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103D CONGRESS
2D SESSION

S. 2357

To achieve universal health insurance coverage, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 3 (legislative day, JULY 20), 1994

Mr. MITCHELL introduced the following bill; which was read the first time

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A BILL

To achieve universal health insurance coverage, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Security Act''.

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

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PART 1—RULES OF GENERAL APPLICABILITY

SEC. 1001. ACCESS TO STANDARDIZED COVERAGE.

(a) IN GENERAL.—A participating State system shall require that each health plan (whether insured or self-insured) or long-term care policy issued, sold, offered for sale, or operated in the State shall be certified by the appropriate certifying authority as one of the following:

(1) A certified standard health plan.

(2) A certified supplemental health benefits plan.

(3) A certified long-term care policy under part 2 of subtitle B of title II.

(b) FEDERAL CERTIFICATION OF MULTISTATE SELF-INSURED PLANS.—For Federal certification of multistate self-insured health plans, see section 1482.

SEC. 1002. STANDARD HEALTH PLAN PRINCIPLES.

In accordance with this Act, the following principles shall apply to all standard health plans:

(1) No standard health plan may discriminate on the basis of medical history, health status, pre-existing medical conditions, or genetic predisposition to medical conditions.

(2) A standard health plan—

(A) shall offer an annual open enrollment period and accept all eligible individuals for coverage;

(B) shall not impose a rider that serves to exclude coverage to an individual; and

(C) shall not impose waiting periods before coverage begins.

(3) A standard health plan shall ensure that all medically necessary or appropriate services, as defined in the benefits package, are provided.

(4) Health benefits coverage shall be portable from one standard health plan to another.

Nothing in this section shall be construed so as to relieve a standard health plan of any obligation or requirement imposed under this Act.

SEC. 1003. PROTECTION OF CONSUMER CHOICE.

Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services.

(2) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care services not included within the standard benefits package established under subtitle C.

(3) An individual who is not an eligible individual from purchasing health insurance.

(4) Employers from providing coverage for benefits in addition to such standard benefits package (subject to part 1 of subtitle D).

(5) An individual from obtaining (at the expense of such individual) health care from any health care provider of such individual's choice.

PART 2—DEFINITIONS

SEC. 1011. DEFINITIONS RELATING TO HEALTH PLANS.

Except as otherwise specifically provided, in this Act the following definitions and rules apply:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term ''health plan'' means any plan or arrangement which provides, or pays the cost of, health benefits. Such term does not include the following, or any combination thereof:

(i) Coverage only for accidental death or dismemberment.

(ii) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

(iii) A medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act).

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

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy provides sufficiently comprehensive coverage of a benefit so that it should be treated as a health plan).

(viii) An equivalent health care program.

(ix) Such other plan or arrangement as the Secretary determines is not a health plan.

Such term includes any plan or arrangement not described in any preceding subparagraph which provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

(B) INSURED HEALTH PLAN.—

(i) IN GENERAL.—The term ''insured health plan'' means any health plan which is a hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by a carrier.

(ii) CARRIER.—The term ''carrier'' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of Internal Revenue Code of 1986 as in effect before the date of the enactment of this Act), a health mainte-

nance organization, or other entity licensed or certified by the State to provide health insurance or health benefits. The Secretary may issue regulations that provide for affiliated carriers to be treated as a single carrier where appropriate under this Act.

(C) SELF-INSURED HEALTH PLAN.—The term 'self-insured health plan' means an employee welfare benefit plan, church plan, or other arrangement which—

(i) provides health benefits funded in a manner other than through the purchase of one or more insured health plans, but

(ii) does not include any coverage or insurance described in clauses (i) through (ix) of subparagraph (A).

(2) CERTIFIED STANDARD HEALTH PLAN.—

(A) IN GENERAL.—The term ''certified standard health plan'' means a standard health plan which is certified by the appropriate certifying authority as meeting the other applicable requirements of this title.

(B) STANDARD HEALTH PLAN.—The term ''standard health plan'' means a health plan which provides for the standard benefits pack-

age or the alternative standard benefits package established under subtitle C.

(3) CERTIFIED SUPPLEMENTAL HEALTH BENEFITS PLAN.—

(A) IN GENERAL.—The term ''certified supplemental health benefits plan'' means a supplemental health benefits plan which is certified by the appropriate certifying authority as meeting the applicable requirements of part 4 of subtitle B.

(B) SUPPLEMENTAL HEALTH BENEFITS PLAN.—The term ''supplemental health benefits plan'' means an insured or self-insured health plan which provides health benefits which consist of supplemental services or cost-sharing described in part 4 of subtitle B. Such term does not include a plan which provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

(4) CERTIFIED LONG-TERM CARE INSURANCE POLICY.—

(A) IN GENERAL.—The term ''certified long-term care insurance policy'' means a long-term care insurance policy which is certified by the applicable certifying authority as meeting the applicable requirements of part 2 of subtitle B of title II.

(B) LONG-TERM CARE INSURANCE POLICY.—The term ''long-term care insurance policy'' has the meaning given such term by section 2721.

(5) TERMS AND RULES RELATING TO COMMUNITY AND EXPERIENCE RATING.—

(A) COMMUNITY-RATED PLAN.—The term ''community-rated plan'' means a health plan provided to community-rated individuals which meets the requirements of section 1116.

(B) COMMUNITY-RATED EMPLOYER.—The term ''community-rated employer'' means, with respect to an employee, an employer that is not an experience-rated employer with respect to such employee.

(C) COMMUNITY-RATED INDIVIDUAL.—The term ''community-rated individual'' means an individual who is not an experience-rated individual.

(D) EXPERIENCE-RATED PLAN.—

(i) IN GENERAL.—The term ''experience-rated plan'' means a health plan which—

(I) is a self-insured health plan of an experience-rated employer, or

(II) is an insured health plan which is experience-rated,

but any such plan may cover only experience-rated individuals.

(ii) COMMUNITY RATING OF GOVERNMENT PLANS.—Such term shall not include a government plan of a State or local government.

(E) EXPERIENCE-RATED EMPLOYER.—

(i) IN GENERAL.—The term ''experience-rated employer'' means, with respect to any calendar year—

(I) any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed more than 500 employees for some portion of the day; or

(II) a multiemployer plan or rural electric cooperative or rural telephone cooperative association plan that covers 500 or more individuals.

(ii) SPECIAL RULE FOR LEASING BUSINESSES.—In the case of an employer the primary trade or business of which is employee leasing—

(I) all of the employees which such employer leases to other employers shall be treated as community-rated individuals, and

(II) this Act shall be applied separately with respect to its other employees.

(iii) U.S. POSTAL SERVICE.—Such term includes the United States Postal Service.

(F) EXPERIENCE-RATED INDIVIDUAL.—The term ''experience-rated individual'' means an individual who is an employee of an experience-rated employer or a member of a plan described in subparagraph (E)(i)(II).

(6) SPECIAL RULE FOR SPOUSES AND DEPENDENTS.—If any individual is offered coverage under a

health plan as the spouse or a dependent of a primary enrollee of such plan, such individual shall have the status of such enrollee unless such individual is eligible to elect other coverage and so elects.

SEC. 1012. DEFINITIONS RELATING TO EMPLOYMENT AND INCOME.

Except as otherwise specifically provided, in this Act the following definitions and rules apply:

(1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND WAGES DEFINED.—Except as provided in this section—

(A) the terms ''wages'' and ''employment'' have the meanings given such terms under section 3121 of the Internal Revenue Code of 1986,

(B) the term ''employee'' has the meaning given such term under section 3121 of such Code, subject to the provisions of chapter 25 of such Code, and

(C) the term ''employer'' has the same meaning as the term ''employer'' as used in such section 3121.

(2) EXCEPTIONS.—For purposes of paragraph (1)—

(A) EMPLOYMENT.—

(i) EMPLOYMENT INCLUDED.—Paragraphs (1), (2), (5), (7) (other than clauses (i) through (iv) of subparagraph (C) and clauses (i) through (v) of subparagraph (F)), (8), (9), (10), (11), (13), (15), (18), and (19) of section 3121(b) of the Internal Revenue Code of 1986 shall not apply.

(ii) EXCLUSION OF INMATES AS EMPLOYEES.—Employment shall not include services performed in a penal institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(B) WAGES.—Paragraph (1) of section 3121(a) of the Internal Revenue Code of 1986 shall not apply.

(C) EMPLOYEES.—

(i) TREATMENT OF SELF-EMPLOYED.—The term ''employee'' includes a self-employed individual.

(ii) EXCLUSION OF CERTAIN FOREIGN EMPLOYMENT.—The term ''employee'' does not include an individual with respect to service, if the individual is not a citizen or

resident of the United States and the service is performed outside the United States.

(3) AGGREGATION RULES FOR EMPLOYERS.—For purposes of this Act—

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) under regulations of the Secretary of Labor, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under subparagraph (B) shall be based on principles similar to the principles which apply to taxable organizations under subparagraph (A).

SEC. 1013. OTHER GENERAL DEFINITIONS.

Except as otherwise specifically provided, in this Act the following definitions apply:

(1) APPROPRIATE CERTIFYING AUTHORITY.—The term ''appropriate certifying authority'' means—

(A) except as provided in subparagraph (B), in the case of a standard health plan, a supplemental health benefits plan, or a long-term care insurance plan, the State commissioner or superintendent of insurance or other State authority in the participating State; or

(B) in the case of a multistate self-insured health plan or a multistate self-insured supplemental health benefits plan, the Secretary of Labor.

(2) COMMUNITY RATING AREA.—The term ''community rating area'' means an area specified by a State under section 1502(a).

(3) EQUIVALENT HEALTH CARE PROGRAM.—The term ''equivalent health care program'' means—

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

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

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

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

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

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

(G) a State single-payer system approved by the Secretary under subpart B of part 3 of subtitle F.

(4) ESSENTIAL COMMUNITY PROVIDER.—The term ''essential community provider'' means an entity certified as such a provider under subpart B of part 2 of subtitle E.

(5) HEALTH PLAN SPONSOR.—The term ''health plan sponsor'' means—

(A) with respect to a community-rated plan, the carrier providing the plan,

(B) with respect to an insured experience-rated plan, the carrier providing the plan, and

(C) with respect to a self-insured experience-rated plan, the experience-rated employer providing the plan.

(6) MEDICARE PROGRAM.—The term ''medicare program'' means the health insurance program under title XVIII of the Social Security Act.

(7) MEDICARE-ELIGIBLE INDIVIDUAL.—The term ''medicare-eligible individual'' means an individual who is entitled to benefits under part A of the medicare program.

(8) MULTIEMPLOYER PLAN.—The term ''multiemployer plan'' has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

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

(10) PARTICIPATING PROVIDER.—The term ''participating provider'' means, with respect to a health plan, a provider of health care services who is a member of a provider network of the plan.

(11) PARTICIPATING STATE.—The term ''participating State'' means a State establishing a State program under this title.

(12) PURCHASING COOPERATIVE.—The term ''purchasing cooperative'' means a health insurance cooperative established under part 2 of subtitle D.

(13) RESIDENCE.—

(A) IN GENERAL.—An individual is considered to reside in the location in which the individual maintains a primary residence (as established under rules of the Secretary).

(B) MULTIPLE RESIDENCES.—Under such rules and subject to section 1112, in the case of an individual who maintains more than one residence, the primary residence of the individual shall be determined taking into account the proportion of time spent at each residence.

(C) COUPLE.—In the case of a couple only one spouse of which is a qualifying employee, except as the Secretary may provide, the residence of the employee shall be the residence of the couple.

(14) RURAL ELECTRIC COOPERATIVE.—The term ''rural electric cooperative'' has the meaning given such term in section 3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

(15) RURAL TELEPHONE COOPERATIVE ASSOCIATIONS.—The term ''rural telephone cooperative

association'' has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

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

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

(18) UNITED STATES.—The term ''United States'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.

Subtitle B—Health Plan Standards

PART 1—ESTABLISHMENT AND APPLICATION OF STANDARDS

SEC. 1101. ESTABLISHMENT OF NATIONAL STANDARDS.

In order for a standard health plan to be eligible to be certified as a standard health plan by a participating State, the standard health plan shall meet the requirements of this Act, including the following uniform national standards established in this subtitle and described in regulations promulgated by the Secretary:

(1) The insurance market reform standards of part 2.

(2) The delivery system reform standards of part 3.

(3) Standards for participation in a guaranty fund established by the State under section 1505 (established by the Secretary of Labor in the case of multistate self-insured standard health plans).

(4) Standards for the collection and reporting of data in accordance with subtitle B of title V.

(5) Standards for effective grievance procedures that enrollees may utilize in pursuing complaints in accordance with subtitle C of title V.

SEC. 1102. GENERAL RULES.

(a) CONSTRUCTION.—Whenever in this subtitle a requirement or standard is imposed on a standard health plan, the requirement or standard is deemed to have been imposed on the insurer or sponsor of the plan or policy in relation to that plan or policy.

(b) USE OF INTERIM, FINAL REGULATIONS.—In order to permit the timely implementation of the provisions of this subtitle, the Secretary and the Secretary of Labor are each authorized to issue regulations under this subtitle on an interim basis that become final on the date of publication, subject to change based on subsequent public comment.

PART 2—INSURANCE MARKET REFORM

SEC. 1111. GUARANTEED ISSUE, AVAILABILITY, AND RENEWABILITY.

(a) GUARANTEED ISSUE.—Except as otherwise provided in this section, a standard health plan sponsor—

(1) offering a community-rated standard health plan shall offer such plan to any community-rated individual applying for coverage (either directly with the plan or through an employer or a purchasing cooperative); and

(2) offering an experience-rated standard health plan shall offer such plan to any experience-rated individual eligible for coverage under the plan through such individual's experience-rated employer.

No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics, such as occupation or affiliation with any person or entity, or those characteristics described in section 1602.

(b) AVAILABILITY.—

(1) IN GENERAL.—A community-rated standard health plan shall be made available to community-rated individuals throughout the entire community rating area in which such plan is offered, including through any employer purchasing cooperative choosing to offer such plan.

(2) GEOGRAPHIC LIMITATIONS.—

(A) NONNETWORK PLANS.—A community-rated nonnetwork plan (as defined in section 1127(d(2)(A)) may deny coverage under the plan to a community-rated individual who resides outside the community rating area in which such plan is offered.

(B) NETWORK PLANS.—A community-rated network plan (as defined in section 1127(e)(5)(A)) may deny coverage under the plan to a community-rated individual who resides outside the health plan service area in which such plan is offered.

(C) RULES REGARDING DENIALS.—No denial may be made under subparagraph (A) or (B) unless such denial is applied uniformly, without regard to health status, insurability of individuals, or other characteristics described in section 1602.

(3) CAPACITY LIMITATIONS.—

(A) IN GENERAL.—With the approval of the appropriate regulatory authority, a standard health plan may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability. If such a limitation

is imposed, the limitation may not be imposed on a basis of personal characteristics, such as occupation or affiliation with any person or entity, or those characteristics described in section 1602.

(B) RESTRICTIONS.—If such a limitation is imposed—

(i) the plan may only enroll individuals under the plan consistent with rules established by the State consistent with subparagraph (C); and

(ii) the plan may not discriminate based on the method through which a family seeks enrollment under the plan.

(C) STATE OVERSIGHT.—Each State shall, in accordance with rules promulgated by the Secretary, establish procedures and methods to assure equal opportunity of enrollment for all families, regardless of when during the open enrollment period, or the method by which, the enrollment has been sought.

(c) RENEWABILITY; LIMITATION ON TERMINATION.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), a standard health plan that is

issued to an individual shall be renewed, at the option of the individual.

(2) GROUNDS FOR REFUSAL TO RENEW OR TERMINATE.—A standard health plan sponsor may refuse to renew, or may terminate, a standard health plan under this title only for—

(A) in the case of plan in a participating State and any community rating area in such State with respect to which the requirements of title X have not become effective, nonpayment of premiums;

(B) fraud on the part of the individual relating to such plan; or

(C) misrepresentation of material facts on the part of the individual relating to an application for coverage or claim for benefits.

(3) TERMINATION OF PLANS.—A standard health plan may elect not to renew or make available the standard health plan through a particular type of delivery system in a community rating area, but only if the standard health plan—

(A) elects not to renew all of its standard health plans using such delivery system in such community rating area; and

(B) provides notice to the appropriate certifying authority and each individual covered under the plan of such termination at least 180 days before the date of expiration of the plan.

In such case, a standard health plan sponsor may not provide for the issuance of any standard health plan using such a delivery system in such community rating area during a 5-year period beginning on the date of the termination of the last plan not so renewed. For purposes of this paragraph, the term ''delivery system'' means a delivery system used by a network plan (as defined in section 1128(e)(5)(A)) or a nonnetwork plan.

(d) CERTAIN EXCLUDED PLANS.—The provisions of this section, other than subsections (c) and (e)(2)(B), shall not apply to any religious fraternal benefit society in existence as of September 1993, which bears the risk of providing insurance to its members, and which is an organization described in section 501(c)(8) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code.

(e) APPLICATION OF INTERIM STANDARDS.—

(1) IN GENERAL.—During the interim standards application period, a health plan sponsor may only offer a health plan in a State if such plan sponsor publicly discloses the health plans such sponsor

offers in the State and each offered plan meets the standards specified in paragraph (2).

(2) SPECIFIED STANDARDS.—

(A) ISSUE AND AVAILABILITY.—The standards specified in subsections (a) and (b) if the individual or group applies for coverage during the open enrollment period required under section 1112(h).

(B) RENEWAL.—The standards specified in subsection (c), except paragraph (3) shall be applied by substituting ''State'' for ''community rating area''.

(3) INTERIM STANDARDS APPLICATION PERIODS.—The interim standards application period is—

(A) in the case of the standard specified in paragraph (2)(A), on or after January 1, 1995, and before January 1, 1997; and

(B) in the case of the standard specified in paragraph (2)(B), on or after August 1, 1994, and before January 1, 1997.

(4) PREEMPTION.—The requirements of this subsection do not preempt any State law unless State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with

such requirements. The Secretary may issue letter determinations with respect to whether this subsection preempts a provision of State law.

(5) CONSTRUCTION.—The provisions of this subsection shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health plans in effect on the effective date of this title.

(6) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations regarding the application of this subsection in the case of health plans (or groups of such plans) which are transferred from one health plan sponsor to another sponsor through assumption, acquisition, or otherwise.

SEC. 1112. ENROLLMENT.

(a) IN GENERAL.—Each standard health plan shall establish an enrollment process consistent with this section.

(b) ANNUAL OPEN ENROLLMENT PERIOD.—Each standard health plan shall permit eligible individuals to enroll (or change enrollment) in the plan during each annual open enrollment period for each community rating area specified by the appropriate certifying authority under section 1503.

(c) ADDITIONAL PERIODS OF AUTHORIZED CHANGES IN ENROLLMENT.—

(1) IN GENERAL.—Each standard health plan shall provide for changes in enrollment with respect to such other periods and occurrences (including changes in residence, appropriate changes in employment, and the insolvency of carriers or experience-rated employers) for which an individual is authorized to change enrollment in standard health plans, as the Secretary shall specify.

(2) DISENROLLMENT FOR CAUSE.—

(A) IN GENERAL.—The Secretary shall establish procedures by which individuals enrolled in a standard health plan may disenroll from such plan for good cause (as defined by Secretary) at any time during a year and enroll in another standard health plan. Such procedures shall be implemented by participating States in a manner that ensures continuity of coverage for the standard benefits package or the alternative standard benefits package for such individuals during the year.

(B) ADDITIONAL REMEDIES.—In the case of an individual who changes enrollment from a plan for good cause due to a pattern of

underservice under a plan, the Secretary may provide rules under which the carrier providing the standard health plan is liable, to the subsequent standard health plan in which the individual is enrolled, for excess costs (as identified in accordance with such rules) during the period for which it may be reasonably anticipated that the individual would (but for such cause) have continued enrollment with the original standard health plan.

(d) EFFECTIVENESS OF CHANGE OF ENROLLMENT.—Except as the Secretary may provide, changes in enrollment during an annual open enrollment period under subsection (a) shall take effect as determined by the appropriate certifying authority. The Secretary shall also provide when a change of enrollment under subsection (c) becomes effective.

(e) DIRECT ENROLLMENT.—

(1) IN GENERAL.—Subject to paragraph (2), each community-rated standard health plan shall provide for the direct enrollment of community-rated individuals in the plan under methods and procedures established by the Secretary.

(2) ENROLLMENT PROCESSES.—The Secretary shall provide standards for States to ensure the

broad availability and processing of enrollment forms, including direct enrollment through the mail, and other such processes as the Secretary may designate.

(f) MARKETING FEES.—A community-rated standard health plan may impose a marketing fee surcharge for community-rated individuals enrolling in the plan through an agent, broker, or other authorized sales method, or through a direct enrollment process. Such surcharge shall be in addition to the highest marketing fee of such plan for community-rated individuals enrolled in such a plan through any purchasing cooperative in the community rating area.

(g) CHANGE OF ENROLLMENT.—As used in this section, the term ''change of enrollment'' includes, with respect to an individual—

(1) a change in the standard health plan in which the individual is enrolled,

(2) a change in the type of family enrollment, and

(3) the enrollment of the individual at the time the individual's status changes to a community-rated individual, experience-rated individual, or a premium subsidy-eligible individual under section 6002.

(h) APPLICATION OF INTERIM STANDARD.—

(1) IN GENERAL.—During the interim standard application period, a health plan sponsor may only offer a health plan in a State if such plan sponsor publicly discloses the health plans such sponsor offers in the State and each offered plan provides for an annual open enrollment period of at least 30 days.

(2) INTERIM STANDARD APPLICATION PERIODS.—The interim standard application period is on or after January 1, 1995, and before January 1, 1997.

(3) APPLICATION OF RULES.—Paragraphs (4), (5), and (6) of section 1111(d) shall apply to this subsection.

SEC. 1113. COVERAGE OF DEPENDENTS.

(a) IN GENERAL.—Except as otherwise provided in this Act, a standard health plan shall enroll all members of the same family (as defined in subsection (b)).

(b) FAMILY DEFINED.—In this Act, unless otherwise provided, the term ''family''—

(1) means, with respect to an individual who is not a child (as defined in subsection (c)), the individual; and

(2) includes the following persons (if any):

(A) The individual's spouse.

(B) The individual's children (and, if applicable, the children of the individual's spouse).

(c) CLASSES OF ENROLLMENT; TERMINOLOGY.—

(1) IN GENERAL.—In this Act, each of the following is a separate class of enrollment:

(A) Coverage only of an individual (referred to in this Act as the ''individual'' enrollment or class of enrollment).

(B) Coverage only of a child (referred to in this Act as the 'single child' enrollment or class of enrollment).

(C) Coverage only of one or more children (referred to in this Act as the 'multiple children' enrollment or class of enrollment).

(D) Coverage of a married couple without children (referred to in this Act as the ''couple-only'' enrollment or class of enrollment).

(E) Coverage of an individual and one or more children (referred to in this Act as the ''single parent'' enrollment or class of enrollment).

(F) Coverage of a married couple and one or more children (referred to in this Act as the ''dual parent'' enrollment or class of enrollment).

(2) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this Act:

(A) FAMILY.—The terms ''family enrollment'' and ''family class of enrollment'', refer to enrollment in a class of enrollment described in any subparagraph of paragraph (1) (other than subparagraph (A)).

(B) COUPLE.—The term ''couple class of enrollment'' refers to enrollment in a class of enrollment described in subparagraph (D) or (F) of paragraph (1).

(d) SPOUSE; MARRIED; COUPLE.—

(1) IN GENERAL.—In this Act, the terms ''spouse'' and ''married'' mean, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

(2) COUPLE.—The term ''couple'' means an individual and the individual's spouse.

(e) CHILD DEFINED.—

(1) IN GENERAL.—In this Act, except as otherwise provided, the term ''child'' means an individual who is a child (as determined under paragraph (3)) who—

(A) is under 25 years of age or is disabled, and

(B) is unmarried.

The Secretary may adjust the age limitation in subparagraph (A) with respect to part-time or full-time students.

(2) APPLICATION OF STATE LAW.—Subject to paragraph (3), determinations of whether a person is the child of another person shall be made in accordance with applicable State law.

(3) NATIONAL RULES.—The Secretary may establish such national rules respecting individuals who will be treated as children under this Act as the Secretary determines to be necessary. Such rules shall be consistent with the following principles:

(A) STEP CHILD.—A child includes a step child who is an individual living with an adult in a parent-child relationship.

(B) DISABLED CHILD.—A child includes an unmarried dependent individual regardless of age who is incapable of self-support because of mental or physical disability which existed before age 25.

(C) CERTAIN INTERGENERATIONAL FAMILIES.—A child includes the grandchild of an individual if—

(i) the parent of the grandchild is a child and the parent and grandchild are living with the grandparent; or

(ii) the grandparent has legal custody of the grandchild.

(D) TREATMENT OF EMANCIPATED MINORS.—An emancipated minor shall not be treated as a child.

(E) CHILDREN PLACED FOR ADOPTION.—

(i) IN GENERAL.—A child includes a child who is placed for adoption with an individual, except when the child is a child in State-supervised care.

(ii) PLACED FOR ADOPTION.—The term ''placed for adoption'' in connection with any placement for adoption of a child with any individual, means the assumption and retention by such individual of a legal obligation for total or partial support of such child in anticipation of the adoption of such child.

(f) ADDITIONAL RULES.—

(1) IN GENERAL.—The Secretary shall provide for such additional exceptions and special rules, including rules relating to—

(A) families in which members are not residing in the same area or in which children are not residing with their parents,

(B) changes in family composition occurring during a year,

(C) treatment of children in State-supervised care, and

(D) treatment of children of parents who are separated or divorced,

as the Secretary finds appropriate.

(2) CHILDREN IN STATE-SUPERVISED CARE.—

(A) IN GENERAL.—In the case of a child in State-supervised care (as described in subparagraph (B)), the child shall be considered as a family of one and enrolled by the State agency who has been awarded temporary or permanent custody of the child (or which has legal responsibility for the child) in a high cost-sharing plan unless the State agency has established a special health service delivery system designated to customize and more efficiently provide health services to children in State-supervised care, in

which case the State agency will enroll the child in the plan appropriate to ensure access to such a special health service delivery system.

(B) CHILDREN IN STATE-SUPERVISED CARE.—For purposes of subparagraph (A), the term ''child in State-supervised care'' means any child who is residing away from the child's parents and is temporarily or permanently, on a voluntary or involuntary basis, under the responsibility of a public child welfare or juvenile services agency or court. Such term includes any child who is not yet made a ward of the court or adjudicated as a delinquent residing in emergency shelter care, any child in the physical custody of public or private agencies, and any child who is with foster parents, or other group or residential care providers. Such term also includes any child who is legally adopted and for whom the Federal or State government is providing adoption assistance payments.

(g) APPLICATION OF INTERIM STANDARDS.—

(1) IN GENERAL.—During the interim standards application period, a health plan sponsor may only offer a health plan in a State if such plan meets the standards specified in this section.

(2) INTERIM STANDARDS APPLICATION PERIODS.—The interim standards application period is on or after January 1, 1995, and before January 1, 1997.

(3) APPLICATION OF RULES.—Paragraphs (4), (5), and (6) of section 1111(d) shall apply to this subsection.

SEC. 1114. NONDISCRIMINATION BASED ON HEALTH STATUS.

(a) NO LIMITS ON COVERAGE; NO PRE-EXISTING CONDITION LIMITS.—Except as provided in subsection (b), a standard health plan may not—

(1) terminate, restrict, or limit coverage or establish premiums based on the health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care services, disability, or lack of evidence of insurability of an individual;

(2) terminate, restrict, or limit coverage in any portion of the plan's community rating area, except as provided in section 1111(b)(2);

(3) except as provided in section 1111(c)(2), cancel coverage for any community-rated individual until that individual is enrolled in another applicable standard health plan;

(4) impose waiting periods before coverage begins; or

(5) impose a rider that serves to exclude coverage of particular individuals or particular health conditions.

(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS.—

(1) IN GENERAL.—Subject to paragraph (4), before January 1, 2002, a standard health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual if—

(A) the condition was diagnosed or treated during the 3-month period ending on the day before the date of enrollment under the plan;

(B) the limitation or exclusion extends for a period not more than 6 months after the date of enrollment under the plan;

(C) the limitation or exclusion does not apply to an individual who, as of the date of birth, was covered under the plan; or

(D) the limitation or exclusion does not relate to pregnancy.

(2) CONTINUOUS COVERAGE.—A standard health plan shall provide that if an individual under such plan is in a period of continuous coverage with respect to particular services as of the date of enrollment under such plan, any period of exclusion of coverage with respect to a preexisting condition as permitted under paragraph (1) shall be prohibited.

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

(A) PERIOD OF CONTINUOUS COVERAGE.—The term ''period of continuous coverage'' means, with respect to particular services, the period beginning on the date an individual is enrolled under a standard health plan or an equivalent health care program which provides benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(B) PREEXISTING CONDITION.—The term ''preexisting condition'' means, with respect to coverage under a standard health plan, a condition which was diagnosed, or which was treated, within the 3-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(4) NO EXCLUSION DURING AMNESTY PERIOD OR WITH RESPECT TO A SUBSIDY-ELIGIBLE INDIVIDUAL.—This subsection shall not apply—

(A) during the first annual open enrollment period specified by the appropriate certifying authority under section 1503, and

(B) with respect to the enrollment of an individual eligible for a premium subsidy under subtitle A of title VI.

(c) APPLICATION OF INTERIM STANDARD.—

(1) IN GENERAL.—During the interim standard application period, a health plan sponsor may only offer a health plan in a State if such plan meets the standard specified in paragraph (2).

(2) SPECIFIED STANDARDS.—

(A) EXCLUSION.—The standards specified in subsection (b) by substituting—

(i) ''6-month'' for ''3-month'' in paragraph (1)(A), and

(ii) ''major medical insurance plan or other plan offering coverage similar to the benefits included in the standard benefits package as established under subtitle C'' for ''standard health plan''.

(B) COVERAGE.—A self-insured health plan may not reduce or limit coverage of any condition or course of treatment that is expected to cost more than $2,500 during any 12-month period.

(3) INTERIM STANDARDS APPLICATION PERIOD.—The interim standards application period is—

(A) in the case of the standard specified in paragraph (2)(A), on or after January 1, 1995, and before January 1, 1997, and

(B) in the case of the standard specified in paragraph (2)(B), on or after August 1, 1994, and before January 1, 1997.

(4) APPLICATION OF RULES.—Paragraphs (4), (5), and (6) of section 1111(e) shall apply to this subsection.

SEC. 1115. BENEFITS.

(a) IN GENERAL.—A standard health plan shall offer to all enrollees in the plan the standard benefits package or the alternative standard benefits package established under subtitle C.

(b) ALTERNATIVE STANDARD BENEFITS PACKAGE.—

(1) IN GENERAL.—A carrier may only offer a standard health plan with an alternative standard benefits package in a community rating area if such carrier also offers a standard health plan with a standard benefits package in such area.

(2) INCLUSION IN RISK ADJUSTMENT AND REINSURANCE PROGRAMS.—Any standard health plan with an alternative standard benefits packages shall be included in any reinsurance or risk adjustment program under section 1117 operating in the community rating area in which such plan is offered.

(3) OFFER PROHIBITED IF MANDATES REQUIRED.—A carrier may not offer an alternative benefits package in a participating State and any community rating area in such State with respect to which the requirements of title X have become effective.

SEC. 1116. COMMUNITY RATING REQUIREMENTS.

(a) APPLICABILITY.—Except as provided in subsection (e), the provisions of this section shall apply to community-rated standard health plans.

(b) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED INDIVIDUALS.—Subject to subsection (d), each community-rated standard health plan shall establish within each community rating area in which the plan is

to be offered a standard premium for individual enrollment for the standard benefits package and the alternative standard benefits package established under subtitle C.

(c) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

(1) IN GENERAL.—Subject to paragraph (2), the standard premium described in subsection (b) for all community-rated individuals within a community rating area shall be the same.

(2) APPLICATION TO ENROLLEES.—

(A) IN GENERAL.—The premium charged for coverage in a standard health plan shall be the product of—

(i) the standard premium (established under paragraph (1));

(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

(iii) the age adjustment factor (specified under subparagraph (C)).

(B) FAMILY ADJUSTMENT FACTOR.—The Secretary, in consultation with the NAIC, shall develop a family adjustment factor that reflects the relative actuarial costs of benefit packages

based on the applicable family enrollment (as compared with such costs for individual enrollment).

(C) AGE ADJUSTMENT FACTOR.—The Secretary, in consultation with the NAIC, shall specify, within 6 months of the date of the enactment of this Act, uniform age categories and rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. The highest age adjustment factor may not exceed twice the lowest age adjustment factor for individuals 18 to 65 years of age. The Secretary shall also provide for the gradual phaseout of age adjustment factors by January 1, 2002.

(d) LOWER PREMIUM THROUGH PURCHASING COOPERATIVES.—Notwithstanding any other provision of this section, no premium may be charged to a community-rated individual by a community-rated standard health plan in a community rating area which is not the same premium negotiated for such plan offered through any purchasing cooperative in such area.

(e) EXPERIENCE RATING.—

(1) APPLICABILITY.—The provisions of this subsection shall apply to experience-rated standard health plans.

(2) RATING.—For purposes of applying this section to experience-rated employers, the employees of the employer involved shall constitute the community with respect to the determination of the premium.

(3) PREMIUMS.—An experience-rated standard health plan may not vary the premium imposed with respect to experience-rated individuals enrolled in the plan, except as may be allowed under this section with respect to geographic and family coverage factors (as determined by the Secretary of Labor) under the plan.

SEC. 1117. RISK ADJUSTMENT AND REINSURANCE.

(a) IN GENERAL.—Except as provided in subsection (b), each standard health plan shall participate in a standard health plan risk adjustment program and a reinsurance program implemented by the State in accordance with section 1504.

(b) MULTISTATE PLANS.—Each multistate self-insured standard health plan shall participate in a reinsurance program developed by the Secretary of Labor under section 1482.

SEC. 1118. FINANCIAL SOLVENCY REQUIREMENTS AND CONSUMER PROTECTION AGAINST PROVIDER CLAIMS.

(a) SOLVENCY PROTECTION.—Each standard health plan shall meet financial solvency requirements to assure protection of enrollees with respect to potential insolvency. Each standard health plan shall meet requirements relating to capital and solvency established by the Secretary under section 1401(h).

(b) PROTECTION AGAINST PROVIDER CLAIMS.—In the case of a failure of a standard health plan to make payments with respect to the standard benefits covered under the plan for any reason, an individual who is enrolled under the plan is not liable to any health care provider with respect to the provision of health services within such set of benefits for payments in excess of the amount for which the enrollee would have been liable if the plan were to have made payments in a timely manner.

PART 3—DELIVERY SYSTEM REFORM

SEC. 1121. PROHIBITION OF DISCRIMINATION.

(a) IN GENERAL.—Each standard health plan shall comply with the antidiscrimination requirements of section 1602.

(b) ADDITIONAL ANTIDISCRIMINATION REQUIREMENTS.—

(1) IN GENERAL.—No standard health plan may discriminate on the basis of the provider's status as a member of a health care profession for the purposes of selecting among providers of health services for participation in a provider network, but only if the State authorizes members of that profession to render the services in question and such services are covered in the standard benefits package established under subtitle C.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(B) shall be construed as requiring any standard health plan to:

(A) include in a network any individual provider;

(B) establish any defined ratio of different categories of health professionals; or

(C) establish any specific utilization review or internal quality standards other than that required in other provisions of this Act.

SEC. 1122. QUALITY ASSURANCE STANDARDS.

(a) IN GENERAL.—Each standard health plan shall comply with the plan performance standards in accordance with subtitle A of title V. Each standard health plan shall establish procedures, including ongoing quality improvement procedures, to ensure that the health care services

provided to enrollees under the plan will be provided under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice and the quality standards established under subtitle A of title V.

(b) INTERNAL QUALITY ASSURANCE PROGRAM.—Each standard health plan shall establish, and communicate to its enrollees and its providers, an ongoing internal program, including periodic reporting, to monitor and evaluate the quality and cost effectiveness of its health care services, pursuant to standards established by the National Quality Council.

SEC. 1123. CONSUMER GRIEVANCE PROCESS.

Each standard health plan shall demonstrate to the appropriate certifying authority the capability to administer the plan in a manner which ensures due process for all enrollees under rules established by the Secretary.

SEC. 1124. HEALTH SECURITY CARDS.

Each standard health plan shall issue a health security card to each individual enrolled in such plan in accordance with subtitle B of title V and regulations promulgated by the Secretary.

SEC. 1125. INFORMATION AND MARKETING STANDARDS.

(a) IN GENERAL.—Each standard health plan shall provide information to the participating State and each

purchasing cooperative through which such plan is offered in accordance with sections 1401(d) and 5009, other applicable information requirements of this Act, and rules promulgated by the Secretary.

(b) MARKETING METHODS; ADVERTISING MATERIALS.—A standard health plan may utilize direct marketing, agency, or other arrangements to distribute health plan information, subject to applicable fair marketing practices laws and standards established by the State or by the Secretary, including standards to prevent selective marketing. All advertising, promotional materials, and other communications with health plan members and the general public must be factually accurate and responsive to the needs of served populations. A standard health plan may not distribute marketing materials to an area smaller than the entire community rating area of the plan.

(c) PAYMENT OF AGENT COMMISSIONS.—A standard health plan—

(1) may pay a commission or other remuneration to an agent or broker in marketing the plan to individuals or groups, but

(2) may not vary such remuneration based, directly or indirectly, on the anticipated or actual claims experience associated with the group or individuals to which the plan was sold.

(d) MATERIALS IN APPROPRIATE LANGUAGES.—In the case of a community rating area that includes a significant number or proportion of residents with limited English proficiency, each standard health plan in such area shall provide all materials under this Act at an appropriate reading level and in the native languages of such residents, as appropriate.

SEC. 1126. INFORMATION REGARDING A PATIENT'S RIGHT TO SELF-DETERMINATION IN HEALTH CARE SERVICES.

(a) IN GENERAL.—Each standard health plan shall provide written information to each individual enrolling in such plan of such individual's right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives (as defined in section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3))), and the written policies of the standard health plan with respect to such right.

(b) PROMOTION OF SHARED DECISION MAKING.—Each standard health plan shall promote shared decision making by assuring that patients are appropriately informed about health care treatment options.

SEC. 1127. CONTRACTS WITH PURCHASING COOPERATIVES.

(a) CONTRACTS WITH COOPERATIVES.—A community-rated standard health plan provided by a carrier shall enter into contracts with each purchasing cooperative seeking such a contract in the community rating area served by the plan.

(b) PRICING.—No community-rated standard health plan shall offer a rate to a purchasing cooperative in the community rating area served by the plan that is more than the premium rate determined under section 1116. Such a plan may charge a marketing fee as specified under section 1324(b)(1).

SEC. 1128. HEALTH PLAN ARRANGEMENTS WITH PROVIDERS.

(a) PROVIDERS OUTSIDE AREA.—A State may not limit the ability of any plan to contract with a provider of health services located outside of the geographic boundaries of a community rating area or the State.

(b) TREATMENT OF COST-SHARING.—Each standard health plan which provides the standard benefits package shall include in its payments to providers such additional reimbursements as may be necessary to reflect cost-sharing reductions to which individuals are entitled under subtitle A of title VI.

(c) PROVIDER VERIFICATION.—Each standard health plan shall ensure that all health care providers reimbursed

by the plan are authorized under State law to provide applicable services. Each standard health plan shall—

(1) verify the credentials of practitioners and facilities;

(2) ensure that all providers meet applicable State licensing and certification standards;

(3) ensure that each health care provider participating in the plan annually discloses information regarding operations, ownership, finances, and workforce necessary to evaluate the providers compliance with this Act;

(4) oversee the quality and performance of participating providers, consistent with section 1122; and

(5) investigate and resolve consumer complaints against participating providers.

(d) REQUIREMENTS FOR NONNETWORK PLANS.—

(1) IN GENERAL.—Each standard health plan shall demonstrate, based on standards established by the Secretary, arrangements with a sufficient number, distribution, and variety of qualified health professionals that will accept the plan's payment rates in full to ensure that all nonnetwork items and services covered by the standard benefits package established under subtitle C are available and accessible

to all enrollees throughout the community rating area with reasonable promptness and in a manner which assures continuity.

(2) DEFINITIONS RELATING TO NONNETWORK PLANS.—For purposes of this Act:

(A) NONNETWORK PLAN DEFINED.—The term ''nonnetwork plan'' means a standard health plan that does not utilize a provider network (as defined in subsection (e)(5)(B)).

(B) NONNETWORK ITEMS AND SERVICES.—The term ''nonnetwork items and services'' means items or services provided to an individual enrolled under a standard health plan by a health care provider who is not a member of a provider network of the plan.

(e) REQUIREMENTS FOR NETWORK PLANS.—

(1) AGREEMENTS.—Each standard health plan shall enter into agreements or have such other arrangements with a sufficient number, distribution, and variety of qualified health professionals within the network that will accept the plan's payment rates as payments in full to ensure that all services covered by the standard benefit package established under subtitle C are available and accessible to all enrollees throughout the health plan service area (es-

tablished under section 1502(d)) with reasonable promptness and in a manner which assure continuity.

(2) GATEKEEPER.—With respect to each standard health plan that utilizes a gatekeeper or similar process to approve health care services, such plan shall ensure that such gatekeeper or process does not create an undue burden for enrollees with complex or chronic health conditions and shall ensure access to relevant specialists for the continued care of such enrollees when medically indicated. In cases of a patient with a severe, complex, or chronic health condition, such plan shall determine, in conjunction with the enrollee and the enrollee's primary care provider, whether it is medically necessary or appropriate to use a specialist or a care coordinator from an interdisciplinary team as the gatekeeper or in the health care approval process.

(3) CONTINUED CARE.—Each standard health plan shall develop and implement mechanisms for coordinating the delivery of care among different providers so as to enhance continuity of care for the patient.

(4) ELIGIBLE CENTERS OF SPECIALIZED TREATMENT EXPERTISE.—

(A) IN GENERAL.—Each standard health plan must demonstrate that adults, children, and individuals with disabilities have access to specialized treatment expertise when medically indicated by meeting evaluation criteria established by the Secretary. In establishing such criteria, the Secretary may consider a process by which a standard health plan could be deemed to meet such evaluation criteria if such plan demonstrates referrals to designated centers of specialized care when medically necessary or appropriate, informs enrollees of the availability of referral care, and ensures compliance with section 1123.

(B) ELIGIBLE CENTERS.—The Secretary shall establish criteria for designating centers of specialized care and shall designate eligible centers based on such criteria. The criteria shall include requirements for staff credentials and experience, and requirements for measured outcomes in the diagnosis and treatment of patients. The Secretary shall develop additional criteria for outcomes of specialized treatment as research findings become available. To be des-

ignated as a center of specialized care, a center shall—

(i) attract patients from outside the center's local geographic region, from across the State or the Nation; and

(ii) either sponsor, participate in, or have medical staff who participate in peer-reviewed research.

(C) LIMITATION.—A State may not establish rules or policies that require or encourage standard health plans to give preference to centers of specialized treatment expertise within the State or within the community rating area. A standard health plan shall not prohibit an academic health center, teaching hospital, or other center for specialized care with which it contracts from contracting with one or more other plans.

(D) SPECIALIZED TREATMENT EXPERTISE.—For purposes of this paragraph, the term ''specialized treatment expertise'', with respect to the treatment of a health condition by an eligible center, means expertise in diagnosing and treating unusual diseases or conditions, diagnosing and treating diseases or conditions

which are unusually difficult to diagnose or treat, and providing other specialized health care.

(5) DEFINITIONS RELATING TO NETWORK PLANS.—For purposes of this Act:

(A) NETWORK PLAN DEFINED.—The term ''network plan'' means a standard health plan that utilizes a provider network.

(B) PROVIDER NETWORK DEFINED.—The term ''provider network'' means, with respect to a standard health plan, providers that have entered into an agreement with the plan under which such providers are obligated to provide items and services in the standard benefits package established under subtitle C to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(C) NETWORK ITEMS AND SERVICES.—The term ''network items and services'' means items or services provided to an individual enrolled under a standard health plan by a health care provider who is a member of a provider network of the plan.

(f) EMERGENCY AND URGENT CARE SERVICES.—

(1) IN GENERAL.—Each standard health plan shall cover emergency and urgent care services provided to enrollees, without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and in the case of emergency services without regard to prior authorization.

(2) PAYMENT AMOUNTS.—In the case of emergency and urgent care provided to an enrollee outside of a standard health plan's community rating area, the payment amounts of the plan shall be based on the applicable fee schedule described in subsection (g).

(g) APPLICATION OF PLAN FEE SCHEDULE.—

(1) IN GENERAL.—Subject to paragraph (2), each standard health plan that provides for payment for services on a fee-for-service basis and has not established an agreement or contractual arrangement with providers specifying a basis for payment shall make such payment to such providers under a fee schedule established by the plan.

(2) RULE OF CONSTRUCTION.—Nothing in the paragraph (1) shall be construed to prevent a standard health plan from providing for a different basis

or level of payment than the fee schedule established under such paragraph as part of a contractual agreement with participating providers under the plan.

(h) PHYSICIAN PARTICIPATION PROGRAM; REQUIREMENT OF DIRECT BILLING.—

(1) PHYSICIAN PARTICIPATION PROGRAM.—

(A) IN GENERAL.—Each standard health plan shall establish a program under which participating physicians shall agree to accept the plan's payment schedule as payment in full, and agree not to charge patients more than the cost-sharing required by such plan. Each such plan shall make available the list of participating physicians to enrollees and prospective enrollees.

(B) COVERAGE UNDER AGREEMENTS WITH PLANS.—The agreements or other arrangements entered into under subsection (e)(1) between a standard health plan and the health care providers providing the standard benefits package established under subtitle C to individuals enrolled with the plan shall prohibit a provider from engaging in balance billing described in subparagraph (A).

(2) DIRECT BILLING.—

(A) IN GENERAL.—A provider may not charge or collect from an enrollee amounts that are payable by the standard health plan (including any cost-sharing reduction assistance payable by the plan) and shall submit charges to such plan in accordance with any applicable requirements of subtitle B of title V (relating to health information systems).

(B) PROHIBITION.—An individual or entity that performs clinical laboratory services may not present or cause to be presented, a claim, bill, or demand for payment to any person other than the individual receiving such services, or to the standard health plan of the individual, except that the Secretary may by regulation establish appropriate exceptions to the requirement of this subparagraph.

(3) PROHIBITION OF BALANCE BILLING OF TAXES.—Any agreement entered into between a standard health plan and a provider shall prohibit the provider from charging patients the amount of any tax recovered from the provider under section 4518 of the Internal Revenue Code of 1986.

(4) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to—

(A) require or force an individual to receive health care solely through the individual's standard health plan; or

(B) prohibit any individual from privately contracting with any health care provider and paying for the treatment or service provider by such provider on a cash basis or any other basis as agreed to between the individual and the provider.

(i) RELATION TO DETENTION.—A standard health plan is not required to provide any reimbursement to any detention facility for services performed in that facility for detainees in the facility.

SEC. 1129. UTILIZATION MANAGEMENT PROTOCOLS AND PHYSICIAN INCENTIVE PLANS.

(a) REQUIRING CONSUMER DISCLOSURE.—Each standard health plan shall disclose upon request to enrollees (and prospective enrollees) and to participating providers (and prospective providers), the protocols and financial incentives used by the plan, including utilization management protocols and physician incentive plans for controlling utilization and costs, while protecting proprietary

business information to the extent specified by the Secretary.

(b) UTILIZATION MANAGEMENT.—The utilization review and management activities of each standard health plan, provided either directly or through contract, shall meet the following standards as defined by the Secretary:

(1) PERSONNEL.—All review determinations shall be made by health professionals who are licensed, certified, or otherwise credentialed and who are qualified to review utilization of the treatment being sought.

(2) REVIEW PROCESS.—Each standard health plan shall base utilization management on current scientific knowledge, stress the efficient delivery of health care and quality outcomes, rely primarily on evaluating and comparing practice patterns rather than routine case-by-case review, be consistent and timely in application, and have a process for making review determinations for urgent and emergency care 24 hours a day.

(3) NO FINANCIAL INCENTIVE.—Utilization management by each standard health plan may not create financial incentives for reviewers or providers to reduce or limit medically necessary or appropriate services.

(c) PHYSICIAN INCENTIVE PLANS.—A standard health plan may not operate a physician incentive plan unless such incentive plan meets the requirements of section 1876(i)(8)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(8)(A)).

PART 4—SUPPLEMENTAL HEALTH BENEFITS PLANS

SEC. 1141. SUPPLEMENTAL HEALTH BENEFITS PLANS.

(a) TREATMENT OF SUPPLEMENTAL HEALTH BENEFITS PLANS.—

(1) IN GENERAL.—Nothing in this Act may be construed as preventing a standard health plan sponsor from offering and pricing (in a manner that is separate from the offering and pricing of the standard health plans offered by such sponsor in the community rating area) supplemental health benefits plans pursuant to the State certification plan, the requirements of this section, and regulations promulgated by the Secretary.

(2) PLANS DEFINED.—In this Act:

(A) SUPPLEMENTAL HEALTH BENEFITS PLAN.—The term ''supplemental health benefits plan'' means a supplemental services plan or a cost-sharing plan.

(B) SUPPLEMENTAL SERVICES PLAN.—The term ''supplemental services plan'' means a health plan which provides—

(i) coverage for services and items not included in the standard benefits package established under subtitle C,

(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope of benefits, or

(iii) both.

(C) COST-SHARING PLAN.—The term ''cost-sharing plan'' means a health plan which provides coverage for deductibles and coinsurance imposed as part of the standard benefits package established under subtitle C.

(b) REQUIREMENTS FOR SUPPLEMENTAL SERVICES PLANS.—

(1) APPLICATION OF CERTAIN HEALTH PLAN STANDARDS.—

(A) IN GENERAL.—The standards specified in subparagraph (B) shall apply with respect to each supplemental services plan in the same manner as such standards apply with respect to a certified standard health plan.

(B) SPECIFIED STANDARDS.—The standards specified in this subparagraph are as follows:

(i) Section 1111 (relating to guaranteed issue, availability, and renewability).

(ii) Section 1112 (relating to enrollment).

(iii) Section 1114 (relating to nondiscrimination based on health status).

(iv) Section 1116 (relating to rating limitations for community-rated market).

(2) NO DUPLICATIVE HEALTH BENEFITS.—A standard health plan sponsor or any other entity may not offer any supplemental services plan that—

(A) duplicates the standard benefits package established under subtitle C, or

(B) duplicates any coverage provided under the medicare program to any medicare-eligible individual.

(3) RESTRICTIONS ON MARKETING ABUSES.—Not later than May 1, 1995, the Secretary shall develop minimum standards that prohibit marketing practices by standard health plan sponsors and other entities offering supplemental services plans that involve—

(A) providing monetary incentives for, or tying or otherwise conditioning, the sale of the plan to enrollees in a certified standard health plan of the sponsor or entity;

(B) linking in any manner to the plan's standard benefits package; or

(C) using or disclosing to any party information about the health status or claims experience of participants in a certified standard health plan for the purpose of marketing a supplemental services plan.

(c) REQUIREMENTS FOR COST-SHARING PLANS.—

(1) RULES FOR OFFERING OF POLICIES.—A cost-sharing plan may be offered to an individual only if—

(A) the plan is offered by the standard health plan in which the individual is enrolled;

(B) the standard health plan offers the plan to all individuals enrolled in the standard health plan;

(C) the individual is not enrolled in an alternative benefits package; and

(D) the plan is offered only during the enrollment periods for standard health plans specified in section 1112.

(2) PROHIBITION OF COVERAGE OF COPAYMENTS.—A cost-sharing plan may not provide any benefits relating to any copayments established under subtitle C.

(3) EQUIVALENT COVERAGE FOR ALL SERVICES.—A cost-sharing plan shall provide coverage for items and services in the standard benefits package to the same extent as the plan provides coverage for all items and services in the package.

(4) REQUIREMENTS FOR PRICING.—

(A) IN GENERAL.—The price of any cost-sharing plan shall—

(i) be the same for each individual or class of family to whom the plan is offered;

(ii) include any expected increase in utilization resulting from the purchase of the plan by individuals enrolled in the standard health plan; and

(iii) not result in a loss-ratio of less than 90 percent.

(B) LOSS-RATIO DEFINED.—In subparagraph (A)(iii), a ''loss-ratio'' is the ratio of the premium returned to the consumer in payout relative to the total premium collected.

Subtitle C—Benefits and Cost-Sharing

PART 1—STANDARD BENEFITS PACKAGES

SEC. 1201. GENERAL DESCRIPTION OF STANDARD BENEFITS PACKAGES.

(a) STANDARD BENEFITS PACKAGE.—For purposes of this title, a standard benefits package is a benefits package that—

(1)(A) provides all of the items and services under the categories of health care items and services described in section 1202; and

(B) provides for at least one of the 3 cost-sharing schedules established under section 1213(c)(2) by the National Health Benefits Board established under section 1211 (referred to in this part as the ''Board'') for such a package; and

(2) has an actuarial value that is equivalent to the actuarial value of the benefits package provided by the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits Program as in effect during 1994, adjusted for an average population and adjusted for the particular cost-sharing schedule provided for in the package.

(b) ALTERNATIVE STANDARD BENEFITS PACKAGE.—For purposes of this title, an alternative standard benefits package is a benefits package that—

(1)(A) provides all of the items and services under the categories of health care items and services described in section 1202; and

(B) provides for the very high deductible cost-sharing schedule established under section 1213(c)(3) by the Board for such a package; and

(2) has an actuarial value that is less than the actuarial value of the benefits package provided by the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits Program as in effect during 1994, adjusted for an average population.

(c) ACTUARIAL VALUES.—The Board shall determine the actuarial values referred to in subsections (a)(2) and (b)(2).

SEC. 1202. DESCRIPTION OF CATEGORIES OF ITEMS AND SERVICES.

(a) IN GENERAL.—The categories of health care items and services described in this section are the following, as defined by the Board under section 1213(a):

(1) HOSPITAL SERVICES.—The hospital (as defined in section 1203(7)) services described in this paragraph include the following:

(A) Inpatient hospital services.

(B) Outpatient hospital services.

(C) 24-hour a day hospital emergency services.

(2) HEALTH PROFESSIONAL SERVICES.—The items and services described in this paragraph are—

(A) health professional services (as defined in section 1203(3)), including consultations, that are provided in a home, office, or other ambulatory care setting, or an institutional setting; and

(B) services and supplies (including drugs and biologicals which cannot be self-administered) furnished as incident to such health professional services.

