEC. 6011. CAP ON FEDERAL PAYMENTS MADE FOR ACUTE**
4 **MEDICAL SERVICES FURNISHED UNDER THE**
5 **MEDICAID PROGRAM.**

6 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et
7 seq.) is amended by redesignating section 1932 as section
8 1933 and by inserting after section 1931 the following new
9 section:

10 “CAP ON FEDERAL PAYMENT MADE FOR ACUTE MEDICAL
11 SERVICES

12 “SEC. 1932. (a) ANNUAL FEDERAL CAP.—Federal
13 financial participation is not available under section
14 1903(a)(1) for expenditures for acute medical services (as
15 defined in subsection (c)(1)), including expenditures con-
16 sisting of payments to qualified health plans under section
17 1931(a)(3) on behalf of individuals enrolling in such plans
18 under section 1902(a)(63), for a class of medicaid categor-
19 ical individuals (as defined in subsection (c)(2)) for a
20 State for a quarter in a fiscal year, to the extent such
21 expenditures exceed $\frac{1}{4}$ of the product of—

22 “(1) the per-capita limit determined under sub-
23 section (b) for the State for such fiscal year for such
24 class, multiplied by

25 “(2) the average number of medicaid categor-
26 ical individuals in such class entitled to receive medi-

1 cal assistance under the State plan in any month in
2 the quarter.

3 “(b) PER-CAPITA LIMIT.—

4 “(1) IN GENERAL.—For purposes of subsection
5 (a), the per-capita limit for a class of medicaid cat-
6 egorical individuals for a State for—

7 “(A) fiscal year 1996, is an amount equal
8 to the base per-capita funding amount (as de-
9 termined under paragraph (2)) for such class
10 for such State, increased by 18.8 percent; and

11 “(B) fiscal year 1997 and each succeeding
12 fiscal year, is an amount equal to the amount
13 determined under this paragraph for the pre-
14 vious fiscal year for the class updated by the
15 applicable percentage for such fiscal year (de-
16 scribed in paragraph (3)).

17 “(2) BASE PER-CAPITA FUNDING AMOUNT.—

18 “(A) IN GENERAL.—The base per-capita
19 funding amount for a State for a class is an
20 amount equal to the quotient of—

21 “(i) the total expenditures made
22 under the State plan with respect to medi-
23 cal assistance furnished for acute medical
24 services for individuals within such class
25 for calendar quarters in fiscal year 1994,

1 but does not include such expenditures for
2 which no Federal financial participation is
3 provided under such plan; divided by

4 “(ii) the average total number of med-
5 icaid categorical individuals in such class
6 in the State in any month during fiscal
7 year 1994.

8 “(B) DISPROPORTIONATE SHARE PAY-
9 MENTS NOT INCLUDED.—In applying subpara-
10 graph (A), payments made under section 1923
11 shall not be counted in the gross amount of
12 payments.

13 “(C) TREATMENT OF DISALLOWANCES.—
14 The amount determined under this paragraph
15 shall take into account amounts (or an estimate
16 of amounts) disallowed.

17 “(3) APPLICABLE PERCENTAGE.—In paragraph
18 (1), the applicable percentage for a fiscal year is
19 equal to—

20 “(A) 6 percent, for each of fiscal years
21 1997 through 2000; and

22 “(B) 5 percent, for fiscal year 2001 and
23 each succeeding fiscal year.

1 “(4) ESTIMATIONS OF AND ADJUSTMENTS TO
2 STATE TOTAL FUNDING AMOUNT.—The Secretary
3 shall—

4 “(A) establish a process for estimating the
5 limit on expenditures for acute medical services
6 applicable under subsection (a) at the beginning
7 of each fiscal year and adjusting such amount
8 during such fiscal year; and

9 “(B) notifying each State of the esti-
10 mations and adjustments referred to in sub-
11 paragraph (A).

12 “(c) DEFINITIONS.—For purposes of this section and
13 section 1931:

14 “(1) ACUTE MEDICAL SERVICES.—The term
15 ‘acute medical services’ means items and services de-
16 scribed in section 1905(a) other than the following:

17 “(A) Nursing facility services (as defined
18 in section 1905(f)).

19 “(B) Intermediate care facility for the
20 mentally retarded services (as defined in section
21 1905(d)).

22 “(C) Personnel care services (as described
23 in section 1905(a)(24)).

24 “(D) Private duty nursing services (as re-
25 ferred to in section 1905(a)(8)).

1 “(E) Home or community-based services
2 furnished under a waiver granted under sub-
3 section (c), (d), or (e) of section 1915.

4 “(F) Home and community care furnished
5 to functionally disabled elderly individuals
6 under section 1929.

7 “(G) Community supported living arrange-
8 ments services under section 1930.

9 “(H) Case-management services (as de-
10 scribed in section 1915(g)(2)).

11 “(I) Home health care services (as referred
12 to in section 1905(a)(7)), clinic services, and re-
13 habilitation services that are furnished to an in-
14 dividual who has a condition or disability that
15 qualifies the individual to receive any of the
16 services described in a previous subparagraph.

17 “(J) Hospice care.

18 “(2) MEDICAID CATEGORICAL INDIVIDUAL.—
19 The term ‘medicaid categorical individual’ means an
20 individual described in section 1902(a)(10)(A).

21 “(3) CLASS OF MEDICAID CATEGORICAL INDI-
22 VIDUALS.—The term ‘class’ means individuals within
23 each of the following classes:

24 “(A) SSI-RELATED INDIVIDUALS.—Medic-
25 aid categorical individuals—

1 “(i) with respect to whom supple-
2 mental security income benefits are being
3 paid under title XVI of the Social Security
4 Act,

5 “(ii) who receiving a supplementary
6 payment under section 1616 of such Act or
7 under section 212 of Public Law 93-66, or

8 “(iii) who receiving monthly benefits
9 under section 1619(a) of such Act (wheth-
10 er or not pursuant to section 1616(c)(3) of
11 such Act).

12 “(B) OTHER INDIVIDUALS.—Medicaid cat-
13 egorical individuals not described in subpara-
14 graph (A).”.

15 (b) REQUIRING STATE MAINTENANCE OF EFFORT.—
16 Section 1902(a) (42 U.S.C. 1369a(a)), as amended by sec-
17 tion 6001(a), is amended—

18 (1) by striking “and” at the end of paragraph
19 (62);

20 (2) by striking the period at the end of para-
21 graph (63) and inserting “; and ”; and

22 (3) by adding at the end the following new
23 paragraph:

24 “(64) provided that the State will continue to
25 make eligible for medical assistance under section

1 1902(a)(10)(A) any class or category of individuals
2 eligible for medical assistance under such section
3 during fiscal year 1994.”.

4 (c) DISCONTINUATION OF REIMBURSEMENT STAND-
5 ARDS FOR INPATIENT HOSPITAL SERVICES.—Section
6 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is amend-
7 ed—

8 (1) by striking “hospital services, nursing facil-
9 ity services, and” and inserting “nursing facilities
10 services and”;

11 (2) by striking “, in the case of hospitals,” and
12 all that follows through “(v)(1)(G)) which”;

13 (3) by striking “and to assure” and all that fol-
14 lows through “adequate quality”; and

15 (4) by striking “each hospital, nursing facility,
16 and ” and inserting “each nursing facility and”.

17 (d) REVISION OF FEDERAL MEDICAL ASSISTANCE
18 PERCENTAGE FOR CERTAIN STATES.—Section 1905(b)
19 (42 U.S.C. 1396d(b)) is amended—

20 (1) by redesignating clauses (1) and (2) as
21 clauses (2) and (3) and by inserting after “except
22 that” the following: “(1) for Alaska and Hawaii, the
23 State percentage shall be that percentage which
24 bears the same ratio to 45 per centum as the square
25 of the adjusted per capita income of such State

1 bears to the square of the per capita income of the
2 United States;” and

3 (2) by inserting after the first sentence the fol-
4 lowing: “The ‘adjusted per capita income’ for Alaska
5 shall be determined by dividing the State 3-year av-
6 erage per capita income by 1.25, and for Hawaii by
7 dividing the State 3-year average per capita income
8 by 1.15.”.

9 (e) EFFECTIVE DATE.—The amendments made by
10 this section shall become effective on October 1, 1995.

11 **PART III—STATE ELIGIBILITY TO CONTRACT FOR**
12 **COORDINATED CARE SERVICES**

13 **SEC. 6021. MODIFICATION OF FEDERAL REQUIREMENTS TO**
14 **ALLOW STATES MORE FLEXIBILITY IN CON-**
15 **TRACTING FOR COORDINATED CARE SERV-**
16 **ICES UNDER MEDICAID.**

17 (a) IN GENERAL.—

18 (1) PAYMENT PROVISIONS.—Section 1903(m)

19 (42 U.S.C. 1396b(m)) is amended to read as follows:

20 “(m)(1) No payment shall be made under this title
21 to a State with respect to expenditures incurred by such
22 State for payment to an entity which is at risk (as defined
23 in section 1933(a)(4)) for services provided by such entity
24 to individuals eligible for medical assistance under the
25 State plan under this title, unless the entity is a risk con-

1 tracting entity (as defined in section 1933(a)(3)) and the
2 State and such entity comply with the applicable provi-
3 sions of section 1933.

4 “(2) No payment shall be made under this title to
5 a State with respect to expenditures incurred by such
6 State for payment for services provided to an individual
7 eligible for medical assistance under the State plan under
8 this title if such payment by the State is contingent upon
9 the individual receiving such services from a specified
10 health care provider or subject to the approval of a speci-
11 fied health care provider, unless the entity receiving pay-
12 ment is a primary care case management entity (as de-
13 fined in section 1933(a)(2)) and the State and such entity
14 comply with the applicable provisions of section 1933.”.

15 (2) REQUIREMENTS FOR COORDINATED CARE
16 SERVICES.—Title XIX (42 U.S.C. 1396 et seq.) is
17 amended by redesignating section 1933 as section
18 1934 and by inserting after section 1932 the follow-
19 ing new section:

20 “REQUIREMENTS FOR COORDINATED CARE SERVICES

21 “SEC. 1933. (a) DEFINITIONS.—For purposes of this
22 title—

23 “(1) PRIMARY CARE CASE MANAGEMENT PRO-
24 GRAM.—The term ‘primary care case management
25 program’ means a program operated by a State
26 agency under which such State agency enters into

1 contracts with primary care case management enti-
2 ties for the provision of health care items and serv-
3 ices which are specified in such contracts and the
4 provision of case management services to individuals
5 who are—

6 “(A) eligible for medical assistance under
7 the State plan,

8 “(B) enrolled with such primary care case
9 management entities, and

10 “(C) entitled to receive such specified
11 health care items and services and case man-
12 agement services only as approved and ar-
13 ranged for, or provided, by such entities.

14 “(2) PRIMARY CARE CASE MANAGEMENT EN-
15 TITY.—The term ‘primary care case management
16 entity’ means a health care provider which—

17 “(A) must be a physician, group of physi-
18 cians, a Federally qualified health center, a
19 rural health clinic, or an entity employing or
20 having other arrangements with physicians op-
21 erating under a contract with a State to provide
22 services under a primary care case management
23 program,

24 “(B) receives payment on a fee for service
25 basis (or, in the case of a Federally qualified

1 health center or a rural health clinic, on a rea-
2 sonable cost per encounter basis) for the provi-
3 sion of health care items and services specified
4 in such contract to enrolled individuals,

5 “(C) receives an additional fixed fee per
6 enrollee for a period specified in such contract
7 for providing case management services (includ-
8 ing approving and arranging for the provision
9 of health care items and services specified in
10 such contract on a referral basis) to enrolled in-
11 dividuals, and

12 “(D) is not an entity that is at risk (as de-
13 fined in paragraph (4)) for such case manage-
14 ment services.

15 “(3) RISK CONTRACTING ENTITY.—The term
16 ‘risk contracting entity’ means an entity which has
17 a contract with the State agency (or a health insur-
18 ing organization described in subsection (n)(2))
19 under which the entity—

20 “(A) provides or arranges for the provision
21 of health care items or services which are speci-
22 fied in such contract to individuals eligible for
23 medical assistance under the State plan, and

24 “(B) is at risk (as defined in paragraph
25 (4)) for part or all of the cost of such items or

1 services furnished to individuals eligible for
2 medical assistance under such plan.