(3) EMERGENCY AND AMBULATORY MEDICAL AND SURGICAL SERVICES.—The items and services described in this paragraph are 24-hour a day emergency services and ambulatory medical or surgical services provided in a facility that is legally authorized to provide such services in the State in which such services are provided.

(4) CLINICAL PREVENTIVE SERVICES.—The items and services described in this paragraph are clinical preventive services, including services for high risk populations, age-appropriate immunizations, tests, and clinician visits furnished consistent with any periodicity schedule specified by the Board under section 1213(a)(2)(B).

(5) MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.—The items and services described in this paragraph are mental illness and substance abuse services, including inpatient, outpatient, residential non-hospital, and intensive non-residential services, for the treatment of mental illness and substance abuse disorders (as defined in section 1203(9)).

(6) FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.—The services described in this section include the following items and services:

(A) Voluntary comprehensive family planning services, including counseling and education.

(B) Contraceptive drugs and devices that are subject to approval by the Secretary under the Federal Food, Drug, and Cosmetic Act.

(C) Services for pregnant women.

(7) HOSPICE CARE.—The hospice care described in this paragraph is items and services provided for end of life care (as defined in section 1203(6)).

(8) HOME HEALTH CARE.—

(A) IN GENERAL.—The home health care described in this paragraph is home health care (as defined in section 1203(4)) and home infusion drug therapy services (as defined in section 1203(5)).

(B) LIMITATIONS.—Coverage for home health care is subject to the following limitations:

(i) INPATIENT TREATMENT ALTERNATIVE.—Such care is covered only as an alternative to inpatient treatment in a hospital, skilled nursing facility (as defined in section 1203(15)), or rehabilitation facility (as defined in section 1203(14)) after an illness, injury, disorder, or other health condition.

(ii) REEVALUATION.—At the end of each 60-day period of home health care, the need for continued care shall be reevaluated by the person who is primarily

responsible for providing the home health care. Additional periods of care are covered only if such person determines that the requirement in clause (i) is satisfied.

(9) EXTENDED CARE SERVICES—

(A) IN GENERAL.—The extended care services described in this section are the items and services described in section 1861(h) of the Social Security Act, when provided to an inpatient of a skilled nursing facility or a rehabilitation facility.

(B) LIMITATIONS.—Extended care services are covered only as an alternative to receiving inpatient hospital services as a result of an illness, injury, disorder, or other health condition.

(10) AMBULANCE SERVICES.—

(A) IN GENERAL.—The ambulance services described in this paragraph are covered only when indicated by the medical condition of the individual receiving such services. Such services include the following:

(i) Ground transportation by ambulance.

(ii) Air or water transportation by an aircraft or vessel equipped for transporting

an injured or sick individual in cases in which there is no other method of transportation or where use of another method of transportation is contra-indicated by the medical condition of such individual.

(11) OUTPATIENT LABORATORY, RADIOLOGY, AND DIAGNOSTIC SERVICES.—The items and services described in this paragraph are laboratory, radiology, and diagnostic services provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

(12) OUTPATIENT PRESCRIPTION DRUGS.—The items described in this paragraph are the following used for a medically accepted indication (as defined in section 1203(8)):

(A) Outpatient prescription drugs.

(B) Blood clotting factors (as defined in section 1203(1)).

(C) Drugs used for home infusion therapy.

(D) Biologicals.

(E) Accessories and supplies used directly with the items described in subparagraphs (A) through (D).

(13) OUTPATIENT REHABILITATION SERVICES.—

(A) IN GENERAL.—The outpatient rehabilitation services described in this paragraph are—

(i) outpatient occupational therapy;

(ii) outpatient physical therapy;

(iii) outpatient respiratory therapy; and

(iv) outpatient speech-language pathology services and outpatient audiology services.

(B) LIMITATIONS.—Coverage for outpatient rehabilitation services is subject to the following limitations:

(i) SERVICE LIMITATION.—Such services include only items or services used to restore or maintain functional capacity or prevent or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition, including attaining new functional abilities at an age-appropriate rate.

(ii) REEVALUATION.—At the end of each 60-day period of outpatient rehabili-

tation services, the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement of paragraph (1) is satisfied.

(14) DURABLE MEDICAL EQUIPMENT AND PROSTHETIC AND ORTHOTIC DEVICES.—

(A) IN GENERAL.—The items and services described in this paragraph are—

(i) durable medical equipment (as defined in section 1203(2);

(ii) prosthetic devices (as defined in section 1203(12);

(iii) orthotics (as defined in section 1203(10)) and prosthetics (as defined in section 1203(11)); and

(iv) accessories and supplies used directly with the equipment or devices described in clauses (i) through (iv).

(B) REPAIR, MAINTENANCE, ETC.—The items and services described in this paragraph include the following with respect to the equip-

ment and devices described in subparagraph (A):

(i) Repair and maintenance of such equipment or devices.

(ii) Replacement of such equipment or devices when required due to loss, irreparable damage, wear, or because of a change in the patient's condition.

(iii) Fitting and training for the use of such equipment or devices.

(15) VISION CARE, HEARING AIDS, AND DENTAL CARE.—

(A) IN GENERAL.—The items described in this paragraph are the vision care described in subparagraph (B), dental care described in subparagraph (C), and hearing care described in subparagraph (D).

(B) VISION CARE.—The vision care described in this subparagraph is routine eye examinations, diagnosis, and treatment for defects in vision furnished to individuals who are under 22 years of age, including eyeglasses and contact lenses furnished according to a periodicity schedule established by the Board.

(C) DENTAL CARE.—

(i) INDIVIDUALS UNDER 22.—The dental care described in this subparagraph shall include the following, as specified by the Board, furnished to individuals who are under 22 years of age:

(I) Emergency dental treatment.

(II) Prevention and diagnosis of dental disease.

(III) Treatment of dental disease.

(IV) Space maintenance procedures to prevent orthodontic complications.

(V) Interceptive orthodontic treatment to prevent severe malocclusion.

(ii) INDIVIDUALS OVER 22.—The dental care described in this subparagraph for individuals who are over 22 years of age is emergency dental treatment, as specified by the Board.

(D) HEARING CARE.—The hearing care items and services described in this paragraph are the following when furnished to an individual who is under 22 years of age:

(i) Routine ear examinations and diagnosis for defects in hearing as part of a physician visit.

(ii) Hearing aids when recommended by a physician or audiologist.

(16) INVESTIGATIONAL TREATMENTS.—The items and services described in this paragraph are items and services required to provide patient care pursuant to the design of a qualified investigational treatment (as defined in section 1203(13)).

(b) LIMITATION.—

(1) IN GENERAL.—Items and services under the categories described in subsection (a) shall be furnished to health plan enrollees when medically necessary or appropriate.

(2) DEFINITION.—For purposes of this subtitle, the term ''medically necessary or appropriate'' when referring to an item or service means an item or service intended to maintain or improve the biological, psychological, or functional condition of a health plan enrollee or to prevent or mitigate an adverse health outcome to an enrollee.

SEC. 1203. DEFINITIONS.

For purposes of this subtitle:

(1) BLOOD CLOTTING FACTORS.—The term ''blood clotting factors'' has the meaning given such term in section 1861(s)(2)(I) of the Social Security Act.

(2) DURABLE MEDICAL EQUIPMENT.—The term ''durable medical equipment'' has the meaning given such term in section 1861(n) of the Social Security Act.

(3) HEALTH PROFESSIONAL SERVICES.—The term ''health professional services'' means professional services that—

(A) are lawfully provided by a physician; or

(B) would be described in subparagraph (A) if provided by a physician, but are provided by another person who is legally authorized to provide such services in the State in which the services are provided.

(4) HOME HEALTH CARE.—The term ''home health care'' means the items and services described in section 1861(m) of the Social Security Act.

(5) HOME INFUSION DRUG THERAPY SERVICES.—The term ''home infusion drug therapy services'' means the home infusion drug therapy services described in section 1861(ll) of the Social Security Act.

(6) HOSPICE CARE.—The term ''hospice care'' means the items and services described in paragraph (1) of section 1861(dd) of the Social Security Act, except that in applying such section for purposes of this paragraph—

(A) paragraphs (4)(B) and (5) shall be disregarded; and

(B) all references to the Secretary of Health and Human Services shall be treated as references to the Board.

(7) HOSPITAL.—The term ''hospital'' has the meaning given such term in section 1861(e) of the Social Security Act, except that such term shall include a facility operated by the uniformed services, the Department of Veterans Affairs, and the Indian Health Service that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e).

(8) MEDICALLY ACCEPTED INDICATION.—The term ''medically accepted indication'' means with respect to the use of a drug, any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(A) the drug has been approved by the Food and Drug Administration; and

(B) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary.

(9) MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS.—The term ''mental illness and substance abuse disorder'' means a mental or substance abuse disorder listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, or the International Classification of Diseases, 9th Revision, the Clinical Modification, Third Edition, or revised versions of such manuals or texts.

(10) ORTHOTICS.—The term ''orthotics'' includes—

(A) an accessory or supply used directly with a prosthetic device to achieve therapeutic benefits and proper functioning; and

(B) leg, arm, back, and neck braces.

(11) PROSTHETICS.—The term ''prosthetics'' includes artificial legs, arms, and eyes.

(12) PROSTHETIC DEVICES.—The term ''prosthetic devices'' means devices that replace all or part of the function of a body organ.

(13) QUALIFIED INVESTIGATIONAL TREATMENT.—The term ''qualified investigational treatment'' means an investigational treatment that is part of a peer-reviewed and approved research program (as defined by the Secretary) or research trials approved by the Secretary, the Directors of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health, including guidelines for cancer center support grants designated by the National Cancer Institute.

(14) REHABILITATION FACILITY.—The term ''rehabilitation facility'' means an institution (or a distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness, injury, disorder, or other health condition. An entity qualifying as a hos-

pital for as defined in paragraph (7) may also qualify as a rehabilitation facility for the purposes of section 1202(a)(9).

(15) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' means an institution (or a distinct part of an institution) which is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care; or

(B) rehabilitation services to residents for rehabilitation from illness, injury, disorder, or other health condition.

PART 2—NATIONAL HEALTH BENEFITS BOARD

SEC. 1211. CREATION OF NATIONAL HEALTH BENEFITS BOARD; MEMBERSHIP.

(a) IN GENERAL.—There is hereby established a National Health Benefits Board (referred to in this part as the ''Board'').

(b) COMPOSITION.—The Board is composed of 7 members appointed by the President, by and with the advice and consent of the Senate. No more than 4 members of the Board may be affiliated with the same political party. Members shall be appointed not later than 90 days after the date of the enactment of this title.

(c) CHAIR.—The President shall designate one of the members of the Board as chair.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the term of each member of the Board is 6 years and begins when the term of the predecessor of that member ends.

(2) INITIAL TERMS.—The initial terms of the members of the Board first taking office after the date of the enactment of this title, shall expire as designated by the President, two at the end of two years, two at the end of four years, and three at the end of six years.

(3) CONTINUATION IN OFFICE.—Upon the expiration of a term of office, a member shall continue to serve until a successor is appointed and qualified.

(e) VACANCIES.—

(1) IN GENERAL.—If a vacancy occurs, other than by expiration of term, a successor shall be appointed by the President, by and with the consent of the Senate, to fill such vacancy. The appointment shall be for the remainder of the term of the predecessor.

(2) NO IMPAIRMENT OF FUNCTION.—A vacancy in the membership of the Board does not impair the

authority of the remaining members to exercise all of the powers of the Board.

(3) ACTING CHAIR.—The Board may designate a member to act as chair during any period in which there is no chair designated by the President.

(f) MEETINGS; QUORUM.—

(1) MEETINGS.—The chair shall preside at meetings of the Board, and in the absence of the chair, the Board shall elect a member to act as chair pro tempore.

(2) FREQUENCY.—The Board shall meet not less frequently than 4 times each year.

(3) QUORUM.—Four members of the Board shall constitute a quorum thereof.

SEC. 1212. QUALIFICATIONS OF BOARD MEMBERS.

(a) CITIZENSHIP.—Each member of the Board shall be a citizen of the United States.

(b) BASIS OF SELECTION.—Board members shall be selected on the basis of their experience and expertise in relevant subjects, including the practice of medicine, nursing, or other clinical practices, health care financing and delivery, State health systems, consumer protection, business, law, and delivery of care to vulnerable populations.

(c) PAY AND TRAVEL EXPENSES.—

(1) PAY.—

(A) CHAIR.—The chair of the Board shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level II of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the chair is engaged in the actual performance of duties vested in the Board.

(B) MEMBERS.—Each member of the Board shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level III of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Board.

(2) TRAVEL EXPENSES.—Members of the Board shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

SEC. 1213. GENERAL DUTIES AND RESPONSIBILITIES.

(a) CLARIFICATION AND REFINEMENT OF ITEMS AND SERVICES.—

(1) IN GENERAL.—The Board shall promulgate such regulations or establish such guidelines as may be necessary to clarify and refine the items and services under the categories of health care items and services described in section 1202 in accordance with the requirements of subsections (a)(2) and (b)(2) of section 1201.

(2) SCHEDULES FOR ITEMS AND SERVICES.—

(A) IN GENERAL.—The Board shall establish and update periodicity schedules for the items and services in the categories of health care items and services described in section 1202.

(B) SPECIAL RULE WITH RESPECT TO CLINICAL PREVENTIVE SERVICES.—With respect to clinical preventive services, the Board—

(i) shall specify and define specific items and services as clinical preventive services and shall establish and update a periodicity schedule for such items and services; and

(ii) in specifying clinical preventive services and establishing and updating periodicity schedules under clause (i), the

Board shall consult with experts in clinical preventive services, including the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.

(3) MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.—

(A) PARITY.—

(i) IN GENERAL.—The Board shall design mental illness and substance abuse services so as to achieve parity with services for other medical conditions. Except as provided in clause (iii), day or visit limits or cost-sharing requirements may not be applied to mental illness and substance abuse services that are not applied to services for other medical conditions.

(ii) PARITY DEFINED.—For purposes of this subparagraph, the term ''parity'' means comprehensive, coverage for all medically necessary or appropriate mental illness and substance abuse services in in-

patient, outpatient, residential, and intensive non-residential settings.

(iii) SPECIAL RULE.—

(I) EFFECT ON OTHER BENEFITS.—If the Board determines that parity of mental illness and substance abuse services with services for other medical conditions cannot be achieved without imposing unduly burdensome cost-sharing requirements on other services, the Board may design mental illness and substance abuse services such that they include the following limits:

(aa) Inpatient hospital care may be limited, but in the case of mental illness the limit may not be set at a level below 30 days per year, and in the case of substance abuse services the limit may not be set at a level below the level sufficient to provide detoxification services.

(bb) After the first 5 visits for outpatient adult psycho-

therapy, the coinsurance for such services may be set at a level higher than the coinsurance for other services, but no higher than a 50 percent coinsurance level.

(cc) Consistent with the process described in section 3510, the Board shall ensure that parity for mental illness and substance abuse services with services for other medical conditions is established no later than January 1, 2001.

(II) LEGISLATIVE PROPOSAL.—If the Board finds that establishing parity for mental illness and substance abuse services with services for other medical conditions cannot be achieved by January 1, 2001, without imposing unduly burdensome cost-sharing on all services, the Board shall develop a legislative proposal for an extension of such date. Not later than January 1, 2000, the Board shall submit to the Congress an implementing bill which

contains such statutory provisions as are necessary or appropriate to implement the legislative proposal developed under the preceding sentence.

(B) MANAGEMENT OF SERVICES.—

(i) IN GENERAL.—The Board shall develop standards for the appropriate management of mental illness and substance abuse services. Such standards shall include quality managed care techniques.

(ii) QUALITY MANAGED CARE.—For purposes of clause (i), the term ''quality managed care'' refers to the administration of benefits through methods of central intake, preauthorization, and utilization review under circumstances that protect individuals from unwarranted denial of services.

(C) SETTINGS.—The Board shall give priority to ensuring that mental illness and substance abuse services are provided in the least restrictive setting that is clinically appropriate and encouraging the use of outpatient and intensive nonresidential treatments to the greatest extent possible.

(b) DETERMINING MEDICAL NECESSITY OR APPROPRIATENESS.—

(1) IN GENERAL.—The Board shall be authorized to establish—

(A) criteria for determinations of medical necessity or appropriateness;

(B) procedures for determinations of medical necessity or appropriateness; and

(C) regulations or guidelines to be used in determining whether an item or service under the categories of health care items and services described in section 1202 is medically necessary or appropriate.

(2) REQUIREMENTS.—The Board shall include the following in establishing criteria, procedures, and regulations under this subsection:

(A) SPECIAL RULES WITH RESPECT TO ENROLLEES UNDER 22 YEARS OF AGE.—In making any determination with respect to medical necessity or appropriateness with respect to an enrollee under 22 years of age, the Board shall consider whether the item or service is—

(i) is appropriate for the age and health status of the enrollee;

(ii) will prevent or ameliorate the effects of a condition, illness, injury, or disorder;

(iii) will aid the overall physical and mental growth and development of the enrollee; or

(iv) will assist in achieving or maintaining maximum functional capacity in performing daily activities.

This subparagraph shall apply to all items and services under the categories of health care items and services described in section 1202 as clarified and refined by the Board under subsection (a).

(B) CONSULTATIONS WITH EXPERT AUTHORITIES.—The Board shall consider the opinions of experts from academia, medical specialty groups, industry, and government in establishing criteria, procedures, and regulations with regard to medical necessity or appropriateness.

(C) RECOMMENDATIONS TO SECRETARY.—In the absence of sufficient evidence to develop regulations with respect to any particular coverage determination, the Board shall rec-

ommend to the Secretary specific areas for which priorities should be given to undertake clinical trials or establish practice guidelines.

(3) HEALTH PLAN REQUIREMENTS.—The regulations established by the Board under this subsection shall provide that health plans shall—

(A) in making any determination with respect to medical necessity or appropriateness, consider the criteria and procedures established by the Board under this subsection;

(B) be guided by—

(i) the initial determination of medical necessity or appropriateness with respect to an item or service made by an enrollee and the health professional furnishing such item or service; and

(ii) available scientific evidence; and

(C) if a health plan has developed a treatment guideline or utilization protocol, or has made a general coverage determination, the plan shall—

(i) provide a copy of, and a written statement of the basis for, the guideline, protocol, or determination at least 60 days prior to the effective date of such guide-

line, protocol, or determination, to each affected provider with which the plan has a contract and the government entity which certifies the plan;

(ii) provide any or all of such information upon request to enrollees, potential enrollees, or other interested parties, including provider groups and specialty organizations; and

(iii) revise such guidelines, protocols, or determinations periodically, or, if new scientific evidence becomes available, as soon as possible after such evidence is available.

(c) COST-SHARING.—The Board shall establish cost-sharing schedules to be provided by health plans providing a standard benefits package or an alternative standard benefits package. In establishing such cost-sharing schedules, the Board shall meet the following requirements:

(1) ANNUAL BASIS.—The Board shall review and update cost-sharing schedules as determined appropriate by the Board, but on at least an annual basis.

(2) PLANS PROVIDING STANDARD BENEFITS PACKAGE.—

(A) IN GENERAL.—The Board shall establish 3 cost-sharing schedules for health plans providing the standard benefits package which permit a variety of delivery system options, including fee-for-service, preferred provider organizations, point of service, and managed care. Such cost-sharing schedules shall consist of—

(i) a low cost-sharing schedule;

(ii) a high cost-sharing schedule; and

(iii) a combination cost-sharing schedule.

(B) ACTUARIAL VALUE OF HIGH COST-SHARING SCHEDULE.—A standard benefit package that provides for the cost-sharing schedule established by the Board under this paragraph that has the lowest actuarial value relative to the actuarial values of all other cost-sharing schedules established by the Board under this paragraph, shall have an actuarial value that is equivalent to the actuarial value of the benefits package provided by the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits Program as in effect during 1994, adjusted for an average population (as determined by the Board).

(3) PLANS PROVIDING ALTERNATIVE STANDARD BENEFITS PACKAGE.—The Board shall establish only one very high deductible cost-sharing schedule for health plans providing the alternative standard benefits package. Such cost-sharing schedule shall provide for a higher deductible than any deductible under a schedule established for health plans providing a standard benefits package.

(4) CLINICAL PREVENTIVE SERVICES.—No cost-sharing schedule established by the Board may include cost-sharing for clinical preventive services and prenatal care.

(5) COST-SHARING RULES.—Cost-sharing schedules established by the Board may include copayments, coinsurance, deductibles, and out-of-pocket limits. The copayments, coinsurance, deductibles and out-of-pocket limits on cost-sharing for a year under the schedules shall be applied based upon expenses incurred for covered items and services furnished in the year.

(6) LIFETIME LIMITS.—No cost-sharing schedule established by the Board may include lifetime limits.

(d) LEGISLATIVE PROPOSALS ON ACTUARIAL EQUIVALENCE AND HEALTH SERVICE CATEGORIES.—

(1) IN GENERAL.—The Board may develop legislative proposals for modifications to the actuarial equivalence provisions of section 1201 and the categories of health care items and services under section 1202.

(2) IMPLEMENTING BILL.—The Board shall submit to the Congress an implementing bill which contains such statutory provisions as are necessary or appropriate to implement the legislative proposals developed under paragraph (1).

(e) REPORTS.—

(1) DENTAL CARE.—The Board shall undertake a study to determine the costs of providing—

(A) preventive dental care to all adults;

(B) restorative dental care to all adults; and

(C) preventive dental care to adults with developmental, cognitive, and other mental disabilities.

Not later than July 1, 1996, the Board shall prepare and submit to the Secretary and the Congress, a report concerning such study.

(2) IN VITRO FERTILIZATION.—The Board shall undertake a study to determine the costs of providing coverage for in vitro fertilization in the standard

benefits package. Not later than July 1, 1996, the Board shall prepare and submit to the Secretary and the Congress, a report concerning such study.

(f) OTHER REQUIREMENTS.—The Board shall satisfy any other requirements imposed on the Board under this title.

SEC. 1214. POWERS.

(a) EXECUTIVE DIRECTOR; STAFF.—

(1) EXECUTIVE DIRECTOR.—

(A) IN GENERAL.—The Board shall, without regard to section 5311(b) of title 5, United States Code, appoint an Executive Director.

(B) PAY.—The Executive Director shall be paid at a rate equivalent to a rate for the Senior Executive Service.

(2) STAFF.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Executive Director, with the approval of the Board, may appoint and fix the pay of additional personnel.

(B) PAY.—The Executive Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid

without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of 120 percent of the annual rate of basic pay payable for GS–15 of the General Schedule.

(C) DETAILED PERSONNEL.—Upon request of the Executive Director, the head of any Federal department or agency may detail any of the personnel of that department or agency to the Board to assist the Board in carrying out its duties under this Act.

(b) CONTRACT AUTHORITY.—To the extent provided in advance in appropriations Acts, the Board may contract with any person (including an agency of the Federal Government) for studies and analysis as required to execute its functions. Any employee of the Executive Branch may be detailed to the Board to assist the Board in carrying out its duties.

(c) CONSULTATIONS WITH EXPERTS.—The Board may consult with any outside expert individuals or groups that the Board determines appropriate in performing its duties under section 1213. The Board may establish advisory committees.

(d) ACCESS TO INFORMATION.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out its functions, to the extent such information is otherwise available to a department or agency of the United States. Upon request of the chair, the head of that department or agency shall furnish that information to the Board.

(e) DELEGATION OF AUTHORITY.—Except as otherwise provided, the Board may delegate any function to such officers and employees as the Board may designate and may authorize such successive redelegations of such functions with the Board as the Board deems to be necessary or appropriate. No delegation of functions by the Board shall relieve the Board of responsibility for the administration of such functions.

(f) RULEMAKING.—The Board is authorized to establish such rules as may be necessary to carry out this subtitle.

SEC. 1215. FUNDING.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Board $5,000,000 for each year and such additional sums as may be necessary to carry out the purposes of this part.

(b) SUBMISSION OF BUDGET.—Under the procedures of chapter 11 of title 31, United States Code, the budget

for the Board for a fiscal year shall be reviewed by the Director of the Office of Management and Budget and submitted to the Congress as part of the President's submission of the Budget of the United States for the fiscal year.

SEC. 1216. APPLICABILITY OF FEDERAL ADVISORY COMMITTEE ACT.

The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Board.

SEC. 1217. CONGRESSIONAL CONSIDERATION OF BOARD PROPOSALS.

(a) IN GENERAL.—Any implementing bill described in section 1213 shall be considered by Congress under the procedures for consideration described in subsection (b).

(b) CONGRESSIONAL CONSIDERATION.—

(1) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementing bill described in subsection (a), and su-

persedes other rules only to the extent that such rules are inconsistent therewith; and

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

(2) INTRODUCTION AND REFERRAL.—On the day on which the implementing bill described in subsection (a) is transmitted to the House of Representatives and the Senate, such bill shall be introduced (by request) in the House of Representatives by the Majority Leader of the House, for himself or herself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader and Minority Leader of the House and shall be introduced (by request) in the Senate by the Majority Leader of the Senate, for himself or herself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate. If either House is not in session on the day on which the implementing bill is transmitted, the bill shall be introduced in the House, as provided in the preceding sentence, on the

first day thereafter on which the House is in session. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(3) AMENDMENTS PROHIBITED.—No amendment to an implementing bill shall be in order in either the House of Representatives or the Senate and no motion to suspend the application of this subsection shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this subsection by unanimous consent.

(4) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), if the committee or committees of either House to which an implementing bill has been referred have not reported it at the close of the 45th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the implementing bill and it shall be placed on the appropriate calendar. A vote on final passage of the implementing bill shall be taken in each House on or before the close of the

45th day after the implementing bill is reported by the committees or committee of that House to which it was referred, or after such committee or committees have been discharged from further consideration of the implementing bill. If prior to the passage by one House of an implementing bill of that House, that House receives the same implementing bill from the other House then—

(i) the procedure in that House shall be the same as if no implementing bill had been received from the other House; but

(ii) the vote on final passage shall be on the implementing bill of the other House.

(B) COMPUTATION OF DAYS.—For purposes of subparagraph (A), in computing a number of days in either House, there shall be excluded—

(i) the days on which either House is not in session because of an adjournment of more than 3 days to a day certain, or an adjournment of the Congress sine die; and

(ii) any Saturday and Sunday not excluded under clause (i) when either House is not in session.

(5) FLOOR CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(A) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an implementing bill shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(B) DEBATE.—Debate in the House of Representatives on an implementing bill shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the bill. A motion further to limit debate shall not be debatable. It shall not be in order to move to recommit an implementing bill or to move to reconsider the vote by which an implementing bill is agreed to or disagreed to.

(C) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives

with respect to the consideration of an implementing bill, and motions to proceed to the consideration of other business, shall be decided without debate.

(D) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to an implementing bill shall be decided without debate.

(E) GENERAL RULES APPLY.—Except to the extent specifically provided in the preceding provisions of this paragraph, consideration of an implementing bill shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions in similar circumstances.

(6) FLOOR CONSIDERATION IN THE SENATE.—

(A) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration of an implementing bill shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(B) GENERAL DEBATE.—Debate in the Senate on an implementing bill, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the Majority Leader and the Minority Leader or their designees.

(C) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an implementing bill shall be limited to not more than one hour, to be equally divided between, and controlled by, the mover and the manager of the implementing bill, except that in the event the manager of the implementing bill is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the passage of an implementing bill, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(D) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable.

A motion to recommit an implementing bill is not in order.

Subtitle D—Access to Health Plans

PART 1—ACCESS THROUGH EMPLOYERS

SEC. 1301. GENERAL EMPLOYER RESPONSIBILITIES.

(a) OFFER OF PLANS.—

(1) IN GENERAL.—Each employer—

(A) shall make available to each employee of the employer the opportunity—

(i) in the case of an experienced-rated employer, to enroll through the employer in one of at least 3 certified experience-rated standard health plans which provide the standard benefits package established under subtitle C, including, if available, a high cost-sharing plan, a combination cost-sharing plan, and a low cost-sharing plan as established under such subtitle; or

(ii) in the case of a community-rated employer—

(I) to enroll in any community-rated plan offered through a purchasing cooperative operating in the community rating area in which such employer is located, and if such coopera-

tive is not a purchasing cooperative described in section 1341, then also through a cooperative so described; and

(II) at the option of the employer, to enroll through the employer in one of at least 3 certified community-rated standard health plans which provide the standard benefits package established under subtitle C, including, if available, a high cost-sharing plan, a combination cost-sharing plan, and a low cost-sharing plan as established under such subtitle; and

(B) shall provide, upon request, payroll withholding of the employee's premiums.

(2) WAIVER OF REQUIREMENT.—The Governor of a participating State (or, the Secretary of Labor, in the case of sponsors of multistate self-insured health plans) may waive the requirement under paragraph (1) for any employer in a rural area of such State which demonstrates an insufficient population density to support 3 types of certified standard health plans. Such an employer shall at least

offer a high cost-sharing plan as established under subtitle C.

(3) PROHIBITION ON OFFERING OF ALTERNATIVE PACKAGE.—No employer may offer an alternative standard benefits package established under subtitle C.

(b) FORWARDING OF INFORMATION.—

(1) INFORMATION REGARDING PLANS.—An employer must provide each employee of such employer—

(A) with information provided by the State under section 1508 regarding all certified standard health plans offered in the community rating area in which the employer is located, and

(B) if the employer knows that an employee resides in another community rating area, information regarding how to obtain information on certified standard health plans offered to residents of such other community rating area.

(2) INFORMATION REGARDING EMPLOYEES.—An employer shall forward the name and address (and any other necessary identifying information

specified by the Secretary) of each employee enrolling through the employer—

(A) to the certified standard health plan in which such employee is enrolling, or

(B) to the purchasing cooperative (if any) through which such employee is enrolling.

SEC. 1302. AUDITING OF RECORDS.

Each employer shall maintain such records, and provide the participating State for the area in which the employer maintains its principal place of employment (as specified by the Secretary of Labor) with access to such records, as may be necessary to verify and audit the information reported under this Act.

SEC. 1303. PROHIBITION OF CERTAIN EMPLOYER DISCRIMINATION.

(a) IN GENERAL.—No employer may discriminate with respect to an employee on the basis of the family status of the employee or on the basis of the class of family enrollment selected with respect to the employee.

(b) OTHER PROHIBITIONS.—For the prohibition of other employer discriminatory practices, see section 4522 of the Internal Revenue Code of 1986.

SEC. 1304. PROHIBITION ON SELF-INSURING COST-SHARING BENEFITS.

A community-rated employer (and an experience-rated employer with respect to employees who are community-rated eligible individuals) may provide benefits to employees that consist of the benefits included in a cost-sharing plan (as defined in section 1141(a)(2)(C)) only through a contribution toward the purchase of a cost-sharing plan which is funded primarily through insurance.

SEC. 1305. RESPONSIBILITIES IN SINGLE-PAYER STATES.

In the case of an individual who resides in a single-payer State and an employer with respect to employees who reside in such a State, the responsibilities of such individual and employer under such system shall supersede the obligations of the individual and employer under this subtitle.

SEC. 1306. DEVELOPMENT OF LARGE EMPLOYER PURCHASING GROUPS.

(a) IN GENERAL.—Nothing in this title shall be construed as prohibiting 2 or more experience-rated employers from joining together to purchase insurance for their employees, except that each such employer shall be responsible for meeting the employer's requirements under this title with respect to its employees.

(b) RULES BY SECRETARY.—The Secretary of Labor shall provide rules for large employer purchasing groups

similar to the rules applicable to purchasing cooperatives, including rules regarding fiduciary responsibilities and financial management.

(c) NO USE OF PURCHASING COOPERATIVES.—An experience-rated employer shall be ineligible to purchase health insurance through a purchasing cooperative, except with respect to health insurance for individuals described in paragraphs (1) and (2) of section 1307(d).

SEC. 1307. RULES GOVERNING LITIGATION INVOLVING RETIREE HEALTH BENEFITS.

(a) MAINTENANCE OF BENEFITS.—

(1) IN GENERAL.—If—

(A) retiree health benefits or plan or plan sponsor payments in connection with such benefits are to be or have been terminated or reduced under an employee welfare benefit plan; and

(B) an action is brought by any participant or beneficiary to enjoin or otherwise modify such termination or reduction,

the court without requirement of any additional showing shall promptly order the plan and plan sponsor to maintain the retiree health benefits and payments at the level in effect immediately before the termination or reduction while the action is

pending in any court. No security or other undertaking shall be required of any participant or beneficiary as a condition for issuance of such relief. An order requiring such maintenance of benefits may be refused or dissolved only upon determination by the court, on the basis of clear and convincing evidence, that the action is clearly without merit.

(2) MODIFICATIONS.—Nothing in this section shall preclude a court from modifying the obligation of a plan or plan sponsor to the extent retiree benefits are otherwise being paid.

(b) BURDEN OF PROOF.—In addition to the relief authorized in subsection (a) or otherwise available, if, in any action described in subsection (a), the terms of the employee welfare benefit plan summary plan description or other materials distributed to employees at the time of a participant's retirement or disability are silent or are ambiguous, either on their face or after consideration of extrinsic evidence, as to whether retiree health benefits and payments may be terminated or reduced for a participant and his or her beneficiaries after the participant's retirement or disability, then the benefits and payments shall not be terminated or reduced for the participant and his or her beneficiaries unless the plan or plan sponsor establishes by a preponderance of the evidence that the sum-

mary plan description and other materials about retiree benefits—

(1) were distributed to the participant at least 90 days in advance of retirement or disability;

(2) did not promise retiree health benefits for the lifetime of the participant and his or her spouse; and

(3) clearly and specifically disclosed that the plan allowed such termination or reduction as to the participant after the time of his or her retirement or disability.

The disclosure described in paragraph (3) must have been made prominently and in language which can be understood by the average plan participant.

(c) REPRESENTATION.—Notwithstanding any other provision of law, an employee representative of any retired employee or the employee's spouse or dependents may—

(1) bring an action described in this section on behalf of such employee, spouse, or dependents; or

(2) appear in such an action on behalf of such employee, spouse or dependents.

(d) RETIREE HEALTH BENEFITS.—For the purposes of this section, the term ''retiree health benefits'' means health benefits (including coverage) which are provided to—

(1) retired or disabled employees who, immediately before the termination or reduction, are entitled to receive such benefits upon retirement or becoming disabled; and

(2) their spouses and dependents.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to actions relating to terminations or reductions of retiree health benefits which are pending or brought, on or after July 20, 1993.

SEC. 1308. ENFORCEMENT.

In the case of a person that violates a requirement of this subtitle, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual.

PART 2—ACCESS THROUGH HEALTH INSURANCE PURCHASING COOPERATIVES

Subpart A—General Requirements

SEC. 1321. ORGANIZATION AND OPERATION.

(a) DESIGNATION OF COOPERATIVES.—A State shall certify health insurance purchasing cooperatives (in this Act referred to as ''purchasing cooperatives'') in accordance with this part. Each cooperative shall be chartered under State law and operated as a not-for-profit corporation.

(b) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each cooperative shall be governed by a Board of Directors to be composed of representatives of community-rated employers, community-rated employees, and community-rated individuals as elected by the members of the purchasing cooperative.

(2) INITIAL BOARD.—The initial Board of Directors of a purchasing cooperative shall be composed of members selected by the sponsoring entity of the cooperative. Subsequent members of the Board of Directors shall be elected as provided for under paragraph (1) after being nominated by a nominating committee appointed by the preceding Board of Directors.

(c) ESTABLISHMENT BY STATE OR LOCAL GOVERNMENT.—A State or local government may establish or sponsor a purchasing cooperative to serve a community rating area. The Secretary shall establish special rules concerning the legal and governing structure of a State or local government purchasing cooperative.

(d) MEMBERSHIP.—A purchasing cooperative shall accept all community-rated employers, community-rated employees, and community-rated individuals residing within the area served by the cooperative as members if such employers, employees, or individuals request such mem-

bership. Members of a cooperative shall have voting rights to select members of the Board of Directors consistent with rules established by the State.

(e) PROHIBITION.—An insurer may not form or underwrite a purchasing cooperative but may administer such a cooperative.

(f) DUTIES OF COOPERATIVES.—Each purchasing cooperative shall—

(1) negotiate (regarding premiums and marketing fees) with and enter into agreements with standard health plans under section 1323;

(2) enter into agreements with community-rated employers;

(3) enroll community-rated employees and community-rated individuals in standard health plans;

(4) collect premiums and make payments to standard health plans on behalf of community-rated employers and community-rated individuals;

(5) provide for coordination with other purchasing cooperatives;

(6) provide comparative information to the public and the participating State on standard health plans offered through the purchasing cooperative from information provided by the plans under section 1125;

(7) have the capability of accepting data from standard health plans as required under subtitle B of title V;

(8) comply with such fiduciary responsibility, financial management, and administrative requirements as the Secretary may establish; and

(9) carry out other functions provided for under this title.

(g) LIMITATION ON ACTIVITIES.—A cooperative shall not—

(1) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

(2) perform any activity (including certification or enforcement) relating to compliance of standard health plans with the requirements of this Act;

(3) assume insurance risk; or

(4) perform other activities identified by the State as being inconsistent with the performance of its duties under this Act.

(h) RULES OF CONSTRUCTION.—

(1) MULTIPLE COOPERATIVES.—Noting in this section shall be construed to prevent a State from certifying or establishing more than one purchasing cooperative in a community rating area.

(2) EXCLUSIVE COOPERATIVE.—

(A) IN GENERAL.—Nothing in this section shall be construed as requiring a State to certify or establish more than one purchasing cooperative serving a community rating area.

(B) SPECIAL RULES.—If a State chooses to certify only one purchasing cooperative in a community rating area, then such cooperative (other than a cooperative established under section 1341) may not negotiate regarding premiums as described in subsection (f)(1) and, notwithstanding section 1323(a)(1), shall enter into an agreement with each standard health plan operating in the area which desires such an agreement.

(3) SINGLE ORGANIZATION SERVING MULTIPLE COMMUNITY RATING AREAS.—Nothing in this section shall be construed as preventing a single not-for-profit corporation from being the purchasing cooperative for more than one community rating area.

(4) VOLUNTARY PARTICIPATION.—Nothing in this section shall be construed as requiring any community-rated individual, community-rated employee, or community-rated employer to purchase a standard health plan exclusively through a cooperative.

SEC. 1322. MEMBERSHIP.

(a) IN GENERAL.—A purchasing cooperative shall offer all community-rated individuals and community-rated employees residing within the community rating area served by the cooperative the opportunity to enroll in any standard health plan that has entered into an agreement with the cooperative under section 1323.

(b) ENROLLMENT PROCESS.—A purchasing cooperative shall establish an enrollment process in accordance with rules established by the Secretary.

(c) COORDINATION AMONG PURCHASING COOPERATIVES.—Each participating State shall establish rules consistent with this section for coordination among purchasing cooperatives in cases in which community-rated employers are located in one community rating area and their community-rated employees reside in a different community rating area.

SEC. 1323. AGREEMENTS WITH STANDARD HEALTH PLANS.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), each purchasing cooperative for a community rating area may enter into an agreement under this section with any standard health plan that the purchasing cooperative desires to be made available through such purchasing cooperative.

(2) MINIMUM REQUIREMENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), each purchasing cooperative shall enter into an agreement under paragraph (1) with at least 3 types of standard health plans which provide the standard benefits package established under subtitle C, including, if available, a high cost-sharing plan, a combination cost-sharing plan, and a low cost-sharing plan as established under such subtitle.

(B) WAIVER OF REQUIREMENT.—The Governor of a participating State may waive the requirement under subparagraph (A), in a manner consistent with section 1301(a)(2)), for any purchasing cooperative in a rural area of such State which demonstrates an insufficient population density to support 3 types of standard health plans. Such a purchasing cooperative shall at least offer a high cost-sharing plan as established under such subtitle.

(3) LIMITATION.—A purchasing cooperative may not enter into an agreement under this section with a standard health plan unless such plan is certified by the State under subtitle E.

(4) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for

a 12-month period. The State shall establish a process for the termination of agreements entered into under this section and a process for appealing such termination under this paragraph. In accordance with rules established by the State—

(A) a cooperative may terminate an agreement with a standard health plan if the health plan's certification for the community rating area involved is terminated or if the health plan fails to fulfill the requirements of the agreement; and

(B) a standard health plan may appeal the termination of an agreement with a cooperative under this paragraph to the State in accordance with rules and procedures established by the State.

(b) RECEIPT OF GROSS PREMIUMS.—

(1) IN GENERAL.—A purchasing cooperative may require that a standard health plan with which such cooperative has an agreement under this section provide for the payment of premiums directly to the cooperative in accordance with rules promulgated by the Secretary.

(2) FORWARDING OF PREMIUMS.—A purchasing cooperative that requires direct payment of pre-

miums under paragraph (1) shall forward to the standard health plan the amounts collected on the behalf of the enrollees in such plan in accordance with the State program of reinsurance and risk adjustment.

(3) CERTIFIED STANDARD HEALTH PLANS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a purchasing cooperative any risk associated with the failure of individuals and employers to make prompt payment of premiums (other than the portion of the premium representing the purchasing cooperative administrative fee under section 1324(a)).

SEC. 1324. MEMBERSHIP AND MARKETING FEES.

(a) COOPERATIVE FEES.—A purchasing cooperative shall charge members a uniform membership fee to cover the cost of activities undertaken by the cooperative (including all administrative costs incurred by the cooperative).

(b) MARKETING FEES.—

(1) IN GENERAL.—A purchasing cooperative shall charge members a separate marketing fee which a standard health plan may charge to cover the cost of marketing and administrative activities undertaken by such plan in such cooperative.

(2) NEGOTIATION.—A purchasing cooperative and a standard health plan shall negotiate the marketing fee. Such negotiated fee shall not be binding on such health plan with respect to other purchasing cooperatives through which the plan is offered.

(3) LIMITATION.—In no case shall a marketing fee assessed by a standard health plan offered outside of a purchasing cooperative be lower than the weighted average of the marketing fees negotiated with all purchasing cooperatives for the community rating area involved.

(c) DISCLOSURE AND MULTIPLE COOPERATIVES.—

(1) DISCLOSURE.—A purchasing cooperative shall, prior to the time of enrollment, publish the membership fee of such cooperative and the marketing fees for each standard health plan offered through the cooperative. Such fees shall be calculated and identified as separate charges from the premium charged by the standard health plans offered by the purchasing cooperative.

(2) SUBMISSIONS TO STATE.—

(A) IN GENERAL.—Each purchasing cooperative in a community rating area shall provide the State with information on the fees described

in paragraph (1) under rules developed by the State.

(B) DOCUMENTATION.—Pursuant to regulations issued by the Secretary, standard health plans shall submit actuarial data and such other documentation as the State may require in order to verify the basis for variation in marketing fees across cooperatives and other insurance distribution sources. States shall use such information in order to make a determination that each plan's marketing fees are based on legitimate variation in marketing and distribution costs across alternative distribution sources.

(3) MULTIPLE COOPERATIVES.—In community rating areas in which States have certified multiple purchasing cooperatives, such cooperatives may compete for members on the basis of the fees described in this section.

Subpart B—Community-Rated Employers

SEC. 1331. DUTIES OF PURCHASING COOPERATIVES.

(a) IN GENERAL.—A purchasing cooperative for a community rating area shall offer to enter into an agreement under this section with each community-rated employer that employs individuals in the community rating area and that desires to join the cooperative. An agree-

ment between such an employer and a cooperative shall include provisions consistent with the requirements of this subtitle.

(b) ELECTION OF ENROLLMENT.—

(1) IN GENERAL.—An employee of a community-rated employer may select coverage under any of the standard health plans offered through a purchasing cooperative of which the employer is a member.

(2) ENROLLMENT OUTSIDE THE COOPERATIVE.—An employee of a community-rated employer may elect to enroll in a plan offered through the purchasing cooperative with which the employer has entered into an agreement or directly with a standard health plan selected by the employer (if such plan is not offered by the cooperative selected by the employer). A community-rated employee not residing in the community rating area served by the purchasing cooperative selected by the employer shall enroll in a standard health plan consistent with rules promulgated by the Secretary. The purchasing cooperative selected by the employer shall be responsible for forwarding premium payments to the appropriate plan or cooperative for each community-rated em-

ployee in accordance with the State program of reinsurance and risk adjustment.

(3) VOLUNTARY EMPLOYER CONTRIBUTION.—If an employer voluntarily contributes to the cost of health insurance coverage for its employees, the employer shall not be required to make a contibution on behalf of an employee who elects to obtain coverage directly from a standard health plan not chosen by such employer or from a purchasing cooperative not chosen by such employer, unless such cooperative is one established under section 1341.

(c) FORWARDING INFORMATION ON ELIGIBLE EMPLOYEES.—Under an agreement between an employer and a cooperative, the employer must forward to the appropriate cooperative such information as may be required by the Secretary.

Subpart C—Federal Employees Health Benefits Program

SEC. 1341. REQUIREMENTS APPLICABLE TO FEHBP.

(a) AVAILABILITY OF PLANS.—

(1) COMMUNITY-RATED INDIVIDUALS.—All standard health plans offered by FEHBP through a purchasing cooperative joined or established by FEHBP in a community rating area under subsection (b) shall be made available to all community-

rated individuals residing within that area at the community-rated premium established under section 1116.

(2) FEDERAL EMPLOYEES AND ANNUITANTS.—Until the date of universal coverage, any Federal employee or annuitant shall obtain coverage under any FEHBP plan offered through such a purchasing cooperative in the community rating area in which such employee or annuitant resides at the rate established under chapter 89 of title 5, United States Code, for such plan.

(3) OFFER OF NATIONAL PLANS.—Each purchasing cooperative joined or established under paragraph (1) shall, not later than January 1, 1998, offer to community-rated individuals covered by such cooperative all national FEHBP plans (including employee organization plans) under rules established by the Office of Personnel Management.

(b) AGREEMENTS WITH PURCHASING COOPERATIVES.—

(1) IN GENERAL.—The Office of Personnel Management shall make every effort to enter into an agreement with a purchasing cooperative in each community rating area in the United States to carry out its responsibilities under this section.

(2) ESTABLISHMENT BY OPM.—If no purchasing cooperative exists in an area or if the Office of Personnel Management is unsuccessful in reaching such an agreement, the Office of Personnel Management shall establish and administer a purchasing cooperative in such area. Such cooperative shall meet all the requirements of this part except rules regarding governance and fiduciary responsibility.

(3) DESIGNATION AS PURCHASING COOPERATIVE.—All FEHBP eligible employees residing in the community rating area served by a cooperative described in paragraph 1 or (2) shall enroll in a standard health plan through such cooperative.

(c) REQUIREMENT OF OPM.—

(1) IN GENERAL.—The Office of Personnel Management is hereby authorized to take such actions as are appropriate to fulfill its responsibilities under this subpart.

(2) RATE BLENDING.—The Office of Personnel Management shall implement rules to blend during the period before the date of universal coverage the premiums for FEHBP plans offered through purchasing cooperatives to Federal employees and community-rated individuals in each community rating area.

(d) AMENDMENTS TO TITLE 5.—

(1) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by adding at the end the following new section:

"§ 8915. Relationship to the Health Security Act

''(a) The provisions of this chapter shall be subject to the provisions of the Health Security Act, to the extent of any inconsistency between such provisions.

''(b) Individuals who are not Federal employees or annuitants and who are enrolled in a health benefits plan pursuant to section 1341 of the Health Security Act shall for all administrative purposes be treated separately from Federal employees and annuitants enrolled under this chapter.

''(c) No provision of the Health Security Act shall be construed to authorize the payment or deposit of any monies from or into the Employees Health Benefits Fund.''.

(2) CONFORMING AMENDMENT.—Section 8914 of title 5, United States Code, is amended by striking out ''Any provision of law'' and inserting in lieu thereof ''Except for the provisions of the Health Security Act, any provision of law''.

(3) TECHNICAL AMENDMENT.—The table of sections for chapter 89 of title 5, United States

Code, is amended by adding after the item relating to section 8914 the following new item:

''8915. Relationship to the Health Security Act.''.

SEC. 1342. SPECIAL RULES FOR FEHBP SUPPLEMENTAL PLANS.

(a) DEVELOPMENT.—The Office of Personnel Management shall develop FEHBP supplemental health benefit plans. The Office of Personnel Management shall meet and confer with representatives of Federal employees and annuitants regarding the supplemental services plans and the cost-sharing plans to be offered (including premium contributions, if any, to be made by the Federal Government with respect to such plans for Federal employees and annuitants) through a process to be established by the National Partnership Council.

(b) OFFERING.—The Federal Government shall offer FEHBP supplemental health benefit plans developed in accordance with subsection (a) and cost-sharing plans as provided in section 1141 to Federal employees, annuitants, and any other community-rated individual.

SEC. 1343. DEFINITIONS.

For purposes of this subpart:

(1) ANNUITANT.—The term ''annuitant'' means an ''annuitant'' as defined by section 8901 of title 5, United States Code.

(2) FEHBP.—The term ''FEHBP'' means the health insurance program under chapter 89 of title 5, United States Code.

(3) FEDERAL EMPLOYEE.—The term ''Federal employee'' means an ''employee'' as defined by section 8901 of title 5, United States Code.

PART 3—TREATMENT OF ASSOCIATION PLANS

SEC. 1351. RULES RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

(a) GENERAL RULE.—A multiple employer welfare arrangement—

(1) shall meet all requirements of this Act applicable to standard health plans, and

(2) may elect to be treated as a health insurance purchasing cooperative if it meets the requirements of part 2 and other applicable requirements of this Act.

(b) TREATMENT FOR RATING PURPOSE.—

(1) IN GENERAL.—Except as provided in paragraph (2), a plan to which subsection (a) applies shall be treated as a community-rated plan and shall meet all requirements of this Act applicable to a community-rated plan.

(2) EXPERIENCE-RATED PLAN.—A plan shall be treated as an experience-rated plan only if the

only participants in the plan are experience-rated individuals.

(c) COORDINATION WITH ERISA.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by striking paragraph (6).

(d) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—For purposes of this section, the term ''multiple employer welfare arrangement'' has the meaning given such term by section 3(40) of the Employer Retirement Income Security Act of 1974.

SEC. 1352. ASSOCIATION PLANS.

(a) GENERAL RULE.—Any health plan to which section 1351 does not apply which is maintained by an association or similar entity shall meet all requirements of this Act applicable to standard health plans.

(b) TREATMENT FOR RATING PURPOSES.—

(1) IN GENERAL.—Except as provided in paragraph (2), a plan to which subsection (a) applies shall be treated as a community-rated plan and shall meet all requirements of this Act applicable to a community-rated plan.

(2) EXPERIENCE-RATED PLAN.—A plan shall be treated as an experience-rated plan only if the

only participants in the plan are experience-rated individuals.

Subtitle E—Federal Responsibilities

PART 1—SECRETARY OF HEALTH AND HUMAN SERVICES

Subpart A—General Duties

SEC. 1401. GENERAL DUTIES AND RESPONSIBILITIES.

(a) IN GENERAL.—Except as otherwise specifically provided in this Act (or with respect to the administration of provisions in the Internal Revenue Code of 1986 or in the Employee Retirement Income Security Act of 1974), the Secretary of Health and Human Services shall administer and implement all of the provisions of this Act.

(b) COVERAGE AND FAMILIES.—The Secretary shall develop and implement standards relating to the eligibility of individuals for coverage in applicable health plans under subtitle B and may provide such additional exceptions and special rules relating to the treatment of family members under section 1113 as the Secretary finds appropriate.

(c) QUALITY MANAGEMENT AND IMPROVEMENT.—The Secretary shall establish and have ultimate responsibility for a performance-based system of quality management and improvement as required by section 5001.

(d) INFORMATION SYSTEM AND INFORMATION RELATED FUNCTIONS.—

(1) IN GENERAL.—The Secretary shall—

(A) develop and implement standards to establish a national health information system to measure quality as required by title V;

(B) provide model format and content requirements for summary plan descriptions;

(C) provide model format and content requirements for comparative plan brochures under section 1125; and

(D) provide model format and content requirements for comparative purchasing cooperative brochures under section 1321.

(2) INFORMATION RELATED FUNCTIONS.—

(A) DESIGNATION.—The Secretary shall provide for the use of entities in the national health data network to perform information related functions under this section with respect to employers, States, contracting entities, and purchasing cooperatives.

(B) FUNCTIONS.—The functions referred to in subparagraph (A) shall include—

(i) receipt of information submitted by employers under section 1301,

(ii) with respect to the information received, transmittal to the States, and

(iii) such other functions as the Secretary specifies.

(e) PARTICIPATING STATE REQUIREMENTS.—Consistent with the provisions of subtitle F, the Secretary shall—

(1) establish requirements for participating States,

(2) monitor State compliance with those requirements, and

(3) provide technical assistance,

in a manner that ensures access to the standard benefit package for all eligible individuals.

(f) DEVELOPMENT OF PREMIUM AND AGE CLASS FACTORS.—The Secretary shall establish premium class and age class factors under subpart D.

(g) DEVELOPMENT OF REINSURANCE AND RISK-ADJUSTMENT METHODOLOGY.—The Secretary shall develop a methodology for the reinsurance and risk-adjustment of premium payments to community-rated and experience-rated health plans in accordance with section 1504.

(h) FINANCIAL REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall establish minimum capital requirements and requirements for

guaranty funds and financial reporting and auditing standards under subpart F.

(2) FINANCIAL MANAGEMENT STANDARDS.—The Secretary, in consultation with the Secretary of Labor, shall establish, for purposes of section 1118, standards relating to the management of finances, maintenance of records, accounting practices, auditing procedures, and financial reporting for States, consumer purchasing cooperatives and health plans. Such standards shall take into account current Federal laws and regulations relating to fiduciary responsibilities and financial management of funds.

(3) AUDITING STATE PERFORMANCE.—The Secretary shall perform periodic financial and other audits of States to assure that such States are carrying out their responsibilities under this Act consistent with this Act. Such audits shall include audits of State performance in the areas of—

(A) assuring enrollment of all community-rated individuals in health plans;

(B) management of premium and cost sharing discounts and reductions provided;

(C) financial management (including the financial activities of cooperatives and State-designated contracting entities); and

(D) assuring enforcement of the anti-discrimination provisions of this Act.

(i) STANDARDS FOR HEALTH PLAN GRIEVANCE PROCEDURES.—The Secretary shall establish standards for health plan grievance procedures that are used by enrollees in pursuing complaints.

(j) FIDUCIARY REQUIREMENTS.—The Secretary shall, in consultation with the Secretary of Labor, develop and promulgate fiduciary requirements for the management of funds by States, plans, cooperatives, and employers.

(k) GUARANTY FUNDS.—The Secretary shall establish standards for guaranty funds as provided for in section 1442.

(l) STANDARDS FOR UTILIZATION MANAGEMENT PROGRAMS.—

(1) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Secretary, in consultation with interested parties which may include one or more accrediting organizations, shall promulgate uniform Federal standards for utilization management programs, to include the activities described in section 1129.

(2) COMPLIANCE.—States shall ensure compliance with the Federal standards established under

paragraph (1), consistent with their role in certifying health plans.

(3) REVIEW AND UPDATE.—The Secretary shall periodically review and update utilization management standards to reflect appropriate policies and practices in health care delivery.

(m) COLLECTION ACTIVITIES.—The Secretary may provide (through contract or otherwise) for collection activities for the collection of amounts owed to States and purchasing cooperatives for health insurance coverage subject to the provisions of this title.

SEC. 1402. ANNUAL REPORT.

(a) IN GENERAL.—The Secretary, in consultation with the National Health Benefits Board and the Health Care Cost and Coverage Commission, shall prepare and submit to the President and the Congress an annual report concerning the overall implementation of the new health care system under this Act.

(b) MATTERS TO BE INCLUDED.—The Secretary shall include in each annual report under this section the following:

(1) Information on Federal and State implementation.

(2) Data related to quality improvement.

(3) Recommendations or changes in the administration and regulation of laws related to health care financing, delivery, and coverage.

SEC. 1403. ASSISTANCE WITH FAMILY COLLECTIONS.

The Secretary shall provide States with such technical and other assistance as may promote the efficient collection of other amounts owed by families under this Act.

SEC. 1404. ADVISORY OPINIONS.

(a) IN GENERAL.—Community- and provider-based plans, and individuals and organizations seeking to establish such plans, shall be eligible to receive advisory opinions from appropriate Federal entities, including opinions concerning whether their arrangement complies with Federal self-referral, fraud and abuse, and anti-trust laws.

(b) REGULATIONS.—The Secretary shall issue regulations setting forth the procedures for obtaining advisory opinions described in subsection (a).

(c) TIMING OF OPINIONS.—An advisory opinions shall be issued not later than 90 days after receipt of a request for such opinion from a plan.

(d) FEES.—Applicants under this section shall pay a fee, the amount of which to be determined by the Secretary, to cover the costs of providing an opinion under this section.

SEC. 1405. FUNDING.

There are authorized to be appropriated to the Secretary, such sums as may be necessary to carry out this subpart for each of the fiscal years 1995 through 1999.

Subpart B—Responsibilities Relating to Review and Approval of State Systems

SEC. 1411. FEDERAL REVIEW AND ACTION ON STATE SYSTEMS.

(a) APPROVAL OF STATE SYSTEMS BY SECRETARY.—

(1) IN GENERAL.—The Secretary shall approve a State health care system for which a plan is submitted under section 1501(a) unless the Secretary determines that the system (as set forth in the plan) does not (or will not) meet the responsibilities for a participating State under this Act.

(2) REGULATIONS.—Not later than July 1, 1995, the Secretary shall issue regulations, prescribing the requirements for State health care systems under this title, except that in the case of a plan submitted under section 1501(a) before the date of issuance of such regulations, the Secretary shall take action on such document notwithstanding the fact that such regulations have not been issued.

(3) NO APPROVAL PERMITTED FOR YEARS PRIOR TO 1996.—Except as otherwise specifically

provided in this Act, the Secretary may not approve a State health care system under this subpart for any year prior to 1996.

(b) REVIEW OF COMPLETENESS OF PLANS.—

(1) IN GENERAL.—If a State submits a plan under subsection (a)(1), the Secretary shall notify the State, not later than 7 working days after the date of submission, whether or not the plan is complete and provides the Secretary with sufficient information to approve or disapprove the document.

(2) ADDITIONAL INFORMATION ON INCOMPLETE PLAN.—If the Secretary notifies a State that the State's plan is not complete, the State shall be provided such additional period (not to exceed 45 days) as the Secretary may by regulation establish in which to submit such additional information as the Secretary may require. Not later than 7 working days after the State submits the additional information, the Secretary shall notify the State respecting the completeness of the plan.

(c) ACTION ON COMPLETED DOCUMENTS.—

(1) IN GENERAL.—The Secretary shall make a determination (and notify the State) on whether the State's plan provides for the implementation of a

State system that meets the applicable requirements of this title—

(A) in the case of a State that did not require an additional period described in subsection (b)(2) to file a complete plan, not later than 90 days after notifying a State under subsection (b) that the State's plan is complete, or

(B) in the case of a State that required an additional period described in subsection (b)(2) to file a complete plan, not later than 90 days after notifying a State under subsection (b) that the State's plan is complete.

(2) REVIEW OF COVERAGE AREA.—The Secretary shall review the State designation of community rating area boundaries to determine whether such boundaries comply with sections 1502 and 1602, and in particular, the requirements of such sections concerning non-discrimination in the establishment of coverage area boundaries.

(3) PLANS DEEMED APPROVED.—If the Secretary does not meet the applicable deadline for making a determination and providing notice under paragraph (1) with respect to a State's plan, the Secretary shall be deemed to have approved the State's plan for purposes of this Act.

(d) OPPORTUNITY TO RESPOND TO REJECTED PLAN.—

(1) IN GENERAL.—If (within the applicable deadline under subsection (c)(1)) the Secretary notifies a State that its plan does not provide for the implementation of a State system that meets the applicable requirements of this title, the Secretary shall provide the State with a period of 60 days in which to submit such additional information and assurances as the Secretary may require.

(2) DEADLINE FOR RESPONSE.—Not later than 30 days after receiving additional information and assurances under paragraph (1), the Secretary shall make a determination (and notify the State) on whether the State's plan provides for the implementation of a State system that meets the applicable requirements of this title.

(3) PLAN DEEMED APPROVED.—If the Secretary does not meet the deadline established under paragraph (2) with respect to a State, the Secretary shall be deemed to have approved the State's plan for purposes of this Act.

(e) APPROVAL OF PREVIOUSLY TERMINATED STATES.—If the Secretary has approved a State system under this part for a year but subsequently terminated

the approval of the system under section 1412(b)(2), the Secretary shall approve the system for a succeeding year if the State—

(1) demonstrates to the satisfaction of the Secretary that the failure that formed the basis for the termination no longer exists, and

(2) provides reasonable assurances that the types of actions (or inactions) which formed the basis for such termination will not recur.

(f) REVISIONS TO STATE SYSTEM.—

(1) SUBMISSION.—A State may revise a system approved for a year under this section, except that such revision shall not take effect unless the State has submitted to the Secretary a document describing such revision and the Secretary has approved such revision.

(2) ACTIONS ON REVISIONS.—Not later than 60 days after a document is submitted under paragraph (1), the Secretary shall make a determination (and notify the State) on whether the implementation of the State system, as proposed to be revised, meets the applicable requirements of this title. If the Secretary fails to meet the requirement of the preceding sentence, the Secretary shall be deemed to have ap-

proved the implementation of the State system as proposed to be revised.

(3) REJECTION OF REVISIONS.—Subsection (d) shall apply to an amendment submitted under this subsection in the same manner as it applies to a completed plan submitted under subsection (b).

SEC. 1412. FAILURE OF PARTICIPATING STATES TO MEET CONDITIONS FOR COMPLIANCE.

(a) IN GENERAL.—In the case of a participating State, if the Secretary determines that the operation of the State system under this title fails to meet the applicable requirements of this Act, the Secretary shall apply against the State in accordance with subsection (b).

(b) TYPE OF SANCTION APPLICABLE.—The sanctions applicable under this section are as follows:

(1) If the Secretary determines that the State's failure does not substantially jeopardize the ability of eligible individuals in the State to obtain coverage for the standard benefit package, the Secretary shall reduce payments with respect to the State in accordance with section 1413.

(2) If the Secretary determines that the failure substantially jeopardizes the ability of eligible individuals in the State to obtain coverage for the standard benefit package—

(A) the Secretary shall terminate its approval of the State system; and

(B) the Secretary shall assume the responsibilities described in section 1422.

(c) TERMINATION OF SANCTION.—A State against which a sanction is imposed under this section may submit information at any time to the Secretary to demonstrate that the failure that led to the imposition of the sanction has been corrected.

(d) PROTECTION OF ACCESS TO BENEFITS.—The Secretary shall take actions under this section with respect to a State only in a manner that assures the continuous coverage of eligible individuals enrolled in community-rated health plans.

SEC. 1413. REDUCTION IN PAYMENTS FOR HEALTH PROGRAMS BY SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Upon a determination by the Secretary under section 1412(b)(1), the Secretary shall reduce the amount of any of the payments described in subsection (b) that would otherwise be made to individuals and entities in the State by such amount as the Secretary determines to be appropriate.

(b) PAYMENTS DESCRIBED.—The payments described in this subsection are as follows:

(1) Payments to academic health centers in the State under subtitle B of title III.

(2) Payments to individuals and entities in the State for health research activities under section 301 and title IV of the Public Health Service Act.

(3) Payments to hospitals in the State under part 4 of subtitle E of title III (relating to payments to hospitals serving vulnerable populations).

SEC. 1414. REVIEW OF FEDERAL DETERMINATIONS.

Any State affected by a determination by the Secretary under this subpart may appeal such determination in accordance with section 5531.

SEC. 1415. FEDERAL SUPPORT FOR STATE IMPLEMENTATION.

(a) PLANNING GRANTS.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall, to the extent amounts are appropriated, make available to each State a planning grant to assist the State in the development of a health care system necessary to enable the State to become a participating State under this title.

(2) FORMULA.—The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $50,000,000 for each of the fiscal years 1995 and 1996 for grants under this subsection.

(b) GRANTS FOR START-UP SUPPORT.—

(1) IN GENERAL.—The Secretary shall, to the extent amounts are appropriated, make available to States, upon their becoming participating States, grants to assist in the establishment of purchasing cooperatives.

(2) FORMULA.—The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) STATE MATCHING FUNDS REQUIRED.—Funds are payable to a State under this subsection only if the State provides assurances, satisfactory to the Secretary, that amounts of State funds (at least equal to the amount made available under this subsection) will be expended for the purposes described in paragraph (1).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $313,000,000 for fiscal year 1996, $625,000,000 for fiscal year 1997, and $313,000,000 for fiscal year 1998, for grants under this subsection.

Subpart C—Responsibilities in Absence of State Systems

SEC. 1421. APPLICATION OF SUBPART.

(a) INITIAL APPLICATION.—This subpart shall apply with respect to a State as of January 1, 1997, unless—

(1) the State submits a plan for a State system under section 1411(a)(1) by July 1, 1996, and

(2) the Secretary determines under section 1411 that such system meets the requirements of subtitle F.

(b) TERMINATION OF APPROVAL OF SYSTEM OF PARTICIPATING STATE.—In the case of a participating State for which the Secretary terminates approval of the State system under section 1412(b)(2), this subpart shall apply with respect to the State as of such date as is appropriate to assure the continuity of coverage for the standard benefit package for eligible individuals in the State.

SEC. 1422. FEDERAL ASSUMPTION OF RESPONSIBILITIES IN NON-PARTICIPATING STATES.

Upon determining that this subpart will apply to a State for a calendar year, the Secretary shall take such steps as are necessary to ensure that the standard benefit package is provided to eligible individuals in the State during the year, including the establishment of community-rating areas within such State as appropriate.

SEC. 1423. IMPOSITION OF SURCHARGE ON PREMIUMS UNDER FEDERALLY-OPERATED SYSTEM.

If this subpart applies to a State for a calendar year, the premiums charged by community-rated health plans in the State shall be equal to premiums that would otherwise be charged, increased by 15 percent. Such 15 percent increase shall be used to reimburse the Secretary for any administrative or other expenses incurred as a result of establishing and operating the system in that State.

SEC. 1424. RETURN TO STATE OPERATION.

(a) APPLICATION PROCESS.—After the establishment and operation of a system by the Secretary in a State under section 1422, the State may at any time apply to the Secretary for the approval of a State system in accordance with the procedures described in section 1411.

(b) TIMING.—If the Secretary approves the system of a State for which the Secretary has operated a system under this subpart during a year, the Secretary shall terminate the operation of the system, and the State shall establish and operate its approved system, as of January 1 of the first year beginning after the Secretary approves the State system. The termination of the Secretary's system and the operation of the State's system shall be conducted in a manner that assures the continuous coverage of eligible individuals in the State under community-rated health plans.

Subpart D—Establishment of Class Factors for Charging Premiums

SEC. 1431. PREMIUM CLASS AND AGE CLASS FACTORS.

(a) IN GENERAL.—For purposes of this title and title X, the Secretary shall establish premium class and age class factors in accordance with section 1113(c).

(b) CONDITIONS.—In establishing such factors, the factor for the class of individual enrollment shall be 1 and the factor for the couple-only class of family enrollment shall be 2.

Subpart E—Risk Adjustment and Reinsurance Methodology for Payment of Plans

SEC. 1435. DEVELOPMENT OF A RISK ADJUSTMENT AND REINSURANCE METHODOLOGY.

(a) ESTABLISHMENT.—The Secretary shall develop a risk adjustment and reinsurance methodology in accordance with section 1504.

(b) RESEARCH AND DEMONSTRATION.—The Secretary shall conduct and support research and demonstration projects to develop and improve, on a continuing basis, the risk adjustment and reinsurance methodology under this subpart.

(c) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in implementing the methodology developed under this subpart.

Subpart F—Responsibilities for Financial Requirements

SEC. 1441. CAPITAL STANDARDS FOR COMMUNITY-RATED PLANS.

(a) IN GENERAL.—The Secretary shall establish, in consultation with the States, minimum capital requirements for carriers, for purposes of section 1118.

(b) $500,000 MINIMUM.—Subject to subsection (c), under such requirements there shall be not less than $500,000 of capital maintained for each carrier.

(c) ADDITIONAL CAPITAL REQUIREMENTS.—The Secretary shall establish standards that provide for additional capital for purposes of this section. The amount of such additional capital required shall reflect factors likely to affect the financial stability of a carrier, including the following:

(1) Projected plan enrollment and number of providers participating in plans of the carrier.

(2) Market share and strength of competition.

(3) Extent and nature of risk-sharing with participating providers and the financial stability of risk-sharing providers.

(4) Prior performance of the carrier, risk history, and liquidity of assets.

(d) COMMUNITY- AND PROVIDER-BASED PLANS.—

(1) IN GENERAL.—States shall consider alternative financial instruments and methods for community- and provider-based plans (as defined in paragraph (2)) to meet the capital and solvency standards developed in accordance with this section. Provisions made for such plans shall ensure the fiscal integrity and financial solvency of such plans.

(2) ELIGIBLE PLANS.—Plans eligible for special consideration by States must be offered by public or not-for-profit entities that are owned, or in which a majority share of the plan's investment is held by—

(A) health care providers who practice in the plan;

(B) individuals who live in the area, or not-for-profit organizations located in the area serviced by the plan;

(C) a combination of individuals and organizations described in subparagraphs (A) and (B); or

(D) organizations located outside the service area which provide for control over local operations by individuals described in subparagraphs (A) or (B).

(e) DEVELOPMENT OF STANDARDS BY NAIC.—The Secretary may request the National Association of Insur-

ance Commissioners to develop model standards for the additional capital requirements described in subsection (c) and to present such standards to the Secretary not later than July 1, 1995. The Secretary may accept such standards as the standards to be applied under subsection (c) or modify the standards in any appropriate manner.

SEC. 1442. STANDARD FOR GUARANTY FUNDS.

(a) IN GENERAL.—In consultation with the States, the Secretary shall establish standards for guaranty funds established by States for community-rated health plans.

(b) GUARANTY FUND STANDARDS.—The standards established under subsection (a) for a guaranty fund shall include the following:

(1) Each fund must have a method to generate sufficient resources to pay health providers and others in the case of a failure of a health plan in order to meet obligations with respect to—

(A) services rendered by the health plan for the standard benefit package, including any supplemental coverage for cost sharing provided by the health plan, and

(B) services rendered prior to health plan insolvency and services to patients after the insolvency but prior to their enrollment in other health plans.

(2) Each fund shall be liable for all claims against the plan by health care providers with respect to their provision of items and services covered under the standard benefit package to enrollees of the failed plan. Such claims, in full, shall take priority over all other claims. The fund is liable, to the extent and in the manner provided in accordance with rules established by the Secretary, for other claims, including other claims of such providers and the claims of contractors, employees, governments, or any other claimants.

(3) The fund stands as a creditor for any payments owed the plan to the extent of the payments made by the fund for obligations of the plan.

(4) The fund has authority to borrow against future assessments in order to meet the obligations of failed plans participating in the fund.

Subpart G—Open Enrollment

SEC. 1445. PERIODS OF AUTHORIZED CHANGES IN ENROLLMENT.

The Secretary shall specify periods of enrollment in accordance with section 1112(c).

SEC. 1446. DISTRIBUTION OF COMPARATIVE INFORMATION.

The Secretary shall specify a period of time prior to open enrollment during which States must provide for the

distribution to community-rated individuals enrollment materials and comparative information on health plans and purchasing cooperatives.

PART 2—ESSENTIAL COMMUNITY PROVIDERS

SEC. 1461. CERTIFICATION.

For purposes of this Act, the Secretary shall certify as an ''essential community provider'' any health care provider or organization that—

(1) is within any of the categories of providers and organizations specified in section 1462(a), or

(2) meets the standards for certification under section 1463(a).

SEC. 1462. CATEGORIES OF PROVIDERS AUTOMATICALLY CERTIFIED.

(a) IN GENERAL.—The categories of providers and organizations, including subrecipients, specified in this subsection are as follows:

(1) CATEGORY 1 ENTITIES.—The following entities shall be considered category 1 entities:

(A) Covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), except that subsections (a)(4)(L)(iii) and (a)(7) of such section shall not apply.

(B) School health services centers under title III.

(C) Public or nonprofit hospitals—

(i) that meet the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act in any cost reporting period in the 3-year period prior to the date of enactment of this Act, except that subsection (a)(4)(L)(iii) of such section shall not apply; or

(ii) meeting alternative criteria developed by the Secretary after the date of enactment of this Act which are comparable to the criteria utilized in determining eligibility under such section 340B;

(D) Public and private, nonprofit mental health and substance abuse providers receiving funds under title V or XIX of the Public Health Service Act.

(E) Runaway homeless youth centers or transitional living programs for homeless youth providing health services under the Runaway Homeless Youth Act of 1974 (42 U.S.C. 5701 et seq.).

(F) Public or nonprofit maternal and child health providers that receive funding under title V of the Social Security Act.

(G) Rural health clinics as defined under section 1861(aa)(2) of the Social Security Act.

(H) Programs of the Indian Health Service (as defined in section 8302(3)).

(2) CATEGORY 2 ENTITIES.—The following entities shall be considered category 2 entities:

(A) Medicare dependent small rural hospitals under section 1886(d)(8)(iii) of the Social Security Act.

(B) Children's hospitals meeting comparable criteria determined appropriate by the Secretary.

(b) STUDY OF FEDERALLY CERTIFIED RURAL HEALTH CLINICS.—The Secretary shall conduct an evaluation of the Rural Health Clinics program as defined in section 1861(aa)(2) of the Social Security Act to examine the causes of the growth in the program and the characteristics of providers certified as rural health clinics and the characteristics of the population served by rural health clinics to ensure that the program meets the needs of rural underserved communities. The Secretary shall report the findings of such evaluation, together with any rec-

ommended changes in the rural health clinics program, to the Congress not later than January 1, 1996.

SEC. 1463. STANDARDS FOR ADDITIONAL PROVIDERS.

(a) STANDARDS.—The Secretary shall publish standards for the certification of additional categories of health care providers and organizations as essential community providers, including the categories described in subsection (b). Such a health care provider or organization shall not be certified unless the Secretary determines, under such standards, that health plans operating in the area served by the applicant would not otherwise be able to assure adequate access to items and services included in the standard benefit package if such a provider was not so certified.

(b) CATEGORIES TO BE INCLUDED.—The categories described in this subsection are as follows:

(1) CERTAIN HEALTH PROFESSIONALS.—A health professional who—

(A) for at least 20 hours per week—

(i) is located in an area (or areas) designated as a health professional shortage area (under section 332 of the Public Health Service Act) or serves a population (or populations) designated as a medically underserved population (under section 330 of the Public Health Service Act); or

(ii)(I) is located or provides services in a neighborhood or community whose residents are at risk of underservice; and

(II) is available to patients at such location on evenings and weekends; and

(B) if the health professional is a physician—

(i) is licensed to practice in the jurisdiction; and

(ii) is either—

(I) granted privileges to practice at one or more hospitals; or

(II) has a consultation and referral arrangement with one or more physicians who are granted privileges to practice at one or more hospitals.

(2) INSTITUTIONAL PROVIDERS.—Public and private nonprofit hospitals and other public and nonprofit institutional health care providers, including family planning clinics, located in health professional shortage areas (as defined under section 332 of the Public Health Service Act) or receiving funding under subtitle E of title III of this Act).

(3) OTHER PROVIDERS.—

(A) IN GENERAL.—Other public and private nonprofit agencies and organizations that—

(i) are located in such an area or providing health services to such a population, and

(ii) provide health care and services essential to residents of such an area or such populations.

(B) NONPROFIT HOSPITALS.—Nonprofit hospitals with a minimum of 200 beds, located in urban areas where—

(i) the cumulative total of its services provided to individuals who are entitled to benefits under title XVIII of the Social Security Act or under a State plan under title XIX of such Act equals a minimum of 65 percent; and

(ii) a minimum of 20 percent of its services are provided to individuals eligible for assistance under such title XIX.

SEC. 1464. CERTIFICATION PROCESS; REVIEW; TERMINATION OF CERTIFICATIONS.

(a) CERTIFICATION PROCESS.—

(1) PUBLICATION OF PROCEDURES.—The Secretary shall publish, not later than 6 months after the date of the enactment of this Act, the procedures to be used by health care professionals, providers, agencies, and organizations seeking certification under this subpart, including the form and manner in which an application for such certification is to be made.

(2) TIMELY DETERMINATION.—The Secretary shall make a determination upon such an application not later than 60 days (or 15 days in the case of a certification for an entity described in section 1462) after the date the complete application has been submitted. The determination on an application for certification of an entity described in section 1462 shall only involve the verification that the entity is an entity described in such section.

(b) REVIEW OF CERTIFICATIONS.—The Secretary shall periodically review whether professionals, providers, agencies, and organizations certified under this subpart continue to meet the requirements for such certification.

(c) TERMINATION OR DENIAL OF CERTIFICATION.—

(1) PRELIMINARY FINDING.—If the Secretary preliminarily finds that an entity seeking certification under this section does not meet the require-

ments for such certification or such an entity certified under this subpart fails to continue to meet the requirements for such certification, the Secretary shall notify the entity of such preliminary finding and permit the entity an opportunity, under subtitle C of title V, to rebut such findings.

(2) FINAL DETERMINATION.—If, after such opportunity, the Secretary continues to find that such an entity continues to fail to meet such requirements, the Secretary shall terminate the certification and shall notify the entity and the State of such termination and the effective date of the termination.

SEC. 1465. NOTIFICATION OF PARTICIPATING STATES.

(a) IN GENERAL.—Not less often than annually the Secretary shall notify each participating State of essential community providers that have been certified under this subpart.

(b) CONTENTS.—Such notice shall include sufficient information to permit each State to notify health plans of the identity of each entity certified as an essential community provider, including—

(1) the location of the provider within each plan's service area,

(2) the health services furnished by the provider, and

(3) other information necessary for health plans to carry out this subpart.

SEC. 1466. HEALTH PLAN REQUIREMENT.

(a) IN GENERAL.—

(1) CATEGORY 1 ENTITIES.—With respect to each essential community provider described in section 1462(a)(1) (other than a provider of school health services) that makes an election under subsection (d), that serves the health plan service area of such health plan, and that requests participation under this section, a health plan shall either—

(A) enter into a written provider participation agreement (described in subsection (b)) with such providers, or

(B) enter into a written agreement under which the plan shall make payments to such provider in accordance with subsection (c).

(2) CATEGORY 2 ENTITIES.—

(A) IN GENERAL.—With respect to at least one essential community provider described in subparagraph (A) and at least one essential community provider described in subparagraph (B) of section 1462(a)(2), that makes an election under subsection (d), that serves the health plan service area of such health plan, and that

requests participation under this section, a health plan shall either—

(i) enter into a written provider participation agreement (described in subsection (b)) with such providers, or

(ii) enter into a written agreement under which the plan shall make payments to such provider in accordance with subsection (c).

(B) EXCEPTION.—A State, as part of the State plan under section 1501(a), may submit to the Secretary for approval a request that the Secretary permit the State to—

(i) require health plans operating in certain community rating areas in the State to contract with more than one essential community provider of each type referred to in subparagraph (A), based on geographic proximity, cultural and language needs, capacity to meet the needs of enrollees, or other factors determined relevant by the State; and

(ii) establish additional types of essential community providers under section

1462(a)(2) that a health plan must contract with under subparagraph (A).

(C) DISCRETION OF SECRETARY.—With respect to a State request under subparagraph (B), the Secretary shall—

(i) approve such request; or

(ii) require the designation of such additional essential community providers in the State as the Secretary determines necessary.

(b) PARTICIPATION AGREEMENT.—A participation agreement between a health plan and an electing essential community provider under this subsection shall provide that the health plan agrees to treat the provider in accordance with terms and conditions the same as those that are applicable to other providers participating in the health plan with respect to each of the following:

(1) The scope of services for which payment is made by the plan to the provider.

(2) The rate of payment for covered care and services.

(3) The availability of financial incentives to participating providers.

(4) Limitations on financial risk provided to other participating providers.

(5) Assignment of enrollees to participating providers.

(6) Access by the provider's patients to providers in medical specialties or subspecialties participating in the plan.

(c) PAYMENTS FOR PROVIDERS WITHOUT PARTICIPATION AGREEMENTS.—

(1) IN GENERAL.—Payment in accordance with this subsection is payment based, as elected by the electing essential community provider, either—

(A) on the fee schedule developed by the State; or

(B) on payment methodologies and rates used under the applicable Medicare payment methodology and rates (or the most closely applicable methodology under such program as the Secretary specifies in regulations).

(2) SPECIAL RULE FOR FEDERALLY QUALIFIED HEALTH CENTERS.—With respect to each federally qualified health center (as such term is defined in section 1861(aa) of the Social Security Act) that is an essential community provider, a health plan shall make payments based on the reasonable cost rates applicable under section 1833(a)(3) of the Social Se-

curity Act, except that the federally qualified health center may accept other payment amounts.

(3) NO APPLICATION OF GATE-KEEPER LIMITATIONS.—Payment in accordance with this subsection may be subject to utilization review, but may not be subject to otherwise applicable gatekeeper requirements under the plan.

(d) ELECTION.—

(1) IN GENERAL.—In this part, the term ''electing essential community provider'' means, with respect to a health plan, an essential community provider certified under this subpart that elects under this subpart to apply to the health plan.

(2) FORM OF ELECTION.—An election under this subsection shall be made in a form and manner specified by the Secretary, and shall include notice to the health plan involved. Such an election may be made annually with respect to a health plan, except that the plan and provider may agree to make such an election on a more frequent basis.

(e) SPECIAL RULE FOR PROVIDERS OF SCHOOL HEALTH SERVICES.—A health plan shall pay, to each provider of school health services located in the plan's service area, an amount determined by the Secretary for such services furnished to enrollees of the plan.

SEC. 1467. RECOMMENDATION ON CONTINUATION OF REQUIREMENT.

(a) STUDIES.—In order to prepare recommendations under subsection (b), the Secretary shall conduct studies regarding essential community providers, including studies that assess—

(1) the definition of essential community provider,

(2) the sufficiency of the funding levels for providers, including the special rule for federally qualified health centers under section 1466(c)(2), for both covered and uncovered benefits under this Act,

(3) the effects of contracting requirements relating to such providers on such providers, health plans, and enrollees,

(4) the impact of the payment rules for such providers, and

(5) the impact of national health reform on such providers.

(b) RECOMMENDATIONS TO AND CONSIDERATION BY CONGRESS.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, the Secretary shall submit to Congress, specific recommendations concerning whether, and to what extent, section 1466 should continue to apply to some or all essen-

tial community providers. Such recommendations may include a description of the particular types of such providers and circumstances under which such section should continue to apply.

(2) JOINT RESOLUTION AND CONSIDERATION BY CONGRESS.—

(A) IN GENERAL.—The recommendations under paragraph (1) shall be implemented unless a joint resolution (described in subparagraph (B)) disapproving such recommendations is enacted in accordance with the provisions of subparagraph (C), before the end of the 45-day period beginning on the date on which such recommendations were submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(B) JOINT RESOLUTION OF DISAPPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the Secretary

submits recommendations under paragraph (1) and—

(i) which does not have a preamble;

(ii) the matter after the resolving clause of which is as follows: ''That Congress disapproves the recommendations of the Secretary of Health and Human Services concerning the extension of certain essential community provider provisions, as submitted by the Secretary on _____.'', the blank space being filled in with the appropriate date; and

(iii) the title of which is as follows: ''Joint resolution disapproving recommendations of the Secretary of Health and Human Services concerning the extension of certain essential community provider provisions, as submitted by the Secretary on _____.'', the blank space being filled in with the appropriate date.

(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF DISAPPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than subsection (a)) of the Defense

Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the Senate (specified by the Majority Leader of the Senate at the time of submission of recommendations under paragraph (1)); and

(ii) any reference to the date on which the President transmits a report shall be

deemed a reference to the date on which the Secretary submits a recommendation under paragraph (1).

SEC. 1468. DEFINITIONS.

As used in subpart:

(1) CHILDREN'S HOSPITAL.—The term ''children's hospital'' means those hospitals whose inpatients are certified by the Secretary or the State to be predominantly under the age of 18.

(2) HEALTH PROFESSIONAL.—The term ''health professional'' means a physician, nurse, nurse practitioner, certified nurse midwife, physician assistant, psychologist, dentist, pharmacist, chiropractor, clinical social worker, and other health care professional recognized by the Secretary.

(3) SUBRECIPIENT.—The term ''subrecipient'' means, with respect to a recipient of a grant under a particular authority, an entity that—

(A) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

(B) meets the requirements established to be a recipient of such a grant.

PART 3—SPECIFIC RESPONSIBILITIES OF SECRETARY OF LABOR.

SEC. 1481. RESPONSIBILITIES OF SECRETARY OF LABOR.

(a) IN GENERAL.—The Secretary of Labor is responsible—

(1) under subtitle D, for the enforcement of requirements applicable to employers (including requirements relating to payment of premiums under title X if applicable) and the administration of large employer purchasing groups;

(2) for the temporary assumption of the operation of self-insured employer sponsored health plans that are insolvent;

(3) for carrying out any other responsibilities assigned to the Secretary under this Act; and

(4) for administering title I of the Employee Retirement Income Security Act of 1974 as it relates to group health plans maintained by large employer purchasing groups.

(b) AGREEMENTS WITH STATES.—The Secretary of Labor may enter into agreements with States in order to enforce responsibilities of employers and large employer purchasing groups, and requirements of employer sponsored health plans, under subtitle B of title I of the Employee Retirement Income Security Act of 1974.

(c) CONSULTATION.—In carrying out activities under this Act with respect to large employer purchasing groups, employer sponsored health plans, and employers, the Secretary of Labor shall consult with the Secretary of Health and Human Services.

(d) GUARANTY FUNDS.—

(1) IN GENERAL.—The Secretary of Labor shall establish standards for guaranty funds to be established by a State with respect to a self-insured plan operating wholly within the State.

(2) MULTISTATE PLANS.—The Secretary of Labor shall establish and administer a guaranty fund with respect to multistate self-insured plans.

(e) EMPLOYER-RELATED REQUIREMENTS.—

(1) IN GENERAL.—The Secretary of Labor, in consultation with the Secretary, shall be responsible for assuring that employers—

(A) make payments of any employer premiums (and withhold and make payment of the family share of premiums with respect to qualifying employees) and provide discounts to employees as required under this Act, including auditing of collection activities with respect to such payments,

(B) submit timely reports as required under this Act, and

(C) otherwise comply with requirements imposed on employers under this Act.

(2) AUDIT AND SIMILAR AUTHORITIES.—The Secretary of Labor—

(A) may carry out such audits (directly or through contract) and such investigations of employers and States and large employer purchasing groups,

(B) may exercise such authorities under section 504 of Employee Retirement Income Security Act of 1974 (in relation to activities under this Act),

(C) may provide (through contract or otherwise) for such collection activities (in relation to amounts owed to large employer purchasing groups, and for the benefit of such groups), and

(D) may impose such civil penalties in accordance with this Act,

as may be necessary to carry out such Secretary's responsibilities under this section.

(3) AUDITING OF EMPLOYER PAYMENTS.—

(A) IN GENERAL.—Each State is responsible for auditing the records of community-

rated employers to assure that employer payments (including the payment of amounts withheld) were made in the appropriate amount as provided under subtitle B of title X.

(B) EMPLOYERS WITH EMPLOYEES RESIDING IN DIFFERENT COMMUNITY-RATING AREAS.—In the case of a community-rated employer which has employees who reside in more than one community rating area in more than one State, the Secretary of Labor, in consultation with the Secretary, shall establish a process for the coordination of State auditing activities among the States involved.

(C) APPEAL.—In the case of an audit conducted by a State on an employer under this paragraph, an employer or other State that is aggrieved by the determination in the audit is entitled to review of such audit by the Secretary of Labor in a manner to be provided by such Secretary.

(f) AUTHORITY.—The Secretary of Labor is authorized to issue such regulations as may be necessary to carry out section 1305 and responsibilities of the Secretary under this Act.

SEC. 1482. FEDERAL ROLE WITH RESPECT TO MULTISTATE SELF-INSURED HEALTH PLANS.

(a) IN GENERAL.—In the case of a multistate self-insured health plan or a multistate self-insured supplemental health benefits plan, the Secretary of Labor shall be responsible for certifying such plans and carrying out activities under this title in the same manner as a participating State would carry out activities under this title with respect to a standard health plan.

(b) SELF-INSURED PLAN STANDARDS.—The Secretary of Labor shall develop and publish standards applicable to self-insured plans offered by large employers. The Secretary shall develop and publish such standards by not later than the date that is 6 months after the date of enactment of this Act. Such standards shall be the certified standard health plan standards applicable to self-insured plans under this title.

(c) DETERMINATION OF MULTISTATE STATUS.—For purposes of this Act, a self-insured health plan or a self-insured supplemental health benefits plan shall be considered a multistate health plan if established or maintained by an experience-rated employer which has a substantial number of employees enrolled in such plan in each of 2 or more States (as determined by the Secretary of Labor).

SEC. 1483. ASSISTANCE WITH EMPLOYER COLLECTIONS.

The Secretary of Labor shall provide States with such technical and other assistance as may promote the efficient collection of all amounts owed under this Act by employers.

SEC. 1484. PENALTIES FOR FAILURE OF LARGE EMPLOYER PURCHASING GROUPS TO MEET REQUIREMENTS.

If the Secretary of Labor finds that a large employer purchasing group has failed substantially to meet the applicable requirements of subtitle D, the Secretary shall impose a civil money penalty of not to exceed $10,000 for each such violation.

SEC. 1485. APPLICABILITY OF ERISA ENFORCEMENT MECHANISMS FOR ENFORCEMENT OF CERTAIN REQUIREMENTS.

The provisions of sections 502 (relating to civil enforcement), 504 (relating to investigative authority) and 506 (relating to criminal enforcement) of the Employee Retirement Income Security Act of 1974 shall apply to enforcement by the Secretary of Labor of the applicable requirements for large group purchasers in the same manner and to same extent as such provisions apply to enforcement of title I of such Act.

SEC. 1486. WORKPLACE WELLNESS PROGRAM.

(a) IN GENERAL.—The Secretary shall develop certification criteria for workplace wellness programs.

(b) APPLICATION OF SECTION.—Any health plan may offer a uniform premium discount, not to exceed 5 percent, to employers maintaining certified workplace wellness programs.

PART 4—OFFICE OF RURAL HEALTH POLICY

SEC. 1491. OFFICE OF RURAL HEALTH POLICY.

(a) APPOINTMENT OF ASSISTANT SECRETARY.—

(1) IN GENERAL.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended—

(A) by striking ''by a Director, who shall advise the Secretary'' and inserting ''by an Assistant Secretary for Rural Health (in this section referred to as the 'Assistant Secretary'), who shall report directly to the Secretary''; and

(B) by adding at the end the following new sentence: ''The Office shall not be a component of any other office, service, or component of the Department.''.

(2) CONFORMING AMENDMENTS.—(A) Section 711(b) of the Social Security Act (42 U.S.C. 912(b)) is amended by striking ''the Director'' and inserting ''the Assistant Secretary''.

(B) Section 338J(a) of the Public Health Service Act (42 U.S.C. 254r(a)) is amended by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(C) Section 464T(b) of the Public Health Service Act (42 U.S.C. 285p–2(b)) is amended in the matter preceding paragraph (1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(D) Section 6213 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 1395x note) is amended in subsection (e)(1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(E) Section 403 of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. 300ff–11 note) is amended in the matter preceding paragraph (1) of subsection (a) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(3) AMENDMENT TO THE EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (5)'' and inserting ''As-

sistant Secretaries of Health and Human Services (6)''.

(b) EXPANSION OF DUTIES.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended by striking ''and access to (and the quality of) health care in rural areas'' and inserting ''access to, and quality of, health care in rural areas, and reforms to the health care system and the implications of such reforms for rural areas''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

Subtitle F—Participating State Responsibilities

PART 1—GENERAL RESPONSIBILITIES

SEC. 1501. STATE PLAN AND CERTIFICATION OF STANDARD HEALTH PLANS AND SUPPLEMENTAL HEALTH BENEFITS PLANS.

(a) STATE PLAN.—

(1) IN GENERAL.—For purposes of the approval of a State health care system by the Secretary under section 1411, a State is a ''participating State'' if the State meets the applicable requirements of this subtitle.

(2) SUBMISSION OF PLAN.—In order to be approved as a participating State under section 1411,

a State shall submit to the Secretary a State plan (in a form and manner specified by the Secretary) that describes the State health care system that the State is establishing (or has established).

(3) DEADLINE.—If a State is not a participating State with a State health care system in operation by January 1, 1997, the provisions of subpart C of part 1 of subtitle E (relating to responsibilities in absence of State systems) shall take effect.

(4) SUBMISSION OF INFORMATION SUBSEQUENT TO APPROVAL.—A State approved as a participating State under section 1411 shall submit to the Secretary an annual update to the State health care system not later than February 15 of each year following the first year for which the State is a participating State. The update shall contain—

(A) such information as the Secretary may require to determine that the system shall meet the applicable requirements of this Act for the succeeding year; and

(B) such information as the Secretary may require to determine that the State operated the system during the previous year in accordance with the Secretary's approval of the system for such previous year.

(b) HEALTH PLAN ACCREDITATION, CERTIFICATION AND ENFORCEMENT PROGRAM.—

(1) ESTABLISHMENT.—The Secretary shall establish a program for the accreditation, certification and enforcement of health plan standards by States (hereafter referred to in this subsection as the ''ACE program''). Under such program, the Secretary shall—

(A) develop guidelines for the accreditation, certification and enforcement of standards for certified standard health plans;

(B) approve State ACE programs as meeting such guidelines; and

(C) monitor the compliance of States with such guidelines.

(2) PROGRAM ELEMENTS.—The guidelines referred to in paragraph (1) shall include the following components:

(A) CERTIFICATION.—State certification, and recertification not less frequently than once during each 3-year period, of standard health plans determined by the State to be in compliance with the standards established under subtitle B and with the regulations promulgated by the Secretary concerning such standards.

(B) DISENROLLMENT DATA.—State review of enrollee disenrollment from each standard health plan to determine whether there is a pattern of disenrollment that does not reflect the distribution of such plans' reenrolling membership.

(C) MONITORING.—State monitoring of the performance of each standard health plan to ensure that such plans continue to meet the criteria for certification.

(3) STATE PROGRAMS.—Each participating State shall develop accreditation, certification and enforcement programs in accordance with the guidelines established by the Secretary under paragraph (1).

(4) USE OF PRIVATE ORGANIZATIONS.—

(A) IN GENERAL.—A State may utilize private accreditation organizations to review the compliance by standard health plans with specific standards with which such organizations have demonstrated expertise. A State may use such reviews as the basis for determining plan compliance with such standards. The Secretary shall approve eligible accreditation organizations and promulgate regulations prohibiting

conflicts of interest in the use of such bodies by States.

(B) LIMITATIONS.—The use of private accreditation organizations by a State under subparagraph (A) shall not relieve such State of its obligations under this subsection. In no case shall a State delegate enforcement authority or enforcement responsibilities to private organizations.

(5) ENFORCEMENT.—A State ACE program shall establish a process for imposing sanctions on standard health plans that fail to comply with the standards established under this title. Such sanctions may include—

(A) limiting or prohibiting new member enrollment;

(B) permitting existing members to disenroll from the health plan without penalty;

(C) State operation of a health plan to provide transitional access;

(D) the imposition of civil monetary penalties in accordance with this Act;

(E) requiring that a plan follow a corrective action plan developed by the State; and

(F) decertification or denial of recertification, but only after the plan has been provided a reasonable opportunity to comply with such standards.

(6) MULTI-STATE PLANS.—The Secretary of Labor, in consultation with the Secretary, shall carry out all certification and enforcement activities described in this subsection with respect to multistate self-insured plans.

(c) OTHER STATE DUTIES.—A participating State shall—

(1) certify each purchasing cooperative that meets the requirements of part 2 of subtitle D; and

(5) administer the State subsidies as provided for in title VI.

(d) EFFECTIVE DATE.—Subsection (b) shall apply to standard health plans and supplemental health benefits plans sold, issued, or renewed on or after January 1, 1997.

SEC. 1502. COMMUNITY RATING AREAS AND HEALTH PLAN SERVICE AREAS.

(a) IN GENERAL.—In accordance with this section, each participating State shall, subject to approval by the Secretary, provide for the division of the State into 1 or more community rating areas.

(b) MULTIPLE AREAS.—With respect to a community rating area—

(1) no metropolitan statistical area in a State may be incorporated into more than 1 such area in the State;

(2) the number of individuals residing within such an area may not be less than 250,000; and

(3) no area incorporated in a community rating area may be incorporated into another such area.

(c) BOUNDARIES.—

(1) IN GENERAL.—In establishing boundaries for community rating areas, a participating State shall comply with the antidiscrimination requirements of section 1602.

(2) COORDINATING MULTIPLE COMMUNITY RATING AREAS.—Nothing in this section shall be construed as preventing a participating State from coordinating the activities of one or more community rating areas in the State.

(3) INTERSTATE COMMUNITY RATING AREAS.—Community rating areas with respect to interstate areas shall be established in accordance with rules established by the Secretary.

(4) COORDINATION IN MULTI-STATE AREAS.—One or more participating States may coordinate

their operations in contiguous community rating areas. Such coordination may include, the following activities, adoption of joint operating rules, contracting with standard health plans, enforcement activities, and establishment of fee schedules for health providers.

(d) HEALTH PLAN SERVICE AREAS.—

(1) IN GENERAL.—Pursuant to guidelines developed under paragraph (2), each State shall designate, by not later than January 1, 19____, health plan service areas.

(2) GUIDELINES.—The State shall designate one or more health plan service areas within each community rating area in the State, that—

(A) prevent discrimination in accordance with section 1602; and

(B) do not cross community rating area boundaries.

SEC. 1503. OPEN ENROLLMENT PERIODS.

Each participating State, based on rules and procedures established by the Secretary, shall specify a uniform, annual open enrollment period for each community rating area during which all eligible individuals are permitted the opportunity to change enrollment among the standard health plans offered to such individuals in such area under

this Act. The initial annual open enrollment period shall be for a period of 90 days.

SEC. 1504. RISK ADJUSTMENT PROGRAM.

(a) REQUIREMENT FOR IMPLEMENTATION.—In accordance with rules established by the Secretary, each State shall implement a risk adjustment methodology developed by the Secretary under subsection (d).

(b) STATE RISK ADJUSTMENT ORGANIZATION.—Each State shall establish a State risk adjustment organization to carry out the adjustments required under the methodology implemented by the State under subsection (a) and make payments in accordance with subsection (c). Such organization shall meet standards established by the Secretary relating to organizational structure, operation, fiduciary responsibilities and financial management.

(c) ADJUSTMENTS AND PAYMENTS.—

(1) CLASSES OF PURCHASERS.—The Secretary shall specify classes of individual health plan purchasers whose expected expenditures are significantly higher than those of employed individuals covered under community-rated plans.

(2) ESTIMATES.—The Secretary shall annually estimate the amount by which the expected expenditures related to specified high-cost community-rated individual health plan purchasers (as specified by

the Secretary under the methodologies developed under subsection (a)) for the year involved will exceed the expected average expenditures for other community-rated health plan enrollees. Based on such estimates, the Secretary shall develop a per capita adjustment amount with respect to each community rating area.

(3) PAYMENTS.—

(A) IN GENERAL.—The State risk adjustment organization shall, using the methodologies developed by the Secretary under subsection (a), apply the per capita adjustment amount to community-rated and experience-rated (and multistate plans under subparagraph (C)) health plans offered within each community rating area in the State.

(B) STANDARD PLANS.—Standard health plans subject to an assessment under subparagraph (A) shall make payments to the State risk adjustment organization for the State in which such plans provide coverage.

(C) MULTISTATE PLANS.—A multistate community-rated or experience-rated plan that is subject to an assessment under subparagraph (A) shall make payments to a single State risk

adjustment organization and provide such organization with information concerning the geographic distribution of the enrollees in such plan. Such organization shall determine the amount of such payments that are applicable to each community-rating area and distribute such amounts to the appropriate State risk adjustment organization.

(D) DISTRIBUTION.—State risk adjustment organizations shall distribute amounts collected under this paragraph to community-rated or experience-rated health plans that are determined to have expenditures for items and services provided to enrolled individuals that are greater than the average expenditures for enrollees in standard health plans. The amounts of such distributions shall be based on the methodology applied by the organization involved.

(d) DEVELOPMENT OF METHODOLOGIES.—

(1) IN GENERAL.—Not later than _____, the Secretary, in consultation with an advisory committee established by the Secretary, shall develop a risk adjustment and reinsur-

ance methodology for use by States in accordance with this section.

(2) METHODOLOGY.—

(A) PURPOSES.—The risk adjustment methodology developed under paragraph (1) shall—

(i) ensure that assessments imposed on or payments provided to standard health plans reflect the expected relative utilization and expenditures for covered items and services by the enrollees of each plan compared to the average utilization and expenditures for all eligible individuals, and

(ii) protect standard health plans that enroll a disproportionate share of eligible individuals with respect to whom expected utilization of health care services (included in the benefit package) and expected health care expenditures for such services are greater than the average level of such utilization and expenditures for eligible individuals.

(B) FACTORS TO BE CONSIDERED.—The methodology shall take into account the following factors:

(i) Demographic characteristics.

(ii) Health status, including prior use of health services.

(iii) Geographic area of residence.

(iv) Socio-economic status.

(v) The cost sharing of the plan.

(vi) Any other factors determined by the Secretary to be material to the purposes described in subparagraph (A).

(3) SPECIAL CONSIDERATION FOR MENTAL ILLNESS AND MENTAL RETARDATION.—In developing the methodology under this section, the Secretary shall give consideration to the unique problems of adjusting payments relating to health plans with respect to individuals with mental illness and mental retardation.

(4) MANDATORY REINSURANCE.—

(A) IN GENERAL.—The methodology developed under this section shall include a system of mandatory reinsurance as a component of the risk adjustment methodology.

(B) REINSURANCE SYSTEM.—The Secretary, in developing the methodology for a mandatory reinsurance system under subparagraph (A), shall—

(i) provide for standard health plans to make payments to state-established reinsurance programs for the purpose of reinsuring all or part of the health care expenditures for items and services included in the standard benefit package for classes of high-cost individual health plan purchasers (as specified by the Secretary) or specific high-cost treatments or diagnosis; and

(ii) specify the manner of creation, structure, and operation of the system in each State, including—

(I) the manner (which may be prospective or retrospective) in which standard health plans make payments to the system, and

(II) the type and level of reinsurance coverage provided by the system.

(5) COST-SHARING ADJUSTMENT.—The standards developed by the Secretary under this sub-

section shall include a cost-sharing adjustment mechanism to adjust for losses among all standard health plans, except multistate self-insured health plans, resulting from the reduced cost-sharing obligations of individuals receiving assistance as is provided under the program described in subtitle A of title VI.

(6) CONFIDENTIALITY OF INFORMATION.—The methodology shall be developed under this section in a manner that is consistent with privacy standards promulgated under title V. In developing such standards, the Secretary shall take into account any potential need of States for certain individually identifiable health information in order to carry out risk-adjustment and reinsurance activities under this Act, but only to the minimum extent necessary to carry out such activities and with protections provided to minimize the identification of the individuals to whom the information relates.

SEC. 1505. GUARANTY FUNDS.

A State, in accordance with the standards established by the Secretary under section 1442, shall establish a State guaranty fund with respect to community-rated plans offered in such State. The State shall establish a

separate guaranty fund with respect to self-insured plans operating in the State in accordance with section 1481.

SEC. 1506. ENROLLMENT ACTIVITIES.

(a) PROVIDER-BASED ENROLLMENT MECHANISMS.—The Secretary shall promulgate rules regarding the establishment by each participating State, in accordance with section 6006, of provider-based enrollment mechanisms for individuals seeking care who are not enrolled in a standard health plan. Such rules shall include provisions requiring standard health plans to pay providers for care delivered to individuals prior to the individual's enrollment in the plan and be consistent with section 1114.

(b) COORDINATION OF ENROLLMENT ACTIVITIES.—Each participating State shall coordinate its activities, including plan enrollment and disenrollment activities, with other States in a manner specified by the Secretary that ensures continuous, nonduplicative coverage of community-rated and experience-rated individuals in standard health plans and that minimizes administrative procedures and paperwork.

SEC. 1507. RURAL AND MEDICALLY UNDERSERVED AREAS.

(a) IN GENERAL.—If, in accordance with appropriate rules established by the Secretary, a State determines that there is inadequate access in the provision of health serv-

ices by standard health plans in any area of a State, the State may authorize—

(1) a standard health plan to be the only standard health plan in the area; or

(2) two or more standard health plans to take joint action to develop and implement a program.

(b) MEDICALLY UNDERSERVED AREA DEFINED.—For purposes of this subtitle the term ''medically underserved area'' means an urban or rural area designated by the Secretary as an area with a shortage of health professional or of health services or facilities.

SEC. 1508. PUBLIC ACCESS SITES.

(a) DESIGNATION.—A State shall designate public access sites within each community rating area through which residents of such areas can obtain consumer information concerning health plans and purchasing cooperatives offered in such areas. Such sites shall be designated in a manner that ensures access to such information by health care consumers.

(b) INFORMATION.—A State shall, through the public access sites designated under subsection (a) and using the information provided to the State under sections 1125 and 1321(f)(6), prepare and make available information, in a comparative form, concerning standard health plans certified by the State and purchasing cooperatives operating

in the State. The State shall provide such materials to employers located within the State.

SEC. 1509. REQUIREMENTS RELATING TO POSSESSIONS OF THE UNITED STATES.

(a) IN GENERAL.—A possession of the United States shall be a participating State meeting the requirements of this Act only if there is an agreement in effect between the United States and such possession pursuant to which—

(1) the laws of such possession impose a part B premium recapture assessment (as defined in subsection (b));

(2) nothing in any provision of law, including the law of such possession, permits such possession to reduce or remit in any way, directly or indirectly, any liability to such possession by reason of such assessment;

(3) any amount received in the Treasury of such possession by reason of such assessment shall be paid (at such time and in such manner as the Secretary of the Treasury shall prescribe) to the Federal Supplementary Medical Insurance Trust Fund;

(4) such assessment is coordinated with the assessment imposed by section 59B of the Internal

Revenue Code of 1986 such that, for any period, an individual would be required to pay (in the aggregate) not more than the applicable amount for such period; and

(5) the possession complies with such other requirements as may be prescribed by the Secretary and the Secretary of the Treasury to carry out the purposes of this paragraph, including requirements prescribing the information individuals to whom such assessment may apply shall furnish to the Secretary and the Secretary of the Treasury.

(b) QUALIFIED PART B PREMIUM RECAPTURE ASSESSMENT.—In subsection (a), the term ''qualified medicare part B premium recapture assessment'' means an assessment imposed and collected by such a possession that is—

(1) equivalent to the assessment imposed under section 59B of the Internal Revenue Code of 1986; and

(2) imposed on all individuals who are bona fide residents of the possession, to the extent such individuals have not paid the assessment imposed under such section 59B to the United States by reason of subsection (d)(5) of such section.

SEC. 1510. RIGHT OF RECOVERY OF CERTAIN TAXES AGAINST PROVIDERS.

Each participating State shall provide that issuers and plan sponsors of certified standard health plans shall have the right of recovery against providers described in section 4518 of the Internal Revenue Code of 1986 and shall provide methods of enforcing such right.

PART 2—TREATMENT OF STATE LAWS

SEC. 1511. PREEMPTION OF CERTAIN STATE LAWS RELATING TO HEALTH PLANS.

(a) LAWS RESTRICTING PLANS OTHER THAN FEE-FOR-SERVICE PLANS.—Except as may otherwise be provided in this section, no State law shall apply to any services provided under a health plan that is not a fee-for-service plan (or a fee-for-service component of a plan) if such law has the effect of prohibiting or otherwise restricting plans from—

(1) limiting the number and type of health care providers who participate in the plan;

(2) requiring enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan;

(3) requiring enrollees to obtain a referral for treatment by a specialized physician or health institution;

(4) establishing different payment rates for participating providers and providers outside the plan;

(5) creating incentives to encourage the use of participating providers; or

(6) requiring the use of single-source suppliers for pharmacy, non-serviced medical equipment, and other health products and services.

(b) PREEMPTION OF STATE CORPORATE PRACTICE ACTS.—Any State law related to the corporate practice of medicine and to provider ownership of health plans or other providers shall not apply to arrangements between health plans that are not fee-for-service plans and their participating providers.

SEC. 1512. OVERRIDE OF RESTRICTIVE STATE PRACTICE LAWS.