3 “(4) AT RISK.—The term ‘at risk’ means an
4 entity which—

5 “(A) has a contract with the State agency
6 under which such entity is paid a fixed amount
7 for providing or arranging for the provision of
8 health care items or services specified in such
9 contract to an individual eligible for medical as-
10 sistance under the State plan and enrolled with
11 such entity, regardless of whether such items or
12 services are furnished to such individual, and

13 “(B) is liable for all or part of the cost of
14 furnishing such items or services, regardless of
15 whether such cost exceeds such fixed payment.

16 “(5) FEDERALLY QUALIFIED HEALTH CEN-
17 TER.—The term ‘Federally qualified health center’
18 means a Federally qualified health center as defined
19 in section 1905(l)(2)(B).

20 “(6) RURAL HEALTH CLINIC.—The term ‘rural
21 health clinic’ means a rural health clinic as defined
22 in section 1905(l)(1).

23 “(b) GENERAL REQUIREMENTS FOR RISK CON-
24 TRACTING ENTITIES.—

1 “(1) ORGANIZATION.—A risk contracting entity
2 meets the requirements of this section only if such
3 entity—

4 “(A)(i) is a qualified health maintenance
5 organization as defined in section 1310(d) of
6 the Public Health Service Act, as determined by
7 the Secretary pursuant to section 1312 of such
8 Act; or

9 “(ii) is described in subparagraph (C), (D),
10 (E), (F), or (G) of subsection (e)(4);

11 “(B) is a Federally qualified health center
12 or a rural health clinic which has made ade-
13 quate provision against the risk of insolvency
14 (pursuant to the guidelines and regulations is-
15 sued by the Secretary under this section), and
16 ensures that individuals eligible for medical as-
17 sistance under the State plan are not held liable
18 for such entity’s debts in case of such entity’s
19 insolvency; or

20 “(C) is an entity which meets all applicable
21 State licensing requirements and has made ade-
22 quate provision against the risk of insolvency
23 (pursuant to the guidelines and regulations is-
24 sued by the Secretary under this section), and
25 ensures that individuals eligible for medical as-

1 sistance under the State plan are not held liable
2 for such entity's debts in case of such entity's
3 insolvency.

4 “(2) GUARANTEES OF ENROLLEE ACCESS.—A
5 risk contracting entity meets the requirements of
6 this section only if—

7 “(A) the geographic locations, hours of op-
8 eration, patient to staff ratios, and other rel-
9 evant characteristics of such entity are suffi-
10 cient to afford individuals eligible for medical
11 assistance under the State plan access to such
12 entities that is at least equivalent to the access
13 to health care providers that would be available
14 to such individuals if such individuals were not
15 enrolled with such entity;

16 “(B) such entity has reasonable and ade-
17 quate hours of operation, including 24-hour
18 availability of—

19 “(i)(I) treatment for an unforeseen ill-
20 ness, injury, or condition of an individual
21 eligible for medical assistance under the
22 State plan and enrolled with such entity;
23 or

24 “(II) referral to other health care pro-
25 viders for such treatment; and

1 “(ii) other information, as determined
2 by the Secretary or the State; and

3 “(C) such entity complies with such other
4 requirements relating to access to care as the
5 Secretary or the State may impose.

6 “(3) CONTRACT WITH STATE AGENCY.—A risk
7 contracting entity meets the requirements of this
8 section only if such entity has a written contract
9 with the State agency which provides—

10 “(A) that the entity will comply with all
11 applicable provisions of this section, that the
12 State has the right to penalize the entity for
13 failure to comply with such requirements and to
14 terminate the contract in accordance with sub-
15 section (j), and that the entity will be subject
16 to penalties imposed by the Secretary under
17 subsection (i) for failure to comply with such
18 requirements;

19 “(B) for a payment methodology based on
20 experience rating or another actuarially sound
21 methodology approved by the Secretary, which
22 guarantees (as demonstrated by such models or
23 formulas as the Secretary may approve) that—

24 “(i) payments to the entity under the
25 contract shall not exceed an amount equal

1 to 100 percent of the costs (which shall in-
2 clude administrative costs and which may
3 include costs for inpatient hospital services
4 that would have been incurred in the ab-
5 sence of such contract) that would have
6 been incurred by the State agency in the
7 absence of the contract; and

8 “(ii) the financial risk for inpatient
9 hospital services is limited to an extent es-
10 tablished by the State;

11 “(C) that the Secretary and the State (or
12 any person or organization designated by ei-
13 ther) shall have the right to audit and inspect
14 any books and records of the entity (and of any
15 subcontractor) that pertain—

16 “(i) to the ability of the entity (or a
17 subcontractor) to bear the risk of potential
18 financial losses; or

19 “(ii) to services performed or deter-
20 minations of amounts payable under the
21 contract;

22 “(D) that in the entity’s enrollment,
23 reenrollment, or disenrollment of individuals eli-
24 gible for medical assistance under the State
25 plan and eligible to enroll, reenroll, or disenroll

1 with the entity pursuant to the contract, the en-
2 tity will not discriminate among such individ-
3 uals on the basis of such individuals' health sta-
4 tus or requirements for health care services;

5 “(E)(i) individuals eligible for medical as-
6 sistance under the State plan who have enrolled
7 with the entity are permitted to terminate such
8 enrollment without cause as of the beginning of
9 the first calendar month (or in the case of an
10 entity described in subsection (e)(4), as of the
11 beginning of the first enrollment period) follow-
12 ing a full calendar month after a request is
13 made for such termination;

14 “(ii) that when an individual has relocated
15 outside the entity's service area, and the entity
16 has been notified of the relocation, services
17 (within reasonable limits) furnished by a health
18 care provider outside the service area will be re-
19 imbursed either by the entity or by the State
20 agency; and

21 “(iii) for written notification of each such
22 individual's right to terminate enrollment,
23 which shall be provided at the time of such indi-
24 vidual's enrollment, and, in the case of a child
25 with special health care needs as defined in sub-

1 section (e)(1)(B)(ii), at the time the entity iden-
2 tifies such a child;

3 “(F) in the case of services immediately re-
4 quired to treat an unforeseen illness, injury, or
5 condition, of an individual eligible for medical
6 assistance under the State plan and enrolled
7 with the entity—

8 “(i) that such services shall not be
9 subject to a preapproval requirement; and

10 “(ii) where such services are furnished
11 by a health care provider other than the
12 entity, for reimbursement of such provider
13 either by the entity or by the State agency;

14 “(G) for disclosure of information in ac-
15 cordance with subsection (h) and section 1124;

16 “(H) that any physician incentive plan op-
17 erated by the entity meets the requirements of
18 section 1876(i)(8);

19 “(I) for maintenance of sufficient patient
20 encounter data to identify the physician who de-
21 livers services to patients;

22 “(J) that the entity will comply with the
23 requirement of section 1902(w) with respect to
24 each enrollee;

1 “(K) that the entity will implement a
2 grievance system, inform enrollees in writing
3 about how to use such grievance system, ensure
4 that grievances are addressed in a timely man-
5 ner, and report grievances to the State at inter-
6 vals to be determined by the State;

7 “(L) that contracts between the entity and
8 each subcontractor of such entity will require
9 each subcontractor—

10 “(i) to cooperate with the entity in the
11 implementation of its internal quality as-
12 surance program under paragraph (4) and
13 adhere to the standards set forth in the
14 quality assurance program, including
15 standards with respect to access to care,
16 facilities in which patients receive care,
17 and availability, maintenance, and review
18 of medical records;

19 “(ii) to cooperate with the Secretary,
20 the State agency and any contractor to the
21 State in monitoring and evaluating the
22 quality and appropriateness of care pro-
23 vided to enrollees as required by Federal or
24 State laws and regulations; and

1 “(iii) where applicable, to adhere to
2 regulations and program guidance with re-
3 spect to reporting requirements under sec-
4 tion 1905(r);

5 “(M) that, where the State deems it nec-
6 essary to ensure the timely provision to enroll-
7 ees of the services listed in subsection
8 (f)(2)(C)(ii), the State may arrange for the pro-
9 vision of such services by health care providers
10 other than the entity and may adjust its pay-
11 ments to the entity accordingly;

12 “(N) that the entity and the State will
13 comply with guidelines and regulations issued
14 by the Secretary with respect to procedures for
15 marketing and information that must be pro-
16 vided to individuals eligible for medical assist-
17 ance under the State plan;

18 “(O) that the entity must provide pay-
19 ments to hospitals for inpatient hospital serv-
20 ices furnished to infants who have not attained
21 the age of 1 year, and to children who have not
22 attained the age of 6 years and who receive
23 such services in a disproportionate share hos-
24 pital, in accordance with paragraphs (2) and
25 (3) of section 1902(s);

1 “(P) that the entity shall report to the
2 State, at such time and in such manner as the
3 State shall require, on the rates paid for hos-
4 pital services (by type of hospital and type of
5 service) furnished to individuals enrolled with
6 the entity;

7 “(Q) detailed information regarding the
8 relative responsibilities of the entity and the
9 State, for providing (or arranging for the provi-
10 sion of), and making payment for, the following
11 items and services:

12 “(i) immunizations;

13 “(ii) the purchase of vaccines;

14 “(iii) lead screening and treatment
15 services;

16 “(iv) screening and treatment for tu-
17 berculosis;

18 “(v) screening and treatment for, and
19 preventive services related to, sexually
20 transmitted diseases, including HIV infec-
21 tion;

22 “(vi) screening, diagnostic, and treat-
23 ment services required under section
24 1905(r);

25 “(vii) family planning services;

1 “(viii) services prescribed under—

2 “(I) an Individual Education
3 Plan or Individualized Family Service
4 Plan under part B or part H of the
5 Individuals with Disabilities Edu-
6 cation Act; and

7 “(II) any other individual plan of
8 care or treatment developed under
9 this title or title V;

10 “(ix) transportation needed to obtain
11 services to which the enrollee is entitled
12 under the State plan or pursuant to an in-
13 dividual plan of care or treatment de-
14 scribed in subclauses (I) and (II) of clause
15 (viii); and

16 “(x) such other services as the Sec-
17 retary may specify;

18 “(R) detailed information regarding the
19 procedures for coordinating the relative respon-
20 sibilities of the entity and the State to ensure
21 prompt delivery of, compliance with any appli-
22 cable reporting requirements related to, and ap-
23 propriate record keeping with respect to, the
24 items and services described in subparagraph
25 (Q); and

1 “(S) such other provisions as the Secretary
2 may require.

3 “(4) INTERNAL QUALITY ASSURANCE.—A risk
4 contracting entity meets the requirements of this
5 section only if such entity has in effect a written in-
6 ternal quality assurance program which includes a
7 systematic process to achieve specified and measur-
8 able goals and objectives for access to, and quality
9 of, care, which—

10 “(A) identifies the organizational units re-
11 sponsible for performing specific quality assur-
12 ance functions, and ensures that such units are
13 accountable to the governing body of the entity
14 and that such units have adequate supervision,
15 staff, and other necessary resources to perform
16 these functions effectively,

17 “(B) if any quality assurance functions are
18 delegated to other entities, ensures that the risk
19 contracting entity remains accountable for all
20 quality assurance functions and has mecha-
21 nisms to ensure that all quality assurance ac-
22 tivities are carried out,

23 “(C) includes methods to ensure that phy-
24 sicians and other health care professionals
25 under contract with the entity are licensed or

1 certified as required by State law, or are other-
2 wise qualified to perform the services such phy-
3 sicians and other professionals provide, and
4 that these qualifications are ensured through
5 appropriate credentialing and recredentialing
6 procedures,

7 “(D) provides for continuous monitoring of
8 the delivery of health care, through—

9 “(i) identification of clinical areas to
10 be monitored, including immunizations,
11 prenatal care, services required under sec-
12 tion 1905(r), and other appropriate clinical
13 areas, to reflect care provided to enrollees
14 eligible for medical assistance under the
15 State plan,

16 “(ii) use of quality indicators and
17 standards for assessing the quality and ap-
18 propriateness of care delivered, and the
19 availability and accessibility of all services
20 for which the entity is responsible under
21 such entity’s contract with the State,

22 “(iii) use of epidemiological data or
23 chart review, as appropriate, and patterns
24 of care overall,

1 “(iv) patient surveys, spot checks, or
2 other appropriate methods to determine
3 whether—

4 “(I) enrollees are able to obtain
5 timely appointments with primary
6 care providers and specialists, and

7 “(II) enrollees are otherwise
8 guaranteed access and care as pro-
9 vided under paragraph (2),

10 “(v) provision of written information
11 to health care providers and other person-
12 nel on the outcomes, quality, availability,
13 accessibility, and appropriateness of care,
14 and

15 “(vi) implementation of corrective ac-
16 tions,

17 “(E) includes standards for timely enrollee
18 access to information and care which at a mini-
19 mum shall incorporate standards used by the
20 State or professional or accreditation bodies for
21 facilities furnishing perinatal and neonatology
22 care and other forms of specialized medical and
23 surgical care,

24 “(F) includes standards for the facilities in
25 which patients receive care,

1 “(G) includes standards for managing and
2 treating medical conditions prevalent among
3 such entity’s enrollees eligible for medical as-
4 sistance under the State plan,

5 “(H) includes mechanisms to ensure that
6 enrollees eligible for medical assistance under
7 the State plan receive services for which the en-
8 tity is responsible under the contract which are
9 consistent with standards established by the ap-
10 plicable professional societies or government
11 agencies,

12 “(I) includes standards for the availability,
13 maintenance, and review of medical records
14 consistent with generally accepted medical prac-
15 tice,

16 “(J) provides for dissemination of quality
17 assurance procedures to health care providers
18 under contract with the entity, and

19 “(K) meets any other requirements pre-
20 scribed by the Secretary or the State.