(a) OVERRIDE.—

(1) IN GENERAL.—No State may, through licensure or otherwise, restrict the practice of any class of practitioners beyond that which is justified by the education and training of such practitioners.

(2) DEFINITION.—As used in this section, the term ''practitioner'' means—

(A) a nurse practitioner;

(B) a certified nurse midwife;

(C) a nurse anesthetist;

(D) a clinical nurse specialist; and

(E) a physicians assistant;

that has been awarded a master's degree or postmaster's certificate following the completion of an accredited training program that prepares individuals in advanced practitioner specialties and that is authorized by the State to practice as such a practitioner.

(b) REGULATIONS.—The Secretary shall promulgate regulations to implement subsection (a) and shall ensure that appropriate technical assistance is available to States for the purpose of complying with this section.

PART 3—STATE FLEXIBILITY

Subpart A—Existing State Laws

SEC. 1521. CONTINUANCE OF EXISTING FEDERAL LAW WAIVERS.

Nothing in this Act shall preempt any feature of a State health care system operating under a waiver granted before the date of the enactment of this Act under titles XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq. or 1396 et seq.) or the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

SEC. 1522. HAWAII PREPAID HEALTH CARE ACT.

(a) ERISA WAIVER.—

(1) IN GENERAL.—Section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)) is amended to read as follows:

''(5)(A) Except as provided in subparagraphs (B) and (C), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 through 393–51).

''(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any State tax law relating to employee benefits plans.

''(C) If the Secretary of Labor notifies the Governor of the State of Hawaii that as the result of an amendment to the Hawaii Prepaid Health Care Act enacted after the date of the enactment of this paragraph—

''(i) the proportion of the population with health care coverage under such Act is less than such proportion on such date, or

''(ii) the level of benefit coverage provided under such Act is less than the actuarial equivalent of such level of coverage on such date,

subparagraph (A) shall not apply with respect to the application of such amendment to such Act after the date of such notification.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) HSA WAIVER.—

(1) IN GENERAL.—The Secretary shall, at the request of the Governor of the State of Hawaii and in accordance with this section, grant a waiver to the State from the requirements of this Act (other than the requirements specified in paragraph (3)).

(2) SCOPE OF WAIVER.—The waiver granted under paragraph (1) shall exempt—

(A) the State of Hawaii;

(B) health plans offered within the State; and

(C) health plan participants, including employers, employees, residents, and health plan sponsors within the State,

from requirements otherwise applicable to the State and such plans and participants.

(3) REQUIRED COMPLIANCE OF OTHER REQUIREMENTS.—The waiver shall initially be granted under paragraph (1) if the State of Hawaii demonstrates to the Secretary that the State maintains—

(A) a requirement that employers make premium contributions comparable to the requirements of this Act;

(B) a comprehensive benefit package (including cost sharing) that is comparable with the requirements of subtitle B of this title;

(C) a percentage of State population with health care coverage that is not less than the national average;

(D) a quality control mechanism and data system that are comparable to the applicable requirements of title V; and

(E) health care cost containment consistent with the provisions of this Act.

(4) WAIVER PERIOD.—The waiver initially granted under paragraph (1) shall extend for the period during which the State of Hawaii continues to comply with the requirements specified in paragraph (3). The Secretary may require the State, every 5 years, to demonstrate to the Secretary the State's continued compliance with such requirements.

(5) PROCEDURE IN THE EVENT OF NON-COMPLIANCE.—

(A) NOTICE.—If, at any time after granting a waiver under paragraph (1), the Secretary

finds that the State of Hawaii is not meeting the requirements specified in paragraph (3), the Secretary shall notify the State of the Secretary's findings.

(B) OPPORTUNITY TO CONTEST.—The State may contest the Secretary's findings under the procedures provided under section 5231.

(C) OPPORTUNITY FOR CORRECTION.—

(i) FINDINGS NOT CONTESTED.—If the State does not contest the Secretary's findings within the 30-day period beginning on the date of receipt of a notice of such findings, the State shall have—

(I) a 90-day period beginning on such date to show a good faith effort to remedy the non-compliance, and

(II) an additional 12-month period to take such actions as may be required to bring the State into compliance with the requirements specified in paragraph (3).

(ii) CONTESTED FINDINGS.—If the State contests the Secretary's findings

within such 30-day period but such findings are upheld, the State shall have—

(I) a 90-day period beginning on the date of final adjudication to show a good faith effort to remedy the noncompliance, and

(II) an additional 12-month period to take such actions as may be required to bring the State into compliance with the requirements specified in paragraph (3).

(D) TERMINATION.—If the State fails to demonstrate a good faith effort under subparagraph (C)(i)(I) or (C)(ii)(I) or to take actions under subparagraph (C)(i)(II) or (C)(ii)(II) within the time period specified, the Secretary may revoke the waiver granted in paragraph (1).

(6) COOPERATIVE AGREEMENT WITH THE SECRETARY.—The Secretary shall enter into cooperative agreements with appropriate officials of the State of Hawaii—

(A) to develop standards and reporting requirements necessary for the issuance and

maintenance of the State's waiver under paragraph (1); and

(B) otherwise to effectuate the provisions of this subsection.

(7) ELIGIBILITY FOR FEDERAL FUNDS PROVIDED TO PARTICIPATING STATES.—Nothing in this subsection shall preclude the eligibility of the State of Hawaii to participate in any public health initiative, grant, or financial aid program under this Act (including the medicaid program under title XIX of the Social Security Act), or the sharing of revenue resulting from the amendments made by title VII, designed to implement the purpose of this Act. The Secretary shall work with appropriate officials of the State of Hawaii to develop comparable, alternative standards to govern the State's entitlement under title XI.

SEC. 1523. ALTERNATIVE STATE PROVIDER PAYMENT SYSTEMS.

Notwithstanding any other provision of law, if a hospital reimbursement system operated by a State meets the requirements of section 1814(b) of the Social Security Act (42 U.S.C. 1395f(b)) and has been approved by the Secretary and in continuous operation since July 1, 1977, the payment rates and methodologies required under the sys-

tem for services provided in the State shall apply to all purchasers and payers, including those under employee welfare benefit plans authorized under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), workers' compensation programs under State law, the Federal Employees' Compensation Act under chapter 81 of title 5, United States Code, and Federal employee health benefit plans under chapter 89 of title 5, United States Code.

SEC. 1524. ALTERNATIVE STATE HOSPITAL SERVICES PAYMENT SYSTEMS.

(a) IN GENERAL.—No State shall be prevented from enforcing—

(1) a State system described in subsection (b), or

(2) a State system described in subsection (c), by any provision of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) or chapter 81 or 89 of title 5, United States Code.

(b) REIMBURSEMENT CONTROL SYSTEM.—A State system is described in this subsection if it is a State reimbursement control system in operation before the date of the enactment of this Act which—

(1) applies to substantially all non-Federal acute care hospitals in the State, and

(2) regulates substantially all rates of payment (including maximum charges) in the State for inpatient hospital services, except payments made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(c) HEALTH INSURANCE REFORM SYSTEM.—A State system is described in this subsection if it is a State health insurance reform system in operation before the date of the enactment of this Act which requires any insurer (including a health maintenance organization) to comply with requirements governing open enrollment and community rating, including premium adjustments or other health care assessments, for the purpose of risk adjustment.

(d) EFFECTIVE DATES.—

(1) SUBSECTION (b).—In the case of a State system described in subsection (b), the provisions of this section shall apply before, on, and after the date of the enactment of this Act.

(2) SUBSECTION (c).—In the case of a State system described in subsection (c), the provisions of this section shall apply before, on, and after the date of the enactment of this Act, and before the effective date of section 1116 of this Act.

Subpart B—Requirements for State Single-Payer Systems

SEC. 1531. SINGLE-PAYER SYSTEM DESCRIBED.

The Secretary shall approve an application of a State to operate a single-payer system if the Secretary finds that the system—

(1) meets the requirements of section 1532; and

(2)(A) in the case of a system offered throughout a State, meets the requirements for a Statewide single-payer system under section 1533; or

(B) in the case of a system offered in a single community rating area of a State, meets the requirements for an area specific single-payer system under section 1534.

SEC. 1532. GENERAL REQUIREMENTS FOR SINGLE-PAYER SYSTEMS.

Each single-payer system shall meet the following requirements:

(1) ESTABLISHMENT BY STATE.—The system is established under State law, and State law provides for mechanisms to enforce the requirements of the system.

(2) OPERATION BY STATE.—The system is operated by the State or a designated agency of the State.

(3) ENROLLMENT OF INDIVIDUALS.—

(A) MANDATORY ENROLLMENT OF ALL COMMUNITY-RATED INDIVIDUALS.—The system shall provide for the enrollment of all community-rated individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area) who are not medicare-eligible individuals.

(B) OPTIONAL ENROLLMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—At the option of the State and if the Secretary has approved an application submitted by the State, the system may provide for the enrollment of medicare-eligible individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area).

(C) OPTIONAL ENROLLMENT OF EXPERIENCE-RATED INDIVIDUALS.—

(i) IN GENERAL.—Except as provided in clause (ii), at the option of the State, a single-payer system may provide for the enrollment of experience-rated individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area).

(ii) PARTICIPATION BY CERTAIN MULTISTATE PLANS.—The system shall not require participation by any experience-rated individual who is enrolled in a certified multistate self-insured standard health plan which is a multiemployer plan described in section 1013(10), or which is sponsored by an experience-rated employer sponsor with at least 5,000 full-time employees.

(D) OPTIONS INCLUDED IN STATE SYSTEM DOCUMENT.—A State may not exercise any of the options described in subparagraphs (B) or (C) for a year unless the State included a description of the option in the submission of its system document to the Secretary for the year under section 1501(a).

(E) EXCLUSION OF CERTAIN INDIVIDUALS.—A single-payer system may not require the enrollment of veterans, active duty military personnel, and American Indians.

(4) DIRECT PAYMENT TO PROVIDERS.—

(A) IN GENERAL.—With respect to providers who furnish items and services included in the standard benefits package established under

subtitle C to individuals enrolled in the system, the State shall make payments directly, or through fiscal intermediaries, to such providers and assume (subject to subparagraph (B)) all financial risk associated with making such payments.

(B) CAPITATED PAYMENTS PERMITTED.—Nothing in subparagraph (A) shall be construed to prohibit providers furnishing items and services under the system from receiving payments on a capitated, at-risk basis based on prospectively determined rates.

(5) PROVISION OF STANDARD BENEFITS PACKAGE.—

(A) IN GENERAL.—The system shall provide for coverage of the standard benefits package established under subtitle C, including the cost-sharing provided under the package (subject to subparagraph (B)), to all individuals enrolled in the system.

(B) IMPOSITION OF REDUCED COST-SHARING.—The system may decrease the cost-sharing otherwise provided in the standard benefits package established under subtitle C with respect to any individuals enrolled in the system

or any class of services included in the package, so long as the system does not increase the cost-sharing otherwise imposed with respect to any other individuals or services.

(6) COST CONTAINMENT.—The system shall provide for mechanisms to ensure, in a manner satisfactory to the Secretary, that—

(A) the rate of growth in health care spending will not be higher than the target established under this Act;

(B) the expenditures described in subparagraph (A) are computed and effectively monitored;

(C) automatic, mandatory, nondiscretionary reductions in payments to health care providers will be imposed to the extent required to assure that such per capita expenditures do not exceed the applicable target referred to in subparagraph (A); and

(D) Federal payments to a single payer State or health care coverage area shall be limited to the payments that would have been made in the absence of the implementation of the single payer system.

(7) FEDERAL PAYMENTS.—The system shall provide for mechanisms to ensure, in a manner satisfactory to the Secretary, that Federal payments to a single-payer State or community rating area shall be limited to the payments that would have been made in the absence of the implementation of the single-payer system.

(8) REQUIREMENTS GENERALLY APPLICABLE TO STANDARD HEALTH PLANS.—The system shall meet the requirements applicable to a standard health plan, except that—

(A) the system does not have the authority provided to standard health plans under section 1111(b)(3) (relating to permissible limitations on the enrollment of community-rated eligible individuals on the basis of limits on the plan's capacity); and

(B) the system is not required to meet the requirements of sections 1116 (relating to rating limitations for community-rated market), 1123(a) (relating to plan solvency), and section 1125 (relating to restrictions on the marketing of plan materials).

SEC. 1533. SPECIAL RULES FOR STATES OPERATING STATEWIDE SINGLE-PAYER SYSTEM.

(a) IN GENERAL.—In the case of a State operating a Statewide single-payer system—

(1) the State shall operate the system throughout the State; and

(2) except as provided in subsection (b), the State shall meet the requirements for participating States under part 1.

(b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR PARTICIPATING STATES.—In the case of a State operating a Statewide single-payer system, the State is not required to meet the following requirements otherwise applicable to participating States under part 1:

(1) ESTABLISHMENT OF COMMUNITY RATING AND SERVICE AREAS.—The requirements of sections 1502(a) (relating to the establishment of community rating areas) and 1502(b) (relating to the designation of health plan service areas).

(2) OTHER REFERENCES INAPPLICABLE.—Any requirement which the Secretary determines is not appropriate to apply to a State single-payer system.

(c) FINANCING.—

(1) IN GENERAL.—A State operating a Statewide single-payer system shall provide for the financing of the system using, at least in part, a payroll-

based financing system that requires employers to pay at least the amount that the employers would be required to pay if the employers were subject to the requirements of title X (determined without regard to any effective date).

(2) USE OF FINANCING METHODS.—Such a State may use, consistent with paragraph (1), any other method of financing.

(d) SINGLE-PAYER STATE DEFINED.—In this title, the term ''single-payer State'' means a State with a State-wide single-payer system in effect that has been approved by the Secretary in accordance with this part.

SEC. 1534. SPECIAL RULES FOR COMMUNITY RATING AREA-SPECIFIC SINGLE-PAYER SYSTEMS.

(a) IN GENERAL.—In the case of a State operating a community rating area specific single-payer system, except as provided in subsection (b), the State shall meet the requirements for participating States under part 1.

(b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR PARTICIPATING STATES.—

(1) ESTABLISHMENT OF SERVICE AREAS.—The requirement of section 1502(b) (relating to the designation of health plan service areas).

(2) OTHER REFERENCES INAPPLICABLE.—Any requirement which the Secretary determines is not

appropriate to apply to a community rating area specific single-payer system.

Subpart C—Early Implementation of Comprehensive State Programs

SEC. 1541. EARLY IMPLEMENTATION OF COMPREHENSIVE STATE PROGRAMS

(a) APPLICATION.—

(1) IN GENERAL.—In accordance with this section, each State desiring to implement the reform standards established in this Act before the applicable effective date for such standards, may submit an application to the Secretary of Health and Human Services and the Secretary of Labor to request approval of a State comprehensive health care reform program established under State law which meets the requirements specified in subsection (b).

(2) ESTABLISHMENT OF CRITERIA.—The Secretaries shall establish not later than January 1, 1995, criteria for—

(A) the approval of such applications, and

(B) the continuing review of such State programs consistent with the provisions of subpart B of part 1.

(3) EXPEDITED PROCEDURE.—The Secretaries shall establish an expedited procedure for the consid-

eration and disposition of applications under this subsection. The procedure established by the Secretaries shall provide that such consideration and disposition be completed within 90 days, and that if the application is approved, multistate employers be notified of such approval.

(b) REQUIREMENTS SPECIFIED.—The State program shall be consistent with the reform standards established in this Act and the interim and final (if any) regulations promulgated by the Secretaries, including—

(1) a standardized benefits package meeting the requirements established under subtitle C, or in the event such requirements have not been fully promulgated on the date of the application, the requirements for a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act (42 U.S.C. 300e-9(d));

(2) insurance reforms and rating requirements as specified under part 2 of subtitle B;

(3) standards for health plans as specified under part 3 of subtitle B;

(4) the recognition of, and standards for, purchasing cooperatives, as specified in part 2 of subtitle D;

(5) compliance with the data collection and privacy procedures established under subtitle B of title V;

(6) uniform administrative procedures as specified in section 1126;

(7) the imposition of employer and individual responsibilities as specified in part 1 of subtitle D and title X (determined without regard to any effective date);

(8) the establishment of the subsidy program under this Act; and

(9) health care cost containment under this Act.

(c) QUALIFICATION FOR FEDERAL FUNDS.—For purposes of this Act, a State with an approved State program under this section shall be considered a participating State and shall maintain such status if such State meets the requirements of this Act as such provisions become effective.

(d) EMPLOYER CERTIFICATION PROCESS.—In the case of any multistate self-insured health plan, certification by the plan to the Secretary of Labor that such plan is in compliance with the applicable Federal standards described in subsection (b) shall satisfy compliance with any State program approved under this section.

(e) FUNDING.—The Secretary of Health and Human Services shall pay over to each State with an approved application under this section for each calendar quarter ending before 1997 an amount equal to the estimated decrease in Federal expenditures (net of any estimated decrease in Federal revenues) for such quarter with respect to such State resulting from the implementation of the State comprehensive health care reform program.

Subtitle G—Miscellaneous Provisions

SEC. 1601. PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

A health professional or a health facility may not be required to provide an item or service in the standard benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

SEC. 1602. ANTIDISCRIMINATION.

(a) IN GENERAL.—The Secretary of Health and Human Services, and any State, health plan, purchasing cooperative, employer, health program or activity receiving Federal financial assistance, or other entity subject to this Act, shall not directly or through contractual arrangements—

(1) deny or limit access to or the availability of health care services, or otherwise discriminate in connection with the provision of health care services; or

(2) limit, segregate, or classify an individual in any way which would deprive or tend to deprive such individual of health care services, or otherwise adversely affect his or her access to health care services;

on the basis of race, national origin, sex, religion, language, income, age, sexual orientation, disability, health status, or anticipated need for health services.

(b) APPLICATION OF SECTION TO SPECIFIC ACTIONS.—This section shall apply to, but is not limited to, the following actions:

(1) The establishing of boundaries for community rating areas under section 1502, the enrollment of individuals in a health care plan or the marketing of a health care plan, and the selection of providers or the setting of the terms or conditions under which providers participate in a health care plan or provider network.

(2) The determination of the scope of services provided by a health care plan, and the providing of

such services and determining of the site or location of health care facilities.

(c) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue regulations to carry out this section.

(d) EFFECT ON OTHER LAWS. Nothing in this Act shall be construed to limit the scope of, or the availability of relief under, any other Federal or State law prohibiting discrimination or providing relief therefore.

TITLE II—NEW BENEFITS

Subtitle A—Coverage of Outpatient Prescription Drugs in Medicare

SEC. 2000. REFERENCES IN SUBTITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this subtitle an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public

Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

PART 1—COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS

SEC. 2001. COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

(a) COVERED OUTPATIENT DRUGS AS MEDICAL AND OTHER HEALTH SERVICES.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended to read as follows:

''(J) covered outpatient drugs;''.

(b) DEFINITION OF COVERED OUTPATIENT DRUG.—Section 1861(t) (42 U.S.C. 1395x(t)) is amended—

(1) in the heading, by adding at the end the following: ''; Covered Outpatient Drugs'';

(2) in paragraph (1)—

(A) by striking ''paragraph (2)'' and inserting ''the succeeding paragraphs of this subsection'', and

(B) by striking the period at the end and inserting '', but only if used for a medically accepted indication.''; and

(3) by striking paragraph (2) and inserting the following:

''(2) Except as otherwise provided in paragraph (3), the term 'covered outpatient drug' means any of the following products used for a medically accepted indication:

''(A) A drug which may be dispensed only upon prescription and—

''(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

''(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of

such Act to enforce section 502(f) or 505(a) of such Act; or

''(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(B) A biological product which—

''(i) may only be dispensed upon prescription,

''(ii) is licensed under section 351 of the Public Health Service Act, and

''(iii) is produced at an establishment licensed under such section to produce such product.

''(C) Insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

''(D) Enteral nutrients (but only if provided as a covered home infusion drug).

''(3) The term 'covered outpatient drug' does not include any product—

''(A) which is administered through infusion in a setting described in paragraph (5)(A)(ii) unless the product is a covered home infusion drug;

''(B) when furnished as part of, or as incident to, any other item or service for which payment may be made under this title (other than physicians' services or services which would be physicians' services if furnished by a physician); or

''(C) which is listed under paragraph (2) of section 1927(d) (other than subparagraph (I) or (J) of such paragraph) as a drug which may be excluded from coverage under a State plan under title XIX and which the Secretary elects to exclude from coverage under part B.

''(4) For purposes of this subsection, the term 'medically accepted indication', with respect to the use of an

outpatient drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

''(A) the drug has been approved by the Food and Drug Administration; and

''(B)(i) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

''(ii) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this clause by the Secretary.

The Secretary may revise the list of compendia in subparagraph (B)(i) designated as appropriate for identifying medically accepted indications for drugs.

''(5)(A) For purposes of this subsection, the term 'covered home infusion drug' means a covered outpatient drug dispensed to an individual that—

''(i) is administered intravenously, subcutaneously, or epidurally, using an access device that is inserted into the body and an infusion device to control the rate of flow of the drug (or through other means of administration determined by the Secretary);

''(ii) is administered—

''(I) in the individual's home,

''(II) in an institution used as the individual's home, but only if the drug is administered during an inpatient day for which payment is not made to the institution under part A for inpatient or extended care services furnished to the individual, or

''(III) in a facility other than the individual's home if the administration of the drug at the facility is determined by the Secretary to be cost-effective (in accordance with such criteria as the Secretary may establish); and

''(iii) with respect to a drug furnished in a home setting—

''(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or the indication to which the drug is applied, that the drug cannot generally be administered safely and effectively in such a setting, or

''(II) is not an antibiotic drug and the Secretary has determined, for the specific drug or the indication to which the drug is applied, that the drug can generally be administered safely and effectively in such a setting.

''(B) Not later than January 1, 1999, (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home infusion drugs, with respect to which home infusion drug therapy may be provided under this title.''.

(c) CONFORMING AMENDMENTS REPEALING SEPARATE COVERAGE OF CERTAIN DRUGS AND PRODUCTS.—(1) Effective January 1, 1999, section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (A), by striking ''(including drugs'' and all that follows through ''self-administered)'';

(B) by striking subparagraphs (G) and (I);

(C) by adding ''and'' at the end of subparagraph (M); and

(D) by striking subparagraphs (O), (P), and (Q).

(2) Effective January 1, 1999, section 1861 (42 U.S.C. 1395x) is amended by striking the subsection (jj) added by section 4156(a)(2) of OBRA–1990.

(3) Effective January 1, 1999, section 1881(b) (42 U.S.C. 1395rr(b)) is amended—

(A) in the first sentence of paragraph (1)—

(i) by striking '', (B)'' and inserting '', and (B)'', and

(ii) by striking '', and (C)'' and all that follows and inserting a period; and

(B) in paragraph (11)—

(i) by striking ''(11)(A)'' and inserting ''(11)'', and

(ii) by striking subparagraphs (B) and (C).

SEC. 2002. PAYMENT RULES AND RELATED REQUIREMENTS FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) PAYMENT FOR AND CERTAIN REQUIREMENTS CONCERNING COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) IN GENERAL.—Payment shall be made under paragraph (2) only for expenses incurred by an individual for a covered outpatient drug during a calendar year after the individual has incurred expenses in the year for such drugs (during a period in which the individual is entitled to benefits under this part) equal to the deductible amount for that year.

"(B) DEDUCTIBLE AMOUNT.—

"(i) For purposes of subparagraph (A), the deductible amount is—

"(I) for 1999, an amount equal to the amount determined under clause (ii)(I);

"(II) for 2000, the amount (rounded to the nearest dollar) that the Secretary estimates will ensure that the percentage of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876, an organization described in section 1833(a)(1)(A), or a medicare drug benefit plan under section 1851) dur-

ing the year who will incur expenses for covered outpatient drugs equal to or greater than such amount will be the same as the percentage for the previous year;

''(III) for 2001, an amount equal to the amount determined under clause (ii)(II); and

''(IV) for any succeeding year, the amount (rounded to the nearest dollar) that the Secretary estimates will ensure that the percentage of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876, an organization described in section 1833(a)(1)(A), or a medicare drug benefit plan under section 1851) during the year who will incur expenses for covered outpatient drugs equal to or greater than such amount will be the same as the percentage for the previous year.

''(ii) For purposes of clause (i), the amount determined under this clause is—

"(I) in 1999, an amount determined by the Secretary such that the amount so determined will result in projected incurred spending and administrative costs (net of projected rebates under section 1851 and any portion of the part B premium attributable to the covered outpatient drug benefit) for providing payment under this title for covered outpatient drugs that would be equal to a spending target equal to $13,500,000,000; and

"(II) in 2001, an amount determined by the Secretary (based on actual experience) that the Secretary estimates will ensure that the percentage of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876, an organization described in section 1833(a)(1)(A), or a medicare drug benefit plan under section 1851) during the year who will incur expenses for covered outpatient drugs equal to or greater than such

amount will be the same as the percentage that would have incurred such expenses had actual experience in such incurred spending and administrative costs (described in subclause (I)) for 1999 been equal to the spending target for 1999 (described in subclause (I)).

''(iii) The Secretary shall promulgate the deductible amount for 1999 and each succeeding year not later than October 1 of the previous year.

''(2) PAYMENT AMOUNT.—

''(A) IN GENERAL.—Subject to the deductible established under paragraph (1), the amount payable under this part for a covered outpatient drug furnished to an individual during a calendar year shall be equal to—

''(i) 80 percent of the payment basis described in paragraph (3), in the case of an individual who has not incurred expenses for covered outpatient drugs during the year (including the deductible imposed under paragraph (1)) in excess of the out-

of-pocket limit for the year under subparagraph (B); and

''(ii) 100 percent of the payment basis described in paragraph (3), in the case of any other individual.

''(B) OUT-OF-POCKET LIMIT DESCRIBED.—

''(i) For purposes of subparagraph (A), the out-of-pocket limit for a year is equal to—

''(I) for 1999, $1275; and

''(II) for any succeeding year, the amount (rounded to the nearest dollar) that the Secretary estimates will ensure that the percentage of the average number of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) during the year who will incur expenses for covered outpatient drugs equal to or greater than such amount will be the same as the percentage for the previous year.

"(ii) The Secretary shall promulgate the out-of-pocket limit for 1999 and each succeeding year not later than October 1 of the previous year.

"(3) PAYMENT BASIS.—For purposes of paragraph (2), the payment basis is the lesser of—

"(A) the actual charge for a covered outpatient drug, or

"(B) the applicable payment limit established under paragraph (4).

"(4) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR SINGLE SOURCE DRUGS AND MULTIPLE SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a covered outpatient drug that is a multiple source drug which has a restrictive prescription, or that is single source drug, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the per unit estimated acquisition cost for the drug product (determined under subparagraph (C)) for the period.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug which does not have a restrictive prescription, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the unweighted median of the unit estimated acquisition cost (determined under subparagraph (C)) for the drug products for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) IN GENERAL.—The Secretary shall determine, for the dispensing or providing of a covered outpatient drug product in the payment calculation period, the estimated acquisition cost for the drug product. With respect to any covered outpatient drug product, the estimated acquisition cost, may not exceed 93 percent of the published average wholesale price for the drug, as determined one month prior to the beginning of the payment calculation period.

"(ii) COMPLIANCE WITH REQUEST FOR INFORMATION.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide price information requested to carry out clause (i), or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as they apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to clause (i) shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part and to permit the Comptroller General and the Director of the Congressional Budget Office to review the information provided.

"(5) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMIT.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the administrative allowance established under this paragraph is—

"(i) for 1999, an amount equal to $5; and

"(ii) for each succeeding year, the amount for the previous year, adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that previous year.

"(B) NO DISPENSING FEE FOR CERTAIN DRUGS AND PRODUCTS.—No administrative allowance may be provided under this paragraph with respect to any of the following covered outpatient drugs:

"(i) Erythropoietin provided to dialysis patients.

"(ii) Drugs and biologicals provided as an incident to a physician's service or to a service which would be a physician's service if furnished by a physician.

"(iii) Covered home infusion drugs.

"(6) MAIL ORDER PHARMACY OPTION.—

"(A) ESTABLISHMENT OF MAIL ORDER OPTION.—The Secretary may establish a competitive bidding process to award contracts to mail order pharmacies for the provision of covered outpatient drugs that are maintenance drugs to individuals who opt to receive such drugs through the mail order pharmacies. The payment amount for a covered outpatient drug under this section to a mail order pharmacy under such a contract shall be equal to the amount bid by such plan under this subparagraph instead of the payment limit determined in accordance with paragraph (4).

"(B) SHARING OF SAVINGS.—To the extent that payment is made under this section for maintenance drugs that are provided through a mail order pharmacy pursuant to subparagraph (A), an individual that opts to receive such drugs from such pharmacy shall receive from the Secretary a rebate or a contribution toward the individual's cost sharing in an amount equal to 25 percent of the excess of the payment limit determined in accordance with paragraph (4) over the amount charged by the mail order pharmacy for such drug.

1 ''(7) ASSURING APPROPRIATE PRESCRIBING
2 AND DISPENSING PRACTICES.—
3 ''(A) IN GENERAL.—The Secretary shall
4 develop a program to—
5 ''(i) provide on-line prospective review
6 of prescriptions on a 24-hour basis (in ac-
7 cordance with subparagraph (B)) and ret-
8 rospective review of claims;
9 ''(ii) establish standards for counsel-
10 ing individuals to whom covered outpatient
11 drugs are prescribed; and
12 ''(iii) identify (and to educate physi-
13 cians, patients, and pharmacists concern-
14 ing)—
15 ''(I) instances or patterns of un-
16 necessary or inappropriate prescribing
17 or dispensing practices for covered
18 outpatient drugs,
19 ''(II) instances or patterns of
20 substandard care with respect to such
21 drugs,
22 ''(III) potential adverse reactions,
23 and
24 ''(IV) appropriate use of generic
25 products.

"(B) PROSPECTIVE REVIEW.—

"(i) IN GENERAL.—The program under this paragraph shall provide for on-line prospective review of each covered outpatient drug prescribed for a patient before the prescription is filled or the drug is furnished, including screening for potential drug therapy problems due to therapeutic duplication, drug-to-drug interactions, and incorrect drug dosage or duration of drug treatment.

"(ii) DISCUSSION OF APPROPRIATE USE.—In conducting prospective review under this subparagraph, any individual or entity that dispenses a covered outpatient drug shall offer to discuss with the patient to whom the drug is furnished or the patient's caregiver (in person if practicable, or through access to a toll-free telephone service) information regarding the appropriate use of the drug, potential interactions between the drug and other drugs dispensed to the individual, and such other matters as the Secretary may require.

''(iii) ADDITIONAL DUTIES.—In carrying out this subparagraph, the Secretary shall—

''(I) develop public domain software which could be used by carriers and pharmacies to provide the on-line prospective review; and

''(II) study the feasibility and desirability of requiring patient diagnosis codes on prescriptions and to the extent that the Secretary finds such a requirement to be feasible and desirable, to implement such a requirement to be effective on and after January 1, 2000.

''(C) PRIOR AUTHORIZATION.—

''(i) DEVELOPMENT OF LIST OF MISUSED DRUGS.—The Secretary shall develop (and periodically) update a list of covered outpatient drugs which the Secretary has determined, based on data collected, may be subject to misuse or inappropriate use. The Secretary shall provide a means for manufacturers to appeal an initial decision to include a drug on the list.

"(ii) PRIOR AUTHORIZATION FOR DRUGS ON LIST.—The Secretary shall establish a process under which (subject to clause (iii)) the Secretary may require advance approval for any covered outpatient drug included on the list developed under clause (i).

"(iii) RESTRICTIONS ON DENIAL OF APPROVAL.—The Secretary may not deny the approval of a drug under the process established under clause (ii) before its dispensing unless the process—

"(I) provides responses by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

"(II) provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in emergency situations (as defined by the Secretary).

"(iv) EXPANSION TO OTHER DRUGS.—If the rate of growth of payments under this part for covered outpatient drugs exceeds the average rate of growth

for parts A and B expenditures and the Secretary finds such action to be feasible and desirable, the Secretary may require advance approval under this subparagraph for the dispensing of a covered outpatient drug in cases where a more cost-effective therapeutically or generically equivalent drug is available.

''(D) DRUG USE REVIEW.—As part of the program established under subparagraph (A), the Secretary shall provide for a drug use review program to provide for the ongoing periodic examination of claims data and other records on covered outpatient drugs furnished to patients under this title in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients.

''(E) ADOPTION OF MEDICAID PROGRAMS.—To the extent considered appropriate by the Secretary, the program developed under this paragraph with respect to drugs furnished in a State may include elements applicable to the furnishing of covered outpatient drugs

under the State medicaid program under section 1927.

''(8) BILLING REQUIREMENTS.—

''(A) MANDATORY ASSIGNMENT.—(i) Payment under this part for a covered outpatient drug may only be made on an assignment-related basis.

''(ii) Except for deductible, coinsurance, or copayment amounts applicable under this part, no person may bill or collect any amount from an individual enrolled under this part or other person for a covered outpatient drug for which payment may be made under this part, and no such individual or person is liable for payment of any amounts billed in violation of this clause. If a person knowingly and willfully bills or collects an amount in violation of the previous sentence, the Secretary may apply sanctions against such person in accordance with section 1842(j)(2). Paragraph (4) of section 1842(j) shall apply in this clause in the same manner as such paragraph applies to such section.

''(B) USE OF ELECTRONIC SYSTEM.—The Secretary shall establish, by not later than January 1, 1998, a point-of-sale electronic system

for use by carriers and pharmacies in the submission of information respecting covered outpatient drugs dispensed to medicare beneficiaries under this part. Such system shall be consistent with the standards established by the National Council of Prescription Drug Programs.

''(9) REQUIRING PHARMACY SUPPLIER NUMBERS.—

''(A) IN GENERAL.—Payment may not be made under this part with respect to a covered outpatient drug dispensed by a pharmacy unless the entity has obtained a supplier number from the Secretary.

''(B) STANDARDS FOR ISSUING SUPPLIER NUMBERS.—The Secretary may not issue a supplier number to an entity for purposes of subparagraph (A) unless the entity demonstrates to the Secretary that it will maintain patient records (in accordance with such standards as the Secretary may impose) and meet the other applicable requirements of this subsection and section 1848(g).

''(10) STUDY ON PHARMACEUTICAL CARE SERVICES.—The Secretary shall conduct a study to de-

velop, in consultation with actively practicing pharmacists, a payment methodology (to be in addition to the administrative allowance established under paragraph (5)) which is based upon and reflects the reasonable charges for varying levels of pharmacist services, including patient consultations provided to individuals under this section. The Secretary shall submit a report, including such recommendations as the Secretary determines to be appropriate, to Congress on the methodology developed under this paragraph not later than September 30, 1998.

''(11) DEFINITIONS.—In this subsection:

''(A) MULTIPLE AND SINGLE SOURCE DRUGS.—The terms 'multiple source drug' and 'single source drug' have the meanings given those terms under section 1927(k)(7), except that the reference in such section to a 'covered outpatient drug' shall be considered a reference to a covered outpatient drug under this part.

''(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if—

''(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and

with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that a particular drug product must be dispensed, or

''(ii) in the case of a prescription issued by telephone—

''(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that a particular drug product must be dispensed, and

''(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug product was required to have been dispensed.

''(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means a calendar year.''.

(b) REQUIRING PHARMACIES TO SUBMIT CLAIMS.—Section 1848(g)(4) (42 U.S.C. 1395w–4(g)(4)) is amended—

(1) in the heading—

(A) by striking ''PHYSICIAN'', and

(B) by inserting ''BY PHYSICIANS AND SUPPLIERS'' after ''CLAIMS'';

(2) in the matter in subparagraph (A) preceding clause (i)—

(A) by striking ''For services furnished on or after September 1, 1990, within 1 year'' and inserting ''Within 1 year (or 90 days in the case of covered outpatient drugs)'',

(B) by striking ''a service'' and inserting ''an item or service'', and

(C) by inserting ''or of providing a covered outpatient drug,'' after ''basis,''; and

(3) in subparagraph (A)(i), by inserting ''item or'' before ''service''.

(c) SPECIAL RULES FOR CARRIERS.—

(1) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

''(D) With respect to activities related to covered outpatient drugs, the Secretary may enter into contracts with

carriers under this section to perform the activities on a regional basis.''.

(2) ADDITIONAL FUNCTIONS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (H);

(B) by adding ''and'' at the end of subparagraph (L);

(C) by redesignating subparagraph (L) as subparagraph (I); and

(D) by inserting after subparagraph (I) (as so redesignated) the following new subparagraphs:

''(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

''(i) receive information transmitted under the electronic system established under section 1834(d)(8)(B), and

''(ii) respond to requests by pharmacies (and individuals entitled to benefits under this part) as to whether or not such an individual has met the prescription drug deductible established under section 1834(d)(1)(A) for a year; and

''(K) will enter into such contracts with organizations described in subsection (f)(3) as the Secretary determines may be necessary to implement and operate (and for related functions with respect to) the electronic system established under section 1834(d)(8)(B) for covered outpatient drugs under this part;''.

(3) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) (42 U.S.C. 1395u(c)(1)(A)) is amended—

(A) by inserting ''(i)'' after ''(c)(1)(A)'',

(B) in the first sentence, by inserting '', except as otherwise provided in clause (ii),'' after ''under this part, and'', and

(C) by adding at the end the following:

''(ii) To the extent that a contract under this section provides for activities related to covered outpatient drugs, the Secretary may provide for payment for those activities based on any method of payment determined by the Secretary to be appropriate.''.

(4) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking ''Each'' and inserting ''Except as provided in paragraph (4), each'';

(B) by adding at the end the following new paragraph:

''(4)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), with respect to claims for payment for covered outpatient drugs shall provide for a payment cycle under which each carrier will, on a monthly basis, make a payment with respect to all claims which were received and approved for payment in the period since the most recent date on which such a payment was made with respect to the participating pharmacy or individual submitting the claim.

''(B) If payment is not issued, mailed, or otherwise transmitted within 5 days of when such a payment is required to be made under subparagraph (A), interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after such 5-day period and ending on the date on which payment is made.''.

(5) USE OF OTHER ENTITIES FOR COVERED OUTPATIENT DRUGS.—Section 1842(f) (42 U.S.C. 1395u(f)) is amended—

(A) by striking ''and'' at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting ''; and'', and

(C) by adding at the end the following:

''(3) with respect to activities related to covered outpatient drugs, any other private entity which the Secretary determines is qualified to conduct such activities.''.

(6) DESIGNATED CARRIERS TO PROCESS CLAIMS OF RAILROAD RETIREES.—Section 1842(g) (42 U.S.C. 1395u(g)) is amended by inserting ''(other than functions related to covered outpatient drugs)'' after ''functions''.

(e) CONFORMING AMENDMENTS.—

(1)(A) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking ''and'' at the end of clause (O), and

(ii) by inserting before the semicolon at the end the following: '', and (Q) with respect to covered outpatient drugs, the amounts paid shall be as prescribed by section 1834(d)''.

(B) Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended in the matter preceding subparagraph (A) by inserting '', except for covered outpatient drugs,'' after ''and (I) of such section''.

(2) Section 1833(b)(2) (42 U.S.C. 1395l(b)(2)) is amended by inserting ''or with respect to covered outpatient drugs'' before the comma.

(3) The first sentence of section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting ''(other than a carrier described in subsection (f)(3))'' after ''Each carrier''.

(4) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) in clause (i), by inserting ''section 1834(d),'' after ''section 1833(b),'', and

(B) in clause (ii), by inserting '', other than for covered outpatient drugs,'' after ''provider)''.

SEC. 2003. MEDICARE REBATES FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Part B of title XVIII is amended by adding at the end the following new section:

''REBATES FOR COVERED OUTPATIENT DRUGS

''Sec. 1850. (a) REQUIREMENT FOR REBATE AGREEMENT.—In order for payment to be available under this part for covered outpatient drugs of a manufacturer dispensed or provided on or after January 1, 1999, the manufacturer must have entered into and have in effect a rebate agreement with the Secretary meeting the require-

ments of subsection (b), and an agreement to give equal access to discounts in accordance with subsection (e).

''(b) TERMS, IMPLEMENTATION, AND ENFORCEMENT OF REBATE AGREEMENT.—

''(1) PERIODIC REBATES.—

''(A) IN GENERAL.—A rebate agreement under this section shall require the manufacturer to pay to the Secretary for each calendar quarter, not later than 30 days after the date of receipt of the information described in paragraph (2) for such quarter, a rebate in an amount determined under subsection (c) for all covered outpatient drugs of the manufacturer described in subparagraph (B).

''(B) DRUGS INCLUDED IN QUARTERLY REBATE CALCULATION.—Drugs subject to rebate with respect to a calendar quarter are drugs which are dispensed or provided during such quarter to individuals (other than individuals enrolled with an entity with a contract under section 1876 or a medicare drug benefit plan with a contract under section 1851) eligible for benefits under this part, as reported to the Secretary.

"(2) INFORMATION FURNISHED TO MANUFACTURERS.—

"(A) IN GENERAL.—The Secretary shall report to each manufacturer, not later than 60 days after the end of each calendar quarter, information on the total number, for each covered outpatient drug, of units of each dosage form, strength, and package size dispensed or provided under the plan during the quarter, on the basis of the data reported to the Secretary described in paragraph (1)(B).

"(B) AUDIT.—The Comptroller General may audit the records of the Secretary to the extent necessary to determine the accuracy of reports by the Secretary pursuant to subparagraph (A). Adjustments to rebates shall be made to the extent determined necessary by the audit to reflect actual units of drugs dispensed.

"(3) PROVISION OF PRICE INFORMATION BY MANUFACTURER.—

"(A) QUARTERLY PRICING INFORMATION.—Each manufacturer with an agreement in effect under this section shall report to the Secretary, not later than 30 days after the last day of each calendar quarter, on the average

manufacturer retail price and the average manufacturer non-retail price for each dosage form and strength of each covered outpatient drug for the quarter.

''(B) BASE QUARTER PRICES.—Each manufacturer of a covered outpatient drug with an agreement under this section shall report to the Secretary, by not later than 30 days after the effective date of such agreement (or, if later, 30 days after the end of the base quarter), the average manufacturer retail price, for such base quarter, for each dosage form and strength of each such covered drug.

''(C) VERIFICATION OF AVERAGE MANUFACTURER PRICE.—The Secretary may inspect the records of manufacturers, and survey wholesalers, pharmacies, and institutional purchasers of drugs, as necessary to verify prices reported under subparagraph (A).

''(D) PENALTIES.—

''(i) CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty on a manufacturer with an agreement under this section—

''(I) for failure to provide information required under subparagraph (A) on a timely basis, in an amount up to $10,000 per day of delay;

''(II) for refusal to provide information about charges or prices requested by the Secretary for purposes of verification pursuant to subparagraph (C), in an amount up to $100,000; and

''(III) for provision, pursuant to subparagraph (A) or (B), of information that the manufacturer knows or should know is false, in an amount up to $100,000 per item of information.

Such civil money penalties are in addition to any other penalties prescribed by law. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(ii) TERMINATION OF AGREEMENT.—If a manufacturer with an agreement under this section has not provided information required under subparagraph (A) or (B) within 90 days of the deadline imposed, the Secretary may suspend the agreement with respect to covered outpatient drugs dispensed after the end of such 90-day period and until the date such information is reported (but in no case shall a suspension be for less than 30 days).

"(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—A rebate agreement shall be effective for an initial period of not less than one year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY THE SECRETARY.—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the

date of notice of such termination. The Secretary shall afford a manufacturer an opportunity for a hearing concerning such termination, but such hearing shall not delay the effective date of the termination.

''(ii) BY A MANUFACTURER.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

''(iii) EFFECTIVE DATE OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

''(iv) NOTICE TO PHARMACIES.—In the case of a termination under this subparagraph, the Secretary shall notify pharmacies and physician organizations not less than 30 days before the effective date of such termination.

''(c) AMOUNT OF REBATE.—

"(1) BASE REBATE.—Each manufacturer shall remit a basic rebate to the Secretary for each calendar quarter in an amount, with respect to each dosage form and strength of a covered outpatient drug, equal to the product of—

"(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B); and

"(B)(i) in the case of a single-source drug or innovator-multiple source drug, 15 percent of the average manufacturer retail price, or

"(ii) in the case of a noninnovator-multiple source drug furnished over-the-counter, insulin or an enteral nutrient, 6 percent (or the applicable percent if the Secretary implements the sliding scale developed in accordance with paragraph (4)) of the average manufacturer retail price.

"(2) ADDITIONAL REBATE.—Each manufacturer shall remit to the Secretary, for each calendar quarter, an additional rebate for each dosage form and strength of a single-source or innovator-multiple-source drug, in an amount equal to—

"(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B), multiplied by

"(B) the amount, if any, by which the average manufacturer retail price for such drugs of the manufacturer exceeds the average manufacturer retail price for the base quarter, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from the end of such base quarter to the month before the beginning of such calendar quarter.

"(3) DEPOSIT OF REBATES.—The Secretary shall deposit rebates under this section in the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"(4) APPLICABLE PERCENT.—

"(A) NONINNOVATOR MULTIPLE SOURCE DRUG.—

"(i) IN GENERAL.—For purposes of this subparagraph, the Secretary may develop and implement a sliding scale to determine the applicable percent for rebates based on the relationship between the average manufacturer retail price of the

noninnovator-multiple source drug furnished over-the-counter and the average manufacturer retail price of the equivalent innovator drug (except as provided in subparagraph (B)) .

''(ii) SLIDING SCALE DESCRIBED.—The sliding scale developed by the Secretary under clause (i) shall—

''(I) require that the applicable percent be not less than 2 percent and not be greater than 15 percent; and

''(II) ensure that the total level of rebates collected under such a sliding scale would be equivalent to a flat 6 percent rebate on such drugs.

''(B) ENTERAL NUTRIENTS AND INSULIN.—For purposes of this subparagraph, the applicable percent for enteral nutrients and insulin under the sliding scale would be equal to 6 percent.

''(d) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by a manufacturer under this section is confidential and shall not be disclosed by the Secretary (or a carrier), except—

''(A) as the Secretary determines to be necessary to carry out this section,

''(B) to permit the Comptroller General to review the information provided, and

''(C) to permit the Director of the Congressional Budget Office to review the information provided.

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

''(1) AVERAGE MANUFACTURER RETAIL PRICE.—The term 'average manufacturer retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States for drugs distributed to the retail pharmacy class of trade.

''(2) AVERAGE MANUFACTURER NON-RETAIL PRICE.—The term 'average manufacturer non-retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the weighted average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section),

but exclusive of nominal prices) paid to the manufacturer for the drug in the United States by hospitals and other institutional purchasers that purchase drugs for institutional use and not for resale.

''(3) BASE QUARTER.—The term 'base quarter' means, with respect to a covered outpatient drug of a manufacturer, the calendar quarter beginning April 1, 1993, or (if later) the first full calendar quarter during which the drug was marketed in the United States.

''(4) DRUG.—The terms 'innovator multiple source drug', 'noninnovator multiple source drug', and 'single source drug' have the meanings given those terms under section 1927(k)(7), except that the reference in such section to a 'covered outpatient drug' shall be considered a reference to a covered outpatient drug under this part.

''(5) MANUFACTURER.—The term 'manufacturer' means, with respect to a covered outpatient drug—

''(A) the entity whose National Drug Code number (as issued pursuant to section 510(e) of the Federal Food, Drug, and Cosmetic Act) appears on the labeling of the drug; or

"(B) if the number described in subparagraph (A) does not appear on the labeling of the drug, the person named as the applicant in a human drug application (in the case of a new drug) or the product license application (in the case of a biological product) for such drug approved by the Food and Drug Administration.".

(b) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking "and" at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting "; or", and

(3) by inserting after paragraph (16) the following new paragraph:

"(17) consisting of a covered outpatient drug (as described in section 1861(t)) furnished during a year for which the drug's manufacturer does not have in effect a rebate agreement with the Secretary that meets the requirements of section 1850 for the year.".

SEC. 2004. PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.

Part B of title XVIII is amended by inserting after section 1846 the following new section:

''PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

''SEC. 1847. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

''(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than January 1, 1996, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

''(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary, one individual representing a research-based pharmaceutical company, and one individual representing a biotechnology company.

''(b)(1) The Commission shall submit to Congress an annual report no later than May 1 of each year, beginning with 1997—

''(A) concerning the implementation and the operation of the coverage of covered outpatient drugs under this part, including recommendations to Congress on changes to the program to improve access to prescription drugs, the quality of prescription drug care, and program efficiencies;

''(B) reviewing the process of contracting with medicare drug benefits plans under section 1851;

''(C) concerning the fiscal soundness of the furnishing of covered outpatient drugs under this part;

''(D) concerning the appropriateness, fairness and effectiveness of the rebate structure under section 1850; and

''(E) concerning the advisability of developing a review process to exempt small manufacturers of single source or innovator multiple source drugs from rebates under section 1850 based on the manufacturer's sales and the historic pricing of the manufacturer's products.

''(c) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

''(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

SEC. 2005. COVERAGE OF HOME INFUSION DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting ''and home infusion drug therapy services'' before the semicolon.

(b) HOME INFUSION DRUG THERAPY SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) inserted by section 4156(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as subsection (kk); and

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

''Home Infusion Drug Therapy Services

''(ll)(1) The term 'home infusion drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

''(A) in a setting described in subsection (t)(5)(A)(ii),

''(B) by a qualified home infusion drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by that provider, and

''(C) under a plan established and periodically reviewed by a physician.

''(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively a drug regimen through use of a covered home infusion drug (as defined in subsection (t)(5)), but do not include such covered home infusion drugs.

''(3) The term 'qualified home infusion drug therapy provider' means any entity that the Secretary determines meets the following requirements (or, in the case of a home health agency or an entity with respect to which the only items and services described in paragraph (2) furnished by the entity are enteral nutrition therapy services, meets any of the following requirements which the Secretary considers appropriate):

''(A) The entity is capable of providing nursing or pharmacy services and providing or arranging for

the other items and services described in paragraph (2) and covered home infusion drugs.

''(B) The entity maintains clinical records on all patients.

''(C) The entity adheres to written protocols and policies with respect to the provision of items and services.

''(D) The entity makes services available (as needed) seven days a week on a 24-hour basis.

''(E) The entity coordinates all services with the patient's physician.

''(F) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

''(G) The entity assures that only trained personnel provide covered home infusion drugs (and any other service for which training is required to provide the service safely).

''(H) The entity assumes responsibility for the quality of services provided by others under arrangements with the entity.

''(I) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, the entity (i) is licensed pursuant to such law, or (ii) is approved, by

the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

''(J) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home infusion drug therapy services and the efficient administration of the home infusion drug therapy benefit.''.

(c) PAYMENT.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended—

(A) in subsection (a)(2)(B), by striking ''or (E)'' and inserting ''(E), or (F)'',

(B) in subsection (a)(2)(D), by striking ''and'' at the end,

(C) in subsection (a)(2)(E), by striking the semicolon and inserting ''; and'',

(D) by inserting after subsection (a)(2)(E) the following new subparagraph:

''(F) with respect to home infusion drug therapy services, the amounts described in section 1834(j);'', and

(E) in the first sentence of subsection (b), by striking ''services, (3)'' and inserting ''serv-

ices and home infusion drug therapy services, (3)''.

(2) AMOUNT DESCRIBED.—Section 1834 is amended by adding at the end the following new subsection:

''(j) HOME INFUSION DRUG THERAPY SERVICES.—

''(1) IN GENERAL.—With respect to home infusion drug therapy services, payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

''(2) ESTABLISHMENT OF FEE SCHEDULE.—

''(A) IN GENERAL.—The Secretary shall establish by regulation before the beginning of 1999 and each succeeding year a fee schedule for home infusion drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

''(B) ADJUSTMENT FOR SERVICES FURNISHED BY INSTITUTIONS.—The fee schedule established by the Secretary under subparagraph (A) shall provide for adjustments in the case of home infusion drug therapy services for which payment is made under this part that are

furnished by a provider of services to avoid duplicative payments under this title for the service costs associated with such services.''.

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (E),

(2) by striking the period at the end of subparagraph (F) and inserting ''; and'', and

(3) by inserting after subparagraph (F) the following:

''(G) in the case of home infusion drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home infusion drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.''.

(e) CERTIFICATION OF HOME INFUSION DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting ''home infusion drug therapy provider,'' after ''hospice program,''.

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C. 1395z) is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), and (ll)(3)''.

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by striking ''an agency is a hospice program'' and inserting ''an agency or entity is a hospice program or a home infusion drug therapy provider,''; and

(B) in the second sentence—

(i) by striking ''institution or agency'' and inserting ''institution, agency, or entity'', and

(ii) by striking ''or hospice program'' and inserting ''hospice program, or home infusion drug therapy provider''.

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 (42 U.S.C. 1395w–2) is amended—

(A) in the heading, by adding ''AND FOR QUALIFIED HOME INFUSION DRUG THERAPY PROVIDERS'' at the end,

(B) in subsection (a), by inserting ''or that a qualified home infusion drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(ll)(3)'' after ''under this part'', and

(C) in subsection (b)(2)(A)(iv), by inserting ''or home infusion drug therapy services'' after ''clinical diagnostic laboratory tests''.

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(k) With respect to carrying out functions relating to payment for home infusion drug therapy services and covered home infusion drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.''.

(g) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended by striking '', except that'' and all that follows through ''equipment''.

(2) Section 1861(n) (42 U.S.C. 1395x(n)) is amended by adding at the end the following: ''Such term does not include any home infusion drug therapy services described in section 1861(ll) or any covered outpatient drug used as a supply related to the furnishing of an item of durable medical equipment.''.

(3) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is amended by inserting after ''dental'' the following: ''devices or enteral and parenteral nutrients, supplies, and equipment''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1999.

SEC. 2006. MEDICARE DRUG BENEFIT PLANS.

(a) IN GENERAL.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 2003, is further amended by adding at the end the following new section:

''SEC. 1851. MEDICARE DRUG BENEFIT PLANS.

''(a) IN GENERAL.—

''(1) GENERAL PERMISSION TO CONTRACT.—The Secretary may enter into contracts with medicare drug benefit plans in a State for the provision of covered outpatient drugs (as defined in section 1861(t)(2)) (except as provided in subsection

(i)(3)(G)) to individuals entitled to benefits under part A and enrolled under part B if the plan meets the requirements of this section with respect to individuals enrolled under this section.

''(2) ENTITIES ELIGIBLE TO ENTER INTO A CONTRACT.—The Secretary may enter into a contract under this section with a medicare drug benefit plan that is—

''(A) a certified standard health plan but only if such plan has not entered into a contract with the Secretary under section 1876;

''(B) a network of chain and independent pharmacy providers;

''(C) a pharmacy benefit management company; or

''(D) any other entity that the Secretary determines is appropriate.

''(3) AVAILABILITY OF PLANS.—

''(A) IN GENERAL.—Every individual entitled to benefits under part A and enrolled under part B shall be eligible to enroll under this section with any medicare drug benefit plan with a contract under this section which serves the State in which the individual resides.

"(B) ENROLLMENT BY AN INDIVIDUAL.—In accordance with the enrollment periods established under subsection (e)(1), an individual may enroll under this section with a medicare drug benefit plan with a contract under this section only through a third party designated by the Secretary in regulations and the individual may only terminate enrollment in accordance with subsection (e)(2).

"(C) INFORMATION DISTRIBUTED BY THE SECRETARY.—

"(i) IN GENERAL.—The Secretary shall develop and distribute comparative materials to individuals eligible to enroll under this section regarding all medicare drug benefit plans with contracts under this section, the availability of payment for covered outpatient drugs under section 1834(d), and the availability of covered outpatient drugs to enrollees of entities with contracts under section 1876. The Secretary shall include in such comparative materials that each medicare drug benefit plan with a contract under this section is authorized by law to terminate or refuse to

renew the contract, and that termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the plan under this section.

''(ii) PROVISION OF INFORMATION BY THE PLAN.—Each medicare drug benefit plan with a contract under this section shall collect and provide such standard information as the Secretary shall prescribe by regulation as necessary to evaluate the performance and quality of such plan, including enrollee satisfaction, and to compare such performance and quality with competing plans.

''(4) PAYMENTS.—

''(A) PAYMENTS IN LIEU OF NORMAL PAYMENTS.—Payments under a contract to a medicare drug benefit plan under this section shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to section 1834, for covered outpatient drugs furnished by or through the plan to individuals enrolled with the plan under this section.

"(B) SOURCE OF PAYMENT.—The payment to a medicare drug benefit plan under this section for individuals enrolled under this section with the plan and entitled to benefits under part A and enrolled under part B shall be made from the Federal Supplementary Medical Insurance Trust Fund.

"(5) DEFINITIONS.—

"(A) SERVICE AREA.—The term 'health plan service area' means a health plan service area designated by the State under section 1502(d) of the Health Security Act.

"(B) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' has the meaning given such term in section 1011(2) of the Health Security Act.

"(b) PAYMENT RULES UNDER CONTRACTS.—

"(1) IN GENERAL.—

"(A) PAYMENTS.—With respect to any calendar year, each medicare drug benefit plan with a contract under this section shall receive a payment under this title with respect to each individual enrolled with the plan for each month such individual is enrolled equal to the applicable monthly percentage of the lesser of—

"(i) 95 percent of the fee for service component determined under paragraph (2)(B)(i) adjusted by the rate factor determined under subparagraph (C) for the class of such individual; or

"(ii) the medicare drug benefit plan component determined under paragraph (2)(B)(ii) for the plan's service area adjusted by the rate factor determined under subparagraph (C) for the class of such individual.

"(B) APPLICABLE MONTHLY PERCENTAGE.—For purposes of subparagraph (A), the Secretary shall annually set the applicable monthly percentage for each month of the calendar year. Such percentage for a month shall be equal to the Secretary's estimate of the proportion of the total covered outpatient drug benefit incurred in such month under section 1834 to the total covered outpatient drug benefit incurred for such year under section 1834.

"(C) DETERMINATION OF CLASSES OF INDIVIDUALS AND RATE FACTORS FOR SUCH CLASSES.—

"(i) DETERMINATION OF CLASSES.—For purposes of this section, the Secretary shall define appropriate classes of individuals based on such factors as the Secretary determines to be appropriate.

"(ii) RATE FACTORS.—The Secretary shall annually determine the rate factors for each class of individuals defined in clause (i) reflecting the differences in the average per capita spending for providing covered outpatient drug coverage under part B among individuals in such classes.

"(2) DETERMINATION OF PAYMENT RATE.—

"(A) DETERMINATION BY SECRETARY.—The Secretary shall annually determine under subparagraph (B), and shall announce (in a manner intended to provide notice to interested parties) not later than October 1 before the calendar year concerned, the payment for each service area.

"(B) FORMULAS FOR DETERMINING PAYMENT AMOUNTS.—

"(i) FEE-FOR-SERVICE COMPONENT.—The amount determined under this clause is the projected average annual

per capita drug fee-for-service costs (as defined in subparagraph (D)) for covered outpatient drugs for the service area for individuals not enrolled in medicare drug benefit plans with contracts under this section or entities with contracts under section 1876, adjusted by the factor described in clause (ii)(I).

''(ii) MEDICARE DRUG BENEFIT PLAN COMPONENT.—The medicare drug benefit plan component determined under this clause is the sum of the following amounts determined with respect to each medicare drug benefit plan—

''(I) the amount of the uniform annual premium submitted by the plan to the Secretary under subparagraph (C), adjusted by a factor determined by the Secretary to normalize the difference in the distribution of individuals projected to be enrolled in the plan among the various classes of individuals defined by the Secretary to the national distribution of all individ-

uals in the program under this title among such classes; multiplied by

''(II) a fraction (expressed as a percentage), the numerator of which is the number of all individuals enrolled in the plan (as projected by the plan using either historical experience or some other methodology developed by the Secretary), and the denominator of which is the number of all individuals enrolled in all medicare drug benefit plans in the service area.

''(C) UNIFORM ANNUAL PREMIUMS; PREMIUM FOR ADDITIONAL SERVICES.—

''(i) IN GENERAL.—Each medicare drug benefit plan shall, not later than August 1 of each year, submit to the Secretary a bid for the next calendar year for each service area with respect to which the plan proposes to serve under a contract under this section. A bid with respect to a service area shall include the following:

''(I) UNIFORM ANNUAL PREMIUM.—A statement of the uniform annual premium amount that the plan

intends to charge for individuals enrolled under this section with the plan.

''(II) PREMIUM FOR SUPPLEMENTAL PLAN.—A statement of the fixed monthly premium amount that the plan intends to charge for each supplemental plan offering additional cost-sharing benefits.

''(ii) NOTICE BEFORE BID SUBMISSIONS.—At least 45 days before the date for submitting bids under clause (i) for a year, the Secretary shall provide for notice to medicare drug benefit plans of—

''(I) proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous calendar year and shall provide such plans an opportunity to comment on such proposed changes;

''(II) the applicable monthly percentage for each month of the calendar year as determined by the Secretary under paragraph (1)(B); and

"(III) the rate factors for such calendar year determined under paragraph (1)(C).

"(D) PROJECTED AVERAGE ANNUAL PER CAPITA FEE-FOR-SERVICE COSTS.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the term 'projected average annual per capita drug fee-for-service costs' means, with respect to a service area, the annual amount that the Secretary estimates in advance would be payable in any contract year for providing payment for covered outpatient drugs for individuals enrolled under part B (including administrative costs incurred by organizations described in section 1842), if the services were to be furnished by other than a medicare drug benefit plan with a contract under this section or by an entities with a contract under section 1876.

"(ii) BASIS FOR ESTIMATES.—The estimate made by the Secretary under clause (i) shall be made on the basis of actual experience of the service area or, if the Secretary determines that the data in that

service area are inadequate to make an accurate estimate, the Secretary may use the actual experience of a similar area, with appropriate adjustments to assure actuarial equivalence, including adjustments the Secretary may determine appropriate to adjust for demographics, health status, and the presence of specific medical conditions. For the first 2 years that contracts are entered into under this section, the Secretary shall base such estimates on the best available data.

''(3) PAYMENT RULES.—

''(A) AMOUNT OF PREMIUM.—

''(i) STANDARD PACKAGE.—Each medicare drug benefit plan with a contract under this section must provide to individuals enrolled with the plan under this section, for each month of the duration of such enrollment during each contract period, the coverage described in subsection (d) for the lesser of—

''(I) the applicable monthly percentage of the uniform annual pre-

mium amount submitted under paragraph (2)(C)(i)(I); or

''(II) the applicable monthly percentage of the amount described in subsection (b)(1)(A).

''(ii) SUPPLEMENTAL PLAN.—

''(I) IN GENERAL.—Each medicare drug benefit plan with a contract under this section must provide to individuals enrolled with the plan under this section, for the duration of such enrollment during each contract period, a fixed monthly premium for the supplemental plan described in paragraph (2)(C)(i)(II) equal to the premium amount determined by the plan under such paragraph. An individual that elects to enroll in the supplemental plan shall be responsible for paying to the plan the fixed monthly premium amount described in the preceding sentence.

''(II) PAYMENT GREATER THAN FIXED MONTHLY PREMIUM.—If, with respect to any individual enrolled in a

medicare drug benefit plan with a contract under this section, the amount paid to the plan under subsection (b)(1)(A) exceeds the applicable monthly percentage of the uniform annual premium amount submitted under paragraph (2)(C)(i)(I), the plan shall apply such excess to a premium for any supplemental policy described in paragraph (2)(C)(ii) that the individual may elect. If the individual does not elect such a policy, the medicare drug benefit plan shall pay such excess to the Secretary for deposit in the Federal Supplementary Medical Insurance Trust Fund.

''(B) MONTHLY PAYMENTS.—

''(i) IN GENERAL.—The Secretary shall make monthly payments in advance and in accordance with the rate determined under paragraph (1)(A) to each medicare drug benefit plan with a contract under this section for each individual enrolled with the plan under this section.

"(ii) ADJUSTMENTS.—The amount of payment under this subparagraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(iii) PAYMENT TO PLAN ONLY.—If an individual is enrolled under this section with a medicare drug benefit plan with a contract under this section, only the plan shall be entitled to receive payments from the Secretary under this title for covered outpatient drugs furnished to the individual.

"(d) COVERAGE OF BENEFITS.—

"(1) DRUGS PROVIDED.—A medicare drug benefit plan with a contract under this section must provide to individuals enrolled in the plan under this section covered outpatient drugs (as defined in section 1861(t)(2)), except as provided in subsection (i)(3)(G).

"(2) PROVISION OF MEDICALLY NECESSARY CARE.—Each medicare drug benefit plan with a contract under this section must—

"(A) make the covered outpatient drugs described in paragraph (1)—

"(i) available and accessible to enrolled individuals within the State with reasonable promptness and in a manner which assures continuity, and

"(ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

"(B) provide for reimbursement with respect to drugs which are described in subparagraph (A) and which are provided to such an individual other than through the plan, if—

"(i) the drugs were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

"(ii) it was not reasonable given the circumstances to obtain the drugs through the plan.

"(3) COST-SHARING.—Each medicare drug benefit plan with a contract under this section must

provide to individuals enrolled under this section with respect to the drugs described in paragraph (1), cost-sharing requirements that are the same as the cost-sharing requirements for covered outpatient drug under section 1834, except that the deductible for a medicare drug benefit plan shall be reduced by an amount determined by the Secretary such that the cost-sharing of the plan is equal to 95 percent of the actuarial value of the cost sharing requirements under section 1834.

''(4) COST-SHARING FOR SUPPLEMENTAL PLANS.—A supplemental plan may not have cost-sharing that applies differential cost-sharing based on the therapeutic class of drug prescribed or other cost-sharing structures that the Secretary determines would be likely to discourage enrollment by individuals with medical conditions that require extensive use of prescription drugs.

''(5) ACTUARIAL EQUIVALENCE OF STANDARD PLAN AND SUPPLEMENTAL PLAN.—The premium charged to an individual enrolled under this section for a supplemental policy that eliminates or reduces the cost-sharing requirement imposed on such individual and the actuarial value of any remaining cost-sharing requirement under the plan shall not exceed

95 percent of the actuarial value of the cost-sharing requirements under section 1834.

''(e) ENROLLMENT.—

''(1) ENROLLMENT PERIODS.—Each medicare drug benefit plan with a contract under this section must have a uniform open enrollment period (which shall be the period specified by the Secretary under section 1876(c)(3)(A)(i)), for the enrollment of individuals under this section, of at least 30 days duration every year. The plan must also have additional enrollment periods in accordance with the enrollment periods required under clauses (ii), (iii), and (iv) of section 1876(c)(3)(A).

''(2) TERMINATION.—An individual may only terminate an individual's enrollment with a medicare drug benefit plan during an open enrollment period described in paragraph (1).

''(3) NONDISCRIMINATION.—The medicare drug benefit plan must provide assurances to the Secretary that it will not discriminate against any individual because of the individual's health status, requirements for covered outpatient drugs, claims experience, medical history, or other factors that are generally related to the need for covered outpatient

drugs and that it will notify each individual of such fact at the time of the individual's enrollment.

''(4) NOTICE OF RIGHTS, ETC.—Each medicare drug benefit plan with a contract under this section shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

''(A) the enrollee's rights to benefits from the plan,

''(B) the restrictions on payments under this title for covered outpatient drugs furnished other than by or through the plan,

''(C) out-of-plan coverage provided by the plan, and

''(D) appeal rights of enrollees.

''(f) MEMBERSHIP REQUIREMENTS.—

''(1) NON-MEDICARE REQUIREMENT.—

''(A) IN GENERAL.—Each entity with a contract under this section shall provide at that at least 1/2 of the individuals who are provided with drug coverage by the entity are individuals who are not enrolled in a medicare drug benefit plan under this section.

"(B) SUSPENSION OF ENROLLMENT.—If the Secretary determines that a medicare drug benefit plan with a contract under this section has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the plan under this section for individuals newly enrolled with the plan, after the date the Secretary notifies the plan of such noncompliance.

"(2) 5000 INDIVIDUALS.—Each medicare drug benefit plan with a contract under this section shall provide covered outpatient drug coverage to at least 5000 individuals, except that the Secretary may enter into such a contract with a medicare drug benefit plan that has fewer enrollees if the plan primarily serves members residing outside of urbanized areas.

"(g) PAYMENT RULES FOR PLANS.—

"(1) SUBROGATION RIGHTS.—Notwithstanding any other provision of law, the medicare drug benefit plan may, (in the case of the provision of covered outpatient drugs to an individual enrolled under this section for a drug for which the member is entitled to benefits under a workmen's compensation law or

plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, under no fault insurance, or under a primary plan (as defined in section 1862(b)(2)(A)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

''(B) such enrollee to the extent that the enrollee has been paid under such law, plan, or policy for such services.

''(2) PROMPT PAYMENT REQUIREMENT.—

''(A) IN GENERAL.—A contract under this section shall require the medicare drug benefit plan to provide prompt payment (consistent with the provisions of section 1842(c)(4)) of claims submitted for covered outpatient drugs furnished to individuals pursuant to such contract, if the drugs are not furnished under a contract between the plan and the provider or supplier.

"(B) FAILURE.—In the case of a plan which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the plan under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

"(h) DURATION, TERMINATION, EFFECTIVE DATE, AND TERMS OF CONTRACT; POWERS AND DUTIES OF SECRETARY.—

"(1) DURATION AND TERMINATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of inten-

tion to terminate at the end of the current term.

''(B) EXCEPTION.—The Secretary may terminate a contract at any time (after such reasonable notice and opportunity for hearing to the medicare drug benefit plan involved as the Secretary may provide in regulations), if the Secretary finds that the plan—

''(i) has failed substantially to carry out the contract,

''(ii) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

''(iii) no longer substantially complies with the requirements of this section.

''(2) EFFECTIVE DATE.—The effective date of any contract executed pursuant to this section shall be specified in the contract.

''(3) TERMS.—Each contract under this section—

''(A) shall provide that the Secretary, or any person or organization designated by the Secretary—

''(i) shall have the right to inspect or otherwise evaluate—

''(I) the quality, appropriateness, and timeliness of drugs provided under the contract, and

''(II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(ii) shall have the right to audit and inspect any books and records of the medicare drug benefit plan that pertain—

''(I) to the ability of the plan to bear the risk of potential financial losses, or

''(II) to drugs provided or determinations of amounts payable under the contract;

''(B) shall require the plan with a contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the plan;

''(C)(i) shall require the plan to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to dis-

closure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members);

''(ii) shall require the plan to provide and supply information determined appropriate by the Secretary in the manner determined appropriate by the Secretary; and

''(iii) shall require the plan to notify the Secretary of loans and other special financial arrangements which are made between the plan and subcontractors, affiliates, and related parties; and

''(D) shall contain such other terms and conditions not inconsistent with this section (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(4) PERIOD OF DISQUALIFICATION.—The Secretary may not enter into a contract with a medicare drug benefit plan if a previous contract with that plan under this section was terminated at the request of the plan within the preceding 5-year period or if the plan submits a bid under subsection (b)(2)(C) and does not enter into a contract, except

in circumstances which warrant special consideration, as determined by the Secretary.

''(5) DISREGARD OF CERTAIN INCONSISTENT LAWS, ETC.—The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(6) FINDINGS OF FAILURE.—

''(A) IN GENERAL.—If the Secretary determines that medicare drug benefit plan with a contract under this section—

''(i) fails substantially to provide medically necessary covered outpatient drugs that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

''(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

''(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the plan whose medical condition or history indicates a need for substantial future covered outpatient drugs;

''(v) misrepresents or falsifies information that is furnished—

''(I) to the Secretary under this section, or

''(II) to an individual or to any other entity under this section;

''(vi) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such

an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

''(B) REMEDIES.—The remedies described in this subparagraph are—

''(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

''(ii) suspension of enrollment of individuals under this section after the date

the Secretary notifies the plan of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(iii) suspension of payment to the plan under this section for individuals enrolled after the date the Secretary notifies the plan of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(i) OTHER GENERAL REQUIREMENTS ON PLANS.—

''(1) GRIEVANCE PROCEDURES.—Each medicare drug benefit plan with a contract under this section must provide meaningful procedures for hearing and resolving grievances between the plan (including any entity or individual through which the

plan provides health care services) and individuals enrolled with the plan under this section.

''(2) APPEALS.—An individual enrolled with a medicare drug benefit plan under this section who is dissatisfied by reason of the individual's failure to receive any covered outpatient drug to which the individual believes the individual is entitled and at no greater charge than the individual believes the individual is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the plan a party. If the amount in controversy is $1,000 or more, the individual or plan shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the plan shall be entitled to be parties to that judicial review.

''(3) ADDITIONAL REQUIREMENTS.—Not later then January 1, 1998, the Secretary shall establish standards for additional requirements for medicare drug benefit plans with contracts under this section, that to the extent possible are consistent with the standards relating to eligible organizations that have

entered into risk contracts under section 1876, and which provide that a medicare drug benefit plan—

''(A) must demonstrate financial solvency;

''(B) must demonstrate the ability to provide benefits to all potential enrollees throughout the State served by the plan;

''(C) must not engage in marketing or other practices designed to discourage or limit the issuance of a medicare outpatient drug coverage plan to any potential enrollee on the basis of health status, claims experience, medical history, or other factors that are generally related to utilization of covered outpatient drugs;

''(D) must inform individuals eligible to enroll with the plan about the plan only in accordance with procedures and conditions determined by the Secretary and may not distribute promotional or informational material unless—

''(i) at least 45 days before its distribution, the plan has submitted the material to the Secretary for review,

''(ii) the material is made available to all individuals eligible to enroll in the plan in the State served by the plan, and

"(iii) the Secretary has not disapproved the distribution of the material due to a determination that in the Secretary's discretion, the material is materially inaccurate or misleading or otherwise makes a material misrepresentation;

"(E) must provide convenient access to pharmacies for individuals in each zip code region of the State taking into account the special needs of individuals who are enrolled in part B;

"(F) in addition to the access described in subparagraph (E), may provide enrollees with a mail-order pharmacy option;

"(G) may establish a formulary system (to be maintained throughout the 1-year contract period) which ensures that—

"(i) the formulary shall cover at least one covered outpatient drug in each therapeutic class of drugs representing a unique mechanism of action (as defined by the Secretary); and

"(ii) that any covered outpatient drug excluded by the formulary is subject to a prior authorization process in which the plan may not deny approval of any drug

unless the plan complies with the process described in section 1834(d)(7)(C)(iii);

''(H) must disclose any special relationships or arrangements with drug manufacturers, including ownership arrangements, distribution arrangements, or alliances;

''(I) must have standards to assure the appropriate use of outpatient prescription medications, including a program of prospective and retrospective drug use review, consistent with standards under the drug use review program developed by the Secretary under section 1834(d)(7), including for any mail order services operated or used by the plan; and

''(J) is able to process claims for outpatient prescription drugs under the program through an on-line real time point of sale system, and has developed a process for processing out-of-area claims.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to contracts entered into on or after January 1, 1999.

SEC. 2007. PAYMENT FOR COVERED OUTPATIENT DRUG BENEFIT UNDER MEDICARE CONTRACTS WITH HMOS AND CMPS.

(a) IN GENERAL.—In providing for payments for the covered outpatient drug benefit, as added by section 2001, to entities with risk contracts under section 1876 of the Social Security Act, the Secretary of Health and Human Services may base such payment on classes of enrollees or geographic factors that are different than the classes or geographic factors otherwise utilized for determining payment under such section.

(b) EFFECTIVE DATE.—This section shall apply to contracts entered into on or after January 1, 1999.

SEC. 2008. MAINTENANCE OF EFFORT.

(a) MAINTENANCE OF EFFORT WITH RESPECT TO PRESCRIPTION DRUGS.—Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended by adding at the end the following new subparagraph:

''(F) PRESCRIPTION DRUGS.—

''(i) IN GENERAL.—A group health plan may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current retirement status with an employer may be eligible to receive covered outpatient drug coverage under part

B, except that this subparagraph shall not prohibit a plan from taking into account that an individual is eligible to receive covered outpatient drug coverage under part B on or after January 1, 2002. To the extent that the group health plan furnishes prescription drugs pursuant to a collectively bargained agreement, this subparagraph shall prohibit a plan from taking into account that an individual is eligible to receive covered outpatient drug coverage under part B for the greater of the period of the agreement or until January 1, 2002.

''(ii) CURRENT RETIREMENT STATUS.—An individual has 'current retirement status' with an employer if the individual no longer has current employment status due to the individual's retirement from such employment status.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to group health plans offering prescription drug coverage on or after January 1, 1994.

Subtitle B—Home and Community-Based Services

PART 1—HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

SEC. 2101. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Each State that has a plan for home and community-based services for individuals with disabilities submitted to and approved by the Secretary under section 2102(b) is entitled to payment in accordance with section 2108.

(b) ENTITLEMENT TO SERVICES.—Nothing in this subtitle shall be construed to create a right to services for individuals or a requirement that a State with an approved plan expend the entire amount of funds to which it is entitled under this subtitle.

(c) DESIGNATION OF AGENCY.—Not later than 6 months after the date of enactment of this subtitle, the Secretary shall designate an agency responsible for program administration under this subtitle.

SEC. 2102. STATE PLANS.

(a) PLAN REQUIREMENTS.—In order to be approved under subsection (b), a State plan for home and commu-

nity-based services for individuals with disabilities must meet the following requirements:

(1) STATE MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—A State plan under this subtitle shall provide that the State will, during any fiscal year that the State is furnishing services under this subtitle, make expenditures of State funds in an amount equal to the State maintenance of effort amount for the year determined under subparagraph (B) for furnishing the services described in subparagraph (C) under the State plan under this subtitle and the State plan under title XIX of the Social Security Act.

(B) STATE MAINTENANCE OF EFFORT AMOUNT.—

(i) IN GENERAL.—The maintenance of effort amount for a State for a fiscal year is an amount equal to—

(I) for fiscal year 1998, the base amount for the State (as determined under clause (ii)) updated through the midpoint of fiscal year 1998 by the estimated percentage change in the consumer price index during the pe-

riod beginning on October 1, 1994 and ending at that midpoint; and

(II) for succeeding fiscal years, an amount equal to the amount determined under this clause for the previous fiscal year updated through the midpoint of the year by the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the projected percentage change in the consumer price index.

(ii) STATE BASE AMOUNT.—The base amount for a State is an amount equal to the total expenditures from State funds made under the State plan under title XIX of the Social Security Act during fiscal year 1994 with respect to medical assistance consisting of the services described in subparagraph (C).

(C) MEDICAID SERVICES DESCRIBED.—The services described in this subparagraph are the following:

(i) Personal care services (as described in section 1905(a)(24) of the Social Security Act).

(ii) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915 of such Act.

(iii) Home and community care furnished to functionally disabled elderly individuals under section 1929 of such Act.

(iv) Community supported living arrangements services under section 1930 of such Act.

(2) ELIGIBILITY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), within the amounts provided by the State and under section 2108 for such plan, the plan shall provide that services under the plan will be available to individuals with disabilities (as defined in section 2103(a)) in the State.

(C) INITIAL SCREENING.—The plan shall provide a process for the initial screening of an individual who appears to have some reasonable likelihood of being an individual with disabilities. Any such process shall require the provision of assistance to individuals who wish to apply but whose disability limits their ability to apply. The initial screening and the determination of disability (as defined under section 2103(b)(1)) shall be conducted by a public agency.

(D) RESTRICTIONS.—The plan may not limit the eligibility of individuals with disabilities based on—

(i) income,

(ii) age,

(iii) residential setting (other than an institutional setting), or

(iv) other grounds specified by the Secretary.

(E) CONTINUATION OF SERVICES.—The plan must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under the State medicaid plan under title XIX of the So-

cial Security Act as of the date a State's plan is approved under this subtitle, the State will continue to make available (either under this plan, under the State medicaid plan, or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

(3) SERVICES.—

(A) NEEDS ASSESSMENT.—Not later than the end of the second year of implementation, the plan or its amendments shall include the results of a statewide assessment of the needs of individuals with disabilities in a format required by the Secretary. The needs assessment shall include demographic data concerning the number of individuals within each category of disability described in this subtitle, and the services available to meet the needs of such individuals.

(B) SPECIFICATION.—Consistent with section 2104, the plan shall specify—

(i) the services made available under the plan,

(ii) the extent and manner in which such services are allocated and made available to individuals with disabilities, and

(iii) the manner in which services under the plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

(C) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disabilities, the availability of informal care.

(D) ALLOCATION.—The State plan—

(i) shall specify how services under the plan will be allocated among covered individuals with disabilities,

(ii) shall attempt to meet the needs of individuals with a variety of disabilities within the limits of available funding,

(iii) shall include services that assist all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions,

(iv) shall demonstrate that services are allocated equitably, in accordance with the needs assessment required under subparagraph (A), and

(v) shall ensure that—

(I) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the plan, under the State medicaid plan, or under both, is not less than,

(II) the proportion of the population of the State that represents individuals who are low-income individuals.

(E) LIMITATION ON LICENSURE OR CERTIFICATION.—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(F) CONSUMER CHOICE.—To the extent feasible, the State shall follow the choice of an individual with disabilities (or that individual's designated representative who may be a family member) regarding which covered services to receive and the providers who will provide such services.

(4) COST SHARING.—The plan shall impose cost sharing with respect to covered services in accordance with section 2105.

(5) TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.—The plan shall specify—

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers of personal assistance services, except that the plan—

(i) may not limit benefits to services provided by registered nurses or licensed practical nurses; and

(ii) may not limit benefits to services provided by agencies or providers certified under title XVIII; and

(B) any requirements for participation applicable to each type of service provider.

(6) PROVIDER REIMBURSEMENT.—

(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of payment to consumer-directed providers of personal assistance services, including payment through the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax and health care coverage provisions.

(B) PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set payment rates for—

(i) agency administered services furnished under the plan; and

(ii) consumer-directed personal assistance services furnished under the plan, including cash payments or vouchers to individuals with disabilities, except that such payments shall be adequate to cover

amounts required under applicable employment tax and health care coverage provisions.

(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted or provided for under section 2105 as payment in full for services furnished under the plan.

(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 2106.

(8) ADVISORY GROUP.—The State plan shall—

(A) assure the establishment and maintenance of an advisory group under section 2107(b), and

(B) include the documentation prepared by the group under section 2107(b)(4).

(9) ADMINISTRATION AND ACCESS.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) COORDINATION.—The plan shall specify how it will—

(i) coordinate services provided under the plan, including eligibility prescreening, service coordination, and referrals for individuals with disabilities who are ineligible for services under this subtitle with the State medicaid plan under title XIX of the Social Security Act, titles V and XX of such Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or assistance targeted to individuals with disabilities; and

(ii) coordinate with health plans.

(C) ADMINISTRATIVE EXPENDITURES.—Effective beginning with fiscal year 2004, the plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this subtitle, including the processing of claims under the plan, and

(B) such data and information as the Secretary may require in a uniform format as specified by the Secretary.

(11) USE OF STATE FUNDS FOR MATCHING.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this subtitle.

(12) HEALTH CARE WORKER REDEPLOYMENT.—The plan shall provide for the following:

(A) Before initiating the process of implementing the State program under such plan, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(B) Negotiations under subparagraph (A) will address the following:

(i) The impact of the implementation of the program upon the workforce.

(ii) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the program.

(C) The plan will provide evidence that there has been compliance with subparagraphs (A) and (B), including a description of the results of the negotiations.

(13) TERMINOLOGY.—The plan shall adhere to uniform definitions of terms, as specified by the Secretary.

(b) APPROVAL OF PLANS.—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after a public comment period of not less than 30 days, and

(2) meets the requirements of subsection (a).

The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before January 1, 1998, shall be effective as of January 1, 1998). In order to budget funds allotted under this subtitle, the Secretary shall establish a deadline for the submission of such a plan before the beginning of a fiscal year as a con-

dition of its approval effective with that fiscal year. Any significant changes to the State plan shall be submitted to the Secretary in the form of plan amendments and shall be subject to approval by the Secretary.

(c) MONITORING.—The Secretary shall annually monitor the compliance of State plans with the requirements of this subtitle according to specified performance standards. In accordance with section 2108(e), States that fail to comply with such requirements may be subject to a reduction in the Federal matching rates available to the State under section 2108(a) or the withholding of Federal funds for services or administration until such time as compliance is achieved.

(d) TECHNICAL ASSISTANCE.—The Secretary shall ensure the availability of ongoing technical assistance to States under this section. Such assistance shall include serving as a clearinghouse for information regarding successful practices in providing long-term care services.

(e) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this subtitle on a timely basis.

SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.

(a) IN GENERAL.—For purposes of this subtitle, the term 'individual with disabilities' means any individual

within one or more of the following categories of individuals:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living (as defined in subsection (d)), and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 90 days.

(2) INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either severe cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living;

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies; or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

(C) who is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 90 days.

Not later than 2 years after the date of enactment of this subtitle, the Secretary shall make recommendations regarding the most appropriate duration of disability under this paragraph.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) YOUNG CHILDREN WITH SEVERE DISABILITIES.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the standards established under paragraphs (1), (2), or (3), and

(B) is expected to have such a disability or condition and require such services over a period of at least 90 days.

(b) DETERMINATION.—

(1) IN GENERAL.—In formulating eligibility criteria under subsection (a), the Secretary shall establish criteria for assessing the functional level of disability among all categories of individuals with disabilities that are comparable in severity, regardless of the age or the nature of the disabling condition of the individual. The determination of whether an individual is an individual with disabilities shall be made by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this subtitle and by using a uniform protocol consisting of an initial screening and a determination of disability specified by the Secretary. A State may not impose cost sharing with respect to a determination of disability. A State may collect additional informa-

tion, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 2104(b) or for other purposes.

(2) PERIODIC REASSESSMENT.—The determination that an individual is an individual with disabilities shall be considered to be effective under the State plan for a period of not more than 6 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(c) ELIGIBILITY CRITERIA.—The Secretary shall reassess the validity of the eligibility criteria described in subsection (a) as new knowledge regarding the assessments of functional disabilities becomes available. The Secretary shall report to the Committees on Finance and Labor and Human Resources of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on its findings under the preceding sentence as determined appropriate by the Secretary.

(d) ACTIVITY OF DAILY LIVING DEFINED.—For purposes of this subtitle, the term 'activity of daily living' means any of the following: eating, toileting, dressing, bathing, and transferring.

SEC. 2104. HOME AND COMMUNITY-BASED SERVICES COVERED UNDER STATE PLAN.

(a) SPECIFICATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the State plan under this subtitle shall specify—

(A) the home and community-based services available under the plan to individuals with disabilities (or to such categories of such individuals), and

(B) any limits with respect to such services.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Subject to subsection (e)(2), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(b) REQUIREMENT FOR NEEDS ASSESSMENT AND PLAN OF CARE.—

(1) IN GENERAL.—The State plan shall provide for home and community-based services to an indi-

vidual with disabilities only if the following requirements are met:

(A) COMPREHENSIVE ASSESSMENT.—A comprehensive assessment of an individual's need for home and community-based services (regardless of whether all need services are available under the plan) shall be made in accordance with a uniform, comprehensive assessment tool that shall be used by a State under this paragraph with the approval of the Secretary. The Secretary shall provide guidance to the States with regard to the appropriate qualifications for individuals who conduct comprehensive assessments.

(B) INDIVIDUALIZED PLAN OF CARE.—An individualized plan of care based on the assessment made under subparagraph (A) shall be developed. A plan of care under this subparagraph shall—

(i) specify which services included under the individual plan will be provided under the State plan under this subtitle;

(ii) identify (to the extent possible) how the individual will be provided any

services specified under the plan of care and not provided under the State plan;

(iii) specify how the provision of services to the individual under the plan will be coordinated with the provision of other health care services to the individual; and

(iv) be reviewed and updated every 6 months (or more frequently if there is a change in the individual's condition).

The State shall make reasonable efforts to identify and arrange for services described in clause (ii). Nothing in this subsection shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(C) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under subparagraph (B) for an individual with disabilities shall—

(i) be developed by qualified individuals (specified under the State plan);

(ii) be developed and implemented in close consultation with the individual (or the individual's designated representative); and

(iii) be approved by the individual (or the individual's designated representative).

(c) REQUIREMENT FOR CARE MANAGEMENT.—

(1) IN GENERAL.—The State shall make available to each category of individuals with disabilities care management services that at a minimum include—

(A) arrangements for the provision of such services, and

(B) monitoring of the delivery of services.

(2) CARE MANAGEMENT SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the care management services described in paragraph (1) shall be provided by a public or private entity that is not providing home and community-based services under this subtitle.

(B) EXCEPTION.—A person who provides home and community-based services under this subtitle may provide care management services if—

(i) the State determines that there is an insufficient pool of entities willing to provide such services in an area due to a low population of individuals eligible for

home and community-based services under this subtitle residing in such area; and

(ii) the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(d) MANDATORY COVERAGE OF PERSONAL ASSISTANCE SERVICES.—The State plan shall include, in the array of services made available to each category of individuals with disabilities, both agency-administered and consumer-directed personal assistance services (as defined in subsection (h)).

(e) ADDITIONAL SERVICES.—

(1) TYPES OF SERVICES.—Subject to subsection (f), services available under a State plan under this subtitle may include any (or all) of the following:

(A) Homemaker and chore assistance.

(B) Home modifications.

(C) Respite services.

(D) Assistive devices, as defined in the Technology Related Assistance for Individuals with Disabilities Act.

(E) Adult day services.

(F) Habilitation and rehabilitation.

(G) Supported employment.

(H) Home health services.

(I) Transportation.

(J) Any other care or assistive services specified by the State and approved by the Secretary that will help individuals with disabilities to remain in their homes and communities.

(2) CRITERIA FOR SELECTION OF SERVICES.—The State electing services under paragraph (1) shall specify in the State plan—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of services to be covered under the plan and to be available to each category of individuals with disabilities, and

(B) how the types, and the amount, duration, and scope, of services specified, within the limits of available funding, provide substantial assistance in living independently to individuals within each of the categories of individuals with disabilities.

(f) EXCLUSIONS AND LIMITATIONS.—A State plan may not provide for coverage of—

(1) room and board,

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally re-

tarded, or other institutional setting specified by the Secretary, or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(g) PAYMENT FOR SERVICES.—In order to pay for covered services, a State plan may provide for the use of—

(1) vouchers,

(2) cash payments directly to individuals with disabilities,

(3) capitation payments to health plans, and

(4) payment to providers.

(h) PERSONAL ASSISTANCE SERVICES.—

(1) IN GENERAL.—For purposes of this subtitle, the term ''personal assistance services'' means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living, whether agency-administered or consumer-directed (as defined in paragraph (2)).

(2) CONSUMER-DIRECTED.—For purposes of this subtitle:

(A) IN GENERAL.—The term ''consumer-directed'' means, with reference to personal as-

sistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) STATE RESPONSIBILITIES.—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) RIGHT OF CONSUMERS.—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including man-

age, train, schedule, and verify services provided) the work of a home care provider.

(3) AGENCY ADMINISTERED.—For purposes of this subtitle, the term 'agency-administered' means, with respect to such services, services that are not consumer-directed.

SEC. 2105. COST SHARING.

(a) NO COST SHARING FOR POOREST.—

(1) IN GENERAL.—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (d)) less than 150 percent of the official poverty level (referred to in paragraph (2)) applicable to a family of the size involved.

(2) OFFICIAL POVERTY LEVEL.—The term 'applicable poverty level' means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(b) SLIDING SCALE FOR REMAINDER.—

(1) REQUIRED COINSURANCE.—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(A) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 175 percent, of such official poverty line (as so applied);

(B) at a rate of 15 percent for such individuals with income not less than 175 percent, and less than 225 percent, of such official poverty line (as so applied);

(C) at a rate of 25 percent for such individuals with income not less than 225 percent, and less than 275 percent, of such official poverty line (as so applied);

(D) at a rate of 30 percent for such individuals with income not less than 275 percent, and less than 325 percent, of such official poverty line (as so applied);

(E) at a rate of 35 percent for such individuals with income not less than 325 percent, and less than 400 percent, of such official poverty line (as so applied); and

(F) at a rate of 40 percent for such individuals with income equal to at least 400 percent of such official poverty line (as so applied).

(2) REQUIRED ANNUAL DEDUCTIBLE.—The State plan shall impose cost sharing in the form of an annual deductible—

(A) of $100 for individuals with disabilities with income not less than 150 percent, and less than 175 percent, of such official poverty line (as so applied);

(B) of $200 for such individuals with income not less than 175 percent, and less than 225 percent, of such official poverty line (as so applied);

(C) of $300 for such individuals with income not less than 225 percent, and less than 275 percent, of such official poverty line (as so applied);

(D) of $400 for such individuals with income not less than 275 percent, and less than 325 percent, of such official poverty line (as so applied);

(E) of $500 for such individuals with income not less than 325 percent, and less than 400 percent, of such official poverty line (as so applied); and

(F) of $600 for such individuals with income equal to at least 400 percent of such official poverty line (as so applied).

(c) RECOMMENDATION OF THE SECRETARY.—The Secretary shall make recommendations to the States as to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the cost-sharing provisions of this section could jeopardize their ability to take advantage of the services offered under this subtitle. The Secretary shall establish a methodology for reducing the cost-sharing burden for individuals with exceptionally high out-of-pocket costs under this subtitle.

(d) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) QUALITY ASSURANCE.—

(1) IN GENERAL.—The State plan shall specify how the State will ensure and monitor the quality of services, including—

(A) safeguarding the health and safety of individuals with disabilities,

(B) setting the minimum standards for agency providers and how such standards will be enforced,

(C) setting the minimum competency requirements for agency provider employees who provide direct services under this subtitle and how the competency of such employees will be enforced,

(D) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services,

(E) establishing a process to receive, investigate, and resolve allegations of neglect and/or abuse,

(F) establishing optional training programs for individuals with disabilities in the use and direction of consumer directed providers of personal assistance services,

(G) establishing an appeals procedure for eligibility denials and a grievance procedure for disagreements with the terms of an individualized plan of care,

(H) providing for participation in quality assurance activities, and

(I) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

(2) ISSUANCE OF REGULATIONS.—Not later than 1 year after the date of enactment of this subtitle, the Secretary shall issue regulations implementing the quality provisions of this subsection.

(b) FEDERAL STANDARDS.—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) The mandatory reporting of abuse, neglect, or exploitation.

(3) The development of a registry of provider agencies or home care workers and consumer directed providers of personal assistance services against whom any complaints have been sustained, which shall be available to the public.

(4) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(5) Surveys of client satisfaction.

(6) State optional training programs for informal caregivers.

(c) CLIENT ADVOCACY.—

(1) IN GENERAL.—The State plan shall provide that the State will expend the amount allocated under section 2109(b)(2) for client advocacy activities. The State may use such funds to augment the budgets of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) or may establish a separate and independent client advocacy office in accordance with paragraph (2) to administer a new program designed to advocate for client rights.

(2) CLIENT ADVOCACY OFFICE.—

(A) IN GENERAL.—A client advocacy office established under this paragraph shall—

(i) identify, investigate, and resolve complaints that—

(I) are made by, or on behalf of, clients; and

(II) relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the clients (including the welfare and rights of the clients with respect to the appointment and activities of guardians and representative payees), of—

(aa) providers, or representatives of providers, of long-term care services;

(bb) public agencies; or

(cc) health and social service agencies;

(ii) provide services to assist the clients in protecting the health, safety, welfare, and rights of the clients;

(iii) inform the clients about means of obtaining services provided by providers or agencies described in clause (i)(II) or services described in clause (ii);

(iv) ensure that the clients have regular and timely access to the services pro-

vided through the office and that the clients and complainants receive timely responses from representatives of the office to complaints; and

(v) represent the interests of the clients before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the clients with regard to the provisions of this subtitle.

(B) CONTRACTS AND ARRANGEMENTS.—

(i) IN GENERAL.—Except as provided in clause (ii), the State agency may establish and operate the office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(C) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.—The State agency may not enter into the contract or other arrangement described in clause (i) with an agency or organization that is responsible for licensing, certifying, or providing long-term care services in the State.

(d) SAFEGUARDS.—

(1) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities). All providers of services shall be required to register with the State agency.

(3) REGULATIONS.—Not later than January 1, 1998, the Secretary shall promulgate regulations with respect to the requirements on States under this subsection.

(e) SPECIFIED RIGHTS.—The State plan shall provide that in furnishing home and community-based services under the plan the following individual rights are protected:

(1) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an indi-

vidual determined incompetent) to participate in planning care or changes in care.

(2) The right to—

(A) voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances,

(B) be told how to complain to State and local authorities, and

(C) prompt resolution of any grievances or complaints.

(3) The right to confidentiality of personal and clinical records and the right to have access to such records.

(4) The right to privacy and to have one's property treated with respect.

(5) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(6) The right to education or training for oneself and for members of one's family or household on the management of care.

(7) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of dis-

cipline or convenience and not included in an individual's plan of care.

(8) The right to be fully informed orally and in writing of the individual's rights.

(9) The right to a free choice of providers.

(10) The right to direct provider activities when an individual is competent and willing to direct such activities.

SEC. 2107. ADVISORY GROUPS.

(a) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group, to advise the Secretary and States on all aspects of the program under this subtitle.

(2) COMPOSITION.—The group shall be composed of individuals with disabilities and their representatives, providers, Federal and State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives.

(b) STATE ADVISORY GROUPS.—

(1) IN GENERAL.—Each State plan shall provide for the establishment and maintenance of an advisory group to advise the State on all aspects of the State plan under this subtitle.

(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representatives, providers, State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives. The members of the advisory group shall be selected from the those nominated as described in paragraph (3).

(3) SELECTION OF MEMBERS.—Each State shall establish a process whereby all residents of the State, including individuals with disabilities and their representatives, shall be given the opportunity to nominate members to the advisory group.

(4) PARTICULAR CONCERNS.—Each advisory group shall—

(A) before the State plan is developed, advise the State on guiding principles and values, policy directions, and specific components of the plan,

(B) meet regularly with State officials involved in developing the plan, during the development phase, to review and comment on all aspects of the plan,

(C) participate in the public hearings to help assure that public comments are addressed to the extent practicable,

(D) report to the Governor and make available to the public any differences between the group's recommendations and the plan,

(E) report to the Governor and make available to the public specifically the degree to which the plan is consumer-directed, and

(F) meet regularly with officials of the designated State agency (or agencies) to provide advice on all aspects of implementation and evaluation of the plan.

SEC. 2108. PAYMENTS TO STATES.

(a) IN GENERAL.—Subject to section 2102(a)(9)(C) (relating to limitation on payment for administrative costs), the Secretary, in accordance with the Cash Management Improvement Act, shall authorize payment to each State with a plan approved under this subtitle, for each quarter (beginning on or after January 1, 1998), from its allotment under section 2109(b), an amount equal to—

(1)(A) if the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan

for individuals with disabilities does not exceed 20 percent of the amount allotted to the State under section 2109(b), 100 percent of the amount demonstrated by State claims to have been expended during the quarter for such services for such individuals; or

(B) for the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan for individuals with disabilities that exceeds 20 percent of the amount allotted to the State under section 2109(b), the Federal home and community-based services matching percentage (as defined in subsection (b)) of such amount; plus

(2) an amount equal to 90 percent of the amount demonstrated by the State to have been expended during the quarter for quality assurance activities under the plan; plus

(3) an amount equal to 90 percent of amount expended during the quarter under the plan for activities (including preliminary screening) relating to determination of eligibility and performance of needs assessment; plus

(4) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2004, 75 percent)

of the amount expended during the quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

(5) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PERCENTAGE.—In subsection (a), the term 'Federal home and community-based services matching percentage' means, with respect to a State, the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) increased by 15 percentage points, except that the Federal home and community-based services matching percentage shall in no case be more than 95 percent.

(c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of the total sum to be expended in such

quarter, and such other information as the Secretary may find necessary.

(2) From the allotment available therefore, the Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

(d) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act.

(e) FAILURE TO COMPLY WITH STATE PLAN.—If a State furnishing home and community-based services under this subtitle fails to comply with the State plan approved under this subtitle, the Secretary may either reduce the Federal matching rates available to the State under subsection (a) or withhold an amount of funds determined appropriate by the Secretary from any payment to the State under this section.

SEC. 2109. APPROPRIATIONS; ALLOTMENTS TO STATES.

(a) APPROPRIATIONS.—

(1) FISCAL YEARS 1998 THROUGH 2004.—Subject to paragraph (5)(C), for purposes of this subtitle, the appropriation authorized under this subtitle for each of fiscal years 1998 through 2004 is the following:

(A) For fiscal year 1998, $1,800,000,000.

(B) For fiscal year 1999, $2,900,000,000.

(C) For fiscal year 2000, $3,600,000,000.

(D) For fiscal year 2001, $5,000,000,000.

(E) For fiscal year 2002, $7,900,000,000.

(F) For fiscal year 2003, $11,400,000,000.

(G) For fiscal year 2004, $15,400,000,000.

(2) SUBSEQUENT FISCAL YEARS.—For purposes of this subtitle, the appropriation authorized for State plans under this subtitle for each fiscal year after fiscal year 2004 is the appropriation authorized under this subsection for the preceding fiscal year multiplied by—

(A) a factor (described in paragraph (3)) reflecting the change in the consumer price index for the fiscal year, and

(B) a factor (described in paragraph (4)) reflecting the change in the number of individuals with disabilities for the fiscal year.

(3) CPI INCREASE FACTOR.—For purposes of paragraph (2)(A), the factor described in this paragraph for a fiscal year is the ratio of—

(A) the annual average index of the consumer price index for the preceding fiscal year, to—

(B) such index, as so measured, for the second preceding fiscal year.

(4) DISABLED POPULATION FACTOR.—For purposes of paragraph (2)(B), the factor described in this paragraph for a fiscal year is 100 percent plus (or minus) the percentage increase (or decrease) change in the disabled population of the United States (as determined for purposes of the most recent update under subsection (b)(3)(D)).

(5) ADDITIONAL FUNDS DUE TO MEDICAID OFFSETS.—

(A) IN GENERAL.—Each participating State must provide the Secretary with information concerning offsets and reductions in the medicaid program resulting from home and community-based services provided disabled in-

dividuals under this subtitle, that would have been paid for such individuals under the State medicaid plan but for the provision of similar services under the program under this subtitle. At the time a State first submits its plan under this subtitle and before each subsequent fiscal year (through fiscal year 2004), the State also must provide the Secretary with such budgetary information (for each fiscal year through fiscal year 2004), as the Secretary determines to be necessary to carry out this paragraph.

(B) REPORTS.—Each State with a program under this subtitle shall submit such reports to the Secretary as the Secretary may require in order to monitor compliance with subparagraph (A). The Secretary shall specify the format of such reports and establish uniform data reporting elements.

(C) ADJUSTMENTS TO APPROPRIATION.—

(i) IN GENERAL.—For each fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2004) and based on a review of information submitted under subparagraph (A), the Secretary shall determine the amount by which the appropria-

tion authorized under subsection (a) will increase. The amount of such increase for a fiscal year shall be limited to the reduction in Federal expenditures of medical assistance (as determined by Secretary) that would have been made under part A of title XIX for home and community based services for disabled individuals but for the provision of similar services under the program under this subtitle.

(ii) ANNUAL PUBLICATION.—The Secretary shall publish before the beginning of such fiscal year, the revised appropriation authorized under this subsection for such fiscal year.

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring States to determine eligibility for medical assistance under the State medicaid plan on behalf of individuals receiving assistance under this subtitle.

(b) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall allot the amounts available under the appropriation authorized for the fiscal year (specified in subsection (a)) to the States with plans approved under this subtitle

in accordance with an allocation formula developed by the Secretary which takes into account—

(A) the percentage of the total number of individuals with disabilities in all States that reside in a particular State;

(B) the per capita costs of furnishing home and community-based services to individuals with disabilities in the State; and

(C) the percentage of all individuals with incomes at or below 150 percent of the official poverty line (as described in section 2105(a)(2)) in all States that reside in a particular State.

(2) ALLOCATION FOR CLIENT ADVOCACY ACTIVITIES.—Each State with a plan approved under this subtitle shall allocate one-half of one percent of the State's total allotment under paragraph (1) for client advocacy activities as described in section 2106(c).

(3) NO DUPLICATE PAYMENT.—No payment may be made to a State under this section for any services provided to an individual to the extent that the State received payment for such services under section 1903(a) of the Social Security Act.

(4) REALLOCATIONS.—Any amounts allotted to States under this subsection for a year that are not

expended in such year shall remain available for State programs under this subtitle and may be reallocated to States as the Secretary determines appropriate.

(c) STATE ENTITLEMENT.—This subtitle constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

SEC. 2110. FEDERAL EVALUATIONS.

(a) IN GENERAL.—Not later than December 31, 2003, December 31, 2006, and each December 31 thereafter, the Secretary shall provide to Congress analytical reports that evaluate—

(1) the extent to which individuals with low incomes and disabilities are equitably served;

(2) the adequacy and equity of service plans to individuals with similar levels of disability across States;

(3) the comparability of program participation across States, described by level and type of disability; and

(4) the ability of service providers to sufficiently meet the demand for services.

(b) GERIATRIC ASSESSMENTS.—Not later than 18 months after the date of enactment of this part, the Secretary shall report to Congress concerning the feasibility of providing reimbursement under health plans and other payers of health services for full geriatric assessment, when recommended by a physician.

PART 2—GRANTS RELATING TO THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS

SEC. 2111. INFORMATION AND TECHNICAL ASSISTANCE GRANTS RELATING TO DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.

(a) FINDINGS.—Congress finds that—

(1) demonstration programs and projects have been developed to offer care management to hospitalized individuals awaiting discharge who are in need of long-term health care services that meet individual needs and preferences in home and community-based settings as an alternative to long-term nursing home care or institutional placement; and

(2) there is a need to disseminate information and technical assistance to hospitals and State and local community organizations regarding such programs and projects and to provide incentive grants to State and local public and private agencies, including area agencies on aging, to establish and ex-

pand programs that offer care management to individuals awaiting discharge from acute care hospitals who are in need of long-term care so that services to meet individual needs and preferences can be arranged in home and community-based settings as an alternative to long-term placement in nursing homes or other institutional settings.

(b) DISSEMINATION OF INFORMATION, TECHNICAL ASSISTANCE, AND INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.—Part C of title III of the Public Health Service Act (42 U.S.C. 248 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 327B. DISSEMINATION OF INFORMATION, TECHNICAL ASSISTANCE AND INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.

''(a) DISSEMINATION OF INFORMATION.—The Secretary shall compile, evaluate, publish and disseminate to appropriate State and local officials and to private organizations and agencies that provide services to individuals in need of long-term health care services, such information and materials as may assist such entities in replicating successful programs that are aimed at offering care management to hospitalized individuals who are in need of

long-term care so that services to meet individual needs and preferences can be arranged in home and community-based settings as an alternative to long-term nursing home placement. The Secretary may provide technical assistance to entities seeking to replicate such programs.

''(b) INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.—The Secretary shall establish a program under which incentive grants may be awarded to assist private and public agencies, including area agencies on aging, and organizations in developing and expanding programs and projects that facilitate the discharge of individuals in hospitals or other acute care facilities who are in need of long-term care services and placement of such individuals into home and community-based settings.

''(c) ADMINISTRATIVE PROVISIONS.—

''(1) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (b) an entity shall be—

''(A)(i) a State agency as defined in section 102(43) of the Older Americans Act of 1965; or

''(ii) a State agency responsible for administering home and community care programs under title XIX of the Social Security Act; or

''(B) if no State agency described in subparagraph (A) applies with respect to a particular State, a public or nonprofit private entity.

''(2) APPLICATIONS.—To be eligible to receive an incentive grant under subsection (b), an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require, including—

''(A) an assessment of the need within the community to be served for the establishment or expansion of a program to facilitate the discharge of individuals in need of long-term care who are in hospitals or other acute care facilities into home and community-care programs that provide individually planned, flexible services that reflect individual choice or preference rather than nursing home or institutional settings;

''(B) a plan for establishing or expanding a program for identifying individuals in hospital or acute care facilities who are in need of individualized long-term care provided in home and community-based settings rather than nursing homes or other institutional settings and under-

taking the planning and management of individualized care plans to facilitate discharge into such settings;

''(C) assurances that nongovernmental case management agencies funded under grants awarded under this section are not direct providers of home and community-based services;

''(D) satisfactory assurances that adequate home and community-based long term care services are available, or will be made available, within the community to be served so that individuals being discharged from hospitals or acute care facilities under the proposed program can be served in such home and community-based settings, with flexible, individualized care which reflects individual choice and preference;

''(E) a description of the manner in which the program to be administered with amounts received under the grant will be continued after the termination of the grant for which such application is submitted; and

''(F) a description of any waivers or approvals necessary to expand the number of individuals served in federally funded home and community-based long term care programs in

order to provide satisfactory assurances that adequate home and community-based long term care services are available in the community to be served.