21 “(c) GENERAL REQUIREMENTS FOR PRIMARY CARE
22 CASE MANAGEMENT PROGRAMS.—A primary care case
23 management program implemented by a State under this
24 section shall—

1 “(1) provide that each primary care case man-
2 agement entity participating in such program has a
3 written contract with the State agency,

4 “(2) include methods for selection and monitor-
5 ing of participating primary care case management
6 entities to ensure—

7 “(A) that the geographic locations, hours
8 of operation, patient to staff ratio, and other
9 relevant characteristics of such entities are suf-
10 ficient to afford individuals eligible for medical
11 assistance under the State plan access to such
12 entities that is at least equivalent to the access
13 to health care providers that would be available
14 to such individuals if such individuals were not
15 enrolled with such entity,

16 “(B) that such entities and their profes-
17 sional personnel are licensed as required by
18 State law and qualified to provide case manage-
19 ment services, through methods such as ongo-
20 ing monitoring of compliance with applicable re-
21 quirements and providing information and tech-
22 nical assistance, and

23 “(C) that such entities—

24 “(i) provide timely and appropriate
25 primary care to such enrollees consistent

1 with standards established by applicable
2 professional societies or governmental
3 agencies, or such other standards pre-
4 scribed by the Secretary or the State, and

5 “(ii) where other items and services
6 are determined to be medically necessary,
7 give timely approval of such items and
8 services and referral to appropriate health
9 care providers,

10 “(3) provide that no preapproval shall be re-
11 quired for emergency health care items or services,
12 and

13 “(4) permit individuals eligible for medical as-
14 sistance under the State plan who have enrolled with
15 a primary care case management entity to terminate
16 such enrollment without cause not later than the be-
17 ginning of the first calendar month following a full
18 calendar month after the request is made for such
19 termination.

20 “(d) EXEMPTIONS FROM STATE PLAN REQUIRE-
21 MENTS.—A State plan may permit or require an individ-
22 ual eligible for medical assistance under such plan to en-
23 roll with a risk contracting entity or a primary care case
24 management entity without regard to the requirements set
25 forth in the following paragraphs of section 1902(a):

1 “(1) Paragraph (1) (concerning statewideness).

2 “(2) Paragraph (10)(B) (concerning com-
3 parability of benefits), to the extent benefits not in-
4 cluded in the State plan are provided.

5 “(3) Paragraph (23) (concerning freedom of
6 choice of provider), except with respect to services
7 described in section 1905(a)(4)(C) and except as re-
8 quired under subsection (e).

9 “(e) STATE OPTIONS WITH RESPECT TO ENROLL-
10 MENT AND DISENROLLMENT.—

11 “(1) MANDATORY ENROLLMENT.—

12 “(A) IN GENERAL.—Except as provided in
13 subparagraph (B), a State plan may require an
14 individual eligible for medical assistance under
15 such plan to enroll with a risk contracting en-
16 tity or a primary care case management entity
17 only if the individual is permitted a choice with-
18 in a reasonable service area (as defined by the
19 State)—

20 “(i) between or among 2 or more risk
21 contracting entities,

22 “(ii) among a risk contracting entity
23 and a primary care case management pro-
24 gram, or

1 “(iii) among primary care case man-
2 agement entities.

3 “(B) SPECIAL NEEDS CHILDREN.—

4 “(i) IN GENERAL.—A State may not
5 require a child with special health care
6 needs (as defined in clause (ii)) to enroll
7 with a risk contracting entity or a primary
8 care case management entity.

9 “(ii) DEFINITION.—For purposes of
10 this subparagraph, the term ‘child with
11 special health care needs’ refers to an indi-
12 vidual eligible for supplemental security in-
13 come under title XVI, a child described
14 under section 501(a)(1)(D), or a child de-
15 scribed in section 1902(e)(3).

16 “(2) REENROLLMENT OF INDIVIDUALS WHO
17 REGAIN ELIGIBILITY.—In the case of an individual
18 who—

19 “(A) in a month is eligible for medical as-
20 sistance under the State plan and enrolled with
21 a risk contracting entity with a contract under
22 this section,

23 “(B) in the next month (or next 2 months)
24 is not eligible for such medical assistance, but

1 “(C) in the succeeding month is again eli-
2 gible for such benefits,
3 the State agency (subject to subsection (b)(3)(E))
4 may enroll the individual for that succeeding month
5 with such entity, if the entity continues to have a
6 contract with the State agency under this sub-
7 section.

8 “(3) DISENROLLMENT.—

9 “(A) RESTRICTIONS ON DISENROLLMENT
10 WITHOUT CAUSE.—Except as provided in sub-
11 paragraph (C), a State plan may restrict the
12 period in which individuals enrolled with risk
13 contracting entities described in paragraph (4)
14 may terminate such enrollment without cause to
15 the first month of each period of enrollment (as
16 defined in subparagraph (B)), but only if the
17 State provides notification, at least once during
18 each such enrollment period, to individuals en-
19 rolled with such entity of the right to terminate
20 such enrollment and the restriction on the exer-
21 cise of this right. Such restriction shall not
22 apply to requests for termination of enrollment
23 for cause.

1 “(B) PERIOD OF ENROLLMENT.—For pur-
2 poses of this paragraph, the term ‘period of en-
3 rollment’ means—

4 “(i) a period not to exceed 6 months
5 in duration, or

6 “(ii) a period not to exceed 1 year in
7 duration, in the case of a State that, on
8 the effective date of this paragraph, had in
9 effect a waiver under section 1115 of re-
10 quirements under this title under which
11 the State could establish a 1-year mini-
12 mum period of enrollment with risk con-
13 tracting entities.

14 “(C) SPECIAL NEEDS CHILDREN.—A State
15 may not restrict disenrollment of a child with
16 special health care needs (as defined in para-
17 graph (1)(B)(ii)).

18 “(4) ENTITIES ELIGIBLE FOR DISENROLLMENT
19 RESTRICTIONS.—A risk contracting entity described
20 in this paragraph is—

21 “(A) a qualified health maintenance orga-
22 nization as defined in section 1310(d) of the
23 Public Health Service Act,

24 “(B) an eligible organization with a con-
25 tract under section 1876,

1 “(C) an entity that is receiving (and has
2 received during the previous 2 years) a grant of
3 at least \$100,000 under section 329(d)(1)(A)
4 or 330(d)(1) of the Public Health Service Act,

5 “(D) an entity that—

6 “(i) received a grant of at least
7 \$100,000 under section 329(d)(1)(A) or
8 section 330(d)(1) of the Public Health
9 Service Act in the fiscal year ending June
10 30, 1976, and has been a grantee under ei-
11 ther such section for all periods after that
12 date, and

13 “(ii) provides to its enrollees, on a
14 prepaid capitation or other risk basis, all
15 of the services described in paragraphs (1),
16 (2), (3), (4)(C), and (5) of section 1905(a)
17 (and the services described in section
18 1905(a)(7), to the extent required by sec-
19 tion 1902(a)(10)(D)),

20 “(E) an entity that is receiving (and has
21 received during the previous 2 years) at least
22 \$100,000 (by grant, subgrant, or subcontract)
23 under the Appalachian Regional Development
24 Act of 1965,

1 “(F) a nonprofit primary health care en-
2 tity located in a rural area (as defined by the
3 Appalachian Regional Commission)—

4 “(i) which received in the fiscal year
5 ending June 30, 1976, at least \$100,000
6 (by grant, subgrant, or subcontract) under
7 the Appalachian Regional Development Act
8 of 1965, and

9 “(ii) which, for all periods after such
10 date, either has been the recipient of a
11 grant, subgrant, or subcontract under such
12 Act or has provided services on a prepaid
13 capitation or other risk basis under a con-
14 tract with the State agency initially en-
15 tered into during a year in which the entity
16 was the recipient of such a grant,
17 subgrant, or subcontract,

18 “(G) an entity that had contracted with
19 the State agency prior to 1970 for the provi-
20 sion, on a prepaid risk basis, of services (which
21 did not include inpatient hospital services) to
22 individuals eligible for medical assistance under
23 the State plan,

24 “(H) a program pursuant to an undertak-
25 ing described in subsection (n)(3) in which at

1 least 25 percent of the membership enrolled on
2 a prepaid basis are individuals who—

3 “(i) are not insured for benefits under
4 part B of title XVIII or eligible for medical
5 assistance under the State plan, and

6 “(ii) (in the case of such individuals
7 whose prepayments are made in whole or
8 in part by any government entity) had the
9 opportunity at the time of enrollment in
10 the program to elect other coverage of
11 health care costs that would have been
12 paid in whole or in part by any govern-
13 mental entity,

14 “(I) an entity that, on the date of enact-
15 ment of this provision, had a contract with the
16 State agency under a waiver under section 1115
17 or 1915(b) and was not subject to a require-
18 ment under this title to permit disenrollment
19 without cause, or

20 “(J) an entity that has a contract with the
21 State agency under a waiver under section
22 1915(b)(5).

23 “(f) STATE MONITORING AND EXTERNAL REVIEW.—

24 “(1) STATE GRIEVANCE PROCEDURE.—A State
25 contracting with a risk contracting entity or a pri-

1 mary care case management entity under this sec-
2 tion shall provide for a grievance procedure for en-
3 rollees of such entity with at least the following ele-
4 ments:

5 “(A) A toll-free telephone number for en-
6 rollee questions and grievances.

7 “(B) Periodic notification of enrollees of
8 their rights with respect to such entity or pro-
9 gram.

10 “(C) Periodic sample reviews of grievances
11 registered with such entity or program or with
12 the State.

13 “(D) Periodic survey and analysis of en-
14 rollee satisfaction with such entity or program,
15 including interviews with individuals who
16 disenroll from the entity or program.

17 “(2) STATE MONITORING OF QUALITY AND AC-
18 CESS.—

19 “(A) RISK CONTRACTING ENTITIES.—A
20 State contracting with a risk contracting entity
21 under this section shall provide for ongoing
22 monitoring of such entity’s compliance with the
23 requirements of subsection (b), including com-
24 pliance with the requirements of such entity’s
25 contract under subsection (b)(3), and shall un-

1 dertake appropriate followup activities to ensure
2 that any problems identified are rectified and
3 that compliance with the requirements of sub-
4 section (b) and the requirements of the contract
5 under subsection (b)(3) is maintained.

6 “(B) PRIMARY CARE CASE MANAGEMENT
7 ENTITIES.—A State electing to implement a
8 primary care case management program shall
9 provide for ongoing monitoring of the pro-
10 gram’s compliance with the requirements of
11 subsection (c) and shall undertake appropriate
12 followup activities to ensure that any problems
13 identified are rectified and that compliance with
14 subsection (c) is maintained.