''(3) AWARDING OF GRANTS.—

''(A) PREFERENCES.—In awarding grants under subsection (b), the Secretary shall give preference to entities submitting applications that—

''(i) demonstrate an ability to coordinate activities funded using amounts received under the grant with programs providing individualized home and community-based case management and services to individuals in need of long term care with hospital discharge planning programs; and

''(ii) demonstrate that adequate home and community-based long term care management and services are available, or will be made available to individuals being served under the program funded with amounts received under subsection (b).

''(B) DISTRIBUTION.—In awarding grants under subsection (b), the Secretary shall ensure that such grants—

''(i) are equitably distributed on a geographic basis;

''(ii) include projects operating in urban areas and projects operating in rural areas; and

''(iii) are awarded for the expansion of existing hospital linkage programs as well as the establishment of new programs.

''(C) EXPEDITED CONSIDERATION.—The Secretary shall provide for the expedited consideration of any waiver application that is necessary under title XIX of the Social Security Act to enable an applicant for a grant under subsection (b) to satisfy the assurance required under paragraph (1)(D).

''(4) USE OF GRANTS.—An entity that receives amounts under a grant under subsection (b) may use such amounts for planning, development and evaluation services and to provide reimbursements for the costs of one or more case mangers to be located in or assigned to selected hospitals who would—

''(A) identify patients in need of individualized care in home and community-based long-term care;

''(B) assess and develop care plans in cooperation with the hospital discharge planning staff; and

''(C) arrange for the provision of community care either immediately upon discharge from the hospital or after any short term nursing-home stay that is needed for recuperation or rehabilitation;

''(5) DIRECT SERVICES SUBJECT TO REIMBURSEMENTS.—None of the amounts provided under a grant under this section may be used to provide direct services, other than case management, for which reimbursements are otherwise available under title XVIII or XIX of the Social Security Act.

''(6) LIMITATIONS.—

''(A) TERM.—Grants awarded under this section shall be for terms of less than 3 years.

''(B) AMOUNT.—Grants awarded to an entity under this section shall not exceed $300,000 per year. The Secretary may waive the limitation under this subparagraph where an applicant demonstrates that the number of hospitals or individuals to be served under the grant justifies such increased amounts.

"(C) SUPPLANTING OF FUNDS.—Amounts awarded under a grant under this section may not be used to supplant existing State funds that are provided to support hospital link programs.

"(d) EVALUATION AND REPORTS.—

"(1) BY GRANTEES.—An entity that receives a grant under this section shall evaluate the effectiveness of the services provided under the grant in facilitating the placement of individuals being discharged from hospitals or acute care facilities into home and community-based long term care settings rather than nursing homes. Such entity shall prepare and submit to the Secretary a report containing such information and data concerning the activities funded under the grant as the Secretary determines appropriate.

"(2) BY SECRETARY.—Not later than the end of the third fiscal year for which funds are appropriated under subsection (e), the Secretary shall prepare and submit to the appropriate committees of Congress, a report concerning the results of the evaluations and reports conducted and prepared under paragraph (1).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for each of the fiscal years 1994 through 1996.''.

Subtitle C—Long-Term Care Insurance Improvement and Accountability

SEC. 2200. SHORT TITLE.

This subtitle may be cited as the ''Long-Term Care Insurance Improvement and Accountability Act''.

PART 1—PROMULGATION OF STANDARDS AND MODEL BENEFITS

SEC. 2201. STANDARDS.

(a) APPLICATION OF STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, in consultation with the NAIC, shall develop and publish specific standards to implement the standards specified in this subtitle.

(2) STATE STANDARDS.—Nothing in this subtitle shall be construed as preventing a participating State from applying standards that provide greater protection to insured individuals under long-term care insurance policies than the standards promulgated under this subtitle, except that such State

standards may not be inconsistent with any of the standards specified in this subtitle.

(b) DEADLINE FOR APPLICATION OF STANDARDS.—

(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is—

(A) the date the State adopts the standards established under subsection (a)(1); or

(B) the date that is 1 year after the first day of the first regular legislative session that begins after the date such standards are first established under subsection (a)(2);

whichever is earlier.

(2) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the

close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

(1) minimum Federal standards for long-term care insurance consistent with the provisions of this subtitle;

(2) standards for the enhanced protection of consumers with long-term care insurance; and

(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program.

(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall, after consultation with representatives of carriers, consumer groups, and providers of long-term care services—

(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

(3) recommend appropriate standards for the regulation of the insurance aspects of supported housing arrangements; and

(4) perform such other activities as determined appropriate by the Secretary.

PART 2—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

SEC. 2211. IMPLEMENTATION OF POLICY STANDARDS.

(a) IN GENERAL.—

(1) REGULATORY PROGRAM.—No long-term care policy (as defined in section (2221)) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2201(b) unless—

(A) the Secretary determines that the State has established a regulatory program that—

(i) provides for the application and enforcement of the standards established under section 2201(a); and

(ii) complies with the requirements of subsection (b);

by the date specified in section 2201(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2201(a) by the date specified in section 2201(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

(2) REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary shall review regulatory programs described in paragraph (1)(A) at least biannually to determine if they continue to provide for

the application and enforcement of the standards and procedures established under section 2201(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2201 for carriers, agents, or associations or its subsidiary in the State plans in the State.

(b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

(1) ENFORCEMENT.—The enforcement under the program—

(A) shall be designed in a manner so as to secure compliance with the standards within 30

days after the date of a finding of noncompliance with such standards; and

(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

(2) PROCESS.—The enforcement process under each State regulatory program shall provide for—

(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

(B) responding to such complaints within 90 days;

(C) the investigation of—

(i) those complaints which have a reasonable probability of validity; and

(ii) such other alleged violations of the standards as the program finds appropriate; and

(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2218) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

(3) PRIVATE ACTIONS.—An individual may commence a civil action in an appropriate State or United States district court to enforce the provisions of this title and may be awarded appropriate relief and reasonable attorney's fees.

(4) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

(A) IN GENERAL.—A State regulatory program shall provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

(5) PROCESS FOR APPROVAL OF PREMIUMS.—

(A) IN GENERAL.—Each State regulatory program shall—

(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

(ii) establish a policy for receipt and consideration of public comments before

approving such a premium increase or decrease.

(B) CONDITIONS FOR APPROVAL.—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

(i) includes a description of the assumptions that justify the increase, including a financial report on expenditures;

(ii) contains such information as may be required under the Standards; and

(iii) is made available to the public.

(C) APPLICATION.—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

(D) EXCEPTION.—Subparagraph (C) shall not apply to—

(i) group conversion policies;

(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

(E) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the Secretary, in consultation with the NAIC, from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

(6) ANNUAL REPORTS.—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

(7) ACCESS TO OTHER INFORMATION.—The State regulatory program shall provide for consumer

access to actuarial memoranda, including financial information, provided under paragraph (4).

(8) DEFAULT.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

(1) IN GENERAL.—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

(2) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this subtitle;

(B) for responding on a timely basis to such complaints; and

(C) for the investigation of—

(i) those complaints that have a reasonable probability of validity; and

(ii) such other alleged violations of the requirements of this subtitle as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

(3) HEARINGS.—

(A) IN GENERAL.—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this subtitle, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

(B) CONDUCT OF HEARING.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

(C) AUTHORITY IN HEARINGS.—In conducting hearings under this paragraph—

(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

(ii) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

(D) ISSUANCE OF ORDERS.—If an administrative law judge determines in a hearing under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this

subtitle, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

(A) IN GENERAL.—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

(i) shall require the agent, association or its subsidiary, or a carrier—

(I) to cease and desist from such violations; and

(II) to pay a civil penalty in an amount not to exceed $15,000 in the case of each agent, and not to exceed $25,000 for each association or its subsidiary or a carrier for each such violation; and

(ii) may require the agent, association or its subsidiary, or a carrier to take such other remedial action as is appropriate.

(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or

association or its subsidiary establishes to the satisfaction of the Secretary that—

(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

(C) WAIVER BY SECRETARY.—In the case of a violation under this subtitle that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

(D) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary

modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

(E) JUDICIAL REVIEW.—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

(F) ENFORCEMENT OF ORDERS.—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

SEC. 2212. REGULATION OF SALES PRACTICES.

(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

(1) IN GENERAL.—Each agent (as defined in section 2233) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

(2) POLICY REPLACEMENT FORM.—With respect to any individual who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such individual completes a policy replacement form developed by the Secretary, in consultation with the NAIC. A copy of such form shall be provided to such individual and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

(3) PROHIBITED PRACTICES.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

(A) TWISTING.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the

purpose of inducing, or tending to induce, any individual to retain or effect a change with respect to a long-term care insurance policy.

(B) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

(C) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(D) OTHERS.—Engaging in such other practices determined inappropriate under guidelines issued by the Secretary, in consultation with the NAIC.

(b) FINANCIAL NEEDS STANDARDS.—The Secretary, in consultation with the NAIC, shall develop recommended minimum financial needs standards (including both income and asset criteria) for the purpose of advising individuals as to the costs and amounts of insurance needed

when considering the purchase of a long-term care insurance policy.

(c) PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term ''service-benefit long-term care insurance policy'' means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

(e) PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.—A carrier may not sell or issue a long-term care insurance policy that reduces, limits, or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

(f) PROVISION OF OUTLINE OF COVERAGE.—No agent, association or its subsidiary, or carrier may sell or offer for sale a long-term care insurance policy without providing to every individual purchaser or potential purchaser (or representative) an outline of coverage that complies with the standards established under section 2201(a).

(g) PENALTIES.—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed $15,000 for each such violation. Any association

or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and in addition, is subject to a civil money penalty of not to exceed $25,000 for each violation. Nothing in this subsection shall be construed as preempting or otherwise limiting the penalties that may be imposed by a State for conduct that violates this section.

(h) AGENT TRAINING AND CERTIFICATION REQUIREMENTS.—The Secretary, in consultation with the NAIC, shall establish requirements for long-term care insurance agent training and certification that—

(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

(2) specify procedures for certifying and recertifying agents who have completed such training and who are qualified to sell or offer for sale long-term care insurance policies.

SEC. 2213. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

(a) REFUND OF PREMIUMS.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2217, the

carrier shall, not later than 30 days after the date of the denial or return, refund directly to the applicant, or in the case of an employer to whomever remits the premium, any premiums paid with respect to such a policy (or certificate). Any such refund shall not be made by delivery by the carrier.

(b) MAILING OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide each individual applicant the policy (or certificate) of insurance and outline of coverage not later than 30 days after the date of the approval.

(c) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the carrier shall, within 15 days of the date of a written request by the policyholder or certificate holder (or representative)—

(1) provide a written explanation of the reasons for the denial;

(2) make available all medical and patient records directly relating to such denial; and

(3) provide a written explanation of the manner in which to appeal the denial.

Except as provided in subsection (e) of section 2215, no claim under such a policy may be denied on the basis of

a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

(d) REPORTING OF INFORMATION.—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the Secretary, in consultation with the NAIC, to the Commissioner, superintendent or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the Secretary, in consultation with the NAIC, concerning—

(1) the long-term care insurance policies of the carrier that are in force;

(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

(3) the lapse rate, replacement rate, and rescission rates by policy;

(4) the names of that 10 percent of its agents that—

(A) have the greatest lapse and replacement rate; and

(B) have produced at least $50,000 of long-term care insurance sales in the previous year; and

(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy. Information required under this subsection shall be reported in a format specified in the standards established under section 2201(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

(e) STANDARDS ON COMPENSATION FOR SALE OF POLICIES.—

(1) IN GENERAL.—Until the Secretary, in consultation with the NAIC, promulgates mandatory standards concerning compensation for the sale of long-term care policies, a carrier that issues one or more long-term care insurance policies may provide a commission or other compensation to an agent or other representative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed—

(A) 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year, or

(B) 50 percent of the premium paid on the first year policy.

(2) SUBSEQUENT YEARS.—The commission or other compensation provided for the sale of long-term care policies to an individual during each of the years during the 5-year period subsequent to the first year of the policy shall be the same as that provided in the second subsequent year.

(3) LIMITATION.—No carrier shall provide compensation to its agents for the sale of a long-term care policy which replaces an existing policy, and no agent shall receive compensation for such sale greater than the renewal compensation payable by the replacing carrier on renewal policies.

(4) COMPENSATION DEFINED.—As used in this subsection, the term ''compensation'' includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including, but not limited to, deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

SEC. 2214. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation, or fraud.

(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premiums when due. A group policy which restricts provision of benefits and services to, or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conver-

sion of coverage if the policy entitles each individual—

(A) whose coverage under the group policy would otherwise be terminated for any reason; and

(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits not less than, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all individuals covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any

exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(c) STANDARDS FOR ISSUANCE.—

(1) IN GENERAL.—

(A) GUARANTEE.—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

(B) PREMIUM FOR CONVERTED POLICY.—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(2) UPGRADE FOR CURRENT POLICIES.—The Secretary, in consultation with the NAIC, shall es-

tablish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

(3) RATE STABILIZATION.—The Secretary, in consultation with the NAIC, shall establish standards for premium rate stabilization.

(d) EFFECT OF INCAPACITATION.—

(1) IN GENERAL.—

(A) PROHIBITION.—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2201(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician, or other health care provider (independent of the issuer of the policy), to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

(B) REINSTATEMENT.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a

period of not less than 5 months after termination and shall allow for the collection of past due premium.

(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

(A) the period of such nonpayment is in excess of 30 days; and

(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

SEC. 2215. BENEFIT STANDARDS.

(a) USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.—Pursuant to standards established under section 2201(a), each long-term care insurance policy shall, with respect to services, providers or facilities—

(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with re-

spect to definitions and terminology used for long-term care services and providers; and

(2) use a uniform format for presenting the outline of coverage under such a policy;

as prescribed under guidelines issued by the Secretary, in consultation with the NAIC, and periodically updated.

(b) DISCLOSURE.—

(1) OUTLINE OF COVERAGE.—

(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage to each individual policyholder under such policy that meets the applicable standards established pursuant to section 2201(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the Secretary, in consultation with the NAIC, and periodically updated.

(B) CONTENTS.—The outline of coverage for each long-term care policy shall substantially and accurately reflect the contents of the policy or the master policy and shall include at least the following:

(i) A description of the benefits and coverage under the policy.

(ii) A statement of the exclusions, reductions, and limitations contained in the policy.

(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

(iv) Consumer protection information, including the manner in which to file a claim and to register complaints.

(v) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only and not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern.

(vi) A description of the terms, specified in section 2217, under which a policy or certificate may be returned and premium refunded.

(vii) Information on—

(I) national average costs for nursing facility and home health care and information (in graph form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs; and

(II) other public and private long-term care insurance products and long-term care programs where made available by the Federal Government or by a State government.

(viii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

(2) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

(A) a description of the principal benefits and coverage provided in the policy;

(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

(C) a statement that the group master policy determines governing contractual provisions.

(3) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

(B) an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits (if any) for each covered individual; and

(C) any exclusions, reductions, and limitations on benefits of long-term care.

(4) ADDITIONAL INFORMATION.—The Secretary, in consultation with the NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.

(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

(1) IN GENERAL.—A long-term care insurance policy may not condition or limit eligibility—

(A) for benefits for a type of services to the need for or receipt of any other services;

(B) for any benefit on the medical necessity for such benefit;

(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, or if no State licensure or certification laws exists, developed by the Secretary, in consultation with the NAIC; or

(D) for residential care (if covered under the policy) only—

(i) to care provided in facilities which provide a higher level of care; or

(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

(2) HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified

home health care or community-based services, the policy—

(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or a home care worker who is licensed or certified under State licensure or certification laws, or if no such laws exist, who is in compliance with qualifications developed by the Secretary, in consultation with the NAIC;

(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

(D) shall provide, at a minimum—

(i) benefits for personal care services (including home health aide and home care worker services as defined by the Secretary, in consultation with the NAIC), home health services, adult day care, and respite care in an individual's home or in another setting in the community; or

(ii) any of such benefits on a respite care basis.

(3) NURSING FACILITY SERVICES.—If a long-term care policy provides benefits for the payment of specified nursing facility services, the policy shall provide such benefits with respect to all nursing facilities in the State. Except as provided by the Secretary, in consultation with the NAIC, under uniform language and definitions established under section 2215(a)(1)), the term 'nursing facilities' has the meaning given such term by section 1919(a) of the Social Security Act.

(4) PER DIEM POLICIES.—

(A) DEFINITION.—For purposes of this subtitle, the term ''per diem long-term care insurance policy'' means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

(B) LIMITATION.—No per diem long-term care insurance policy (or certificate) may condi-

tion, limit or otherwise exclude benefit payments based on the receipt of any type services from any type providers of long-term care service providers.

(d) PROHIBITION OF DISCRIMINATION.—A long-term care insurance policy may not, with respect to benefits under the policy, treat an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment, differently from an individual having a functional impairment for which such benefits may be made available.

(e) LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.—

(1) INITIAL ISSUANCE.—

(A) IN GENERAL.—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

(B) 6-MONTH LIMIT.—A long-term care policy or certificate issued under this subtitle may impose a limitation or exclusion of benefits

relating to treatment of a condition based on the fact that the condition preexisted the effective date of the policy or certificate with respect to an individual if—

(i) a condition that was diagnosed or treated during the 6-month period ending on the day before the first date of coverage under the policy or certificate; and

(ii) the limitation or exclusion extends for a period not more than 6 months after the date of coverage under the policy or certificate.

(2) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

(f) ELIGIBILITY FOR BENEFITS.—

(1) LONG-TERM CARE POLICIES.—Each long-term care insurance policy shall—

(A) describe the level of benefits available under the policy; and

(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

(2) FUNCTIONAL ASSESSMENT.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her functional or cognitive abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the Secretary, in consultation with the NAIC, to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy.

(3) CLAIMS REVIEW.—Except as provided in paragraph (4), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

(4) APPEALS PROCESS.—

(A) IN GENERAL.—Each long-term care insurance policy shall provide for a timely and

independent appeals process, meeting standards established by the Secretary, in consultation with the NAIC, for individuals who dispute the results of the claims review conducted under paragraph (3) or the policyholder's functional assessment conducted under paragraph (2).

(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's functional or cognitive abilities.

(C) CONDUCT.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the Secretary, in consultation with the NAIC, to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

(ii) by an entity that provides services to the policyholder or certificate holder for which benefits are available under the long-term care insurance policy; or

(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

(5) STANDARD ASSESSMENTS.—Not later than 2 years after the date of enactment of this subtitle, the advisory committee established under section 2201(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

(6) CONTROL DEFINED.—For purposes of paragraphs (2) and (4), the term ''control'' means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing at least 10 percent of the voting securities of another person.

(g) INFLATION PROTECTION.—

(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, in-

cluding each group policyholder, the option to purchase a long-term care insurance policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one of the following:

(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such

additional benefit may not be less than the difference between—

(i) the existing policy benefit; and

(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this subtitle:

(A) A comparison (shown as a graph) of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison

shall show benefit levels over not less than a 20-year period.

(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

(4) CONTINUATION OF PROTECTION.—Benefit increases under a policy described in paragraph (1) shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

(5) CONSTANT PREMIUM.—A policy described in paragraph (1) that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a carrier obtains a written

rejection of such protection signed by the policyholder.

SEC. 2216. NONFORFEITURE.

(a) IN GENERAL.—Each long-term care insurance policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period (specified under the standards under section 2201(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the Secretary, in consultation with the NAIC.

(b) ESTABLISHMENT OF STANDARDS.—The standards under section 2201(a) shall provide that the percentage or amount of benefits under subsection (a) shall increase based upon the policyholder's equity in the policy.

SEC. 2217. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or intentional misrepresentation relating to the issuance of the policy unless notice of such fraud or misrepresentation is provided within a time period to be determined by the Secretary, in consultation with the NAIC.

(b) RIGHT TO RETURN.—Each applicant for a long-term care insurance policy shall have the right to return

the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

SEC. 2218. CIVIL MONEY PENALTY.

(a) CARRIER.—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

(1) fails to make a refund in accordance with section 2213(a);

(2) fails to transmit a policy in accordance with section 2213(b);

(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2213;

(4) provides a commission or compensation in violation of section 2213(e);

(5) fails to provide an outline of coverage in violation of section 2215(b)(1); or

(6) issues a policy without obtaining certain information in violation of section 2215(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

(b) AGENTS.—Any agent that sells or offers for sale a long-term care insurance policy and that—

(1) fails to make a refund in accordance with section 2213(a);

(2) fails to transmit a policy in accordance with section 2213(b);

(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2213;

(4) fails to provide an outline of coverage in violation of section 2215(b)(1); or

(5) issues a policy without obtaining certain information in violation of section 2215(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

(c) EFFECT ON STATE LAW.—Nothing in this section shall be construed as preempting or otherwise limiting the penalties that may be imposed by a State for the types of conduct described in this section.

PART 3—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

SEC. 2221. LONG-TERM CARE INSURANCE POLICY DEFINED.

(a) IN GENERAL.—As used in this section, the term ''long-term care insurance policy'' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered individual on an expense in-

curred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

(1) group and individual annuities and life insurance policies, riders or certificates that provide directly, or that supplement long-term care insurance; and

(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

(b) ISSUANCE.—Long-term care insurance policies may be issued by—

(1) carriers;

(2) fraternal benefit societies;

(3) nonprofit health, hospital, and medical service corporations;

(4) prepaid health plans;

(5) health maintenance organizations; or

(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

(c) POLICIES EXCLUDED.—The term ''long-term care insurance policy'' shall not include any insurance policy,

rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates—

(1) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement,

(2) that provide the option of a lump-sum payment for those benefits, or

(3) with respect to which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(d) APPLICATIONS.—Notwithstanding any other provision of this subtitle, this subtitle shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

SEC. 2222. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

Not later than 1 year after the date of enactment of this subtitle, the Secretary, in consultation with the NAIC, shall issue guidelines that shall apply to organizations and associations (other than employers and labor organizations that do not accept compensation) that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

Subtitle D—Life Care

SEC. 2301. SHORT TITLE.

This title may be cited as the ''Life Care Act''.

SEC. 2302. LIFE CARE: PUBLIC INSURANCE PROGRAM FOR NURSING HOME CARE.

The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE XXVII—LIFE CARE: PUBLIC INSURANCE PROGRAM FOR NURSING HOME CARE

"SEC. 2701. ESTABLISHMENT OF VOLUNTARY LONG-TERM CARE INSURANCE PROGRAM.

''The Secretary shall establish a voluntary insurance program for individuals 35 years of age and over to cover the nursing home stays of such individuals. The Secretary shall establish a process for enrollment in the Life Care program.

"SEC. 2702. BENEFITS.

''(a) IN GENERAL.—

''(1) ELIGIBILITY FOR COVERAGE.—Subject to subsection (c), an individual who meets the eligibility criteria prescribed in section 2703 shall be eligible under the program established under this title for coverage for necessary services described in subsection (b) (in the amounts described in subsection

(c)) that are provided to the individual by a nursing facility while the individual is an inpatient of the facility.

''(2) NONFORFEITURE.—The Secretary shall establish standards to ensure the nonforfeiture of benefits for which premiums have been paid.

''(b) TYPES.—Coverage may be provided under this title for—

''(1) nursing care provided by or under the supervision of a registered professional nurse;

''(2) physical, occupational, or speech therapy furnished by a facility or by others under arrangements with a facility;

''(3) medical social work services;

''(4) drug, biological, supply, appliance, and equipment for use in the facility, that is ordinarily furnished by the facility for the care and treatment of an inpatient;

''(5) such other services necessary to the functioning of a patient, including personal care and assistance with activities of daily living, as are generally provided by a nursing home facility; and

''(6) with respect to the initial 6 months of covered residence in a nursing facility, such room and

board costs as are not covered by beneficiary copayment.

''(c) COVERAGE AMOUNT.—

''(1) IN GENERAL.—The amount of coverage provided with respect to an eligible individual for the services described in subsection (b) shall, based on an election made by the individual, not exceed $30,000, $60,000, or $90,000 over the lifetime of the eligible individual. Such amounts shall be adjusted by the Secretary to reflect increases in the Consumer Price Index.

''(2) ASSET PROTECTION.—An eligible individual shall be entitled to the asset protection provided under section 2708.

''(d) PAYMENT.—Amounts provided under this title with respect to an eligible individual for the services described in subsection (b) shall be paid from the general fund of the Treasury of the United States.

''(e) RESIDENTIAL CARE FACILITIES.—The Secretary shall consider the feasibility of making payments under this title for services delivered in residential care facilities. Not later than 2 years after the date of enactment of this Act, the Secretary shall report its findings to the Congress with respect to the feasibility of making such payments.

"SEC. 2703. ELIGIBILITY.

''(a) IN GENERAL.—An individual shall be eligible for benefits under this title if—

''(1) the individual—

''(A) is a legal resident of the United States and has elected coverage under subsection (c); and

''(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2707)—

''(i)(I) to require hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living; or

''(II) to require hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies; or

''(III) to display symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; or

"(IV) has achieved a score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, that indicates either severe cognitive impairment or severe mental impairment, or both; and

"(ii) to require such assistance, supervision, or cueing over a period of at least 90 days; and

"(2)(A) the individual has filed an application for such benefits, and is in need of, benefits covered under this title; or

"(B) the legal guardian of the individual has filed an application on behalf of an individual who is in need of benefits covered under this title; or

"(C) the representative of an individual who is cognitively impaired and who is in need of benefits covered under this title has filed an application on behalf of the individual.

"(b) CURRENT INDIVIDUALS.—An individual who is in a hospital or nursing home on the date of the enrollment of the individual in the program established under this title shall be ineligible for coverage under this section

until the individual's first spell of illness beginning after such date.

''(c) ELECTION OF COVERAGE.—

''(1) IN GENERAL.—Subject to this subsection, an individual shall have the option to purchase coverage under this title when the individual is 35 years of age, 45 years of age, 55 years of age, or 65 years of age.

''(2) INITIAL YEAR.—During the 1-year period beginning on the date on which final regulations that implement this title are issued, an individual who is 35 years of age or older shall be eligible to purchase insurance under this title, except that such an individual shall not be eligible to purchase such insurance—

''(A) while confined to a hospital or nursing home;

''(B) within the 6-month period after the individual's confinement in a nursing home; or

''(C) within the 90-day period after the individual's confinement in a hospital.

Individuals described in the matter preceding subparagraph (A) shall become eligible to receive benefits under this title on the expiration of the 3-year

period beginning on the date such individuals purchase insurance under this title.

''(3) EXTENSION BEYOND INITIAL YEAR.—If an individual is confined to a nursing home or hospital during a period that extends beyond the first year after the effective date of this title, an individual shall be eligible to enroll in the program established by this title during the 60-day period beginning after the individual's spell of illness.

''(4) SUBSEQUENT YEARS.—During years subsequent to the 1-year period referred to in paragraph (2), an individual shall be eligible to purchase insurance under this title within 6 months of the 35th, 45th, 55th or 65th birthday of the individual.

''(5) ACTIVATION OF BENEFITS.—To receive coverage under the insurance program established by this title, an individual shall have purchased such coverage not later than 1 month prior to admission to a nursing facility, unless the reason for the need of services is a result of an accident or stroke subsequent to the date that such individual enrolled for coverage under this title.

''(d) PUBLIC EDUCATION.—In the 12 months preceding the initial enrollment period, the Secretary shall, either directly or through grants and contracts, conduct a public

service and education campaign designed to inform potentially eligible individuals as to the nature of the benefits and the limited enrollment period. In conducting such campaigns the Secretary shall make information available to individuals through the open enrollment process for obtaining health care benefits under this Act.

"SEC. 2704. PREMIUM RATES.

''(a) IN GENERAL.—The Secretary shall determine one premium rate for individuals electing to purchase coverage under this title at age 35 (or between the ages of 35 and 44 during the initial enrollment period), a separate rate for those individuals who elect coverage at age 45 (or between the ages of 45 and 54 during the initial enrollment period), a separate rate for those individuals who elect such coverage at age 55 (or between that ages of 55 and 64 during the initial enrollment period), and a separate rate for those individuals who elect such coverage at age 65 (or at age 65 and over during the initial enrollment period). During the initial enrollment period, the Secretary shall establish actuarily fair, age-rated premiums for persons age 65 and over.

''(b) REVISION.—The Secretary shall revise premium rates annually to increase such rates to reflect the amount of the increase in the cost of living adjustment with respect to benefits under title II of the Social Security Act.

''(c) RATES.—In developing premium rates under the program established under this title, the Secretary shall establish rates that are expected to cover 100 percent of the reimbursement amount provided under this title for nursing home stays for those individuals enrolled in the program.

''(d) WAIVER.—An individual electing to purchase coverage under this title shall not be required to pay premiums during any period in which such individual is receiving benefits under this title.

''(e) PAYMENT.—Premiums shall be paid under this section into the general fund of the Treasury of the United States.

"SEC. 2705. QUALIFIED SERVICE PROVIDERS.

''(a) IN GENERAL.—To be considered as a covered nursing home service under this title, such service must have been provided by a qualified service provider.

''(b) TYPES.—A provider shall be considered a qualified service provider under this title if the provider is a nursing facility that is certified by the State and meets the requirements of this title and any other standards established by the Secretary by regulation for the safe and efficient provision of services covered under this title.

"SEC. 2706. REIMBURSEMENT.

''(a) AMOUNT.—Monthly reimbursement for nursing facility services under this title shall equal 65 percent (or during the initial 6 months of coverage, 80 percent) of the amount the Secretary determines to be reasonable and appropriate to cover the cost of care provided under this title.

''(b) PROSPECTIVE PAYMENT.—To the extent feasible, the Secretary shall establish a prospective payment mechanism for payment for nursing home services under this title that takes into account the expected resource utilization of individual patients based on their degree of disability, the methodology recommended for reimbursement of skilled nursing facilities under title XVIII of the Social Security Act, and other factors determining service requirements.

''(c) ROOM AND BOARD PAYMENT.—An individual receiving benefits under this program shall be responsible for the payment of an amount for room and board that is equal to—

''(1) with respect to the initial 6 months of residence in a nursing facility, 20 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this title; and

''(2) with respect to subsequent periods of residence, 35 percent of the average per diem rate paid

by the Secretary to nursing facilities receiving reimbursement under this title. Payments under subsection (a) and (c) shall be considered payment in full for services received under this section.

''(d) PRIORITY PAYERS.—Notwithstanding any other provision of this title, reimbursement for nursing facility services provided under this title to an individual shall, to the extent available, be made under the Medicare program, under Department of Veterans Affairs' programs, or under private insurance policies prior to reimbursement under this title.

"SEC. 2707. LONG-TERM CARE SCREENING AGENCY.

''(a) ESTABLISHMENT.—The Secretary shall contract with entities to act as Long-Term Care Screening Agencies (hereafter referred to in this title as the 'Screening Agency') for each designated area of a State. It shall be the responsibility of such agency to assess the eligibility of individuals residing in the geographic jurisdiction of the Agency, for services provided under this title according to the requirements of this title and regulations prescribed by the Secretary. In entering into such contracts, the Secretary shall give preference to State governmental entities and private nonprofit agencies.

''(b) ELIGIBILITY.—The Screening Agency shall determine the eligibility of an individual under this title

based on the results of a preliminary telephone interview or written questionnaire (completed by the applicant, by the caregiver of the applicant, or by the legal guardian or representative of the applicant) that shall be validated through the use of a screening tool administered in person to each applicant determined eligible through initial telephone or written questionnaire interviews not later than 15 days from the date on which such individual initially applied for services under this title.

''(c) QUESTIONNAIRES AND SCREENING TOOLS.—

''(1) IN GENERAL.—The Secretary shall establish a telephone or written questionnaire and a screening tool to be used by the Screening Agency to determine the eligibility of an individual for services under this title consistent with requirements of this title and the standards established by the Secretary by regulation.

''(2) QUESTIONNAIRES.—The questionnaire shall include questions about the functional impairment and mental status of an individual and other criteria that the Secretary shall prescribe by regulation.

''(3) SCREENING TOOLS.—The screening tool should measure functional impairment caused by physical or cognitive conditions as well as informa-

tion concerning cognition disability, behavioral problems (such as wandering or abusive and aggressive behavior), and any other criteria that the Secretary shall prescribe by regulation. The screening tool shall be administered in person.

''(d) NOTIFICATION.—Not later than 15 days after the date on which an individual initially applied for services under this title (by telephone or written questionnaire), the Screening Agency shall notify such individual that such individual is not eligible for benefits, or that such individuals must schedule an in-person screening to determine final eligibility for benefits under this title. The Screening Agency shall notify such individual of its final decision not later than 2 working days after the in-person screening.

''(e) IN-PERSON SCREENING.—An individual (or the legal guardian or representative of such individual) whose application for benefits under this title is denied on the basis of information provided through a telephone or written questionnaire, shall be notified of such individual's right to an in-person screening by a nurse or appropriate health care professionals.

''(f) APPEALS.—The Secretary shall establish a mechanism for hearings and appeals in cases in which in-

dividuals contest the eligibility findings of the Screening Agency.

''(g) PAYMENT.—

''(1) PAYMENT FOR SCREENING.—The Screening Agency may require payment from individuals only in accordance with standards established by the Secretary.

''(2) NO PAYMENT FOR POOREST.—The Screening Agency may not require payment for individuals with incomes of less than 150 percent of the official poverty line.

"SEC. 2708. ASSET PROTECTION.

''Notwithstanding any other provision of law, the assets an eligible individual may retain and be determined eligible for nursing facility benefits, including payments of room and board under this title, under State Medicaid programs (in accordance with section 1902(a)(10)) shall be increased by the amount of coverage ($30,000, $60,000, or $90,000) elected under section 2702.

"SEC. 2709. RELATION TO PRIVATE INSURANCE.

''(a) IN GENERAL.—Except as provided in subsection (b), an insurer may not offer a long-term care insurance policy to an individual who has purchased coverage under this title if the coverage under such policy duplicates the coverage provided under this title.

''(b) DEVELOPMENT OF STANDARD PACKAGES.—The Secretary shall develop standard long-term care insurance benefits packages that insurers may offer to insured individuals under this title. Such packages shall provide coverage for benefits that compliment, but do not duplicate, those covered under this title.

''SEC. 2710. DEFINITIONS.

''As used in this title:

''(1) NURSING FACILITY.—The term 'nursing facility' means—

''(A) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act); or

''(B) a facility that is a nursing facility (as defined in section 1919(a) of such Act) which meets the requirements of section 1819(b)(4)(C) of such Act (relating to nursing care).

''(2) SPELL OF ILLNESS.—The term 'spell of illness' means a period of consecutive days beginning with the first day on which an individual is furnished services as an inpatient in a hospital or nursing facility and ending with the close of the first 6 consecutive months thereafter during which the individual is no longer an inpatient of a nursing facility,

or 90 days after the individual is no longer an inpatient in a hospital.

"SEC. 2711. REPORTS.

''(a) IN GENERAL.—Prior to the promulgation of regulations implementing this title, the Secretary shall report to Congress on—

''(1) the actuarially-sound premium rates to be used in the implementation of this Act, including whether the premiums will cover 100 percent of the benefits paid out, and whether Federal funds will be required to support the payment of benefits;

''(2) an assessment of the impact of such premium rates on the affordability of coverage under this Act;

''(3) a projected enrollment of individuals by age category; and

''(4) an estimate of current and projected enrollment of individuals, by age category in coverage under private long-term care insurance.

''(b) LIFE CARE REPORT.—Not later than 2 years after the promulgation of regulations implementing this title, the Secretary shall report to Congress on the following aspects of the Life Care Act:

''(1) The current and projected premium rates.

''(2) The current and projected enrollment of individuals, by age category and an estimate of current and projected enrollment of individuals by age category in private long-term care insurance.

''(3) The projected use of benefits and the impact of use on premium rates.

''(4) An assessment of the impact of projected premium rates on the affordability of coverage under this Act.

''(c) RECOMMENDATIONS.—The Secretary shall make recommendations to Congress regarding necessary revisions to the Life Care Act as a result of the findings provided in the reports submitted under this section.''.

Subtitle E—Study and Report

SEC. 2401. STUDY OF ISSUES RELATED TO END OF LIFE CARE.

(a) STUDY.—

(1) IN GENERAL.—Within 6 months after the date of the enactment of this Act, the Secretary shall enter into an agreement with the Institute of Medicine of the National Academy of Sciences (or with another nonprofit, nongovernmental organization or consortium of institutions if the Institute declines to perform the study) to investigate and report on issues relating to appropriate care at the

end of life, including how to determine the appropriateness of curative or life-prolonging or palliative services for gravely or terminally ill or injured persons of all ages.

(2) SPECIFIC ISSUES.—The study described in paragraph (1) shall specifically include an examination of the following issues:

(A) The epidemiology of dying.

(B) The feasibility and utility of clinical practice guidelines for appropriate care.

(C) Conditions that promote or impede appropriate care (such as professional training and beliefs, financing and organization of services, patient and public knowledge and attitudes).

(D) Priorities for research on the issues described in the preceding subparagraphs.

(E) Concerns of health care practitioners and providers, medical educators, the general public, and those responsible for public and private decisions about the organization, financing, and quality of health care in the United States.

(b) REPORT.—The Institute of Medicine (or the organization conducting the study under this section) shall submit to the Secretary and the Congress a report on the

study described in subsection (a) within 27 months after the date of the enactment of this Act.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the purposes of this section.

TITLE III—HEALTH PROFESSIONS WORKFORCE

Subtitle A—Workforce Priorities Under Federal Payments

SEC. 3000. DEFINITIONS.

For purposes of this subtitle:

(1) The term ''academic year'' has the meaning given such term in section 3011(b)(3)(A).

(2) The term ''allocation period'' has the meaning given such term in section 3015(d).

(3) The term ''annual number of specialty positions'' has the meaning given such term in section 3013(g)(1).

(4) The term ''approved physician training program'' has the meaning given such term in section 3011(b)(1).

(5) The term ''consumer price index'' has the meaning given such term in section 3033(e)(1).

(6) The term ''designation period'' has the meaning given such term in section 3013(g)(2).

(7) The term ''funding agreement'' has the meaning given such term in section 3011(b)(3)(B).

(8) The term ''general health care inflation factor'' has the meaning given such term in section 3033(e)(4).

(9) The term ''medical school'' has the meaning given such term in section 3001(e)(2).

(10) The term ''medical specialty'' has the meaning given such term in section 3011(b)(3)(C).

(11) The term ''National Council'' has the meaning given such term in section 3001(e)(3).

(12) The term ''primary health care'' has the meaning given such term in section 3013(g)(3).

(13) The term ''qualified applicant'' has the meaning given such term in section 3011(b)(2), in the case of subpart B; and has the meaning given such term in section 3031(c), in the case of subpart C.

(14) The term ''specialty position'' has the meaning given such term in section 3013(g)(4).

(15) The term ''training participant'' has the meaning given such term in section 3013(g)(5).

PART 1—INSTITUTIONAL COSTS OF GRADUATE MEDICAL EDUCATION; WORKFORCE PRIORITIES

Subpart A—National Council Regarding Workforce Priorities

SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—There is established within the Department of Health and Human Services a council to be known as the National Council on Graduate Medical Education.

(b) DUTIES.—The Secretary shall carry out subpart B acting through the National Council.

(c) COMPOSITION.—

(1) IN GENERAL.—The membership of the National Council shall include between 12 and 16 individuals who are appointed to the Council from among individuals who are not officers or employees of the United States. Such individuals shall be appointed by the Secretary, and shall include individuals from each of the following categories in the following proportions:

(A) One-quarter composed of consumers of health care services, at least one of whom resides in a rural area.

(B) One-quarter composed of primary health care physicians who are faculty members

of medical schools (including officials of medical schools and executives of teaching hospitals) and primary health care physicians who are practicing and are not faculty members of medical schools, at least one of whom resides in a rural area.

(C) One-quarter composed of non-primary health care specialty physicians who are faculty members of medical schools, non-primary health care specialty physicians who are not faculty members of medical schools, officials of medical schools, and executive officers of teaching hospitals.

(D) One-quarter composed of officers and employees of health plans, and officers or members of purchasing cooperatives.

(2) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the National Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary or other Federal officers who are appointed by the President with the advice and consent of the Senate.

(d) CHAIR.—The Secretary shall, from among members of the National Council appointed under subsection (c)(1), designate an individual to serve as the Chair of the Council.

(e) DEFINITIONS.—For purposes of this subtitle:

(1) The term ''academic health center'' means an entity defined in section 3051(c)(1).

(2) The term ''medical school'' means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as defined in such section).

(3) The term ''National Council'' means the council established in subsection (a).

(f) CONFORMING AMENDMENT REPEALING THE COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME).—Effective on the date of the first meeting of the National Council, section 30 of the Health Professions Education Extension Amendments of 1992 (Public Law 102-408) is repealed.

Subpart B—Authorized Positions in Specialty Training

SEC. 3011. COOPERATION REGARDING APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—With respect to an approved physician training program in a medical specialty, a funding

agreement with a qualified applicant for payments under section 3031 and section 3051 for a calendar year is that the qualified applicant will ensure that the number of individuals enrolled in the program in the subsequent academic year is in accordance with this subpart.

(b) DEFINITIONS.—

(1) APPROVED PROGRAM.—For purposes of this subtitle:

(A) The term ''approved physician training program'', with respect to the medical specialty involved, means a residency or other postgraduate program that trains physicians and meets the following conditions:

(i) Participation in the program may be counted toward certification in the medical specialty as determined under the applicable standards of the American Board of Medical Specialties or the Council on Postdoctoral Training of the American Osteopathic Association.

(ii) The program is accredited by the Accreditation Council on Graduate Medical Education, or approved by the Council on Postdoctoral Training of the American Osteopathic Association.

(B) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A) that provides health services in an ambulatory setting, without regard to whether the program provides inpatient hospital services.

(C) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A), whether operated by academic health centers, teaching hospitals, group practices, ambulatory care providers, prepaid health plans, or other entities.

(D) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A) that provides fellowship training in family medicine, general internal medicine or general pediatrics, and provides training for a faculty position in family medicine, general medicine or general pediatrics.

(2) QUALIFIED APPLICANT; SUBPART DEFINITION.—For purposes of this subpart, the term ''qualified applicant'', with respect to an academic year, means an entity that trains individuals in an approved physician program that receives payments

under subpart C for the calendar year in which the academic year begins.

(3) OTHER DEFINITIONS.—For purposes of this subtitle:

(A)(i) Except as provided in clause (iii), the term ''academic year'' means the 1-year period beginning on July 1. The academic year beginning July 1, 1993, is academic year 1993–1994.

(ii) With respect to the funding agreement described in subsection (a), the term ''subsequent academic year'' means the academic year beginning July 1 of the calendar year for which payments are to be made under the agreement.

(iii) For purposes of determining the academic year in which a training participant enters an approved physician training program, the academic year is the 1-year period beginning on or after June 1.

(B) The term ''funding agreement'', with respect to payments under section 3031 and 3051 to a qualified applicant, means that the Secretary may make the payments only if the qualified applicant signs the agreement involved.

(C) The term ''medical specialty'' includes all medical, surgical, and other physician specialties and subspecialties.

SEC. 3012. ANNUAL AUTHORIZATION OF TOTAL NUMBER OF GRADUATE MEDICAL EDUCATION POSITIONS.

With respect to the numbers designated by the Council for individuals entering eligible programs for an academic year pursuant to section 3011, the Council shall ensure that the aggregate number of individuals first entering any such program for the year does not exceed the following number (expressed as a percentage), as applicable to the academic year involved:

(1) For academic year 1998–1999, 134 percent of the number of individuals who graduated from medical schools in the United States in academic year 1997–1998.

(2) For academic year 1999–2000, 126 percent of such number.

(3) For academic year 2000–2001, 118 percent of such number.

(4) For academic year 2001–2002 and each subsequent academic year, 110 percent of such number, except as provided in section 3014.

SEC. 3013. ANNUAL AUTHORIZATION OF NUMBER OF SPECIALTY POSITIONS; REQUIREMENTS REGARDING PRIMARY HEALTH CARE.

(a) ANNUAL AUTHORIZATION OF NUMBER OF POSITIONS.—In the case of each medical specialty, the National Council shall, pursuant to section 3011, designate for academic year 1998–1999 and each subsequent academic year the number of individuals nationwide who are authorized to be enrolled in eligible programs in each medical specialty for the academic year involved.

(b) PRIMARY HEALTH CARE.—

(1) REQUIREMENT ACROSS SPECIALITIES.—In carrying out subsection (a) for an academic year, the National Council shall ensure that, of the class of training participants entering all eligible programs for their first year of graduate medical education for academic year 1998–1999 or any subsequent academic year, the percentage of such class that completes eligible programs in primary health care and does not subsequently enter a non-primary health care training program, is not less than the following, as applicable to the academic year involved:

(A) For academic year 1998–1999, 39 percent.

(B) For academic year 1999–2000, 44 percent.

(C) For academic year 2000–2001, 49 percent.

(D) For academic year 2001–2002 and each subsequent academic year, 55 percent, except as provided in section 3014.

(2) RULE OF CONSTRUCTION.—The requirement of paragraph (1) regarding a percentage applies in the aggregate to training participants entering eligible programs for the academic year involved, and not individually to any eligible program.

(c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

(1) DESIGNATION PERIODS.—For each medical specialty, the National Council shall make the annual designations under subsection (a) for periods of 3 academic years.

(2) INITIAL PERIOD.—The first designation period established by the National Council after the date of the enactment of this Act shall be the academic years 1998–1999 through 2000–2001.

(d) CERTAIN CONSIDERATIONS IN DESIGNATING ANNUAL NUMBERS.—

(1) IN GENERAL.—Factors considered by the National Council in designating the annual number of specialty positions for an academic year for a medical specialty shall include the extent to which

there is a need for additional practitioners in the speciality, as indicated by the following:

(A) The characteristics of diseases, disorders, or health conditions treated, including—

(i) the incidence and prevalence (in the general population and in various other populations) of the diseases, disorders, or other health conditions with which the specialty is concerned;

(ii) the intensity of care required for each of these diseases, disorders, or health conditions;

(iii) the relevant training received and experience attained by primary health care and specialist physicians in caring for each of these diseases, disorders, or health conditions; and

(iv) should sufficient data become available, the extent to which individuals with certain diseases, disorders, or health conditions have better health outcomes when treated by non-primary health care physicians than by primary health care physicians.

(B) The number of physicians who will be practicing in the specialty in the academic year.

(C) The number of physicians who will be practicing in the specialty at the end of the 5-year period beginning on the first day of the academic year.

(D) Whether, after examining medical specialty requirements, the National Council determines that specialty is a medical shortage specialty (as defined by the National Council).

(2) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In designating the annual number of specialty positions for an academic year for a medical specialty, the National Council shall consider the recommendations of organizations representing physicians in the specialty, organizations representing academic medicine, and the recommendations of organizations representing consumers of the services of such physicians.

(e) VOLUNTARY COMPLIANCE.—

(1) ESTABLISHMENT OF THE POSITIONS FOR FIRST DESIGNATION PERIOD.—Not later than June 1, 1996, the National Council shall establish the number of positions in each medical specialty that will be allocated under subsection (a) for the aca-

demic years 1998–1999, 1999–2000, and 2000–2001.

(2) VOLUNTARY COMPLIANCE.—A medical specialty shall not be subject to the mandatory allocation system described in section 3015 if—

(A) by June 1, 1997, each eligible approved physician training program has submitted to the National Council a proposal for first year positions in approved physician training programs in that particular medical specialty for the academic years 1998–99, 1999–2000, and 2000–2001 and the total proposed number of all such positions for the specialty does not exceed the number of positions established for such specialty under paragraph (1) for each such academic year; and

(B) in subsequent academic years, the total proposed number of first year positions in approved physician training programs in that particular medical specialty does not exceed the number of individuals nationwide who are authorized to be enrolled in approved medical training programs for such medical specialty for such year pursuant to subsection (a).

(3) LOSS OF COMPLIANCE.—The National Council may, at any time, determine that a specialty is not in compliance with the number of positions established by the Council under paragraph (1) or subsection (a) and initiate, with respect to that specialty, the system of mandatory allocations described in section 3015.

(f) STUDY.—Not later than January 1, 2005, the Secretary shall arrange for the completion, by the Institute of Medicine or other similar entity, of an independent study concerning the effect of medical workforce regulation and planning in general and in particular geographic areas. The results of such study together with recommendations concerning the appropriateness of modifying or eliminating workforce regulations shall be compiled in a report and transmitted by the Secretary to the President and the Congress.

(g) DEFINITIONS.—For purposes of this subtitle:

(1) The term ''annual number of specialty positions'', with respect to a medical specialty, means the number designated by the National Council under subsection (a) for eligible programs for the academic year involved.

(2) The term ''designation period'' means a 3-year period under subsection (c)(1) for which des-

ignations under subsection (a) are made by the National Council.

(3) The term ''primary health care'' means the following medical specialties: Family medicine, general internal medicine, general pediatrics, geriatric medicine, and obstetrics and gynecology. Only those participants in programs with a significant primary care training emphasis will be considered to have completed an eligible program in primary care for the purposes of subsection (b)(1). Determination of the meaning of a ''significant primary care training emphasis'' will be made by the National Council.

(4) The term ''specialty position'' means a position as a training participant.

(5) The term ''training participant'' means an individual who is enrolled in an approved physician training program.

SEC. 3014. NATIONAL COUNCIL RECOMMENDATION OF NUMBER OF GRADUATE MEDICAL EDUCATION POSITIONS.

(a) IN GENERAL.—

(1) RECOMMENDATIONS.—Beginning with academic year 2001-2002 and each subsequent academic year, the National Council may after consider-

ing the factors described in paragraph (2) annually recommend to the Secretary a change in—

(A) the aggregate number of all training participants entering the first year of graduate medical education training in approved physician training programs nationwide determined under section 3012(4); and

(B) in accordance with subsection (b), the distribution of positions among medical specialties determined under section 3013(a) and 3013(b)(1)(D).

(2) FACTORS FOR CONSIDERATION.—In developing a recommendation under paragraph (1), the Secretary shall consider the impact on rural, inner city, and public hospitals of reducing numbers of individuals authorized to enter approved physician training programs and the appropriate supply of physicians in the aggregate and in particular medical specialties.

(b) LIMITATIONS ON RECOMMENDED PERCENT FOR PRIMARY CARE FOR ACADEMIC YEAR 2001–2002.—For the academic year 2001–2002, the number that the National Council may recommend under subsection (a)(1)(B) may not be more than 5 percentage points less or 5 per-

centage points more than the number described in section 3013(b)(1)(D).

(c) CONSIDERATION AND IMPLEMENTATION BY THE SECRETARY.—The Secretary shall in the Secretary's discretion implement the recommendations by the National Council under subsection (a) in accordance with sections 3012 and 3013(b)(1). The Secretary may not modify such recommendations.

SEC. 3015. ALLOCATIONS AMONG SPECIALITIES AND PROGRAMS.

(a) IN GENERAL.—Subject to the provisions of sections 3012 and 3013, for each academic year, the National Council shall for each medical specialty make allocations among eligible programs of the annual number of specialty positions that the Council has designated for such year. The preceding sentence is subject to subsection (b)(3).

(b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

(1) IN GENERAL.—For each medical specialty, the National Council shall make the annual allocations under subsection (a) for periods of 3 academic years.

(2) ADVANCE NOTICE TO PROGRAMS.—With respect to the first academic year of an allocation period established by the National Council, the National Council shall, not later than July 1 of the pre-

ceding academic year, notify each eligible program of the allocations made for the program for each of the academic years of the period.

(3) INITIAL PERIOD.—The first allocation period established by the National Council after the date of the enactment of this Act shall be the academic years 1998–1999 through 2000–2001.

(c) CERTAIN CONSIDERATIONS.—

(1) GEOGRAPHIC AREAS.—In making allocations under subsection (a) for eligible programs of the various geographic areas, the National Council shall include among the factors considered the—

(A) distribution of approved physician training programs with respect to population and community need; and

(B) historical distribution of approved physician training programs among the geographic areas.

(2) QUALITY OF PROGRAMS.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the quality of such programs.

(3) UNDERREPRESENTATION OF MINORITY GROUPS AND WOMEN.—In making an allocation under subsection (a) for an eligible program, the

National Council shall include among the factors considered the following:

(A) The extent to which the population of training participants in the program includes training participants who are members of racial or ethnic minority groups and women.

(B) With respect to a racial or ethnic group or women represented among the training participants, the extent to which the group is underrepresented in the field of medicine generally and in the various medical specialities.

(4) UNDERSERVED RURAL AND INNER-CITY COMMUNITIES.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the extent to which the population of training participants in the program includes training participants who have resided in rural or inner-city communities for a substantial period, as defined by the Council and the proportion of past participants in the program who are practicing in rural or inner-city communities.

(5) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the recommendations of organizations rep-

resenting physicians in the medical specialties, the recommendations of organizations representing academic medicine and the recommendations of organizations representing consumers of the services of such physicians.

(d) DEFINITIONS.—For purposes of this subtitle, the term ''allocation period'' means a 3-year period under subsection (b)(1) for which allocations under subsection (a) are made by the National Council.

Subpart C—Costs of Graduate Medical Education

CHAPTER 1—OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

SEC. 3031. FEDERAL FORMULA PAYMENTS TO QUALIFIED ENTITIES FOR THE COSTS OF THE OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—In the case of a qualified entity that in accordance with section 3032 submits to the Secretary an application for calendar year 1997 or any subsequent calendar year, the Secretary shall make payments for such year to the qualified entity for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3033 and 3034, and may administer the payments as a contract, grant, or cooperative agreement.

(b) PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.—The purpose of payments under subsection (a) is to assist a qualified applicant with the costs of operation of an approved physician training program. A funding agreement for such payments is that the qualified applicant involved will expend the payments only for such purpose or for such other related purposes as the Secretary may authorize.

(c) QUALIFIED APPLICANT; SUBPART DEFINITION.—

(1) IN GENERAL.—For purposes of this subpart, the term ''qualified applicant'', with respect to the calendar year involved, means an entity—

(A) that trains individuals in approved physician training programs; and

(B) that submits to the Secretary an application for such year in accordance with section 3032.

(2) ENTITIES INCLUDED.—The term ''qualified applicant'' may include an approved physician training program, teaching hospital, medical school, group practice, an entity representing two or more parties engaged in a formal association, a community health center or another entity operating an approved physician training program.

(d) TREATMENT OF PODIATRIC AND DENTAL RESIDENCY PROGRAMS.—Except as provided in section 3034, for the purposes of this subpart, an approved physician training program includes training programs approved by the Commission on Dental Accreditation or the Council of Podiatric Medical Education of the American Podiatric Medical Association. This subsection shall not apply for purposes of subpart B.

SEC. 3032. APPLICATION FOR PAYMENTS.

(a) IN GENERAL.—

(1) IN GENERAL.—For purposes of section 3031(a), an application for payments under such section for a calendar year is in accordance with this section if—

(A) the eligible entity involved submits the application not later than the date specified by the Secretary;

(B) the application demonstrates that the condition described in subsection (b) is met with respect to the program;

(C) the application contains each funding agreement described in this part and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(D) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(2) CERTAIN ENTITIES.—If an applicant under paragraph (1) is an entity representing two or more parties—

(A) the application shall contain a written agreement, signed by all participants, in which all of the participants agree as to the manner in which the payments will be allocated; and

(B) the applicant shall agree to submit additional documentation, if requested by the National Council, that demonstrates that the funds are distributed in the manner agreed upon by all participants.

(b) CERTAIN CONDITIONS.—An eligible entity meets the condition described in this subsection for receiving payments under section 3031 for a calendar year if—

(1) the entity agrees to use such funds only to support an approved physician training program;

(2) with respect to—

(A) a specialty for which programs have received allocations under section 3015, the en-

tity agrees that funds will be used only to support approved training programs for which the number of specialists in training is consistent with the allotment under section 3015; and

(B) a specialty for which a voluntary program has received allocations under section 3013(e), the entity agrees that funds will only be used to support approved training programs for which the number of specialists in training is consistent with the allocations under section 3015(e); and

(3) the entity notifies each residency training program director of each approved physician training program operated by the entity of the amount of payments received by the entity under this section and sections 3051 and 3055 that is attributable to the number of training participants in the program.

(c) RESIDENCY TRAINING PROGRAM DIRECTOR.—For purposes of this section, the term ''residency training program director'' means an individual specified in the application of the entity as the official with primary administrative responsibility for an approved physician training program.

SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) GRADUATE MEDICAL EDUCATION ACCOUNT.—

(1) IN GENERAL.—Subject to paragraph (2) and except as provided in section 3034, the following amounts shall be available for a calendar year for making payments under sections 3031 and 3055 from the Graduate Medical Education Account established under section 9551(a)(2)(A) of the Internal Revenue Code of 1986:

(A) In the case of calendar year 1997, $3,200,000,000.

(B) In the case of calendar year 1998, $3,550,000,000.

(C) In the case of calendar year 1999, $5,800,000,000.

(D) In the case of each of calendar years 2000 and 2001, $5,800,000,000.

(E) In the case of each subsequent calendar year, the amount specified in subparagraph (C) increased by the product of such amount and the general health care inflation factor for such year (as defined in subsection (e)).

(2) TRANSITIONAL PROVISION.—

(A) IN GENERAL.—With respect to making payments under sections 3031 and 3055 for calendar year 1997 or 1998, the Secretary shall first make payments under section 3031 to eligible programs described in subparagraph (B) in the amount determined for the programs under subsection (b) for such year, and then, from such amounts as remain available under paragraph (1) for such year, shall make payments under section 3031 to other eligible programs and shall make payments under section 3055.

(B) PARTICIPATING STATE.—An eligible program described in this subparagraph is such a program that is operated in a State that is a participating State under title I.

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE ENTITIES.—

(1) IN GENERAL.—Except as provided in section 3034, payment amounts with respect to any physician training program under this section shall be equal to the product of the number of full time equivalent training participants in the program, and the per resident amount for the training program.

(2) PER RESIDENT AMOUNT.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the per resident amount for a training program shall be equal to—

(i) with respect to—

(I) the first calendar year during which the program receives payment under subsection (a), 90 percent;

(II) the second calendar year during which the program receives payment under subsection (a), 80 percent;

(III) the third calendar year during which the program receives payment under subsection (a), 70 percent;

(IV) the fourth calendar year during which the program receives payment under subsection (a), 60 percent; and

(V) the fifth and subsequent calendar year during which the program receives payment under subsection (a), 50 percent;

of the approved FTE resident amount that would have been determined under section 1886(h)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(h)(2)(D)) for the hospital operating such approved physician training program for a cost reporting period beginning in such calendar year if the amendments made by section 4306 of the Health Security Act had not been made; and

(ii) with respect to—

(I) the first calendar year during which the program receives payment under subsection (a), 10 percent;

(II) the second calendar year during which the program receives payment under subsection (a), 20 percent;

(III) the third calendar year during which the program receives payment under subsection (a), 30 percent;

(IV) the fourth calendar year during which the program receives

payment under subsection (a), 40 percent; and

(V) the fifth and subsequent calendar years during which the program receives payment under subsection (a), 50 percent;

of the geographically adjusted national average per resident amount.

(B) MINIMUM PER RESIDENT AMOUNT.—Notwithstanding the provisions of subparagraph (A), the per resident amount for a training program shall not be less than 75 percent of the geographically adjusted national average per resident amount determined in accordance with subparagraph (A)(ii).

(C) NO HISTORIC PAYMENT BASIS.—For purposes of subparagraph (A)(i), the Secretary shall determine the appropriate per resident amount applicable to an entity that—

(i) has an approved physician training program that sponsored or is affiliated with more than one hospital that had a per resident amount determined under section 1886(h) of the Social Security Act which

reflects the average per resident amounts under such section for such hospitals; or

(ii) is an institution that did not have a per resident amount determined under such section for cost reporting periods beginning before 1996 which reflects the national average per resident amount.

(3) ADJUSTMENT FACTOR.—Payments under this section shall be subject to an adjustment factor, as determined by the Secretary, so that total payments in any year will not exceed the amounts specified in subsection (a) and as provided in subsection (d).

(4) ADDITIONAL PROVISIONS REGARDING NATIONAL AVERAGE COST.—

(A) DETERMINATION OF NATIONAL AVERAGE COST.—The Secretary shall in accordance with clause (ii) of subsection (b)(2)(A) determine, for academic year 1992–1993, an amount equal to the geographically adjusted national average per resident amount described in such clause with respect to training a participant in an approved physician training program. The national average applicable under such clause for a calendar year for such programs is, sub-

ject to subparagraph (B), the amount determined under the preceding sentence increased by the amount necessary to offset the effects of inflation occurring since academic year 1992–1993, as determined through use of the consumer price index.

(B) GEOGRAPHIC ADJUSTMENT.—The national average determined under subparagraph (A) and applicable to a calendar year shall, in the case of the eligible entity involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

(5) FUNDING LEVEL AND ALLOCATION METHOD.—Not later than January 1, 1998, the Secretary shall complete a study to determine the effect and appropriateness of the funding level and allocation method described in subsection (a) and paragraphs (1), (2), (3), and (4) of this subsection on the operation of training programs and on national workforce goals and shall compile the findings and recommendations derived from such study in a report to be submitted to the President and the Congress.

(c) DETERMINATION OF FULL-TIME-EQUIVALENT TRAINING PARTICIPANTS.—

(1) RULES.—The Secretary shall establish rules consistent with this subsection for the computation of the number of full-time-equivalent training participants in approved physician training programs under subsection (b)(1).

(2) ADJUSTMENT FOR PART-YEAR OR PART-TIME TRAINING PARTICIPANTS.—Such rules shall take into account individuals who serve as training participants for only a portion of a period in an approved physician training program or simultaneously with more than one such program.

(3) WEIGHTING FACTORS FOR CERTAIN TRAINING PARTICIPANTS.—

(A) IN GENERAL.—Subject to paragraph (4), such rules shall provide, in calculating the number of full-time-equivalent training participants in an approved physician training program—

(i) for a training participant who is in the participant's initial training period, the weighting factor is 1.00,

(ii) except as provided in clause (iii), for a training participant who is not in the participant's initial training period, the weighting factor is 0.75, and

(iii) in an academic year in which the total number of training participant positions in all approved physician training programs does not exceed—

(I) 134 percent of United States medical school graduates in academic year 1997–1998, the weighting factor for a training participant who is not in the training participant's initial training period is 0.70;

(II) 126 percent of United States medical school graduates in academic year 1997–1998, the weighting factor for such a participant is 0.90;

(III) 118 percent of United States medical school graduates in 1997–1998, the weighting factor for such a participant is 0.95 percent; and

(IV) 110 percent of United States medical school graduates in academic year 1997–1998, the weighting factor for such a participant, the weighting factor is 1.0.

(B) STUDY.—Not later than January 1, 1998, the Secretary shall complete a study to determine the effect that applying weighting factors in calculating the number of full-time-equivalent training participants would have on supporting national workforce goals.

(4) INTERNATIONAL MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—Such rules shall provide that, in the case of an individual who is an international medical graduate, the individual shall not be counted as a training participant unless—

(A) the individual has passed the FMGEMS examination or the U.S. Medical Licensing Examination, or

(B) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(5) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a training participant under an approved physician training program shall be counted towards the determination

of full-time equivalency, without regard to the setting in which the activities are performed.

(d) LIMITATION.—Subject to subsection (a), if the amount available from the Graduate Medical Education Account established under section 9551(a)(2)(A) of the Internal Revenue Code of 1986 for a calendar year is insufficient for providing each eligible entity with the amount of payments determined under subsection (b) for the entity for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under section 3031 for such year equals the amount specified under section 3033(a).

(e) DEFINITIONS.—For purposes of this subtitle:

(1) CONSUMER PRICE INDEX.—The term ''consumer price index'' means the Consumer Price Index for All Urban Consumers (U.S. city average).

(2) INTERNATIONAL MEDICAL GRADUATE.—The term ''international medical graduate'' means a training participant who is a graduate of a school of medicine, school of osteopathy, school of dentistry, or school of podiatry that is not—

(A) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Associa-

tion of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(B) a school of osteopathic medicine accredited by the American Osteopathic Association, or approved by such Association as meeting the standards necessary for such accreditation,

(C) a school of dentistry which is accredited by the Commission on Dental Accreditation, or

(D) a school of podiatric medicine which is accredited by the Council of Podiatric Medical Education of the American Podiatric Medical Association.

(3) FMGEMS EXAMINATION.—The term ''FMGEMS examination'' means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(4) GENERAL HEALTH CARE INFLATION FACTOR.—(A) The term ''general health care inflation factor'', with respect to a year, means the percentage increase in the consumer price index for the year plus the following:

(i) For 1997, 1.0 percentage points.

(ii) For 1998, 0.5 percentage points.

(iii) For 1999 and for 2000, 0 percentage points.

(B) YEARS AFTER 2000.—

(i) RECOMMENDATION TO CONGRESS.—In 1999, the Secretary shall submit to Congress recommendations, after consultation with the Federal Reserve Board, on what the general health care inflation factor should be for years beginning with 2001.

(ii) FAILURE OF CONGRESS TO ACT.—If the Congress fails to enact a law specifying the general health care inflation factor for a year after 2000, the Secretary, in January of the year before the year involved, shall compute such factor for the year involved. Such factor shall be the product of the factors described in subparagraph (C) for that fiscal year, minus 1.

(iii) STUDY BY FEDERAL RESERVE BOARD.—Not later than January 1, 1999, the Federal Reserve Board shall conduct a study, and report to the Secretary, concerning what the general health care inflation factor should be for years beginning with 2001. Such study

shall consider whether continued indexing with respect to such factor is advisable and whether the consumer price index should be used (in whole or in part, modified or unmodified) with respect to premium caps for future years. The recommendations of the Federal Reserve Board under such study shall be considered in the recommendations submitted under clause (i).

(C) FACTORS.—The factors described in this subparagraph for a year are the following:

(i) CPI.—1 plus the percentage change in the CPI for the year, determined based upon the percentage change in the average of the CPI for the 12-month period ending with August 31 of the previous fiscal year over such average for the preceding 12-month period.

(ii) REAL GDP PER CAPITA.—1 plus the average annual percentage change in the real, per capita gross domestic product of the United States during the 3-year period ending in the preceding calendar year, determined by the Secretary based on data supplied by the Department of Commerce.

(5) INITIAL TRAINING PERIOD.—The term ''initial training period'' means the period of time required for board eligibility, except that—

(A) except as provided in subparagraph (B), in no case shall the initial period of participation exceed an aggregate period of formal training of more than 5 years for any individual, and

(B) a period, of not more than 2 years, during which an individual is in a—

(i) residency or fellowship program in geriatric medicine, preventive medicine, or adolescent medicine, or

(ii) a fellowship program in family medicine, general internal medicine or general pediatrics, which provides training for a faculty position in family medicine, general internal medicine or general pediatrics,

shall be treated as part of the initial training participation period, but shall not be counted against any limitation on the initial training period.

The initial training period shall be determined, with respect to a training participant, as of the time the

training participant enters any approved physician training program.

(6) PERIOD OF TIME REQUIRED FOR BOARD ELIGIBILITY.—

(A) GENERAL RULE.—Subject to subparagraphs (B) and (C), the term ''period of time required for board eligibility'' means, for a training participant, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the training participant is training.

(B) APPLICATION OF 1985–1986 DIRECTORY.—Except as provided in subparagraph (C), the period of time required for board eligibility shall be such period specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education or a more current version of such Directory or the equivalent directory regarding postdoctoral training for osteopathic physician training programs.

(C) CHANGES IN PERIOD OF TIME REQUIRED FOR BOARD ELIGIBILITY.—If the Accreditation Council on Graduate Medical Edu-

cation, in its Directory of Residency Training Programs or the equivalent directory regarding postdoctoral training for osteopathic physician training programs—

(i) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985–1986 Directory, the Secretary may increase the period of time required for board eligibility for that specialty, but not to exceed the period of time required for board eligibility specified in that later Directory, or

(ii) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985–1986 Directory, the Secretary may decrease the period of time required for board eligibility for that specialty, but not below the period of time required for board eligibility specified in that later Directory.

SEC. 3034. PAYMENTS FOR DENTAL AND PODIATRIC POSITIONS.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), the provisions of this chapter shall apply with respect to dental and podiatric medicine training programs.

(b) LIMITATION.—Subject to the amount made available under section 3033(a), the aggregate amount available for making payments to all approved physician training programs in dentistry and podiatric medicine may not exceed $200,000,000 in any calendar year.

(c) PAYMENT METHODOLOGY.—The Secretary shall determine the amount to be paid to approved dental and podiatric training programs on the basis of a methodology to be developed by the Secretary that is equivalent to the methodology described in section 3033(b)(5).

CHAPTER 2—ACADEMIC HEALTH CENTERS AND OTHER ELIGIBLE INSTITUTIONS

SEC. 3051. FEDERAL FORMULA PAYMENTS TO ACADEMIC HEALTH CENTERS AND OTHER ELIGIBLE INSTITUTIONS.

(a) IN GENERAL.—In the case of an eligible institution that in accordance with section 3052 submits to the Secretary a written request for calendar year 1997 or any subsequent calendar year, the Secretary shall make pay-

ments for such year to the eligible institution for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3053, and may administer the payments as a contract, grant, or cooperative agreement.

(b) PAYMENTS FOR COSTS INCURRED BY ELIGIBLE INSTITUTIONS.—

(1) COSTS ATTRIBUTABLE TO ACADEMIC NATURE OF INSTITUTIONS.—With respect to an eligible institution that is a qualified academic health center or a qualified teaching hospital, the purpose of payments under subsection (a) is to assist such institutions with costs that are not routinely incurred by other entities in providing health services, but are incurred by such institutions in providing health services by virtue of the academic nature of such institutions. Such costs include—

(A) with respect to productivity in the provision of health services, costs resulting from the reduced rate of productivity of faculty due to teaching responsibilities;

(B) the uncompensated costs of clinical research; and

(C) exceptional costs associated with the treatment of health conditions with respect to

which an eligible institution has specialized expertise (including treatment of rare diseases, treatment of unusually severe conditions, and providing other specialized health care).

(2) HIGH INTENSITY NONTEACHING RURAL HOSPITAL.—With respect to an eligible institution that is a high intensity nonteaching rural hospital, the purpose of payments under subsection (a) is to assist the institution with the costs of treating a substantial number of severely ill patients.

(c) DEFINITIONS.—

(1) ACADEMIC HEALTH CENTER.—For purposes of this subtitle, the term ''academic health center'' means an entity that operates a teaching hospital that sponsors or is affiliated with an approved physician training program.

(2) ELIGIBLE INSTITUTION.—For purposes of this subtitle, the term ''eligible institution'', with respect to a calendar year, means a qualified academic health center, qualified teaching hospital, or high intensity nonteaching rural hospital that submits to the Secretary a written request in accordance with section 3052.

(3) HIGH INTENSITY NONTEACHING RURAL HOSPITAL.—For purposes of this subtitle, the term

''high intensity nonteaching rural hospital'' means a nonteaching hospital located in a rural area as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) that the Secretary determines has a case-mix index (defined as the average weight of all cases in the hospital for all diagnosis-related groups as determined in accordance with section 1886(d)(4) of such Act (42 U.S.C. 1395ww(d)(4)) of greater than 120 percent of the national average case-mix index for all rural hospitals.

(4) QUALIFIED CENTER OR HOSPITAL.—For purposes of this subtitle:

(A) The term ''qualified academic health center'' means an academic health center that operates a teaching hospital.

(B) The term ''qualified teaching hospital'' means any teaching hospital other than a teaching hospital that is operated by an academic health center.

(5) TEACHING HOSPITAL.—For purposes of this subtitle, the term ''teaching hospital'' means a hospital that sponsors or is affiliated with an approved physician training program (as defined in section 3011(b) or section 3031(d)).

SEC. 3052. REQUEST FOR PAYMENTS.

(a) IN GENERAL.—For purposes of section 3051, a written request for payments under such section is in accordance with this section if—

(1) the eligible institution involved submits the request not later than the date specified by the Secretary;

(2) the request is accompanied by each funding agreement described in this part; and

(3) the request is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(b) CONTINUED STATUS AS ELIGIBLE INSTITUTION.—A funding agreement for payments under section 3051 is that the eligible institution involved will maintain status as such an eligible institution. For purposes of this subtitle, the term ''funding agreement'', with respect to payments under section 3051 to such an eligible institution, means that the Secretary may make the payments only if the eligible institution makes the agreement involved.

(c) COMPLIANCE WITH SPECIALTY ALLOCATIONS.—A funding agreement for payments under section 3051 is that an eligible institution that operates or is affiliated with an approved physician training program shall receive

such payments only if the number of specialists in such a program is consistent with the allotment under section 3015 or 3013(e).

SEC. 3053. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) ANNUAL ACADEMIC HEALTH CENTER ACCOUNT.—

(1) AVAILABILITY OF FUNDS FROM ACCOUNT.—Except as provided in paragraph (2), the following amounts shall be available for a calendar year for making payments under section 3051 from the Academic Health Center Account established under section 9551(a)(2)(B) of the Internal Revenue Code of 1986 is the following, as applicable to the calendar year:

(A) In the case of calendar year 1997, $6,280,000,000.

(B) In the case of calendar year 1997, $7,250,000,000.

(C) In the case of calendar year 1997, $8,220,000,000.

(D) In the case of calendar year 2000, $9,400,000,000.

(E) In the case of calendar year 2001, $10,640,000,000.

(F) In the case of each subsequent calendar year, the amount specified in subparagraph (E) increased by the product of such amount and the general health care inflation factor (as defined in subsection (d)).

(2) SPECIAL ALLOTMENTS.—Of the amounts available for a calendar year for making payments under subsection (a) pursuant to paragraph (1)—

(A) such amounts as are necessary shall be reserved to make payments to eligible institutions that are high intensity nonteaching rural hospitals; and

(B) the remainder of the amounts available for making payments under subsection (a), shall be expended for making payments under section 3051 to other eligible institutions.

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE INSTITUTIONS.—

(1) QUALIFIED ACADEMIC HEALTH CENTERS AND QUALIFIED TEACHING HOSPITALS.—The amount of payments required in section 3051 to be made to a qualified academic health center or a qualified teaching hospital for a calendar year is an amount equal to the product of—

(A) the amount available for making such payments for the calendar year from the Academic Health Center Account established under section 9551(a)(2)(B) of the Internal Revenue Code of 1986; and

(B) the percentage constituted by the ratio of—

(i) the product of—

(I) the sum, for all discharges of individuals, of the amounts otherwise paid on behalf of such individuals; and

(II) an adjustment factor equal to (e raised to the power (.405 × r) –1), where ''r'' is the ratio of the qualified academic health center's or the qualified teaching hospital's full-time equivalent training participants to beds and ''e'' is the natural log of one; and

(ii) the sum of the respective amounts determined under clause (i) for qualified academic health centers and qualified teaching hospitals.

(2) HIGH INTENSITY NONTEACHING RURAL HOSPITAL.—Subject to the annual amount reserved for high intensity nonteaching rural hospitals under subsection (a)(2)(A) for a calendar year, the amount required under section 3051 to be made to a high intensity nonteaching rural hospital is an amount equal to 5 percent of the inpatient costs of patient care for all patients of the hospital.

(3) ADJUSTMENT FACTOR.—Payments under this section shall be subject to an adjustment factor, as determined by the Secretary, so that total payments in any year will not exceed the amounts specified in 3053(a).

(c) REPORT REGARDING MODIFICATIONS IN FORMULA.—Not later than July 1, 2000, the Secretary shall submit to the Congress a report containing any recommendations of the Secretary for the modification of the program of formula payments described in this chapter. In preparing such report the Secretary shall consider—

(1) the costs described in section 3051(b) incurred by academic health centers;

(2) the adequacy of the formula payments established in this chapter to cover such costs, taking into account any additional revenues to cover such

costs paid by other payers, including private health plans;

(3) the impact of the current payment methodology on training in the ambulatory setting of national workforce goals, and its effect on the education and training of primary care physicians;

(4) the importance to the maintenance of a quality national health care system of academic health centers in providing for the training of health professionals, in conducting clinical research, and in providing innovative, technically advanced care; and

(5) the overall impact of the reformed health care system on the ability of academic health centers to perform such functions.

(d) GENERAL HEALTH CARE INFLATION FACTOR.—For purposes of this subtitle, the term ''general health care inflation factor'', with respect to a year, has the meaning given such term in section 3033(e)(4) for such year.

Subpart D—Transitional Provisions

SEC. 3055. TRANSITIONAL PAYMENTS TO INSTITUTIONS.

(a) PAYMENTS REGARDING EFFECTS OF SUBPART B ALLOCATIONS.—For each of the calendar years specified in subsection (b)(2), in the case of an eligible entity that submits to the Secretary an application for such year in

accordance with subsection (d), the Secretary shall make payments for the year to the entity for the purpose specified in subsection (c). The Secretary shall make the payments in an amount determined in accordance with subsection (e), and may administer the payments as a contract, grant, or cooperative agreement.

(b) ELIGIBLE ENTITIES LOSING SPECIALTY POSITIONS; RELEVANT YEARS REGARDING PAYMENTS.—

(1) ELIGIBLE ENTITIES LOSING SPECIALTY POSITIONS.—The Secretary may make payments under subsection (a) to an eligible entity only if, with respect to the calendar year involved, the entity meets the following conditions:

(A) During the year preceding the initiation of transitional payments, the entity—

(i) received payments under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for residents in one or more approved programs, or

(ii) sponsored or was affiliated with one or more approved physician training programs that received payments under section 3031.

(B) The aggregate number of full-time-equivalent training participant positions in such

programs have been reduced below the aggregate number of full-time-equivalent training participant positions for the academic year 1993–1994.

(C) The aggregate number of full-time-equivalent training participant positions in such programs spend in patient care activities at the hospital have been reduced below the aggregate number of full-time-equivalent training participant positions for the academic year 1993–1994, as a result of allocations under subpart B, or as a result of voluntary changes under section 3013(e) prior to January 1, 2002.

(2) RELEVANT YEARS.—Except as provided in subsection (e)(3), the Secretary may make payments under subsection (a) to an eligible entity only for the first four calendar years after the initial calendar year for which the entity meets the conditions described in paragraph (1).

(3) ELIGIBLE ENTITY.—For purposes of this section, the term ''eligible entity'' means a qualified academic health center or teaching hospital entity that submits to the Secretary an application in accordance with subsection (d).

(c) PURPOSE OF PAYMENTS.—The purpose of payments under subsection (a) is to assist an eligible entity with the costs of operation. A funding agreement for such payments is that the entity involved will expend the payments only for such purpose.

(d) APPLICATION FOR PAYMENTS.—For purposes of subsection (a), an application for payments under such subsection is in accordance with this subsection if—

(1) the eligible entity involved submits the application not later than the date specified by the Secretary;

(2) the application demonstrates that the entity meets the conditions described in subsection (b)(1) and that the entity has cooperated with the approved physician training programs of the entity in meeting the condition described in section 3032(b);

(3) the application contains each funding agreement described in this subpart and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

(e) AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—Subject to the amounts available from the Graduate Medical Education Account established under section 9551(a)(2)(A) of the Internal Revenue Code of 1986 in the calendar year involved, the amount of payments required in subsection (a) to be made to an eligible entity for such year is the product of the amount determined under paragraph (2) and the applicable percentage specified in paragraph (3).

(2) NUMBER OF SPECIALTY POSITIONS LOST.—For purposes of paragraph (1), the amount determined under this paragraph for an eligible entity for the calendar year involved is the product of—

(A) an amount equal to the aggregate number of full-time equivalent specialty positions lost; and

(B) the amount that would be received under section 3033 for each speciality position lost.

(3) APPLICABLE PERCENTAGE.—

(A) IN GENERAL.—Except as provided under subparagraph (B), for purposes of paragraph (1), the applicable percentage for a calendar year is the following, as applicable to such year:

(i) For the first calendar year after calendar year 1996 for which the eligible entity involved meets the conditions described in subsection (b)(1), 100 percent.

(ii) For the second such year, 75 percent.

(iii) For the third such year, 50 percent.

(iv) For the fourth such year, 25 percent.

(B) EXCEPTIONS.—

(i) URBAN OR RURAL UNDERSERVED COMMUNITIES.—If the Secretary determines that access to health care in a rural or urban underserved community would be impaired by the annual reductions of the applicable percentage described in subparagraph (A), the Secretary may eliminate such annual reduction or adjust such percentage (at the discretion of the Secretary) to eligible institutions in such a community.

(ii) VOLUNTARY COMPLIANCE POSITIONS.—For the number of positions determined in paragraph (4)(A) that result

from voluntary reductions in the number of specialty positions under section 3013(e), the applicable percentage for a calendar year is the following as applicable to such year:

(I) For the first 2 calendar years after calendar year 1997 for which the eligible entity involved meets the conditions described in subsection (b)(1), 100 percent.

(II) For the third such year, 75 percent.

(III) For the fourth such year, 50 percent.

(IV) For the fifth such year, 25 percent.

(4) DETERMINATION OF SPECIALTY POSITIONS LOST.—

(A) For purposes of this paragraph, the aggregate number of specialty positions lost, with respect to a calendar year, is the difference between—

(i) the aggregate number of specialty positions described in subparagraph (B) that are estimated for the eligible entity in-

volved for the academic year beginning in such calendar year; and

(ii) the aggregate number of such specialty positions at the entity for academic year 1993–1994.

(B) For purposes of subparagraph (A), the specialty positions described in this subparagraph are specialty positions in the medical specialities with respect to which payments under section 3031 are made to the approved physician training programs of the eligible entities involved.

(C) The total number of physicians lost for all eligible entities may not exceed the number by which the aggregate number of specialty positions with respect to which payments are made under section 3031 for the academic year beginning in such calendar year is below the number of full-time-equivalent positions for the academic year 1993–1994.

SEC. 3056. WAIVER OF FOREIGN COUNTRY RESIDENCE REQUIREMENT WITH RESPECT TO INTERNATIONAL MEDICAL GRADUATES.

(a) WAIVER.—Section 212(e) of the Immigration and Nationality Act (8 U.S.C. 1182(e)) is amended—

(1) in the first proviso by inserting ''(or, in the case of an alien described in clause (iii), pursuant to the request of an interested State agency)'' after ''interested United States Government agency''; and

(2) by inserting after ''public interest'' the following: ''except that in the case of a waiver requested by an interested State agency the waiver shall be subject to the requirements of section 214(k)''.

(b) RESTRICTIONS ON WAIVER.—Section 214 of that Act (8 U.S.C. 1184) is amended by adding at the end the following:

''(k)(1) In the case of a request by an interested State agency for a waiver of the two-year foreign residence requirement under section 212(e) with respect to an alien described in clause (iii) of that section, the Attorney General shall not grant such waiver unless—

''(A) in the case of an alien who is otherwise contractually obligated to return to a foreign country the Director of such country furnishes a statement in writing that it has no objection to such waiver;

''(B) the alien demonstrates a bona fide offer of full-time employment at a health facility and begins employment at such facility within 90 days of arrival and agrees to continue to work in accordance with

paragraph (2) at the health care facility in which the alien is employed for a total of not less than 3 years (unless the Attorney General determines that extenuating circumstances such as the closure of the facility or hardship to the alien would justify a lesser period of time);

''(C) the alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than 3 years only in the geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

''(D) the grant of such waiver would not cause the number of waivers allotted for that State for that fiscal year to exceed twenty.

''(2) Whenever an interested State agency requests the waiver of the two-year residence requirement under section 212(e) with respect to an alien described in clause (iii) of that section, the Attorney General shall adjust the status of the alien to that of an alien described in section 101(a)(15)(H)(b).

''(3) If an alien whose status was adjusted under paragraph (2) demonstrates that the alien has worked for a period of 10 years in a health professional shortage area, then the Attorney General may approve a petition filed

on the alien's behalf by the health care facility in which the alien is employed seeking adjustment of the alien's status to that of a special immigrant described in section 101(a)(27)(L).

''(4) Notwithstanding any other provision of this subsection, the two-year foreign residence requirement under section 212(e) shall apply with respect to an alien described in clause (iii) of that section, who has not otherwise been accorded status under section 101(a)(27)(L), if at any time the alien practices medicine in an area other than an area described in paragraph (1)(C).''.

(c) SPECIAL IMMIGRANT STATUS.—Section 101(a)(27) of the Immigration and Nationality Act is amended by adding at the end the following new subparagraph:

> ''(L) immigrants whose status have been adjusted from that of an alien described in paragraph (15)(H)(b) pursuant to section 214(k)(2), except that not more than 500 immigrants may be admitted in any fiscal year under this subparagraph.''.

(d) GROUNDS FOR DEPORTATION.—Section 241(a) of the Immigration and Nationality Act (8 U.S.C. 1251(a)) is amended by adding at the end the following new subparagraph:

"(I) FAILURE TO MAINTAIN EMPLOYMENT AS A HEALTH CARE PROFESSIONAL.—Any alien described in section 212(e)(iii) who fails to maintain employment in accordance with subparagraphs (B) and (C) of section 212(k)(1).".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to aliens admitted to the United States under section 101(a)(15)(J) of the Immigration and Nationality Act, or acquiring such status after admission to the United States, before, on, or after the date of enactment of this Act and before June 1, 2005.

PART 2—HEALTH PROFESSIONS SCHOOLS PAYMENTS

Subpart A—Payments to Medical Schools

SEC. 3061. FEDERAL PAYMENTS TO MEDICAL SCHOOLS.

(a) ENTITLEMENT.—Each eligible medical school that in accordance with section 3062 submits to the Secretary an application for academic year 1997, or any subsequent academic year, shall be entitled to payments for such year for the purpose specified in subsection (b). The Secretary shall make such payments in an amount determined in accordance with section 3063, and shall administer the payments as a grant. The preceding sentence constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Govern-

ment to provide funding for such payments in the amounts, and for the years specified in this subpart.

(b) PAYMENTS TO MEDICAL SCHOOLS.—The purpose specified in this subsection is to assist an eligible medical school with the direct costs of academic programs including the education of medical students (especially in primary health care and ambulatory training), graduate students in biomedical sciences, and otherwise unfunded faculty research. Payments under this section shall supplement and not supplant existing resources for this purpose. A funding agreement for such payments is that the medical school involved will expend the payments received pursuant to section 3063(b) as follows:

(1) 50 percent shall be expended for primary health care education (including prevention), and peer reviewed primary care research in departments and divisions of primary care, including family medicine departments, and divisions of general internal medicine, geriatric medicine, and general pediatrics, or in medical schools in which primary care activities are primarily performed by other organizational units of the medical school, such other units. The medical school will distribute such amounts among the departments, divisions, or other units of primary care so that the distribution of such amounts bears

a reasonable relationship to the amount of ambulatory primary care education of medical students in such departments and divisions and the national workforce goals and shall specify such information and the distribution of funds in the application under section 3062.

(2) 25 percent shall be expended for other ambulatory training.

(3) 25 percent shall be expended for the support of peer-reviewed faculty research in biomedicine and health services.

(c) PER CAPITA PAYMENTS BY MEDICAL SCHOOLS FOR OFF-SCHOOL EDUCATION.—A funding agreement for payments under subsection (a) for an eligible medical school for an academic year is that if, for the academic year, one or more students is enrolled (or accepted for enrollment) in the medical school on the contingency of successfully completing for the academic year a substantial number of hours in medical education through an educational institution that does not operate a medical school, and if the medical school provides credit toward a doctorate in medicine for the hours successfully completed at such other institution, then the medical school will pay to the other institution for such academic year an amount equal to the product of—

(1) the product of—

(A) the number of such students attending the other institution for such academic year; and

(B) the percentage of the academic year spent at the other institution; and

(2) the quotient of—

(A) the amount of payments made to the medical school under subsection (a) for the academic year; over

(B) the number of students in the eligible medical school in the academic year (including students described in this subsection).

(d) ELIGIBLE MEDICAL SCHOOL; SUBPART DEFINITION.—For purposes of this subpart, the term ''eligible medical school'' with respect to the academic year involved, means an approved medical school that submits to the Secretary an application for such year in accordance with section 3062.

SEC. 3062. APPLICATION FOR PAYMENTS.

For purposes of section 3061(a), an application for payments under such section for an academic year is in accordance with this section if—

(1) the dean (or appropriate presiding official) of the eligible medical school submits the application not later than the date specified by the Secretary;

(2) the application contains each funding agreement described in this subpart and provides such assurances of compliance with the agreements as the Secretary may require; and

(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

SEC. 3063. AUTHORIZATION OF APPROPRIATIONS; ANNUAL AMOUNT OF PAYMENTS.

(a) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—The appropriation authorized for each each of the following academic years for making payments pursuant to section 3061(a) shall not be less than or in excess of the following:

(A) In the case of academic year 1997, $200,000,000.

(B) In the case of academic year 1998, $300,000,000.

(C) In the case of academic year 1998, $400,000,000.

(D) In the case of academic year 2000, $500,000,000.

(E) In the case of academic year 2001, $600,000,000.

(F) In the case of each subsequent academic year, the amount specified in subparagraph (F) increased by the product of such amount and the general health care inflation factor (as defined in subsection (d)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE PROGRAMS.—Subject to the annual amount available for making payments pursuant to subsection (a) for an academic year, the amount of the payment required under section 3041 to be made to an eligible medical school for the academic year is an amount equal to the sum of—

(1) the product of ½ of the amount available for the academic year pursuant to subsection (a) and the proportion of students (as determined by the Secretary) at the eligible medical school in academic year 1993–1994 compared to all students enrolled in eligible medical schools nationwide in academic year 1993–1994;

(2) the product of ¼ of the amount available for the academic year pursuant to subsection (a) and the proportion of peer-reviewed research con-

ducted by the faculty at the eligible medical school (including health services research) compared to all such research conducted by the faculty at all eligible medical schools nationwide; and

(3) the product of ¼ of the amount available for the academic year pursuant to subsection (a) and the proportion of the eligible medical school's number of graduates in primary care specialties from the class graduating 6 years prior to such academic year who complete eligible programs in primary health care and do not subsequently enter a nonprimary health care training program compared to such number of graduates of all eligible medical schools nationwide in such year.

The Secretary shall establish a method for measuring faculty research contributions.

(c) STUDIES.—

(1) FUNDING LEVEL AND ALLOCATION METHOD.—Not later than January 1, 1998, the Secretary shall arrange for an independent study and report to be completed, by the Institute of Medicine or other similar entity, concerning the amount of and allocation method for medical school funding, and the impact of the payments under this part on national workforce goals, including the education and train-

ing of primary care physicians. Such report shall be submitted to the President and the Congress and shall include findings and recommendations as to the appropriateness of modifying funding levels or allocations.

(2) IMPACT OF HEALTH CARE REFORM ON MEDICAL EDUCATION.—Not later than January 1, 2000, the Secretary shall arrange for an independent study and report to be completed, by the Institute of Medicine or other similar entity, concerning the impact of health reform on undergraduate medical education. Such report shall be submitted to the President and the Congress and shall include appropriate findings and recommendations.

(d) GENERAL HEALTH CARE INFLATION FACTOR.—As used in this subtitle, the term ''general health care inflation factor'' with respect to a year, has the meaning given such term in section 3033(e)(4) for such year.

Subpart B—Payments to Nursing Programs

SEC. 3071. FEDERAL PAYMENTS TO GRADUATE NURSE TRAINING PROGRAMS.

(a) FEDERAL PAYMENTS TO GRADUATE NURSE TRAINING PROGRAMS.—

(1) ENTITLEMENT.—Each eligible graduate nurse training program that in accordance with

paragraph (2) submits to the Secretary an application for calendar year 1997 or any subsequent calendar year shall be entitled to payments for such year to the program for the purpose specified in paragraph (3). The Secretary shall make such payments in an amount determined in accordance with subsection (b), and shall administer the payments as a grant. The preceding sentence constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the years specified in this subpart.

(2) APPLICATION FOR PAYMENTS.—For purposes of paragraph (1), an application for payments for a calendar year is in accordance with this paragraph if—

(A) the eligible graduate nurse training program involved submits the application not later than the date specified by the Secretary;

(B) the application provides such assurances as the Secretary may require that the program will expend payments only for the purpose described in paragraph (3);

(C) the application contains each funding agreement described in this subpart and the ap-

plication provides such assurances of compliance with the agreements as the Secretary may require;

(D) the application contains an assurance that the graduate nurse training program shall annually submit a report on the costs of clinical training of nurses in such manner as the Secretary may require; and

(E) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(3) PAYMENTS FOR OPERATION OF GRADUATE NURSE TRAINING PROGRAMS.—The purpose of payments under paragraph (1) is to assist an eligible graduate nurse training program with the costs of the clinical portions of training programs and supporting full-time enrollees in such training programs.

(b) AUTHORIZATION OF APPROPRIATIONS; ANNUAL AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—The appropriation authorized for each of the following calendar years for

making payments pursuant to subsection (a)(1) shall not be less than or in excess of the following:

(A) In the case of calendar year 1997, $200,000,000.

(B) In the case of each subsequent calendar year, the amount specified in subparagraph (A) increased by the product of such amount and the general health care inflation factor as defined in subsection (c).

(2) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE PROGRAMS.—Subject to the annual amount available under paragraph (1) for a calendar year, the amount of payments required under subsection (a) to be made to an eligible graduate nurse training program that submits to the Secretary an application for such year in accordance with subsection (a)(2) is an amount equal to the product of—

(A) the number of full-time enrollees in the program; and

(B) the estimated national average per full-time enrollee cost of each graduate nurse training program described in subsection (c)(1) for the calendar year (as determined by the Secretary), adjusted by a factor to reflect re-

gional differences in the applicable wage and wage related costs.

(3) LIMITATION.—If the annual amount available under paragraph (1) for a calendar year is insufficient for providing each eligible graduate nurse training program that submits to the Secretary an application for such year in accordance with subsection (a)(2) with the amount of payments determined under paragraph (2) for the program for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under subsection (a) for such year equals the total of such amount.

(c) DEFINITIONS.—For purposes of this part:

(1) ELIGIBLE GRADUATE NURSE TRAINING PROGRAM.—The term ''eligible graduate nurse training program'' means programs in advanced practice nurse education that are programs for education as nurse practitioners, programs for education as nurse midwives, programs for education as nurse anesthetists, and programs for training clinical nurse specialists that are—

(A) designated by the Secretary as eligible graduate nurse training programs;

(B) accredited programs that award a master degree or a post-nurse master certificate and provide training preparing an individual for practice as an advanced practice nurse; and

(C) existing programs funded in 1994 under section 822 or 831 of the Public Health Service Act that do not award a master degree may also be designated eligible programs.

(2) PROGRAMS FOR EDUCATION AS NURSE PRACTITIONERS.—The term ''programs for education as nurse practitioners'' means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as a nurse practitioners.

(3) PROGRAMS FOR EDUCATION AS NURSE MIDWIVES.—The term ''programs for education as nurse midwives'' means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as nurse midwives.

(4) PROGRAMS FOR TRAINING CLINICAL NURSE SPECIALISTS.—The term ''programs for training clinical nurse specialists'' means programs in advanced practice nurse education meeting the condi-

tions to be programs for which awards of grants and contracts may be made under section 821 of the Public Health Service Act.

(5) FULL-TIME ENROLLEE.—The term ''full-time enrollee'' means an individual who is enrolled in an advanced nurse training program and qualifies as a full-time student at the institution operating such program.

(6) GENERAL HEALTH CARE INFLATION FACTOR.—The term ''general health care inflation factor'', with respect to a year, has the meaning given such term in section 3033(e)(4)for such year.

SEC. 3072. NATIONAL COUNCIL ON GRADUATE NURSE TRAINING.

(a) IN GENERAL.—There is established within the Department of Health and Human Services a council to be known as the National Council on Graduate Nurse Training.

(b) DUTIES.—The National Council on Graduate Nurse Training shall—

(1) collect and analyze data on trends of supply and demand for advanced practice nurses;

(2) analyze and consider the supply of advanced practice nurses in the context of changes in the overall supply of health professionals;

(3) recommend priorities for support of graduate nurse training by type of programs described in section 3071(c);

(4) report to Congress annually and include in its report the number of students who graduated the previous year from funded programs; and

(5) consider and recommend appropriate standards for assessing the quality of advanced practice nursing clinical training programs.

(c) COMPOSITION.—

(1) IN GENERAL.—The membership of the National Council on Graduate Nurse Training shall include individuals who are appointed to the Council from among individuals who are not officers or employees of the United States. Such individuals shall be appointed by the Secretary, and shall include—

(A) a nurse practitioner, a nurse-midwife, a nurse anesthetist, and a clinical nurse specialist; and

(B) an official of a school of nursing, an official of a teaching hospital or other health services entity, and other experts in health care financing, delivery, and professions training.

(2) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the

National Council on Graduate Nurse Training shall include individuals designated by the Secretary, the Secretary of Veterans Affairs, and the Secretary of the Department of Defense to serve as members of the Council from among Federal officers or employees who are appointed by the President, by the Secretary, the Secretary of Veterans Affairs, the Secretary of Defense, or other Federal officers who are appointed by the President with the advice and consent of the Senate.

(d) CHAIR.—The Secretary shall, from among members of the National Council on Graduate Nurse Training appointed under subsection (c)(1), designate an individual to serve as the Chair of the Council.

Subpart C—Payments to Dental Schools

SEC. 3073. DENTAL SCHOOLS.

(a) FEDERAL PAYMENTS TO DENTAL SCHOOLS.—

(1) ENTITLEMENT.—Each eligible school of dentistry that in accordance with paragraph (2) submits to the Secretary an application for calendar year 1997 or any subsequent calendar year shall be entitled to payments for such year to the program for the purpose specified in paragraph (3). The Secretary shall make such payments in an amount determined in accordance with subsection (b), and

shall administer the payments as a grant. The preceding sentence constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the years specified in this subpart.

(2) APPLICATION FOR PAYMENTS.—For purposes of paragraph (1), an application for payments for a calendar year is in accordance with this paragraph if—

(A) the dean (or appropriate presiding official of the eligible school of dentistry involved) submits the application not later than the date specified by the Secretary;

(B) the application provides such assurances as the Secretary may require that the program will expend payments only for the purpose described in paragraph (3);

(C) the application contains each funding agreement described in this subpart and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(D) the application is in such form, is made in such manner, and contains such agree-

ments, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

(3) PURPOSE.—With respect to an eligible school of dentistry, the purpose of payments under paragraph (1) is to assist such school with the costs of training dentists, including unreimbursed oral health care costs. A funding agreement for such payments is that the school of dentistry involved will expend the payments only for direct expenses determined as allowable by the Secretary.

(4) SCHOOL OF DENTISTRY.—For purposes of this subtitle, the term ''eligible school of dentistry'' means an accredited public or nonprofit private school in a State that provides training leading to a degree of doctor of dentistry or an equivalent degree, and any advanced training relating to such training.

(b) AUTHORIZATION OF APPROPRIATIONS; ANNUAL AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—The appropriation authorized for each of the following calendar years for making payments pursuant to subsection (a)(1) shall not be less than or in excess of the following:

(A) In the case of each of calendar years 1997, 1998, 1999 and 2000, $50,000,000.

(B) In the case of each subsequent calendar year, the amount specified in subparagraph (A) increased by the product of such amount and the general health care inflation factor as defined in subsection (c).

(2) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE PROGRAMS.—Subject to the annual amount available under paragraph (1) for a calendar year, the amount of payments required under subsection (a) to be made to an eligible school of dentistry that submits to the Secretary an application for such year in accordance with subsection (a)(2) is an amount equal to the sum of—

(A) 75 percent of the amount available pursuant to paragraph (1) multiplied by the ratio of the number of full-time equivalent training participants in the school of dentistry (determined in accordance with a method to be developed by the Secretary) to the national number of full-time equivalent training participants in all schools of dentistry (as determined by the Secretary) in the academic year 1993–1994; and

(B) 25 percent of the amount available pursuant to paragraph (1) multiplied by the

ratio of the unreimbursed oral health care costs of the school of dentistry to the national unreimbursed oral health care costs of all schools of dentistry (as determined by the Secretary).

(c) ELIGIBLE SCHOOL OF DENTISTRY.—For purposes of this subpart, the term ''eligible school of dentistry'' with respect to a calendar year involved, means a school of dentistry that submits to the Secretary an application for such year in accordance with subsection (a)(2).

Subpart D—Payments to Schools of Public Health

SEC. 3074. SCHOOLS OF PUBLIC HEALTH.

(a) FEDERAL PAYMENTS TO SCHOOLS OF PUBLIC HEALTH.—

(1) ENTITLEMENT.—Each eligible school of public health that in accordance with paragraph (2) submits to the Secretary an application for calendar year 1997 or any subsequent calendar year shall be entitled to payments for such year to the program for the purpose specified in paragraph (3). The Secretary shall make such payments in an amount determined in accordance with subsection (b), and shall administer the payments as a grant. The preceding sentence constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding

for such payments in the amounts, and for the years specified in this subpart.

(2) APPLICATION FOR PAYMENTS.—For purposes of paragraph (1), an application for payments for a calendar year is in accordance with this paragraph if—

(A) the dean (or appropriate presiding official of the eligible school of public health involved submits the application not later than the date specified by the Secretary;

(B) the application provides such assurances as the Secretary may require that the program will expend payments only for the purpose described in paragraph (3);

(C) the application contains each funding agreement described in this subpart and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(D) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

(3) PURPOSE.—With respect to an eligible school of public health, the purpose of payments under this paragraph is to assist such school with the costs of training public health professionals in disease prevention and health promotion, the management of health services, health care policy and health care organization, public health practice, outcomes and quality of care, and epidemiologic and biostatistical research. A funding agreement for such payments is that the school of public health involved will expend the payments only for direct expenses determined as allowable by the Secretary.

(4) SCHOOL OF PUBLIC HEALTH.—For purposes of this subpart, the term ''school of public health'' means an accredited public or non-profit private school in a State that—

(A) is located within a university accredited by one of the recognized regional accrediting bodies;

(B) has as its central concept the prevention of disease and the promotion of health through research, education and professional practice;

(C) offers the Master of Public Health degree;

(D) provides, with sufficient faculty and other resources, education at the master degree level with an emphasis in at least each of the following areas:

(i) Behavioral sciences.

(ii) Biostatistics.

(iii) Environmental and health sciences.

(iv) Epidemiology.

(v) Health services administration; and

(E) offers graduate education at the doctoral degree level in at least 1 of the 5 areas described in subparagraph (D).

(b) AUTHORIZATION OF APPROPRIATIONS; ANNUAL AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—The appropriation authorized for each of the following calendar years for making payments pursuant to subsection (a)(1) shall not be less than or in excess of the following:

(A) In the case of each of calendar years 1997, 1998, 1999 and 2000, $25,000,000.

(B) In the case of each subsequent calendar year, the amount specified in subparagraph (A) increased by the product of such

amount and the general health care inflation factor.

(2) PAYMENTS TO SCHOOLS OF PUBLIC HEALTH.—

(A) IN GENERAL.—The amount required under subsection (a) to be made to an eligible school of public health is an amount equal to the product of—

(i) the amount available for making such payments for the calendar year pursuant to paragraph (1); and

(ii) the percentage constituted by the ratio of the number of full-time students enrolled in degree programs in such schools and the number of full-time equivalents of part-time students enrolled in degree programs in such school (determined in accordance with subparagraph (B)) to the national number of all such students in all schools of public health in the academic year beginning in the previous fiscal year.

(B) FULL-TIME EQUIVALENCE.—For the purposes of this paragraph, the number of full-time equivalents of part-time students for a

school of public health for any school year is a number equal to—

(i) the total number of credit hours of instructions in such year for which study leading to a graduate degree in public health or an equivalent degree, divided by

(ii) the number of credit hours of instructions which a student pursuing a full-time course of study leading to a graduate degree in public health or equivalent degree.

(C) NEW SCHOOL.—In the case of a new school of public health which applies for a grant under this section in the fiscal year preceding the fiscal year in which it will admit its first class, the enrollment for purposes of subparagraph (A)(ii) shall be the number of full-time students which the Secretary determines, on the basis of assurances provided by the school, will be enrolled in the school, in the fiscal year after the fiscal year in which the grant is made.

(c) ELIGIBLE SCHOOL OF PUBLIC HEALTH.—The term ''eligible school of public health'' with respect to the calendar year involved, means a school of public health

that submits to the Secretary for such year in accordance with subsection (a)(2).

PART 3—RELATED PROGRAMS

Subpart A—Workforce Development

SEC. 3081. PROGRAMS OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—

(1) FUNDING.—For purposes of carrying out the programs described in this section, there is authorized to be appropriated $100,000,000 for each of the fiscal years 1995 and 1996, and $150,000,000 for each of the fiscal years 1997 through 2000 (in addition to amounts that may otherwise be authorized to be appropriated for carrying out the programs).

(2) ADMINISTRATION.—The programs described in this section and carried out with amounts made available under subsection (a) shall be carried out by the Secretary of Health and Human Services.

(b) PRIMARY CARE PHYSICIAN AND PHYSICIAN ASSISTANT TRAINING.—For purposes of subsection (a), the programs described in this section include programs to support projects to train additional numbers of primary care physicians and physician assistants, including projects to enhance community-based generalist training

for medical students, residents, and practicing physicians; to retrain mid-career physicians previously certified in a nonprimary care medical specialty; to expand the supply of physicians with special training to serve in rural and inner-city medically underserved areas; to support expansion of service-linked educational networks that train a range of primary care providers in community settings; to provide for training in managed care, cost-effective practice management, and continuous quality improvement; to provide interdisciplinary training for medical students, residents or practicing physicians, and dental students, residents, and dental hygienists, to deliver primary care to individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age; and to develop additional information on primary care workforce issues as required to meet future needs in health care.

(c) TRAINING OF UNDERREPRESENTED RACIAL AND ETHNIC MINORITIES AND DISADVANTAGED PERSONS.—For purposes of subsection (a), the programs described in this section include a program to support projects to increase the number of racial and ethnic underrepresented minority and disadvantaged persons in medicine, osteopathy, dentistry, advanced practice nursing, public health, psychology, and other health professions, including

projects to provide continuing financial assistance for such persons entering health professions training programs; for financial assistance for facility renovation or construction; to increase support for recruitment and retention of such persons in the health professions; to maintain efforts to foster interest in health careers among such persons at the preprofessional level; and to increase the number of racial and ethnic minority health professions faculty at programs that have a significant number of underrepresented racial and ethnic minorities.

(d) EXPANDING RURAL HEALTH CAREER OPPORTUNITIES AND RETENTION EFFORTS.—

(1) IN GENERAL.—For purposes of subsection (a), the programs described in this section include programs to support projects to increase the number of individuals living in rural, underserved communities who enter the fields of medicine, osteopathy, dentistry, advanced practice nursing, public health, psychology, and other health professions, and to encourage the retention of such health care professionals in rural, underserved communities.

(2) RURAL HEALTH CAREER TRAINING.—Projects to increase the number of individuals recruited from rural, underserved areas include projects—

(A) to provide continuing financial assistance for such persons entering health professions education and training programs;

(B) to increase efforts to foster interest in health careers among such persons at the preprofessional level;

(C) to foster the development of training curricula appropriate to rural health care settings; and

(D) to increase support for recruitment of such persons in the health professions.

(3) RETENTION OF RURAL HEALTH CARE PROVIDERS.—Projects to encourage the retention of individuals providing health care in rural, underserved areas include projects—

(A) to establish State and regional locum tenans programs in rural health care settings so that substitute health care providers are available when permanent staff is absent from the health care setting;

(B) to implement programs to foster interdisciplinary team approaches to rural health training and practice; and

(C) to develop state-of-the-art network telecommunications and telemedicine systems to

link rural health professionals to other health care providers and academic health care centers.

(e) NURSE TRAINING.—For purposes of subsection (a), the programs described in this section include a program to support projects to support midlevel provider training and address priority nursing workforce needs, including projects to train additional nurse practitioners and nurse midwives; to support baccalaureate-level nurse training programs providing preparation for careers in teaching, community health service, and specialized clinical care; to train additional nurse clinicians and nurse anesthetists; to support interdisciplinary school-based community nursing programs; and to promote research on nursing workforce issues.

(f) INAPPROPRIATE PRACTICE BARRIERS; FULL UTILIZATION OF SKILLS.—For purposes of subsection (a), the programs described in this section include a program—

(1) to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants, and to otherwise support efforts to remove inappropriate barriers to practice by such nurses and such physician assistants; and

(2) to promote the full utilization of the professional education and clinical skills of advanced practice nurses and physician assistants.

(g) ADVISORY BOARD ON HEALTH CARE WORKFORCE DEVELOPMENT.—

(1) IN GENERAL.—The Secretary shall establish an Advisory Board known as the National Advisory Board on Health Care Workforce Development to advise, consult with, and make recommendations to the Secretary and to the Secretary of Labor on matters relating to—

(A) health care worker supply and its adequacy to assure proper health care delivery system staffing in both rural and urban areas; and

(B) the impact of this Act, and of related changes in law regarding health care, on health care workers and the needs of such workers, including needs regarding education, training, and other career development matters and the relationship of health care workers to health care professionals.