15 “(C) SERVICES.—

16 “(i) IN GENERAL.—The State shall
17 establish procedures (in addition to those
18 required under subparagraphs (A) and
19 (B)) to ensure that the services listed in
20 clause (ii) are available in a timely manner
21 to an individual enrolled with a risk con-
22 tracting entity or a primary care case man-
23 agement entity. Where necessary to ensure
24 the timely provision of such services, the
25 State shall arrange for the provision of

1 such services by health care providers
2 other than the risk contracting entity or
3 the primary care case management entity
4 in which an individual is enrolled.

5 “(ii) SERVICES LISTED.—The services
6 listed in this clause are—

7 “(I) prenatal care;

8 “(II) immunizations;

9 “(III) lead screening and treat-
10 ment;

11 “(IV) prevention, diagnosis and
12 treatment of tuberculosis, sexually
13 transmitted diseases (including HIV
14 infection), and other communicable
15 diseases; and

16 “(V) such other services as the
17 Secretary may specify.

18 “(iii) REPORT.—The procedures re-
19 ferred to in clause (i) shall be described in
20 an annual report to the Secretary provided
21 by the State.

22 “(3) EXTERNAL INDEPENDENT REVIEW.—

23 “(A) IN GENERAL.—Except as provided in
24 paragraph (4), a State contracting with a risk
25 contracting entity under this section shall pro-

1 vide for an annual external independent review
2 of the quality and timeliness of, and access to,
3 the items and services specified in such entity's
4 contract with the State agency. Such review
5 shall be conducted by a utilization control and
6 peer review organization with a contract under
7 section 1153 or another organization unaffili-
8 ated with the State government or with any
9 risk contracting entity and approved by the
10 Secretary.

11 “(B) CONTENTS OF REVIEW.—An external
12 independent review conducted under this para-
13 graph shall include the following:

14 “(i) A review of the entity's medical
15 care, through sampling of medical records
16 or other appropriate methods, for indica-
17 tions of quality of care and inappropriate
18 utilization (including overutilization) and
19 treatment.

20 “(ii) A review of enrollee inpatient
21 and ambulatory data, through sampling of
22 medical records or other appropriate meth-
23 ods, to determine trends in quality and ap-
24 propriateness of care.

1 “(iii) Notification of the entity and
2 the State when the review under this para-
3 graph indicates inappropriate care, treat-
4 ment, or utilization of services (including
5 overutilization).

6 “(iv) Other activities as prescribed by
7 the Secretary or the State.

8 “(C) AVAILABILITY.—The results of each
9 external independent review conducted under
10 this paragraph shall be available to the public
11 consistent with the requirements for disclosure
12 of information contained in section 1160.

13 “(4) DEEMED COMPLIANCE WITH EXTERNAL
14 INDEPENDENT QUALITY OF CARE REVIEW REQUIRE-
15 MENTS.—

16 “(A) IN GENERAL.—The Secretary may
17 deem the State to have fulfilled the requirement
18 for independent external review of quality of
19 care with respect to an entity which has been
20 accredited by an organization described in sub-
21 paragraph (B) and approved by the Secretary.

22 “(B) ACCREDITING ORGANIZATION.—An
23 accrediting organization described in this sub-
24 paragraph must—

1 “(i) exist for the primary purpose of
2 accrediting coordinated care organizations;

3 “(ii) be governed by a group of indi-
4 viduals representing health care providers,
5 purchasers, regulators, and consumers (a
6 minority of which shall be representatives
7 of health care providers);

8 “(iii) have substantial experience in
9 accrediting coordinated care organizations,
10 including an organization’s internal quality
11 assurance program;

12 “(iv) be independent of health care
13 providers or associations of health care
14 providers;

15 “(v) be a nonprofit organization; and

16 “(vi) have an accreditation process
17 which meets requirements specified by the
18 Secretary.

19 “(5) FEDERAL MONITORING RESPONSIBIL-
20 ITIES.—The Secretary shall review the external inde-
21 pendent reviews conducted pursuant to paragraph
22 (3) and shall monitor the effectiveness of the State’s
23 monitoring and followup activities required under
24 subparagraph (A) of paragraph (2). If the Secretary
25 determines that a State’s monitoring and followup

1 activities are not adequate to ensure that the re-
2 quirements of paragraph (2) are met, the Secretary
3 shall undertake appropriate followup activities to en-
4 sure that the State improves its monitoring and fol-
5 lowup activities.

6 “(g) PARTICIPATION OF FEDERALLY QUALIFIED
7 HEALTH CENTERS AND RURAL HEALTH CLINICS.—

8 “(1) IN GENERAL.—Each risk contracting en-
9 tity shall, with respect to each electing essential
10 community provider (as defined in paragraph (5))
11 located within the plan’s service area, either—

12 “(A) enter into a written provider partici-
13 pation agreement (described in paragraph (2))
14 with the provider, or

15 “(B) enter into a written agreement under
16 which the plan shall make payment to the pro-
17 vider in accordance with paragraph (3).

18 “(2) PARTICIPATION AGREEMENT.—A partici-
19 pation agreement between a risk contracting entity
20 and an electing essential community provider under
21 this subsection shall provide that the entity agrees to
22 treat the provider in accordance with terms and con-
23 ditions at least as favorable as those that are appli-
24 cable to other participating providers with the risk

1 contracting entity with respect to each of the follow-
2 ing:

3 “(A) The scope of services for which pay-
4 ment is made by the entity to the provider.

5 “(B) The rate of payment for covered care
6 and services.

7 “(C) The availability of financial incentives
8 to participating providers.

9 “(D) Limitations on financial risk provided
10 to other participating providers.

11 “(E) Assignment of enrollees to participat-
12 ing providers.

13 “(F) Access by the provider’s patients to
14 providers in medical specialties or subspecialties
15 participating in the plan.

16 “(3) PAYMENTS FOR PROVIDERS WITHOUT PAR-
17 TICIPATION AGREEMENTS.—Payment in accordance
18 with this paragraph is payment based on payment
19 methodologies and rates used under the applicable
20 Medicare payment methodology and rates (or the
21 most closely applicable methodology under such pro-
22 gram as the Secretary of Health and Human Serv-
23 ices specifies in regulations).

24 “(4) ELECTION.—

1 “(A) IN GENERAL.—In this subsection, the
2 term ‘electing essential community provider’
3 means, with respect to a risk contracting entity,
4 an essential community provider that elects this
5 subpart to apply to the entity.

6 “(B) FORM OF ELECTION.—An election
7 under this paragraph shall be made in a form
8 and manner specified by the Secretary, and
9 shall include notice to the risk contracting en-
10 tity involved. Such an election may be made an-
11 nually with respect to an entity, except that the
12 entity and provider may agree to make such an
13 election on a more frequent basis.

14 “(5) PROVIDERS DESCRIBED.—The categories
15 of providers and organizations described in this sub-
16 section are as follows:

17 “(A) MIGRANT HEALTH CENTERS.—A re-
18 cipient or subrecipient of a grant under section
19 329 of the Public Health Service Act.

20 “(B) COMMUNITY HEALTH CENTERS.—A
21 recipient or subrecipient of a grant under sec-
22 tion 330 of the Public Health Service Act.

23 “(C) HOMELESS PROGRAM PROVIDERS.—A
24 recipient or subrecipient of a grant under sec-
25 tion 340 of the Public Health Service Act.

1 “(D) PUBLIC HOUSING PROVIDERS.—A re-
2 recipient or subrecipient of a grant under section
3 340A of the Public Health Service Act.

4 “(E) FAMILY PLANNING CLINICS.—A re-
5 cipient or subrecipient of a grant under title X
6 of the Public Health Service Act.

7 “(F) INDIAN HEALTH PROGRAMS.—A serv-
8 ice unit of the Indian Health Service, a tribal
9 organization, or an urban Indian program, as
10 defined in the Indian Health Care Improvement
11 Act.

12 “(G) AIDS PROVIDERS UNDER RYAN
13 WHITE ACT.—A public or private nonprofit
14 health care provider that is a recipient or sub-
15 recipient of a grant under title XXIII of the
16 Public Health Service Act.

17 “(H) MATERNAL AND CHILD HEALTH PRO-
18 VIDERS.—A public or private nonprofit entity
19 that provides prenatal care, pediatric care, or
20 ambulatory services to children, including chil-
21 dren with special health care needs, and that
22 receives funding for such care or services under
23 title V of the Social Security Act.

24 “(I) FEDERALLY QUALIFIED HEALTH CEN-
25 TER; RURAL HEALTH CLINIC.—A Federally-

1 qualified health center or a rural health clinic
2 (as such terms are defined in section 1861(aa)).

3 “(6) SUBRECIPIENT DEFINED.—In this sub-
4 section, the term ‘subrecipient’ means, with respect
5 to a recipient of a grant under a particular author-
6 ity, an entity that—

7 “(A) is receiving funding from such a
8 grant under a contract with the principal recipi-
9 ent of such a grant, and

10 “(B) meets the requirements established to
11 be a recipient of such a grant.

12 “(7) SUNSET OF REQUIREMENT.—The require-
13 ments of this subsection shall only apply to risk con-
14 tracting entities during calendar years 1995 through
15 2000.

16 “(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

17 “(1) IN GENERAL.—Each risk contracting en-
18 tity which is not a qualified health maintenance or-
19 ganization (as defined in section 1310(d) of the
20 Public Health Service Act) must report to the State
21 and, upon request, to the Secretary, the Inspector
22 General of the Department of Health and Human
23 Services, and the Comptroller General of the United
24 States a description of transactions between the en-
25 tity and a party in interest (as defined in section

1 1318(b) of such Act), including the following trans-
2 actions:

3 “(A) Any sale or exchange, or leasing of
4 any property between the entity and such a
5 party.

6 “(B) Any furnishing for consideration of
7 goods, services (including management serv-
8 ices), or facilities between the entity and such
9 a party, but not including salaries paid to em-
10 ployees for services provided in the normal
11 course of their employment.

12 “(C) Any lending of money or other exten-
13 sion of credit between the entity and such a
14 party.

15 The State or the Secretary may require that infor-
16 mation reported with respect to a risk contracting
17 entity which controls, or is controlled by, or is under
18 common control with, another entity be in the form
19 of a consolidated financial statement for the risk
20 contracting entity and such entity.

21 “(2) AVAILABILITY OF INFORMATION.—Each
22 risk contracting entity shall make the information
23 reported pursuant to paragraph (1) available to its
24 enrollees upon reasonable request.

25 “(i) REMEDIES FOR FAILURE TO COMPLY.—

1 “(1) IN GENERAL.—If the Secretary determines
2 that a risk contracting entity or a primary care case
3 management entity—

4 “(A) fails substantially to provide services
5 required under section 1905(r), when such an
6 entity is required to do so, or provide medically
7 necessary items and services that are required
8 to be provided to an individual enrolled with
9 such an entity, if the failure has adversely af-
10 fected (or has substantial likelihood of adversely
11 affecting) the individual;

12 “(B) imposes premiums on individuals en-
13 rolled with such an entity in excess of the pre-
14 miums permitted under this title;

15 “(C) acts to discriminate among individ-
16 uals in violation of the provision of subsection
17 (b)(3)(D), including expulsion or refusal to
18 reenroll an individual or engaging in any prac-
19 tice that would reasonably be expected to have
20 the effect of denying or discouraging enrollment
21 (except as permitted by this section) by eligible
22 individuals with the entity whose medical condi-
23 tion or history indicates a need for substantial
24 future medical services;

1 “(D) misrepresents or falsifies information
2 that is furnished—

3 “(i) to the Secretary or the State
4 under this section; or

5 “(ii) to an individual or to any other
6 entity under this section; or

7 “(E) fails to comply with the requirements
8 of section 1876(i)(8),
9 the Secretary may provide, in addition to any other
10 remedies available under law, for any of the rem-
11 edies described in paragraph (2).

12 “(2) ADDITIONAL REMEDIES.—The remedies
13 described in this paragraph are—

14 “(A) civil money penalties of not more
15 than \$25,000 for each determination under
16 paragraph (1), or, with respect to a determina-
17 tion under subparagraph (C) or (D)(i) of such
18 paragraph, of not more than \$100,000 for each
19 such determination, plus, with respect to a de-
20 termination under paragraph (1)(B), double the
21 excess amount charged in violation of such
22 paragraph (and the excess amount charged
23 shall be deducted from the penalty and returned
24 to the individual concerned), and plus, with re-
25 spect to a determination under paragraph

1 (1)(C), \$15,000 for each individual not enrolled
2 as a result of a practice described in such para-
3 graph, or

4 “(B) denial of payment to the State for
5 medical assistance furnished by a risk contract-
6 ing entity or a primary care case management
7 entity under this section for individuals enrolled
8 after the date the Secretary notifies the entity
9 of a determination under paragraph (1) and
10 until the Secretary is satisfied that the basis for
11 such determination has been corrected and is
12 not likely to recur.

13 The provisions of section 1128A (other than sub-
14 sections (a) and(b)) shall apply to a civil money pen-
15 alty under subparagraph (A) in the same manner as
16 such provisions apply to a penalty or proceeding
17 under section 1128A(a).

18 “(j) TERMINATION OF CONTRACT BY STATE.—Any
19 State which has a contract with a risk contracting entity
20 or a primary care case management entity may terminate
21 such contract if such entity fails to comply with the terms
22 of such contract or any applicable provision of this section.

23 “(k) FAIR HEARING.—Nothing in this section shall
24 affect the rights of an individual eligible to receive medical

1 assistance under the State plan to obtain a fair hearing
2 under section 1902(a)(3) or under applicable State law.

3 “(l) DISPROPORTIONATE SHARE HOSPITALS.—Noth-
4 ing in this section shall affect any requirement on a State
5 to comply with section 1923.

6 “(m) REFERRAL PAYMENTS.—For 1 year following
7 the date on which individuals eligible for medical assist-
8 ance under the State plan in a service area are required
9 to enroll with a risk contracting entity or a primary care
10 case management entity, Federally qualified health cen-
11 ters and rural health centers located in such service area
12 or providing care to such enrollees, shall receive a fee for
13 educating such enrollees about the availability of services
14 from the risk contracting entity or primary care case man-
15 agement entity with which such enrollees are enrolled.

16 “(n) SPECIAL RULES.—

17 “(1) NONAPPLICABILITY OF CERTAIN PROVI-
18 SIONS TO CERTAIN RISK CONTRACTING ENTITIES.—

19 In the case of any risk contracting entity which—

20 “(A)(i) is an individual physician or a phy-
21 sician group practice of less than 50 physicians,
22 and

23 “(ii) is not described in paragraphs (A)
24 and (B) of subsection (b)(1), and

1 “(B) is at risk only for the health care
2 items and services directly provided by such en-
3 tity,
4 paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4)
5 of subsection (b), and paragraph (3) of subsection
6 (f), shall not apply to such entity.

7 “(2) EXCEPTION FROM DEFINITION OF RISK
8 CONTRACTING ENTITY.—For purposes of this sec-
9 tion, the term ‘risk contracting entity’ shall not in-
10 clude a health insuring organization which was used
11 by a State before April 1, 1986, to administer a por-
12 tion of the State plan of such State on a statewide
13 basis.

14 “(3) NEW JERSEY.—The rules under section
15 1903(m)(6) as in effect on the day before the effec-
16 tive date of this section shall apply in the case of an
17 undertaking by the State of New Jersey (as de-
18 scribed in such section 1903(m)(6)).

19 “(o) CONTINUATION OF CERTAIN COORDINATED
20 CARE PROGRAMS.—The Secretary may provide for the
21 continuation of any coordinated care program operating
22 under section 1115 or 1915 without requiring compliance
23 with any provision of this section which conflicts with the
24 continuation of such program and without requiring any
25 additional waivers under such sections 1115 and 1915 if

1 the program has been successful in assuring quality and
2 containing costs (as determining by the Secretary) and is
3 likely to continue to be successful in the future.

4 “(p) GUIDELINES, REGULATIONS, AND MODEL CON-
5 TRACT.—

6 “(1) GUIDELINES AND REGULATIONS ON SOL-
7 VENCY.—At the earliest practicable time after the
8 date of enactment of this section, the Secretary shall
9 issue guidelines and regulations concerning solvency
10 standards for risk contracting entities and sub-
11 contractors of such risk contracting entities. Such
12 guidelines and regulations shall take into account
13 characteristics that may differ among risk contract-
14 ing entities including whether such an entity is at
15 risk for inpatient hospital services.

16 “(2) GUIDELINES AND REGULATIONS ON MAR-
17 KETING.—At the earliest practicable time after the
18 date of enactment of this section, the Secretary shall
19 issue guidelines and regulations concerning—

20 “(A) marketing undertaken by any risk
21 contracting entity or any primary care case
22 management program to individuals eligible for
23 medical assistance under the State plan, and

24 “(B) information that must be provided by
25 States or any such entity to individuals eligible

1 for medical assistance under the State plan
2 with respect to—

3 “(i) the options and rights of such in-
4 dividuals to enroll with, and disenroll from,
5 any such entity, as provided in this section,
6 and

7 “(ii) the availability of services from
8 any such entity (including a list of services
9 for which such entity is responsible or
10 must approve and information on how to
11 obtain services for which such entity is not
12 responsible).

13 In developing the guidelines and regulations under
14 this paragraph, the Secretary shall address the spe-
15 cial circumstances of children with special health
16 care needs (as defined in subsection (e)(1)(B)(ii))
17 and other individuals with special health care needs.

18 “(3) MODEL CONTRACT.—The Secretary shall
19 develop a model contract to reflect the requirements
20 of subsection (b)(3) and such other requirements as
21 the Secretary determines appropriate.”.

22 (b) WAIVERS FROM REQUIREMENTS ON COORDI-
23 NATED CARE PROGRAMS.—Section 1915(b) (42 U.S.C.
24 1396n) is amended—

1 (1) in the matter preceding paragraph (1), by
2 striking “as may be necessary” and inserting “, and
3 section 1933 as may be necessary”;

4 (2) in paragraph (1), by striking “a primary
5 care case management system or”;

6 (3) by striking “and” at the end of paragraph
7 (3);

8 (4) by striking the period at the end of para-
9 graph (4) and inserting “, and”;

10 (5) by inserting after paragraph (4) the follow-
11 ing new paragraph:

12 “(5) to permit a risk contracting entity (as de-
13 fined in section 1933(a)(3)) to restrict the period in
14 which individuals enrolled with such entity may ter-
15minate such enrollment without cause in accordance
16 with section 1933(e)(3)(A).”.

17 (c) STATE OPTION TO GUARANTEE MEDICAID ELIGI-
18 BILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is
19 amended—

20 (1) in subparagraph (A), by striking all that
21 precedes “(but for this paragraph)” and inserting
22 “In the case of an individual who is enrolled—

23 “(i) with a qualified health maintenance
24 organization (as defined in title XIII of the
25 Public Health Service Act) or with a risk con-

1 tracting entity (as defined in section
2 1933(a)(3)), or

3 “(ii) with any risk contracting entity (as
4 defined in section 1933(a)(3)) in a State that,
5 on the effective date of this provision, had in ef-
6 fect a waiver under section 1115 of require-
7 ments under this title under which the State
8 could extend eligibility for medical assistance
9 for enrollees of such entity, or

10 “(iii) with an eligible organization with a
11 contract under section 1876,

12 and who would”,

13 (2) in subparagraph (B), by striking “organiza-
14 tion or” each place it appears, and

15 (3) by adding at the end the following new sub-
16 paragraph:

17 “(C) The State plan may provide, notwith-
18 standing any other provision of this title, that
19 an individual shall be deemed to continue to be
20 eligible for benefits under this title until the end
21 of the month following the month in which such
22 individual would (but for this paragraph) lose
23 such eligibility because of excess income and re-
24 sources, if the individual is enrolled with a risk
25 contracting entity or primary care case manage-

1 ment entity (as those terms are defined in sec-
2 tion 1933(a)).”.

3 (d) ENHANCED MATCH RELATED TO QUALITY
4 REVIEW.—Section 1903(a)(3)(C) (42 U.S.C.
5 1396b(a)(3)(C)) is amended—

6 (1) by striking “organization or by” and insert-
7 ing “organization, by”; and

8 (2) by striking “section 1152, as determined by
9 the Secretary,” and inserting “section 1152, as de-
10 termined by the Secretary, or by another organiza-
11 tion approved by the Secretary which is unaffiliated
12 with the State government or with any risk contract-
13 ing entity (as defined in section 1933(a)(3)),”.

14 (e) ACCUMULATION OF RESERVES BY CERTAIN EN-
15 TITIES.—Any organization referred to in section 329, 330,
16 or 340, of the Public Health Service Act which has con-
17 tracted with a State agency as a risk contracting entity
18 under section 1933(g)(3)(A) of the Social Security Act
19 may accumulate reserves with respect to payments made
20 to such organization under section 1933(g)(3)(C) of such
21 Act.

22 (f) CONFORMING AMENDMENTS.—

23 (1) Section 1128(b)(6)(C)(i) (42 U.S.C. 1320a-
24 7(b)(6)(C)(i)) is amended by striking “health main-

1 tenance organization” and inserting “risk contract-
2 ing entity”.

3 (2) Section 1902(a)(23) (42 U.S.C.
4 1396a(a)(23)) is amended by striking “primary
5 care-case management system (described in section
6 1915(b)(1)), a health maintenance organization,”
7 and inserting “primary care case management pro-
8 gram (as defined in section 1933(a)(1)), a risk con-
9 tracting entity (as defined in section 1933(a)(3)),”.

10 (3) Section 1902(a)(30)(C) (42 U.S.C.
11 1396a(a)(30)(C)) is amended by striking “use a uti-
12 lization” and all that follows through “with the re-
13 sults” and inserting “provide for independent review
14 and quality assurance of entities with contracts
15 under section 1933, in accordance with subsection
16 (f) of such section 1933, with the results”.

17 (4) Section 1902(a)(57) (42 U.S.C.
18 1396a(a)(57)) is amended by striking “or health
19 maintenance organization (as defined in section
20 1903(m)(1)(A))” and inserting “risk contracting en-
21 tity, or primary care case management entity (as de-
22 fined in section 1933(a))”.

23 (5) Section 1902(a) (42 U.S.C. 1396a), as
24 amended by sections 6001(a) and 6011(b), is
25 amended—

1 (A) by striking “and” at the end of para-
2 graph (63);

3 (B) by striking the period at the end of
4 paragraph (64) and inserting “; and”; and

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

7 “(65) at State option, provide for a primary
8 care case management program in accordance with
9 section 1933; and

10 “(66) at State option, provide for a program
11 under which the State contracts with risk contract-
12 ing entities in accordance with section 1933.”.

13 (6) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2))
14 is amended by striking “health maintenance organi-
15 zation (as defined in section 1903(m))” and insert-
16 ing “risk contracting entity (as defined in section
17 1933(a)(3))”.

18 (7) Section 1902(w) (42 U.S.C. 1396a(w)) is
19 amended—

20 (A) in paragraph (1), by striking “section
21 1903(m)(1)(A)” and inserting “section
22 1933(a)(3)”, and

23 (B) in paragraph (2)(E)—

1 (i) by striking “health maintenance
2 organization” and inserting “risk contract-
3 ing entity”, and

4 (ii) by striking “organization” and in-
5 sserting “entity”.

6 (8) Section 1903(k) (42 U.S.C. 1396b(k)) is
7 amended by striking “health maintenance organiza-
8 tion which meets the requirements of subsection (m)
9 of this section” and inserting “risk contracting en-
10 tity which meets the requirements of section 1933”.

11 (9) Section 1903(w)(7)(A)(viii) (42 U.S.C.
12 1396b(w)(7)(A)(viii)) is amended by striking “health
13 maintenance organizations (and other organizations
14 with contracts under section 1903(m))” and insert-
15 ing “risk contracting entities with contracts under
16 section 1933”.

17 (10) Section 1905(a) (42 U.S.C. 1396d(a)) is
18 amended, in the matter preceding clause (i), by in-
19 sserting “(which may be on a prepaid capitation or
20 other risk basis)” after “payment”.

21 (11) Section 1916(b)(2)(D) (42 U.S.C.
22 1396o(b)(2)(D)) is amended by striking “health
23 maintenance organization (as defined in section
24 1903(m))” and inserting “risk contracting entity (as
25 defined in section 1933(a)(3))”.

1 (12) Section 1925(b)(4)(D)(iv) (42 U.S.C.
2 1396r-6(b)(4)(D)(iv)) is amended—

3 (A) in the heading, by striking “**HMO**”
4 and inserting “**RISK CONTRACTING ENTITY**”,

5 (B) by striking “health maintenance orga-
6 nization (as defined in section 1903(m)(1)(A))”
7 and inserting “risk contracting entity (as de-
8 fined in section 1933(a)(3))”, and

9 (C) by striking “health maintenance orga-
10 nization in accordance with section 1903(m)”
11 and inserting “risk contracting entity in accord-
12 ance with section 1933”.

13 (13) Paragraphs (1) and (2) of section 1926(a)
14 (42 U.S.C. 1396r-7(a)) are each amended by strik-
15 ing “health maintenance organizations under section
16 1903(m)” and inserting “risk contracting entities
17 under section 1933”.

18 (14) Section 1927(j)(1) is amended by striking
19 “* * * Health Maintenance Organizations, includ-
20 ing those organizations that contract under section
21 1903(m)” and inserting “risk contracting entities
22 (as defined in section 1933(a)(3))”.

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

PART IV—OTHER PROVISIONS**SEC. 6031. PHASED-IN ELIMINATION OF MEDICAID HOSPITAL DISPROPORTIONATE SHARE ADJUSTMENT PAYMENTS.**

(a) IN GENERAL.—Section 1923 (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

“(g) PHASED-IN ELIMINATION OF FEDERAL FINANCIAL PARTICIPATION FOR DISPROPORTIONATE SHARE ADJUSTMENTS.—Notwithstanding any other provisions of this section, the amount of payments under section 1903(a) with respect to any payment adjustment made under this section for hospitals in a State for quarters—

“(1) in fiscal year 1996, shall not exceed 80 percent of the amount otherwise determined under subsection (f);

“(2) in fiscal year 1997, shall not exceed 60 percent of the amount otherwise determined under subsection (f);

“(3) in fiscal year 1998, shall not exceed 40 percent of the amount otherwise determined under subsection (f);

“(4) in fiscal year 1999, shall not exceed 20 percent of the amount otherwise determined under subsection (f); and

1 (b) CONTENTS OF THE PROPOSAL.—A proposal for
2 legislation submitted under subsection (a) shall—

3 (1) provide for an appropriate methodology by
4 which the Secretary shall make payment to qualified
5 health plans for the enrollment of medicare bene-
6 ficiaries;

7 (2) provide individuals the opportunity to re-
8 main enrolled in a qualified plan without an inter-
9 ruption in coverage upon becoming medicare bene-
10 ficiaries; and

11 (3) provide medicare beneficiaries with the op-
12 portunity to enroll in a qualified health plan.

13 **SEC. 6102. INTERIM ENROLLMENT OF MEDICARE BENE-**
14 **FICIARIES IN QUALIFIED HEALTH PLANS.**

15 (a) INTERIM ENROLLMENT OF MEDICARE BENE-
16 FICIARIES IN QUALIFIED HEALTH PLANS.—

17 (1) IN GENERAL.—Notwithstanding title XVIII
18 of the Social Security Act, the Secretary shall pro-
19 vide for a monthly payment as provided under sub-
20 section (b)(1) to a qualified health plan on behalf of
21 enrolled medicare beneficiaries.

22 (2) MEDICARE BENEFICIARY.—For purposes of
23 this section, the term “medicare beneficiary” means
24 an individual who is eligible for benefits under part

1 A of title XVIII of the Social Security Act and is en-
2 rolled under part B of such title.

3 (b) PAYMENT SPECIFIED.—

4 (1) FEDERAL PAYMENT.—

5 (A) IN GENERAL.—The amount of pay-
6 ment specified in this paragraph for an individ-
7 ual who is enrolled in a qualified health plan is
8 the lesser of—

9 (i) the applicable rate specified in sec-
10 tion 1876(a)(1)(C) of the Social Security
11 Act (but at 100 percent, rather than 95
12 percent, of the applicable amount); or

13 (ii) the monthly premium charged the
14 individual for coverage under the qualified
15 health plan.

16 (B) SOURCE OF PAYMENT.—The payment
17 to a qualified health plan under this paragraph
18 for individuals entitled to benefits under part A
19 and enrolled under part B of title XVIII of the
20 Social Security Act shall be made from the
21 Federal Hospital Insurance Trust Fund and
22 the Federal Supplementary Medical Insurance
23 Trust Fund, with the allocation to be deter-
24 mined by the Secretary.

1 (2) INDIVIDUAL'S SHARE.—If the monthly pre-
 2 mium for the qualified health plan in which the indi-
 3 vidual is enrolled is greater than the amount speci-
 4 fied under paragraph (1)(A)(i), the individual shall
 5 be responsible for paying to the qualified health plan
 6 the difference between the monthly premium charged
 7 the individual for coverage under the qualified health
 8 plan and the amount specified in paragraph
 9 (1)(A)(i).

10 (c) PAYMENTS UNDER THIS SECTION AS SOLE MEDI-
 11 CARE BENEFITS.—Payments made under this section
 12 shall be instead of the amounts that would otherwise be
 13 payable, pursuant to sections 1814(b) and 1833(a) of the
 14 Social Security Act, for services furnished to medicare
 15 beneficiaries.

16 **PART II—ENHANCEMENT OF MEDICARE RISK**

17 **CONTRACTS**

18 **SEC. 6111. REVISIONS IN THE PAYMENT METHODOLOGY**

19 **FOR RISK CONTRACTORS.**

20 Section 4204(b) of the Omnibus Budget Reconcili-
 21 ation Act of 1990 is amended to read as follows:

22 “(b) REVISIONS IN THE PAYMENT METHODOLOGY
 23 FOR RISK CONTRACTORS.—(1)(A) Not later than 1 year
 24 after the date of the enactment of the Health Equity and
 25 Access Reform Today Act of 1993, the Secretary of

1 Health and Human Services (in this subsection referred
2 to as the ‘Secretary’) shall submit a proposal to the Con-
3 gress that provides for revisions to the payment method
4 to be applied in years beginning with 1996 for organiza-
5 tions with a risk-sharing contract under section 1876(g)
6 of the Social Security Act.

7 “(B) In proposing the revisions required under sub-
8 paragraph (A), the Secretary shall consider—

9 “(i) the difference in costs associated with med-
10 icare beneficiaries with differing health status and
11 demographic characteristics;

12 “(ii) the difference in costs associated with
13 medicare beneficiaries who receive health benefits
14 from a primary payer other than medicare; and

15 “(iii) the effects of using alternative geographic
16 classifications on the determinations of costs associ-
17 ated with beneficiaries residing in different areas.

18 “(2) Not later than 3 months after the date of sub-
19 mittal of the proposal under paragraph (1), the Physician
20 Payment Review Commission and the Prospective Pay-
21 ment Assessment Commission shall review the proposal
22 and shall report to Congress on the appropriateness of the
23 proposed modifications.”.

1 **SEC. 6112. ADJUSTMENT IN MEDICARE CAPITATION PAY-**
2 **MENTS TO TAKE INTO ACCOUNT SECONDARY**
3 **PAYER STATUS.**

4 (a) IN GENERAL.—In defining the classes to be used
5 in determining the annual per capita rate of payment
6 under section 1876(a)(1)(B) of the Social Security Act to
7 an eligible organization with a risk-sharing contract under
8 such section (for months beginning after June 1994), the
9 Secretary shall treat as a separate class individuals enti-
10 tled to benefits under title XVIII of such Act with respect
11 to whom there is a group health plan that is a primary
12 plan (within the meaning of section 1862(b)(2)(A) of such
13 Act).

14 (b) DEADLINE FOR ANNOUNCEMENT OF RATES.—
15 Not later than May 15, 1994, the Secretary shall an-
16 nounce annual per capita rates of payment for eligible or-
17 ganizations described in subsection (a) that take into ac-
18 count the separate treatment of individuals with respect
19 to whom there is a group health plan that is a primary
20 plan.

21 **SEC. 6113. ESTABLISHMENT OF OUTLIER POOL.**

22 (a) GENERAL RULE.—Section 1876(a)(1) (42 U.S.C.
23 1395mm(a)(1)) is amended by adding at the end the fol-
24 lowing new subparagraph:

25 “(G)(i) In the case of an eligible organization with
26 a risk-sharing contract, the Secretary may make addi-

1 tional payments to the organization equal to not more
2 than 50 percent of reasonable cost above the threshold
3 amount of items and services covered under parts A and
4 B and provided (or paid for) in a year by the organization
5 to any individual enrolled with the organization under this
6 section.

7 “(ii) For purposes of clause (i), the ‘threshold
8 amount’ is an amount determined by the Secretary from
9 time to time, adjusted by the geographic factor utilized
10 in determining payments to the organization under sub-
11 paragraph (C) and rounded to the nearest multiple of
12 \$100, such that the total amount to be paid under this
13 subparagraph for a year is estimated to be 5 percent or
14 less of the total amount to be paid under risk-sharing con-
15 tracts for services furnished for that year.

16 “(iii) An eligible organization shall submit a claim for
17 additional payments under subsection (i) within such time
18 as the Secretary may specify.”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) applies to services furnished after 1994.

21 **PART III—MEDICARE SELECT**

22 **SEC. 6121. MEDICARE SELECT.**

23 (a) AMENDMENTS TO PROVISIONS RELATING TO
24 MEDICARE SELECT POLICIES.—

1 (1) PERMITTING MEDICARE SELECT POLICIES
2 IN ALL STATES.—Subsection (c) of section 4358 of
3 the Omnibus Budget Reconciliation Act of 1990 is
4 hereby repealed.

5 (2) REQUIREMENTS OF MEDICARE SELECT
6 POLICIES.—Section 1882(t)(1) (42 U.S.C.
7 1395ss(t)(1)) is amended to read as follows:

8 “(1)(A) If a medicare supplemental policy meets the
9 requirements of the 1991 NAIC Model Regulation or 1991
10 Federal Regulation and otherwise complies with the re-
11 quirements of this section except that—

12 “(i) the benefits under such policy are re-
13 stricted to items and services furnished by certain
14 entities (or reduced benefits are provided when items
15 or services are furnished by other entities), and

16 “(ii) in the case of a policy described in sub-
17 paragraph (C)(i)—

18 “(I) the benefits under such policy are not
19 one of the groups or packages of benefits de-
20 scribed in subsection (p)(2)(A),

21 “(II) except for nominal copayments im-
22 posed for services covered under part B of this
23 title, such benefits include at least the core
24 group of basic benefits described in subsection
25 (p)(2)(B), and

1 “(III) an enrollee’s liability under such pol-
2 icy for physician’s services covered under part
3 B of this title is limited to the nominal
4 copayments described in subclause (II),
5 the policy shall nevertheless be treated as meeting
6 those requirements if the policy meets the require-
7 ments of subparagraph (B).

8 “(B) A policy meets the requirements of this sub-
9 paragraph if—

10 “(i) full benefits are provided for items and
11 services furnished through a network of entities
12 which have entered into contracts or agreements
13 with the issuer of the policy,

14 “(ii) full benefits are provided for items and
15 services furnished by other entities if the services are
16 medically necessary and immediately required be-
17 cause of an unforeseen illness, injury, or condition
18 and it is not reasonable given the circumstances to
19 obtain the services through the network,

20 “(iii) the network offers sufficient access,

21 “(iv) the issuer of the policy has arrangements
22 for an ongoing quality assurance program for items
23 and services furnished through the network,

1 “(v)(I) the issuer of the policy provides to each
2 enrollee at the time of enrollment an explanation
3 of—

4 “(aa) the restrictions on payment under
5 the policy for services furnished other than by
6 or through the network,

7 “(bb) out of area coverage under the pol-
8 icy,

9 “(cc) the policy’s coverage of emergency
10 services and urgently needed care, and

11 “(dd) the availability of a policy through
12 the entity that meets the 1991 Model NAIC
13 Regulation or 1991 Federal Regulation without
14 regard to this subsection and the premium
15 charged for such policy, and

16 “(II) each enrollee prior to enrollment acknowl-
17 edges receipt of the explanation provided under
18 subclause (I), and

19 “(vi) the issuer of the policy makes available to
20 individuals, in addition to the policy described in this
21 subsection, any policy (otherwise offered by the is-
22 suer to individuals in the State) that meets the 1991
23 Model NAIC Regulation or 1991 Federal Regulation
24 and other requirements of this section without re-
25 gard to this subsection.

1 “(C)(i) A policy described in this subparagraph—

2 “(I) is offered by an eligible organization (as
3 defined in section 1876(b)),

4 “(II) is not a policy or plan providing benefits
5 pursuant to a contract under section 1876 or an ap-
6 proved demonstration project described in section
7 603(c) of the Social Security Amendments of 1983,
8 section 2355 of the Deficit Reduction Act of 1984,
9 or section 9412(b) of the Omnibus Budget Reconcili-
10 ation Act of 1986, and

11 “(III) provides benefits which, when combined
12 with benefits which are available under this title, are
13 substantially similar to benefits under policies of-
14 fered to individuals who are not entitled to benefits
15 under this title.

16 “(ii) In making a determination under subclause (III)
17 of clause (i) as to whether certain benefits are substan-
18 tially similar, there shall not be taken into account, except
19 in the case of preventive services, benefits provided under
20 policies offered to individuals who are not entitled to bene-
21 fits under this title which are in addition to the benefits
22 covered by this title and which are benefits an entity must
23 provide in order to meet the definition of an eligible orga-
24 nization under section 1876(b)(1).”.

1 (b) RENEWABILITY OF MEDICARE SELECT POLI-
2 CIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is
3 amended—

4 (1) by striking “(1) Each” and inserting
5 “(1)(A) Except as provided in subparagraph (B),
6 each”;

7 (2) by redesignating subparagraphs (A) and
8 (B) as clauses (i) and (ii), respectively; and

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(B)(i) In the case of a policy that meets the
12 requirements of subsection (t), an issuer may cancel
13 or nonrenew such policy with respect to an individ-
14 ual who leaves the service area of such policy; except
15 that, if such individual moves to a geographic area
16 where such issuer, or where an affiliate of such is-
17 suer, is issuing medicare supplemental policies, such
18 individual must be permitted to enroll in any medi-
19 care supplemental policy offered by such issuer or
20 affiliate that provides benefits comparable to or less
21 than the benefits provided in the policy being can-
22 celed or nonrenewed. An individual whose coverage
23 is canceled or nonrenewed under this subparagraph
24 shall, as part of the notice of termination or
25 nonrenewal, be notified of the right to enroll in other

1 medicare supplemental policies offered by the issuer
2 or its affiliates.

3 “(ii) For purposes of this subparagraph, the
4 term ‘affiliate’ shall have the meaning given such
5 term by the 1991 NAIC Model Regulation.”.

6 (c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C.
7 1395ss(t)(2)) is amended—

8 (1) by striking “(2)” and inserting “(2)(A)”;

9 (2) by redesignating subparagraphs (A), (B),
10 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-
11 spectively;

12 (3) in clause (iv), as redesignated—

13 (A) by striking “paragraph (1)(E)(i)” and
14 inserting “paragraph (1)(B)(v)(I); and

15 (B) by striking “paragraph (1)(E)(ii)” and
16 inserting “paragraph (1)(B)(v)(II)”;

17 (4) by striking “the previous sentence” and in-
18 serting “this subparagraph”; and

19 (5) by adding at the end the following new sub-
20 paragraph:

21 “(B) If the Secretary determines that an issuer of
22 a policy approved under paragraph (1) has made a mis-
23 representation to the Secretary or has provided the Sec-
24 retary with false information regarding such policy, the
25 issuer is subject to a civil money penalty in an amount

1 not to exceed \$100,000 for each such determination. The
2 provisions of section 1128A (other than the first sentence
3 of subsection (a) and other than subsection (b)) shall
4 apply to a civil money penalty under this subparagraph
5 in the same manner as such provisions apply to a penalty
6 or proceeding under section 1128A(a).”.

7 (d) EFFECTIVE DATES.—

8 (1) NAIC STANDARDS.—If, within 6 months
9 after the date of the enactment of this Act, the Na-
10 tional Association of Insurance Commissioners
11 (hereafter in this subsection referred to as the
12 “NAIC”) makes changes in the 1991 NAIC Model
13 Regulation (as defined in section 1882(p)(1)(A) of
14 the Social Security Act) to incorporate the additional
15 requirements imposed by the amendments made by
16 this section, section 1882(g)(2)(A) of such Act shall
17 be applied in each State, effective for policies issued
18 to policyholders on and after the date specified in
19 paragraph (3), as if the reference to the Model Reg-
20 ulation adopted on June 6, 1979, were a reference
21 to the 1991 NAIC Model Regulation (as so defined)
22 as changed under this paragraph (such changed
23 Regulation referred to in this subsection as the
24 “1994 NAIC Model Regulation”).

1 (2) SECRETARY STANDARDS.—If the NAIC
2 does not make changes in the 1991 NAIC Model
3 Regulation (as so defined) within the 6-month period
4 specified in paragraph (1), the Secretary of Health
5 and Human Services (hereafter in this subsection re-
6 ferred to as the “Secretary”) shall promulgate a reg-
7 ulation and section 1882(g)(2)(A) of the Social Se-
8 curity Act shall be applied in each State, effective
9 for policies issued to policyholders on and after the
10 date specified in paragraph (3), as if the reference
11 to the Model Regulation adopted on June 6, 1979,
12 were a reference to the 1991 NAIC Model Regula-
13 tion (as so defined) as changed by the Secretary
14 under this paragraph (such changed Regulation re-
15 ferred to in this subsection as the “1994 Federal
16 Regulation”).

17 (3) DATE SPECIFIED.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), the date specified in this paragraph
20 for a State is the earlier of—

21 (i) the date the State adopts the 1994
22 NAIC Model Regulation or the 1994 Fed-
23 eral Regulation, or

24 (ii) 1 year after the date the NAIC or
25 the Secretary first adopts such regulations.

1 (B) ADDITIONAL LEGISLATIVE ACTION RE-
2 QUIRED.—In the case of a State which the Sec-
3 retary identifies, in consultation with the NAIC,
4 as—

5 (i) requiring State legislation (other
6 than legislation appropriating funds) in
7 order for medicare supplemental policies to
8 meet the 1994 NAIC Model Regulation or
9 the 1994 Federal Regulation, but

10 (ii) having a legislature which is not
11 scheduled to meet in 1995 in a legislative
12 session in which such legislation may be
13 considered,

14 the date specified in this paragraph is the first
15 day of the first calendar quarter beginning after
16 the close of the first legislative session of the
17 State legislature that begins on or after Janu-
18 ary 1, 1995. For purposes of the previous sen-
19 tence, in the case of a State that has a 2-year
20 legislative session, each year of such session
21 shall be deemed to be a separate regular session
22 of the State legislature.

23 **PART IV—OTHER PROVISIONS**

24 **SEC. 6131. MEDICARE PART B PREMIUM.**

25 Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

- 1 (1) in paragraph (1)(A)—
2 (A) by striking “(A)”; and
3 (B) by striking “and prior to January
4 1999”;
5 (2) in paragraph (1)(B), by striking “(B)” and
6 inserting “(2)”; and
7 (3) by striking paragraph (2).

8 **SEC. 6132. INCREASE IN MEDICARE PART B PREMIUM FOR**
9 **INDIVIDUALS WITH HIGH INCOME.**

10 (a) IN GENERAL.—Subchapter A of chapter 1 of the
11 Internal Revenue Code of 1986 is amended by adding at
12 the end the following new part:

13 **“PART VIII—MEDICARE PART B PREMIUMS FOR**
14 **HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Medicare part B premium tax.

15 **“SEC. 59B. MEDICARE PART B PREMIUM TAX.**

16 “(a) IMPOSITION OF RECAPTURE AMOUNT.—In the
17 case of an individual, if the modified adjusted gross in-
18 come of the taxpayer for the taxable year exceeds the
19 threshold amount, such taxpayer shall pay (in addition to
20 any other amount imposed by this subtitle) a recapture
21 amount for such taxable year equal to the sum of the ag-
22 gregate of the medicare part B recapture amounts (if any)
23 for months during such year that a premium is paid under

1 part B of title XVIII of the Social Security Act for the
2 coverage of the individual under such part.

3 “(b) MEDICARE PART B PREMIUM RECAPTURE
4 AMOUNT FOR MONTH.—For purposes of this section, the
5 medicare part B premium recapture amount for any
6 month is the amount equal to the excess of—

7 “(1) 150 percent of the monthly actuarial rate
8 for enrollees age 65 and over determined for that
9 calendar year under section 1839(b) of the Social
10 Security Act, over

11 “(2) the total monthly premium under section
12 1839 of the Social Security Act (determined without
13 regard to subsections (b) and (f) of section 1839 of
14 such Act).

15 “(c) PHASE-IN OF RECAPTURE AMOUNT.—If the
16 modified adjusted gross income of the taxpayer for any
17 taxable year exceeds the threshold amount by less than
18 \$10,000, the recapture amount imposed by this section for
19 such taxable year shall be an amount which bears the
20 same ratio to the recapture amount which would (but for
21 this subsection) be imposed by this section for such tax-
22 able year as such excess bears to \$10,000.

23 “(d) OTHER DEFINITIONS AND SPECIAL RULES.—
24 For purposes of this section—

1 “(1) THRESHOLD AMOUNT.—The term ‘thresh-
2 old amount’ means—

3 “(A) except as otherwise provided in this
4 paragraph, \$90,000,

5 “(B) \$115,000 in the case of a joint re-
6 turn, and

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

8 “(i) is married (as determined under
9 section 7703) but does not file a joint re-
10 turn for such year, and

11 “(ii) does not live apart from his
12 spouse at all times during the taxable year.

13 “(2) MODIFIED ADJUSTED GROSS INCOME.—
14 The term ‘modified adjusted gross income’ means
15 adjusted gross income—

16 “(A) determined without regard to sections
17 135, 911, 931, and 933, and

18 “(B) increased by the amount of interest
19 received or accrued by the taxpayer during the
20 taxable year which is exempt from tax.

21 “(3) JOINT RETURNS.—In the case of a joint
22 return—

23 “(A) the recapture amount under sub-
24 section (a) shall be the sum of the recapture

1 amounts determined separately for each spouse,
2 and

3 “(B) subsections (a) and (c) shall be ap-
4 plied by taking into account the combined modi-
5 fied adjusted gross income of the spouses.

6 “(4) COORDINATION WITH OTHER PROVI-
7 SIONS.—

8 “(A) TREATED AS TAX FOR SUBTITLE F.—
9 For purposes of subtitle F, the recapture
10 amount imposed by this section shall be treated
11 as if it were a tax imposed by section 1.

12 “(B) NOT TREATED AS TAX FOR CERTAIN
13 PURPOSES.—The recapture amount imposed by
14 this section shall not be treated as a tax im-
15 posed by this chapter for purposes of determin-
16 ing—

17 “(i) the amount of any credit allow-
18 able under this chapter, or

19 “(ii) the amount of the minimum tax
20 under section 55.”.

21 (b) TRANSFERS TO SUPPLEMENTAL MEDICAL IN-
22 SURANCE TRUST FUND.—

23 (1) IN GENERAL.—There are hereby appro-
24 priated to the Supplemental Medical Insurance
25 Trust Fund amounts equivalent to the aggregate in-

1 crease in liabilities under chapter 1 of the Internal
2 Revenue Code of 1986 that are attributable to the
3 application of section 59B(a) of such Code, as added
4 by this section.

5 (2) TRANSFERS.—The amounts appropriated
6 by paragraph (1) to the Supplemental Medical In-
7 surance Trust Fund shall be transferred from time
8 to time (but not less frequently than quarterly) from
9 the general fund of the Treasury on the basis of es-
10 timates made by the Secretary of the Treasury of
11 the amounts referred to in paragraph (1). Any quar-
12 terly payment shall be made on the first day of such
13 quarter and shall take into account the recapture
14 amounts referred to in such section 59B(a) for such
15 quarter. Proper adjustments shall be made in the
16 amounts subsequently transferred to the extent prior
17 estimates were in excess of or less than the amounts
18 required to be transferred.

19 (c) REPORTING REQUIREMENTS.—

20 (1)(A) Paragraph (1) of section 6050F(a) of
21 the Internal Revenue Code of 1986 (relating to re-
22 turns relating to social security benefits) is amended
23 by striking “and” at the end of subparagraph (B)
24 and by inserting after subparagraph (C) the follow-
25 ing new subparagraph:

1 “(D) the number of months during the cal-
2 endar year for which a premium was paid under
3 part B of title XVIII of the Social Security Act
4 for the coverage of such individual under such
5 part, and”.

6 (B) Paragraph (2) of section 6050F(b) of such
7 Code is amended to read as follows:

8 “(2) the information required to be shown on
9 such return with respect to such individual.”.

10 (C) Subparagraph (A) of section 6050(c)(1) of
11 such Code is amended by inserting before the
12 comma “and in the case of the information specified
13 in subsection (a)(1)(D)”.

14 (D) The heading for section 6050F of such
15 Code is amended by inserting “**AND MEDICARE**
16 **PART B COVERAGE**” before the period.

17 (E) The item relating to section 6050F in the
18 table of sections for subpart B of part III of sub-
19 chapter A of chapter 61 of such Code is amended by
20 inserting “and medicare part B coverage” before the
21 period.

22 (d) WAIVER OF ESTIMATED TAX PENALTIES FOR
23 1996.—No addition to tax shall be imposed under section
24 6654 of the Internal Revenue Code of 1986 (relating to
25 failure to pay estimated income tax) for any period before

1 April 16, 1997, with respect to any underpayment to the
2 extent that such underpayment resulted from section
3 59B(a) of the Internal Revenue Code of 1986, as added
4 by this section.

5 (e) CLERICAL AMENDMENT.—The table of parts for
6 subchapter A of chapter 1 of such Code is amended by
7 adding at the end thereof the following new item:

“Part VIII. Medicare Part B Premiums for High-Income Individ-
uals.”.

8 (f) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to periods after December 31,
10 1994, in taxable years ending after such date.

11 **SEC. 6133. PERMANENT 10-PERCENT REDUCTION IN PAY-**
12 **MENTS FOR CAPITAL-RELATED COSTS OF**
13 **OUTPATIENT HOSPITAL SERVICES.**

14 Section 1861(v)(1)(S)(ii)(I) (42 U.S.C.
15 1395x(v)(1)(S)(ii)(I)) is amended by striking “fiscal years
16 1992 through 1998” and inserting “fiscal year 1992, and
17 each subsequent fiscal year,”.

18 **SEC. 6134. PERMANENT REDUCTION IN PAYMENTS FOR**
19 **OTHER COSTS OF OUTPATIENT HOSPITAL**
20 **SERVICES.**

21 Section 1861(v)(1)(S)(ii)(II) (42 U.S.C.
22 1395x(v)(1)(S)(ii)(II)) is amended by striking “fiscal
23 years 1991 through 1998” and inserting “fiscal year
24 1991, and each subsequent fiscal year”.

1 **SEC. 6135. IMPOSITION OF COINSURANCE ON LABORATORY**
2 **SERVICES.**

3 (a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of
4 section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

5 (1) by striking “(or 100 percent” and all that
6 follows through “the first opinion))”; and

7 (2) by striking “100 percent of such negotiated
8 rate” and inserting “80 percent of such negotiated
9 rate”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) shall apply to tests furnished on or after
12 January 1, 1995.

13 **SEC. 6136. IMPOSITION OF COPAYMENT FOR CERTAIN**
14 **HOME HEALTH VISITS.**

15 (a) IN GENERAL.—

16 (1) PART A.—Section 1813(a) (42 U.S.C.
17 1395e(a)) is amended by adding at the end the fol-
18 lowing new paragraph:

19 “(5) The amount payable for home health services
20 furnished to an individual under this part shall be reduced
21 by a copayment amount equal to 20 percent of the average
22 of all per visit costs for home health services furnished
23 under this title determined under section 1861(v)(1)(L)
24 (as determined by the Secretary on a prospective basis for
25 services furnished during a calendar year), unless such
26 services were furnished to the individual during the 30-

1 day period that begins on the date the individual is dis-
2 charged as an inpatient from a hospital.”.

3 (2) PART B.—Section 1833(a)(2) (42 U.S.C.
4 13951(a)(2)) is amended—

5 (A) in subparagraph (A), by striking “to
6 home health services,” and by striking the
7 comma after “opinion)”;

8 (B) in subparagraph (D), by striking
9 “and” at the end;

10 (C) in subparagraph (E), by striking the
11 semicolon at the end and inserting “; and”; and

12 (D) by adding at the end the following new
13 subparagraph:

14 “(F) with respect to home health serv-
15 ices—

16 “(i) the lesser of—

17 “(I) the reasonable cost of such
18 services, as determined under section
19 1861(v), or

20 “(II) the customary charges with
21 respect to such services,

22 less the amount a provider may charge as
23 described in clause (ii) of section
24 1866(a)(2)(A),

1 “(ii) if such services are furnished by
2 a public provider of services, or by another
3 provider which demonstrates to the satis-
4 faction of the Secretary that a significant
5 portion of its patients are low-income (and
6 requests that payment be made under this
7 clause), free of charge or at nominal
8 charges to the public, the amount deter-
9 mined in accordance with section
10 1814(b)(2), or

11 “(iii) if (and for so long as) the condi-
12 tions described in section 1814(b)(3) are
13 met, the amounts determined under the re-
14 imbursement system described in such sec-
15 tion,

16 less a copayment amount equal to 20 percent of
17 the average of all per visit costs for home
18 health services furnished under this title deter-
19 mined under section 1861(v)(1)(L) (as deter-
20 mined by the Secretary on a prospective basis
21 for services furnished during a calendar year),
22 unless such services were furnished to the indi-
23 vidual during the 30-day period that begins on
24 the date the individual is discharged as an inpa-
25 tient from a hospital;”.

1 (3) PROVIDER CHARGES.—Section
2 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is
3 amended—

4 (A) by striking “deduction or coinsurance”
5 and inserting, “deduction, coinsurance, or
6 copayment”; and

7 (B) by striking “or (a)(4)” and inserting
8 “(a)(4), or (a)(5)”.

9 (b) EFFECTIVE DATE.—The amendments made by
10 subsection (a) shall apply to home health services fur-
11 nished on or after January 1, 1995.

12 **SEC. 6137. PHASED-IN ELIMINATION OF MEDICARE HOS-**
13 **PITAL DISPROPORTIONATE SHARE ADJUST-**
14 **MENT PAYMENTS.**

15 Section 1886(d)(5)(F) of the Social Security Act (42
16 U.S.C. 1395ww(d)(5)(F)) is amended—

17 (1) in clause (ii), by striking “The amount of
18 such payment” and inserting “Subject to clause (ix),
19 the amount of such payment”; and

20 (2) by adding at the end the following new
21 clause:

22 “(ix) The amount of the additional payment made
23 under this paragraph for a discharge shall be equal to—

1 “(I) for discharges occurring during fiscal year
2 1996, 80 percent of the amount otherwise deter-
3 mined for the discharge under clause (ii);

4 “(II) for discharges occurring during fiscal year
5 1997, 60 percent of the amount otherwise deter-
6 mined for the discharge under clause (ii);

7 “(III) for discharges occurring during fiscal
8 year 1998, 40 percent of the amount otherwise de-
9 termined for the discharge under clause (ii);

10 “(IV) for discharges occurring during fiscal
11 year 1999, 20 percent of the amount otherwise de-
12 termined for the discharge under clause (ii); and

13 “(V) for discharges occurring during fiscal year
14 2000, and each subsequent fiscal year, 0 percent of
15 the amount otherwise determined for the discharge
16 under clause (ii).”.

17 **SEC. 6138. ELIMINATION OF BAD DEBT RECOGNITION FOR**
18 **HOSPITAL SERVICES.**

19 (a) IN GENERAL.—Effective October 1, 1995, in
20 making any payment to hospitals under title XVIII of the
21 Social Security Act, the Secretary shall discontinue pay-
22 ments under title XVIII of such Act to providers of service
23 for reasonable costs relating to unrecovered costs associ-
24 ated with unpaid deductible and coinsurance amounts in-
25 curred under such title.

1 (b) CONFORMING AMENDMENTS.—

2 (1) IN GENERAL.—(A) Subsection (c) of section
3 4008 of the Omnibus Budget Reconciliation Act of
4 1987 is repealed.

5 (B) Section 1833 (42 U.S.C. 1395l) is amend-
6 ed—

7 (i) in subsection (l)(5), by striking sub-
8 paragraph (C); and

9 (ii) in subsection (r), by striking paragraph
10 (4).

11 (2) EFFECTIVE DATE.—The amendments made
12 by paragraph (1) shall take effect on October 1,
13 1995.

14 **SEC. 6139. MEDICARE AS SECONDARY PAYER.**

15 (a) PERMANENT EXTENSION OF DATA MATCH PRO-
16 GRAM.—

17 (1) IN GENERAL.—Section 1862(b)(5)(C) (42
18 U.S.C. 1395y(b)(5)(C)) is amended by striking
19 clause (iii).

20 (2) PERMANENT EXTENSION OF CERTAIN TAX-
21 PAYER IDENTITY INFORMATION DISCLOSURE RE-
22 QUIREMENTS.—Section 6103(l)(12) of the Internal
23 Revenue Code of 1986 is amended by striking sub-
24 paragraph (F).

1 (b) PERMANENT EXTENSION OF MEDICARE SECOND-
2 ARY PAYER TO DISABLED BENEFICIARIES.—Section
3 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)), is
4 amended—

5 (1) in the heading, by striking “SUNSET” and
6 inserting “EFFECTIVE DATE”; and

7 (2) by striking “, and October 1, 1998”.

8 (c) PERMANENT EXTENSION OF 18-MONTH RULE
9 FOR ESRD BENEFICIARIES.—The second sentence of sec-
10 tion 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amend-
11 ed by striking “and on or before October 1, 1998”.

12 **TITLE VII—PATIENT’S RIGHT TO**
13 **SELF-DETERMINATION RE-**
14 **GARDING HEALTH CARE**

15 **SEC. 7001. TREATMENT OF ADVANCE DIRECTIVES.**

16 (a) IN GENERAL.—An advance directive that fails to
17 meet the formalities of execution, form, or language re-
18 quired by State law shall be given effect to the extent that
19 the treating health care provider in good faith believes that
20 such directive constitutes a reliable expression of the wish-
21 es of the individual executing such directive concerning
22 such individual’s health care.

23 (b) CONSTRUCTION.—Nothing in subsection (a) may
24 be construed to authorize the administration, withholding,

1 or withdrawal of health care otherwise prohibited by the
2 laws of the State.

3 **SEC. 7002. EFFECT ON OTHER LAWS.**

4 Written policies and written information adopted by
5 health care providers pursuant to sections 4206 and 4751
6 of the Omnibus Budget Reconciliation Act of 1990 (Public
7 Law 101–508), shall be modified within 6 months of en-
8 actment of this title to conform to the provisions of this
9 title.

10 **SEC. 7003. INFORMATION PROVIDED TO CERTAIN INDIVID-**
11 **UALS.**

12 The Secretary shall provide on a periodic basis writ-
13 ten information regarding an individual's right to consent
14 to, or to decline, medical treatment as provided in this
15 title to individual's who are beneficiaries under titles II,
16 XVI, XVIII, and XIX of the Social Security Act.

17 **SEC. 7004. RECOMMENDATIONS TO THE CONGRESS ON IS-**
18 **SUES RELATING TO A PATIENT'S RIGHT OF**
19 **SELF-DETERMINATION.**

20 Not later than 180 days after the date of the enact-
21 ment of this Act the Secretary shall study the implementa-
22 tion of sections 4206 and 4751 of the Omnibus Budget
23 Reconciliation Act of 1990 (Public Law 101–508) and
24 provide recommendations to the Congress concerning the
25 results of the study and the medical, legal, ethical, social,

1 and educational issues related to provisions of this title.
 2 In developing recommendations under this section the Sec-
 3 retary shall address the following issues:

4 (1) Issues pertaining to the education of the
 5 public regarding their rights to execute advance di-
 6 rectives.

7 (2) Issues pertaining to the education and
 8 training of health care professionals concerning pa-
 9 tients' self-determination rights.

10 (3) Issues pertaining to health care profes-
 11 sionals' duties with respect to patients' rights, and
 12 health care professionals' roles in identifying, assess-
 13 ing, and presenting for patient consideration medi-
 14 cally indicated treatment options.

15 (4) Such other issues as the Secretary may
 16 identify.

17 **SEC. 7005. EFFECTIVE DATE.**

18 This title shall take effect on the date that is 6
 19 months after the date of enactment of this Act.

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