(2) COMPOSITION.—The Board established under paragraph (1) shall be composed of the following members with expertise in health care workforce

issues appointed by the Secretary in consultation with the Secretary of Labor:

(A) Five representatives of labor organizations representing health care workers.

(B) Five representatives of health care delivery institutions.

(C) Two representatives from health care education organizations.

(D) Two representatives from consumer organizations.

(3) ASSISTANCE.—The Secretary shall provide the Board with such administrative assistance as may be necessary for the Board to carry out this subsection.

(h) OTHER PROGRAMS.—For purposes of subsection (a), the programs described in this section include a program to train health professionals and administrators in managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.

(i) RELATIONSHIP TO EXISTING PROGRAMS.—This section may be carried out through programs established in title VII or VIII of the Public Health Service Act, as appropriate and as consistent with the purposes of such programs.

(j) MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES.—Title VII of the Public Health Service Act is amended by inserting after section 778, the following new section:

"SEC. 779. MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES.

''(a) IN GENERAL.—The Secretary may make grants and enter into contracts with university affiliated programs, schools of medicine, and schools of dentistry to assist in meeting the costs of such programs or schools to—

''(1) improve the interdisciplinary training of primary care physicians and dentists in the health care services needs of individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age;

''(2) develop, evaluate, and disseminate curricula relating to the health care service needs of individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those individuals who are more than 18 years of age;

''(3) support the training and retraining of faculty to provide such instruction; and

''(4) support continuing education of health professionals who provide health care services and

support to individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated, $10,000,000 for each of the fiscal years 1995 through 2000.''.

SEC. 3082. PROGRAMS OF THE SECRETARY OF LABOR.

(a) IN GENERAL.—

(1) FUNDING.—For purposes of carrying out the programs described in this section, and for carrying out section 3083, there is authorized to be appropriated $200,000,000 for fiscal year 1995 and each subsequent fiscal year (in addition to amounts that may otherwise be authorized to be appropriated for carrying out the programs).

(2) ADMINISTRATION.—The programs described in this section and carried out with amounts made available under subsection (a) shall be carried out by the Secretary of Labor (in this section referred to as the ''Secretary'').

(b) RETRAINING PROGRAMS; ADVANCED CAREER POSITIONS; WORKFORCE ADJUSTMENT PROGRAMS.—

(1) IN GENERAL.—For purposes of subsection (a), the programs described in this section are the following:

(A) A program for skills upgrading and occupational retraining (including retraining health care workers for more advanced positions as technicians, nurses, and physician assistants), and for quality and workforce improvement.

(B) A demonstration program to assist workers in health care institutions in obtaining advanced career positions.

(C) A program to develop and operate health care industry worker job banks in local employment services agencies or one-stop career centers, subject to the following:

(i) Such job banks shall be available to all health care providers in the community involved.

(ii) Such job banks shall begin operation not later than 90 days after the date of the enactment of this Act.

(iii)(I) With respect to each affected community, the local employment service agency or one-stop career center serving

such community shall be allocated not less than one counselor whose responsibility it shall be to develop and operate health and insurance industry worker job banks. Where the impact of health care industry restructuring in the affected community is such that the functions required under this clause cannot be adequately provided by one counselor, additional counselors shall be allocated to carry out such functions.

(II) Such counselor shall solicit job openings from local health care industry employers, maintain frequent contacts with these and other employers, and monitor and update all job listings appropriate for displaced health care workers seeking employment.

(III) The local employment service agency or one-stop career center shall provide directly, or facilitate the provision of, labor exchange services to displaced health care industry workers, including assessment, counseling, testing, job-search assistance, job referral and placement, and re-

ferral to training and educational programs, where appropriate.

(IV) The Secretary of Labor shall develop performance goals for the effective performance of such job banks with respect to the number and quality of jobs listed, the degree of participation by employers in the affected community, and success in placement of job bank users in jobs listed, taking into account specific geographic, economic and labor market characteristics of the community served.

(D) A program to provide for joint labor-management decision-making in the health care sector on workplace matters related to the restructuring of the health care delivery system provided for in this Act.

(E) A program to collect data regarding the adequacy of the supply of health care workers by occupation and sector of the health industry in light of existing and projected demand for such workers.

(F)(i) A program to encourage the adoption and utilization of high performance, high quality health care delivery systems, including

employee participation committees and employee team systems that will contribute to more effective health care by increasing the role and the area of independent decisionmaking of health care workers.

(ii) For purposes of this subparagraph, the term ''employee participation committees'' means committees of workers independently selected by and from a facility's nonmanagerial workforce, or selected by unions where collective bargaining agreements are in effect, and which operate independently without employer interference and consult with management on issues of efficiency, productivity, and quality of care, except that an employee participation committee established under and operating in conformity with this subparagraph shall not be considered a labor organization within the meaning of section 2(5) of the National Labor Relations Act or a representative within the meaning of section 1, sixth, of the Railway Labor Act.

(2) USE OF FUNDS.—Amounts made available under subsection (a) for carrying out this section may be expended for program support, faculty development, trainee support, workforce analysis, and dis-

semination of information, as necessary to produce required performance outcomes.

(c) CERTAIN REQUIREMENTS FOR PROGRAMS.—In carrying out the programs described in subsection (b), the Secretary shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Explicit, clearly defined skill requirements developed for all the positions and projections of the number of openings for each position.

(2) Opportunities for internal career movement.

(3) Opportunities to work while training or completing an educational program.

(4) Evaluation and dissemination.

(5) Training opportunities in several forms, as appropriate.

(d) ADMINISTRATIVE REQUIREMENTS.—In carrying out the programs described in subsection (b), the Secretary shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Joint labor-management implementation and administration.

(2) Discussion with employees as to training needs for career advancement.

(3) Commitment to a policy of internal hirings and promotion.

(4) Provision of support services.

(5) Consultations with employers and with organized labor.

SEC. 3083. REQUIREMENT FOR CERTAIN PROGRAMS REGARDING REDEPLOYMENT OF HEALTH CARE WORKERS.

(a) STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.—With respect to the plan required in section 2102(a) (for State programs for home and community-based services for individuals with disabilities under part 1 of subtitle B of title II), the plan shall, in addition to requirements under such part, provide for the following:

(1) Before initiating the process of implementing the State program under such plan, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(2) Negotiations under paragraph (1) will address the following:

(A) The impact of the implementation of the program upon the workforce.

(B) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the program.

(3) The plan will provide evidence that there has been compliance with paragraphs (1) and (2), including a description of the results of the negotiations.

(b) PLAN FOR INTEGRATION OF MENTAL HEALTH SYSTEMS.—With respect to the plan required in section 3511(a) (relating to the integration of the mental health and substance abuse services of a State and its political subdivisions with the mental health and substance abuse services included in the comprehensive benefit package under title I), the plan shall, in addition to requirements under such section, provide for the following:

(1) Before initiating the process of implementing the integration of such services, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(2) Negotiations under paragraph (1) will address the following:

(A) The impact of the proposed changes upon the workforce.

(B) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the proposed changes.

(3) The plan will provide evidence that there has been compliance with paragraphs (1) and (2),

including a description of the results of the negotiations.

Subpart B—Transitional Provisions for Workforce Stability

SEC. 3091. APPLICATION.

(a) LIMITATION TO TRANSITION PERIOD.—The provisions of this subpart are intended to minimize, to the extent possible, disruptions in established employment relationships during the period of transition to a restructured health care delivery system, and shall terminate December 31, 2000.

(b) HEALTH CARE ENTITIES COVERED BY SUBPART.—The provisions of this subpart, including references to displacing employers, hiring employers, successors and contractors, apply only to health care entities that employ more than 25 individuals.

SEC. 3092. DEFINITIONS.

(a) HEALTH CARE ENTITY.—As used in this subpart, the term ''health care entity'' includes individuals, sole proprietorships, partnerships, associations, business trusts, corporations, governmental institutions, and public agencies (including state governments and political subdivisions thereof) that—

(1) provide health care services under title I (including nonmandatory health care services under

title I) or under the amendments made or programs referred to in titles IV and VIII; or

(2) provide necessary related services, including administrative, food service, janitorial or maintenance services, to an entity that provides health care services (as described in subparagraph (1));

except that an entity that solely manufactures or provides goods or equipment to a health care entity shall not be considered a health care entity.

(b) AFFILIATED ENTERPRISE.—As used in this subpart, the term ''affiliated enterprise'' means a health care entity that, together with the displacing employer, is considered a single employer as defined under 414 of the Internal Revenue Code of 1986.

(c) PREFERENCE ELIGIBLE EMPLOYEE.—As used in this subpart, the term ''preference eligible employee'' means an employee who—

(1) has been employed for in excess of 1 year by a health care entity; and

(2) has been displaced by or has received notice of an impending displacement by such entity.

(d) DISPLACEMENT.—As used in this subpart, the term ''displacement'' includes a lay off, termination, significant cutback in paid work hours, or other loss of employment, except that a discharge for just cause shall not

constitute a displacement within the meaning of this paragraph.

SEC. 3093. OBLIGATIONS OF DISPLACING EMPLOYER AND AFFILIATED ENTERPRISES IN EVENT OF DISPLACEMENT.

(a) NOTICE.—A health care entity which displaces a preference eligible employee shall provide such employee with—

(1) written notice, no later than the date of displacement, of employment rights under this subpart, including employment rights with respect to affiliated enterprises of the displacing employer; and

(2) notice of any existing or subsequent vacancies with the displacing employer or an affiliated enterprise, which notice may be given by posting of such vacancies wherever notices to applicants for employment are customarily posted, by listing such vacancies with the local employment services agency, or in such other manner as the Secretary of Labor, by regulation, may hereafter specify.

Any such vacancy shall remain open for applications by preference eligible employees for not less than 14 calendar days from the date on which the initial notice is provided.

(b) HIRING PREFERENCE.—

(1) IN GENERAL.—A qualified preference eligible employee who applies during the notice period described in subsection (a)(2) for a vacant position with the displacing employer or an affiliated enterprise, which position is in the employee's occupational specialty and is located in the same State or Standard Metropolitan Statistical Area in which the employee was employed prior to the displacement, shall be given the right to accept or decline the position before the employer may offer the position to a nonpreference eligible employee.

(2) MULTIPLE APPLICATIONS.—When considering applications from more than one qualified preference eligible employee, the hiring health care entity shall have discretion as to which of such employees will be offered the position.

(3) EMPLOYMENT QUALIFICATIONS.—Nothing in this subsection shall be construed to prohibit the hiring health care entity from establishing reasonable employment qualifications for a vacancy to which this subpart applies, except that employees who performed essentially the same work prior to their displacement shall be deemed presumptively qualified for comparable positions.

(c) TERMINATION OF PREFERENCE ELIGIBILITY.—A displaced employee's preference eligibility shall terminate—

(1) at such time as the displaced employee obtains substantially equivalent employment with the displacing employer; or

(2) if the employee does not obtain such employment—

(A) with respect to health care entities other than the displacing employer, 2 years after the date of the displacement; or

(B) with respect to the displacing employer, upon the termination of this subpart pursuant to section 3081(a).

SEC. 3094. EMPLOYMENT WITH SUCCESSORS.

A health care entity that succeeds another health care entity through merger, consolidation, acquisition, contract, or other similar manner shall provide employees of the previous health care entity who would otherwise be displaced the right to continued employment in the job positions held by such employees prior thereto, unless the employer can establish that such positions no longer exist.

SEC. 3095. COLLECTIVE BARGAINING OBLIGATIONS DURING TRANSITION PERIOD.

(a) CONTINUATION OF PREVIOUSLY RECOGNIZED BARGAINING REPRESENTATIVES AND AGREEMENTS.—If a majority of the employees in an appropriate bargaining unit consists of employees who were previously covered by a bargaining agreement or represented by an exclusive representative with respect to terms and conditions of employment, and there has not been a substantial change in the operations performed by the employees in that unit, the employer shall recognize such representative as the exclusive representative for the unit and shall assume the bargaining agreement, except that where application of this subsection would result in the recognition of more than one bargaining representative for a single unit, the question concerning which representative shall be recognized as the exclusive representative for the unit shall be resolved in accordance with applicable Federal or State law.

(b) JOINT EMPLOYER STATUS.—If employees of a contractor are assigned on a regular basis to perform work on the premises of a contracting entity and the tasks performed by these employees are functionally integrated with the operations of the contracting entity on whose premises such employees work, both the contractor and the contracting entity shall be considered joint employers of the

employees with respect to work performed on those premises for purposes of determining compliance with labor relations laws. Employees of such joint employers may not be excluded from a bargaining unit within either entity on the basis of such joint employer status.

SEC. 3096. GENERAL PROVISIONS.

(a) REGULATIONS.—Not later than 120 days after the date of enactment of this Act, the Secretary shall promulgate regulations to implement the requirements of section 3093.

(b) OTHER LAWS.—The standards and requirements of this subpart shall not preempt or excuse noncompliance with any other applicable Federal or State law, regulation or municipal ordinance that establishes additional notice and preference standards or requirements concerning employee dislocation, employee representation, or collective bargaining.

(c) RULES OF CONSTRUCTION.—Nothing in this subpart shall be construed—

(1) to excuse or otherwise limit the obligation of an employer to comply with any collective bargaining agreement or any employment benefit plan that provides rights to employees in addition to those provided under this subpart; or

(2) to require an employer to recognize or bargain with a labor organization in violation of State law.

(d) ENFORCEMENT.—Unless otherwise specifically provided in this subpart, the enforcement provisions of section 107 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2617) shall apply with respect to the enforcement of the individual rights, including notice requirements, provided under section 3093. The collective bargaining and contractual rights provided under sections 3094 and 3095 shall be enforced through administrative and judicial procedures otherwise provided under Federal or State law with respect to such rights.

Subtitle B—Academic Health Centers

SEC. 3131. DISCRETIONARY GRANTS REGARDING ACCESS TO CENTERS.

(a) RURAL INFORMATION AND REFERRAL SYSTEMS.—The Secretary may make grants to eligible centers for the establishment and operation of information and referral systems to provide the services of such centers to rural health plans.

(b) OTHER PURPOSES REGARDING URBAN AND RURAL AREAS.—The Secretary may make grants to community- and provider-based health plans under section

1651(d) to carry out activities (other than activities carried out under subsection (a)) for the purpose of providing the services of eligible centers to residents of rural or urban communities who otherwise would not have adequate access to such services.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriate, $3,000,000 for fiscal year 1995, $4,000,000 for fiscal year 1996, and $5,000,000 for each of the fiscal years 1997 through 2000.

Subtitle C—Health Research Initiatives

PART 1—PROGRAMS FOR CERTAIN AGENCIES

SEC. 3201. BIOMEDICAL, BEHAVIORAL AND HEALTH SERVICES RESEARCH.

(a) FINDINGS.—Congress finds the following:

(1) Nearly 4 of 5 peer reviewed research projects deemed worthy of funding by the National Institutes of Health are not funded, and 9 of 10 peer reviewed research projects deemed worthy of funding by the Agency for Health Care Policy and Research are not funded.

(2) Less than 2 percent of the nearly one trillion dollars our Nation spends on health care is de-

voted to health research, while the defense industry spends 15 percent of its budget on research.

(3) Public opinion surveys have shown that Americans want more Federal resources put into health research and support by having a portion of their health insurance premiums set aside for this purpose.

(4) Ample evidence exists to demonstrate that health research has improved the quality of health care in the United States. Advances such as the development of vaccines, the cure of many childhood cancers, drugs that effectively treat a host of diseases and disorders, a process to protect our Nation's blood supply from the HIV virus, progress against cardiovasculor disease including heart attack and stroke, and new strategies for the early detection and treatment of diseases such as colon, breast, and prostate cancer clearly demonstrates the benefits of health research.

(5) Among the most effective methods to control health care costs are the prevention of intentional and unintentional injury and the prevention and cure of disease and disability, thus, health research which holds the promise of prevention of intentional and unintentional injury and cure and pre-

vention of disease and disability is a critical component of any comprehensive health care reform plan.

(6) The state of our Nation's research facilities at the National Institutes of Health and at universities is deteriorating significantly. Renovation and repair of these facilities are badly needed to maintain and improve the quality of research.

(7) Because the Omnibus Budget Reconciliation Act of 1993 freezes discretionary spending for the next 5 years, the Nation's investment in health research through the National Institutes of Health and the Agency for Health Care Policy and Research is likely to decline in real terms unless corrective legislative action is taken.

(8) A health research fund is needed to maintain our Nation's commitment to health research and to increase the percentage of approved projects which receive funding at the National Institutes of Health and the Agency for Health Care Policy and Research to at least 33 percent.

(9) Private sector investment in research and development has been responsible for the vast majority of new developments in pharmaceuticals, medical devices, biotechnology and other health care innovations. Over 90 percent of the most prescribed drugs

in the United States were discovered by the research-based pharmaceutical industry.

(10) United States industry is the preeminent world leader in the research, development and delivery of innovative therapies that improve the quality of care for people throughout the world.

(11) Global health care budgets may constrict private sector investment in research and development. Further, they may be inconsistent with the goal of developing promising new cost effective treatment therapies.

(b) AVAILABILITY OF FUNDS.—

(1) IN GENERAL.—With respect to each calendar year, the Secretary shall pay, from funds in the Treasury not otherwise appropriated, for activities under this section, an amount equal to 0.25 percent in 1996 and subsequent years, of all private premiums required to be paid in accordance with the Act.

(2) DEFINITION.—For purposes of this subsection, the term ''private health premiums'' means all premium related payments made by employers, individuals, and families for coverage under this Act.

(3) MAINTENANCE OF EFFORT.—No amounts made available under this subsection shall replace or

reduce the amount of appropriations for the National Institutes of Health or the Agency for Health Care Policy and Research.

(c) PURPOSES FOR EXPENDITURES.—Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 404F. EXPENDITURES FOR BIOMEDICAL AND BEHAVIORAL RESEARCH.

''(a) IN GENERAL.—With respect to 80 percent of the amounts made available under section 3201 of the Health Security Act in a fiscal year, the Secretary shall distribute—

''(1) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

''(A) for carrying out the responsibilities of the Office of the Director, in including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Alternative Medicine and the Office of Rare Diseases Research; and

''(B) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

''(2) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

''(3) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV with respect to health information communications; and

''(4) the remainder of such amounts during any fiscal year to member institutes of the National Institutes of Health and Centers in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

''(b) PLANS OF ALLOCATION.—The amounts transferred under subsection (a) shall be allocated by the Director of NIH or the various directors of the institutes and

centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.''.

SEC. 3202. HEALTH SERVICES RESEARCH.

(a) IN GENERAL.—The Secretary shall distribute the remainder of the amounts made available under section 3201 in a fiscal year (not to exceed 20 percent of the total of amounts available in a fiscal year under such section), to the Agency for Health Care Policy and Research for policy-initiated and investigator-initiated research.

(b) RESEARCH ON HEALTH CARE REFORM.—Section 902 of the Public Health Service Act (42 U.S.C. 299a), as amended by section 2(b) of Public Law 102–410 (106 Stat. 2094), is amended by adding at the end the following subsection:

''(f) RESEARCH ON HEALTH CARE REFORM.—

''(1) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support research on the reform of the health care system of the United States, as directed by the Secretary.

''(2) PRIORITIES.—In carrying out paragraph (1), the Administrator shall give priority to the following:

''(A) Conducting and supporting research on the appropriateness and effectiveness of al-

ternative clinical strategies (including community-based programs and preventive services), the quality and outcomes of care, and administrative simplification.

''(B) Conducting and supporting research on the appropriateness and effectiveness of alternative community-based and clinical strategies including integrating preventive services into primary care, the effectiveness of preventive counseling and health education, and the efficacy and cost-effectiveness of clinical preventive services.

''(C) Conducting and supporting research on consumer choice and information resources; on the role of shared decision making in enhancing patient and provider therapeutic options; the effects of health care reform on health delivery systems; methods for risk adjustment; factors influencing access to health care for vulnerable populations, including children, persons with low-income, persons with disabilities, or individuals with chronic or complex health conditions, and primary care.

''(D) The development of clinical practice guidelines consistent with section 913, the dis-

semination of such guidelines consistent with section 903, and the assessment of the effectiveness of such guidelines.''.

SEC. 3203. AHCPR GUIDELINES AND STANDARDS.

(a) TRAINEESHIP PROGRAM.—Section 902(c) of the Public Health Service Act (42 U.S.C. 299a(c)) is amended—

(1) by redesignating the matter following the subsection heading as paragraph (1) and realigning the margin of such so as to align with the margin of section 903(a)(1);

(2) by inserting before ''The Administrator'' the following: ''IN GENERAL.—''; and

(3) by adding at the end thereof the following new paragraph:

''(2) TRAINEESHIP PROGRAM.—The Administrator shall establish a traineeship program for not to exceed 25 investigators, to enable such investigators to carry out research at the Agency that would benefit the mission of the Agency and further the educational needs of such investigators. Such investigator positions shall not be counted against any Federal employment ceilings affecting the Agency.''.

(b) PRINTING SERVICES.—Section 902 of such Act (42 U.S.C. 299a) is amended by adding at the end thereof the following new subsection:

''(f) AUTHORITY TO CONTRACT FOR PRINTING SERVICES.—The Administrator may publish or arrange for the publication of research findings and practice guidelines, without regard to section 501 of title 44, United States Code.''.

(c) PANELS.—Section 913(a) of the Public Health Service Act (42 U.S.C. 299b–2(a)) is amended by adding at the end thereof the following new flush sentence:

''Panels convened for the purpose of carrying out paragraphs (1) and (2) shall not be considered advisory committees within the meaning of section 3(2) of the Federal Advisory Committee Act (5 U.S.C. App. 3(2)), and prior to publication by the Administrator, clinical practice guidelines, performance measures, and review criteria as described in section 912(a) are not subject to the requirements of section 552 of title 5, United States Code.''.

(d) ARRANGEMENTS.—Section 913 of such Act (42 U.S.C. 299b–2) is amended by adding at the end thereof the following new subsection:

''(d) ARRANGEMENTS.—

''(1) IN GENERAL.—Upon the request of a public or private entity, the Administrator may collect,

tabulate, and analyze statistics, perform technology assessments, carry out health services and outcomes and effectiveness research, and facilitate the development of clinical practice guidelines under arrangements with such entities under which such entities compensate the Administrator for the costs of the services provided.

''(2) AMOUNTS AND PERSONNEL.—Amounts collected from payments under this subsection shall be available to the Administrator for obligation until expended, and personnel used to provide such services shall not be counted against any Federal employment ceilings affecting the Agency.''.

(e) TECHNICAL AMENDMENT.—Section 913(c) of such Act (42 U.S.C. 299b–2(c)) is amended by moving the first sentence so as appear after the subsection heading.

PART 2—FUNDING FOR PROGRAM

SEC. 3211. AUTHORIZATIONS OF APPROPRIATIONS.

(a) RELATION TO OTHER FUNDS.—Amounts made available under this subtitle are in addition to any other authorizations of appropriations that are available to carry out section 3202 and the amendments made by such section.

(b) TRIGGER AND RELEASE OF MONIES.—No expenditure shall be made pursuant to section 3201(b) during any fiscal year in which the annual amount appropriated for the National Institutes of Health and the Agency for Health Care Policy and Research is less than the amount so appropriated for the prior fiscal year. With respect to amounts available for expenditure pursuant to section 3201(b) which, as a result of the application of this subsection remain unexpended, such amounts shall be obligated by the Secretary of Health and Human Services under the public health initiative under subtitle H.

PART 3—MEDICAL TECHNOLOGY IMPACT STUDY

SEC. 3221. MEDICAL TECHNOLOGY IMPACT STUDY.

(a) ASSESSMENT OF THE STANDARD IMPACT OF MEDICAL TECHNOLOGIES.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Agency for Health Care Policy and Research (hereafter referred to in this section as the ''Administrator''), shall undertake an interdisciplinary study (to be known as the ''Medical Technology Impact Study'') to assess the overall economic costs, economic benefits, and effect on patient outcomes of medical technologies used in treating each of a list of target diseases and conditions. The Secretary shall submit the report of the Admin-

istrator to Congress (in accordance with subsection (c)) concerning the results of the study and may provide any recommendations determined to be necessary to ensure the availability, access, and appropriate use of medical technologies to improve the quality of health care in the United States.

(2) PURPOSE.—The purpose of the study under paragraph (1) is to assess the impact of old, new, and emerging medical technologies on health care costs, social costs, and patient outcomes, and to identify the factors, including government and private payor reimbursement policies, that impede or encourage innovation that improves patient outcomes. Congress intends that the study complement the technology assessment, outcomes research, and guideline development activities authorized under title IX of the Public Health Service Act by providing a comprehensive context for understanding the economic and social factors related to the development and use of medical technologies.

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

(A) ECONOMIC BENEFITS.—The term ''economic benefits'' may include, based on available data—

(i) reductions in the economic costs of disease;

(ii) increases in employment attributable to the medical technology industry;

(iii) increases in Federal and State tax revenues attributable to the medical technology industry and its employees;

(iv) improvements in the balance of trade deficit attributable to the medical technology industry; and

(v) other benefits that are determined by the Advisory Committee established under subsection (b) to be relevant to assessing the impact of medical technology.

(B) ECONOMIC COSTS.—The term 'economic costs' may include, based on available data—

(i) the financial costs to the health care system of diagnosing and treating disease, including the costs of nontreatment and palliative care;

(ii) the financial costs to employers resulting from worker illness, including the costs of productivity losses and worker absenteeism;

(iii) the financial costs to families resulting from illness of a family member, including costs associated with loss of income, hiring of caretakers, and long term and hospice care;

(iv) the financial costs to government of illness, including reductions in income tax revenues attributable to worker illness and worker related injuries and increases in transfer payments, including unemployment, disability, welfare, and survivor benefit payments, made to individuals and families on account of illness; and

(v) other costs that are determined by the Advisory Committee established under subsection (b) to be relevant to assessing the impact of medical technology.

(C) MEDICAL TECHNOLOGIES.—The term 'medical technologies' includes drugs, biologics (including vaccines), medical devices, drug delivery systems, and surgical services and other procedures for preventing, diagnosing, and treating diseases or health conditions.

(D) MEDICAL TECHNOLOGY INDUSTRY.—The term 'medical technology industry' includes

the biotechnology, pharmaceutical, and medical device industries, and such other industries that invent, develop, or market medical technologies.

(E) PATIENT OUTCOMES.—The term 'patient outcomes' may include—

(i) changes in clinical outcomes, including stabilization of patients with progressive disease or health conditions, resulting from the use of safe and effective medical technology in prevention, diagnosis, or treatment;

(ii) changes in mortality, morbidity, and health service use, including stabilization of patients with progressive diseases;

(iii) changes in quality of life, including ability to perform activities of daily living, ability to return to work, relief from discomfort or pain, alleviation of fatigue, and improved mental functioning and well-being; and

(iv) other outcomes that are determined by the Advisory Committee to be relevant to assessing the impact of medical technology.

(b) ADVISORY COMMITTEE.—

(1) IN GENERAL.—The Administrator shall establish an Advisory Committee to assist the Agency for Health Care Policy and Research in preparing the reports required under subsection (c). Except as provided in paragraph (3), no member of the Advisory Committee shall be an employee of the Federal Government.

(2) MEMBERSHIP.—The Advisory Committee shall be balanced in its representation of interested parties and shall be composed of at least two individuals appointed by the President of the Institute of Medicine and two individuals from each of the following categories to be appointed by the Administrator:

(A) Experts in medical technology assessment.

(B) Experts in objective measures of improved patient outcomes, such as clinical outcomes, mortality, morbidity, and health service use.

(C) Experts in subjective measures of improved patient outcomes, such as quality of life.

(D) Experts in quantifying the economic costs of disease to the health care system, including public and private payers.

(E) Experts in quantifying the economic impact of the medical technology industry.

(F) Experts in health statistics and epidemiology.

(G) Physicians and other health care providers.

(H) Officers or employees of health plans and other health care payers.

(I) Experts in the ethical implications of health care.

(J) Experts in private sector financial market investment in the medical technology industry.

(K) Consumers and members of patient advocacy groups.

(L) Health professional organizations.

(M) Officers or employees of biotechnology companies.

(N) Officers or employees of medical device companies.

(O) Officers or employees of pharmaceutical companies.

(3) EX OFFICIO.—The following individuals or their designees shall serve as ex officio members of the Advisory Committee:

(A) The Director of the National Institutes of Health.

(B) The Commissioner of Food and Drugs.

(C) The Director of the Centers for Disease Control and Prevention.

(D) The Administrator of the Health Care Financing Administration.

(E) The Under Secretary of Commerce for Technology.

(F) The Director of the Congressional Office of Technology Assessment.

(c) INTERDISCIPLINARY STUDY AND REPORT.—

(1) IN GENERAL.—The Administrator, in consultation with the Advisory Committee established under subsection (b), shall determine which diseases or conditions should be studied in the Medical Technology Impact Study under subsection (a). In carrying out the medical technology assessment required under this subsection, the Administrator shall consider various factors, including those outlined in section 904(b)(2) of the Public Health Service Act and government and private payor reimbursement policies that impede or encourage innovation that improves patient outcomes. The diseases or conditions

studied in such Study shall be those considered to be high priority according to the following criteria:

(A) Aggregate economic costs to the United States.

(B) Overall importance to public heath.

(C) Potential for improvements in patient outcomes.

(D) Significant changes expected in management of the condition.

(E) Other criteria identified by the Advisory Committee.

(2) DESIGN.—The Administrator, in consultation with the Advisory Committee established under subsection (b), and the Institute of Medicine pursuant to paragraph (3), shall develop a design, based on the list of target diseases and conditions, for undertaking the Medical Technology Impact Study under subsection (a).

(3) CONTRACT.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to enter into a contract to review the design of the Medical Technology Impact Study under subsection (a) and report to the Administrator concerning any recommendations for revising such de-

sign, in the interest of assuring that it reflects the best available scientific methodologies.

(4) PUBLICATION.—The Administrator shall publish the study design under this section and list of target diseases and conditions, the recommendations of the Institute of Medicine, and the response of the Administrator to such recommendations in the Federal Register for a 60-day period for public comment. Any such comments shall be considered by the Administrator in completing the proposed study design for submission to the Secretary.

(5) DESIGN REPORT.—The Secretary shall report to Congress concerning the proposed design of the Medical Technology Impact Study, together with recommendations for appropriations necessary to carry out the Study.

(6) GRANTS AND CONTRACTS.—Beginning in the first fiscal year for which Congress appropriates funds under subsection (d), and ending on September 30 of that year, the Administrator shall enter into grants and contracts with appropriate entities to conduct any investigations and analyses that may be required to carry out the design of the Medical Technology Impact Study under subsection (a).

(7) REPORT ON FINDINGS.—The Administrator, in consultation with the Advisory Committee established under subsection (b), shall develop a draft comprehensive report concerning the findings of the Medical Technology Impact Study under subsection (a), shall make copies of the draft report available to the public, and shall publish a notice in the Federal Register providing for a 60-day period of public comment. Any such comments shall be considered by the Administrator in completing and submitting the final report to the Secretary.

(8) FINAL REPORT.—Not later than 3 years after the date of enactment of this section, the Secretary shall submit the report of the Administrator under this section to Congress, and may include any recommendations determined necessary to assure the availability, access and appropriate use of medical technologies to improve the quality of health care in the United States.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle D—Core Functions of Public Health Programs; National Initiatives Regarding Preventive Health

PART 1—FUNDING

SEC. 3301. AUTHORIZATIONS OF APPROPRIATIONS.

(a) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For the purpose of carrying out part 2, there are authorized to be appropriated $123,000,000 for fiscal year 1995, $184,500,000 for fiscal year 1996, $266,500,000 for fiscal year 1997, $348,500,000 for fiscal year 1998, $410,000,000 for fiscal year 1999, $512,500,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

(b) NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION.—For the purpose of carrying out part 3, there are authorized to be appropriated $102,500,000 for each of the fiscal years 1996 through 1998, $123,000,000 for each of the fiscal years 1999 and 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsections (a) and (b) are in addition to any other authorizations of appro-

priations that are available for the purposes described in such subsections.

PART 2—CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS

SEC. 3311. PURPOSES.

Subject to the subsequent provisions of this subtitle, the purposes of this part are to strengthen the capacity of State and local public health agencies to carry out the following functions:

(1) To monitor and protect the health of communities against communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products, and poor quality health care.

(2) To identify and control outbreaks of infectious disease and patterns of chronic disease and injury.

(3) To inform and educate health care consumers and providers about their roles in preventing injury, preventing and controlling disease and the appropriate use of medical services.

(4) To develop and test new prevention and public health control interventions.

(5) To integrate and coordinate the prevention programs and services of standard health plans,

community-based providers, local health departments, State health departments, purchasing cooperatives, and other sectors of State and local government that affect health, including education, labor, transportation, welfare, criminal justice, environment, agriculture, and housing.

(6) To conduct research on the effectiveness and cost-effectiveness of public health programs.

SEC. 3312. GRANTS TO STATES FOR CORE FUNCTIONS OF PUBLIC HEALTH.

(a) IN GENERAL.—The Secretary shall make grants to States that submit applications as prescribed in section 3313 in an amount which bears the same ratio to the available amounts for that fiscal year as the amounts provided by the Secretary under the provisions of law listed in section 1902(2) of the Public Health Service Act to the State for fiscal year 1981 bear to the total amount appropriated for such provisions of law for fiscal year 1981.

(b) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For purposes of subsection (a), the functions described in this subsection are, subject to subsection (c), as follows:

(1)(A) Data collection, activities related to population health (including the population of individuals ineligible for the comprehensive benefit pack-

age) measurement and outcomes monitoring, including the acquisition and installation of hardware and software, personnel training and technical assistance to operate and support automated and integrated information systems, the regular collection and analysis of public health data, vital statistics, and personal health services data and analysis for planning and needs assessment purposes of data collected from health plans through the information system under title V of this Act.

(B) Data measures under this paragraph must include an ethnic identifier on all forms. To the extent feasible, ethnic identifiers should be classified by ethnic sub-group populations. Access to data must be ensured for research organizations and data clearinghouses. Population health measurement and outcome monitoring should focus on health status differentials between racial, and ethnic groups, by subpopulation, and gender differences.

(2) Activities to protect the environment and to assure the safety of housing, workplaces, food and water, including the following activities:

(A) Monitoring and improving the overall public health quality and safety of communities.

(B) Assessing exposure to high lead levels and water contamination.

(C) Providing support for poison control centers.

(D) Monitoring sewage and solid waste disposal, radiation exposure, radon exposure, and noise levels.

(E) Abatement of lead-related hazards.

(F) Assuring recreation, home and worker safety.

(G) Public information and education programs that help to reduce intentional and unintentional injuries, including training parents and children on use of safety devices.

(H) Enforcing public health safety and sanitary codes.

(I) Other activities relating to promoting the public health of communities.

(3) Investigation and control of adverse health conditions, including improvements in emergency treatment preparedness, injury prevention, cooperative activities to reduce violence levels in homes and communities, activities to control the outbreak of disease, exposure related conditions and other threats to the health status of individuals.

(4) Public information and education programs to reduce risks to health such as use of tobacco, alcohol and other drugs, sexual activities that increase the risk to HIV transmission and sexually transmitted diseases, domestic violence, poor diet, physical inactivity, and low childhood immunization levels.

(5) Accountability and quality assurance activities, including monitoring the quality of personal health services furnished by health plans and providers of medical and health services in a manner consistent with the overall quality of care monitoring activities undertaken under title V, and monitoring communities' overall access to health services.

(6) Provision of public health laboratory services to complement private clinical laboratory services and that screen for diseases and conditions such as metabolic diseases in newborns, provide toxicology assessments of blood lead levels and other environmental toxins, diagnose sexually transmitted diseases, tuberculosis and other diseases requiring partner notification, test for infectious and food-borne diseases, and monitor the safety of water and food supplies.

(7) Training and education to assure provision of care by all health professionals, with special em-

phasis placed on the training of public health professions including epidemiologists, biostatisticians, health educators, public health administrators, sanitarians and laboratory technicians.

(8) Leadership, policy development and administration activities, including needs assessment, the setting of public health standards, the development of community public health policies, and the development of community public health coalitions.

(9) Establishment of programs that encourage partnerships among local law enforcement and community groups for the purpose of developing community response teams to assist victims of domestic violence.

(c) RESTRICTIONS ON USE OF GRANT.—

(1) IN GENERAL.—A funding agreement for a grant under subsection (a) for a State is that the grant will not be expended—

(A) to provide inpatient services;

(B) to make cash payments to intended recipients of health services;

(C) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(D) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(E) to provide financial assistance to any entity other than a public or nonprofit private entity.

(2) LIMITATION ON ADMINISTRATIVE EXPENSES.—A funding agreement for a grant under subsection (a) is that the State involved will not expend more than 10 percent of the grant for administrative expenses with respect to the grant.

(d) MAINTENANCE OF EFFORT.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of non-Federal amounts for core health functions at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant.

SEC. 3313. SUBMISSION OF INFORMATION.

The Secretary may make a grant under section 3312 only if the State involved submits to the Secretary the following information:

(1) A description of existing deficiencies in the State's public health system (at the State level and

the local level), using standards of sufficiency developed by the Secretary.

(2) A description of health status measures to be improved within the State (at the State level and the local level) through expanded public health functions.

(3) Measurable outcomes and process objectives for improving health status and core health functions for which the grant is to be expended.

(4) Information regarding each such function, which—

(A) identifies the amount of State and local funding expended on each such function for the fiscal year preceding the fiscal year for which the grant is sought; and

(B) provides a detailed description of how additional Federal funding will improve each such function by both the State and local public health agencies.

(5) A description of the core health functions to be carried out at the local level, and a specification for each such function of—

(A) the communities in which the function will be carried out; and

(B) the amount of the grant to be expended for the function in each community so specified.

SEC. 3314. REPORTS.

A funding agreement for a grant under section 3312 is that the States involved will, not later than the date specified by the Secretary, submit to the Secretary a report describing—

(1) the purposes for which the grant was expended; and

(2) describing the extent of progress made by the State in achieving measurable outcomes and process objectives described in section 3313(3).

SEC. 3315. APPLICATION FOR GRANT.

The Secretary may make a grant under section 3312 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 3314, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

SEC. 3316. ALLOCATIONS FOR CERTAIN ACTIVITIES.

Of the amounts made available under section 3301 for a fiscal year for carrying out this part, the Secretary

may reserve not more than 5 percent for carrying out the following activities:

(1) Technical assistance with respect to planning, development, and operation of core health functions carried out under section 3312, including provision of biostatistical and epidemiological expertise and provision of laboratory expertise.

(2) Development and operation of a national information network among State and local health agencies.

(3) Program monitoring and evaluation of core health functions carried out under section 3312.

(4) Development of a unified electronic reporting mechanism to improve the efficiency of administrative management requirements regarding the provision of Federal grants to State public health agencies.

SEC. 3317. DEFINITIONS.

For purposes of this part:

(1) The term ''funding agreement'', with respect to a grant under section 3312 to a State, means that the Secretary may make the grant only if the State makes the agreement involved.

(2) The term ''core health functions'', with respect to a State, means the functions described in section 3312(b).

SEC. 3318. SINGLE APPLICATION AND UNIFORM REPORTING SYSTEMS FOR CORE FUNCTIONS OF PUBLIC HEALTH AND PUBLIC HEALTH CATEGORICAL GRANT PROGRAMS ADMINISTERED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) SINGLE APPLICATION.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a single consolidated application to enable States to apply for the Core Functions of Public Health Grants Program and any or all of the Public Health Service Act categorical programs described in subsection (b).

(2) REQUIREMENTS.—The application developed under paragraph (1) shall—

(A) be designed so that information collected will be consistent with the requirements of this part including subsection (b);

(B) be designed and implemented not later than 1 year after the date of enactment of this Act; and

(C) be developed with resources made available under section 3316 (not resources made available for the programs described in subsection (b)).

(3) STATE PUBLIC HEALTH OFFICERS.—In developing the single consolidated application form to be used under this subsection the Secretary shall consult with Federal, State and local public health agencies.''.

(4) ELIGIBILITY.—States and local governments that have grants, contracts or cooperative agreements in effect with the Centers for Disease Control and Prevention on the date of enactment of this Act shall be eligible to use a single application under this section to apply for any or all of the Public Health Service Act categorical programs described in subsection (b).

(b) ELIGIBLE PUBLIC HEALTH SERVICE ACT PROGRAMS.—Eligible Public Health Service Act categorical programs described in this subsection are the following:

(1) The Preventive Health and Health Services Block Grant under section 1903 of the Public Health Service Act.

(2) The Childhood Lead Poisoning Prevention Program under section 317A of the Public Health Service Act.

(3) The Sexually Transmitted Diseases Program under section 318 of the Public Health Service Act.

(4) The Prevention of Sexually Transmitted Diseases-Related Infertility Program under section 318A of the Public Health Service Act.

(5) The Breast and Cervical Cancer Early Detection Program under sections 1501 through 1509 of the Public Health Service Act.

(6) The National Program of Cancer Registries under section 399H of the Public Health Service Act.

(7) The Injury Control and Prevention Program under sections 391 through 394 of the Public Health Service Act.

(8) The preventive health for prostate cancer program under section 317D of the Public Health Service Act.

(9) The birth defects data program under section 317C of the Public Health Service Act.

(10) Programs under subtitle D of this title.

(11) Other relevant programs as determined appropriate by the Secretary.

(c) ALLOCATION OF FUNDS.—In awarding grants to States and local governments under a single application under this section, the Secretary shall delineate to each grantee the amounts to be dedicated to each of the programs described in subsection (b) and ensure that funding allotments for each of such programs are consistent with the requirements of Federal law.

(d) UNIFORM CORE FUNCTIONS OF PUBLIC HEALTH REPORTING SYSTEM.—

(1) DEVELOPMENT.—The Secretary, acting through the Director of the Office of Disease Prevention and Health Promotion and the Director of the Centers for Disease Control and Prevention, in consultation with other relevant Federal and State health agencies with data collection responsibilities, shall develop and implement a Uniform Core Public Health Functions Reporting System to collect program and fiscal data concerning the programs described in subsection (b).

(2) REQUIREMENTS.—The system developed under paragraph (1) shall—

(A) use outcomes consistent with the goals of Healthy People 2000;

(B) be designed so that information collected will be consistent with the requirements of this part including subsection (b);

(C) be designed and implemented not later than 2 years after the date of enactment of this Act; and

(D) be developed with resources made available under section 3316 of this Act (not resources made available for the programs described in subsection (b)).

(3) STATE PUBLIC HEALTH OFFICERS.—In developing the data set to be used under Uniform Core Public Health Functions Reporting System the Secretary shall consult with Federal, State and local public health agencies.

(e) STUDY.—

(1) IN GENERAL.—Within a reasonable period of time after the date of enactment of this Act, the Secretary shall request that the Institute of Medicine conduct a study concerning—

(A) the effects of consolidating any or all of the grant programs administered by the Centers for Disease Control and Prevention and described in subsection (b) into a Core Functions of Public Health Block Grant Program;

(B) the development of alternative methods for implementing a block grant program or categorical grant program; and

(C) alternative formulas for allocating State grants that incorporate measures of health status, population and degree of poverty.

In particular, the impact of program consolidation on the targeted recipients, including women and vulnerable populations, shall be addressed in the study. If the Institute of Medicine declines to do the study, the Secretary shall make grants to or enter into contracts with a public or nonprofit private entity with relevant expertise for the conduct of such a study.

(2) REPORT.—Not later than 1 year after the date of the receipt of the contract under paragraph (1), the contract recipient shall prepare and submit to the Secretary, the Energy and Commerce Committee of the House of Representatives, and the Committee on Labor and Human Resources of the Senate a report that contains the results of the study conducted under paragraph (1).

(3) ISSUANCE OF PLAN.—Not later than 1 year after the date on which the report under paragraph (2) is received by the Secretary and the committees referred to in such paragraph, the Secretary shall

issue a plan in response to the report. Such a plan shall include the identification of relevant changes in authorizing language.

PART 3—NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION

Subpart A—General Grants

SEC. 3331. GRANTS FOR NATIONAL PREVENTION INITIATIVES.

(a) IN GENERAL.—The Secretary may make grants to entities described in subsection (b) for the purpose of carrying out projects to develop and implement innovative community-based strategies to provide for health promotion and disease prevention activities for which there is a significant need, as identified under section 1701 of the Public Health Service Act.

(b) ELIGIBLE ENTITIES.—The entities referred to in subsection (a) are agencies of State or local government, private nonprofit organizations (including research institutions), and coalitions that link two or more of these groups.

(c) CERTAIN ACTIVITIES.—The Secretary shall ensure that projects carried out under subsection (a)—

(1) reflect approaches that take into account the special needs and concerns of the affected populations;

(2) are targeted to the most needy and vulnerable population groups and geographic areas of the Nation;

(3) examine links between various high priority preventable health problems and the potential community-based remedial actions; and

(4) establish or strengthen the links between the activities of agencies engaged in public health activities with those of purchasing cooperatives, health care providers, and other entities involved in the personal health care delivery system described in title I.

SEC. 3332. PRIORITIES.

(a) ESTABLISHMENT.—

(1) ANNUAL STATEMENT.—The Secretary shall for each fiscal year develop a statement of proposed priorities for grants under section 3331 for the fiscal year.

(2) ALLOCATIONS AMONG PRIORITIES.—With respect to the amounts available under section 3301(b) for the fiscal year for carrying out this part, each statement under paragraph (1) for a fiscal year shall include a specification of the percentage of the amount to be devoted to projects addressing each of the proposed priorities established in the statement.

(3) PROCESS FOR ESTABLISHING PRIORITIES.—

(A) PREFERENCE.—In establishing priorities for grants under this part, preference shall be given to projects that—

(i) reduce the prevalence of chronic diseases including cardiovascular disease, stroke, diabetes, and cancer;

(ii) prevent violence against women by training providers and other health care professionals to identify victims of domestic violence, to provide appropriate examination and treatment, and to refer the victims for appropriate social and legal services; and

(iii) establish community health advisor programs described in subparagraph (B).

(B) COMMUNITY HEALTH ADVISOR PROGRAMS.—For purposes of subparagraph (A)(iii), the term ''community health advisor program'' means a program that performs the following functions:

(i) Provides outreach services to inform the community of the availability of program services.

(ii) Collaborate efforts with health care providers and related entities to facilitate the provision of health services and health related social services.

(iii) Provide public education on health promotion and disease prevention and efforts to facilitate the use of available health services and health-related social services.

(iv) Provide health-related counseling.

(v) Make referrals for available health services and health-related social services.

(vi) Improve the ability of individuals to use health services and health-related social services under Federal, State, and local programs, through assisting individuals in establishing eligibility under the programs.

(vii) Establish a community health advisor training program.

(viii) Provide services in the language and cultural context most appropriate for the individuals served by the program.

(ix) Provide compensation for the services of, and opportunities for training

and employment of, community health advisors.

(x) Such other services as the Secretary determines to be appropriate, which may include transportation and translation services.

(C) PUBLICATION OF STATEMENT.—Not later than January 1 of each fiscal year, the Secretary shall publish a statement under paragraph (1) in the Federal Register. A period of 60 days shall be allowed for the submission of public comments and suggestions concerning the proposed priorities. After analyzing and considering comments on the proposed priorities, the Secretary shall publish in the Federal Register final priorities (and associated reservations of funds) for approval of projects for the following fiscal year.

(D) DEFINITION OF COMMUNITY HEALTH ADVISOR.—For purposes of subparagraph (B), the term ''community health advisor'' means an individual—

(i) who has demonstrated the capacity to carry out one or more of the authorized program services;

(ii) who, for not less than 1 year, has been a resident of the community in which the community health advisor program involved is to be operated; and

(iii) is a member of a socioeconomic group to be served by the program.

(b) APPLICABILITY TO MAKING OF GRANTS.—

(1) IN GENERAL.—The Secretary may make grants under section 3331 for projects that the Secretary determines—

(A) are consistent with the applicable final statement of priorities and otherwise meets the objectives described in subsection (a); and

(B) will assist in meeting a health need or concern of a population within a defined health care coverage area or other service area.

(2) SPECIAL CONSIDERATION FOR CERTAIN PROJECTS.—In making grants under section 3331, the Secretary shall give special consideration to applicants that will carry out projects that, in addition to being consistent with the applicable published priorities under subsection (a) and otherwise meeting the requirements of this part, have the potential for replication in other communities.

SEC. 3333. SUBMISSION OF INFORMATION.

The Secretary may make a grant under section 3331 only if the applicant involved submits to the Secretary the following information:

(1) A description of the activities to be conducted, and the manner in which the activities are expected to contribute to meeting one or more of the priority health needs specified under section 3332 for the fiscal year for which the grant is initially sought.

(2) A description of the total amount of Federal funding requested, the geographic area and populations to be served, and the evaluation procedures to be followed.

(3) Such other information as the Secretary determines to be appropriate.

SEC. 3334. APPLICATION FOR GRANT.

The Secretary may make a grant under section 3331 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 3333, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

Subpart B—Development of Telemedicine in Rural Underserved Areas

SEC. 3341. GRANTS FOR DEVELOPMENT OF RURAL TELEMEDICINE.

(a) IN GENERAL.—

(1) GRANTS AWARDED.—The Secretary, acting through the Office of Rural Health Policy, shall award grants to eligible entities that have applications approved under subsection (b) for the purpose of expanding access to health care services for individuals in rural areas through the use of telemedicine. Grants shall be awarded under this section to encourage the initial development of rural telemedicine networks, expand existing networks, link existing networks together, or link such networks to existing fiber optic telecommunications systems.

(2) ELIGIBLE ENTITY.—For purposes of this section, the term ''eligible entity'' means a public or nonprofit entity operating in a nonmetropolitan area (as defined by the Secretary of Commerce) as part of a network of community-based providers that includes at least three of the following:

(A) Community or migrant health centers.

(B) Local health departments.

(C) Community mental health centers.

(D) Nonprofit hospitals.

(E) Private practice health professionals, including rural health clinics.

(F) Other publicly funded health or social services agencies.

(b) APPLICATION.—To be eligible to receive a grant under this section an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require, including a description of the use to which the entity will apply any amounts received under the grant.

(c) PREFERENCE.—The Secretary shall, in awarding grants under this section, give preference to applicants that—

(1) are health care providers in rural health care networks or providers that propose to form such networks, and the majority of the providers in such a network are located in a medically underserved or health professional shortage areas;

(2) can demonstrate broad geographic coverage in the rural areas of the State, or States in which the applicant is located;

(3) propose to use Federal funds to develop plans for, or to establish, telemedicine systems that

will link rural hospitals and rural health care providers to other hospitals and health care providers;

(4) will use the amounts provided under the grant for a range of health care applications such as teleradiology, telepathology, interactive video consultation and remote educational services, and to promote greater efficiency in the use of health care resources; and

(5) propose to use local matching funds to finance projects.

(d) USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall be utilized for the development of telemedicine networks involving two or more providers. Such amounts may be used to cover the costs associated with the development of telemedicine networks and the acquisition or construction of telecommunications facilities and equipment including—

(1) the development and acquisition through lease or purchase of computer hardware and software, audio and visual equipment, computer network equipment, telecommunications transmission facilities, telecommunications terminal equipments, interactive video equipment, data terminal equipment, and other facilities and equipment that would further the purposes of this section;

(2) the provision of technical assistance and instruction for the development and use of such programming equipment or facilities;

(3) the development and acquisition of instructional programming;

(4) demonstration projects for teaching or training medical students, residents, and other health professions students in rural training sites about the application of telemedicine;

(5) transmission costs, maintenance of equipment, and compensation of specialists and referring practitioners;

(6) demonstration projects to use telemedicine to facilitate collaboration between physicians and nonphysician primary care practitioners such as physician assistants, nurse practitioners, and certified nurse-midwives; or

(7) such other uses that are consistent with achieving the purposes of this section as approved by the Secretary.

(e) PROHIBITED USES.—Amounts received under a grant awarded under this section may not be used for any of the following:

(1) Expenditures to purchase or lease equipment to the extent the expenditures would exceed more than 60 percent of the total grant funds.

(2) Expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 10 percent of the total grant funds.

SEC. 3342. REPORT AND EVALUATION OF TELEMEDICINE.

Not later than the date that is 3 years after the date on which the first grant is awarded under section 3341, the Secretary, in consultation with the Administrator of the Rural Electrification Administration, the Secretary of Veterans Affairs, and other agencies and departments that have responsibilities for overseeing telemedicine projects, shall prepare and submit to the appropriate committees of Congress a report that evaluates telemedicine in the United States. Such report shall contain an evaluation of—

(1) whether telemedicine expands access to health care services;

(2) the cost effectiveness of telemedicine services; and

(3) the quality of telemedicine services delivered.

SEC. 3343. REGULATIONS ON REIMBURSEMENT OF TELEMEDICINE.

Not later than July 1, 1996, the Secretary, in consultation with the Director of the Office of Rural Health and the Administrator of the Health Care Financing Administration, shall issue regulations concerning reimbursement for telemedicine services provided under title XVIII of the Social Security Act.

SEC. 3344. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this subpart.

SEC. 3345. DEFINITIONS.

As used in this part:

(1) COMPUTER NETWORKS.—The term ''computer networks'' means computer hardware and software, terminals, signal conversion equipment including both modulators and demodulators, or related devices, used to communicate with other computers to process and exchange date through a telecommunication network in which signals are generated, modified, or prepared for transmission, or received, via telecommunications terminal equipment and telecommunications transmission facilities.

(2) DATA TERMINAL EQUIPMENT.—The term ''data terminal equipment'' means equipment that converts user information into data signals for

transmission, or reconverts the received data signals into user information, and is normally found on the terminal of a circuit and on the premises of the end user.

(3) FIBER OPTIC CABLE.—The term ''fiber optic cable'' means a bundle of optical transmission elements or waveguides usually consisting of a fiber core and fiber cladding that can guide a lightwave and that are incorporated into an assembly of materials that provide tensile strength and external protection.

(4) INTERACTIVE VIDEO EQUIPMENT.—The term ''interactive video equipment'' means equipment used to produce and prepare for transmission audio and visual signals from at least two distant locations in order that individuals at such locations can verbally and visually communicate with each other, and such equipment includes monitors, other display devices, cameras or other recording devices, audio pick-up devices, and other related equipment.

(5) RURAL HEALTH CARE NETWORK.—The term ''rural health care network'' means a group of rural hospitals or other rural care health care providers (including clinics, physicians and non-physicians primary care providers) that have entered into

a formal relationship with each other or with nonrural hospitals and health care providers for the purpose of strengthening the delivery of health care services in rural areas or specifically to improve their patients' access to telemedicine services. At least 75 percent of hospitals and other health care providers participating in the network shall be located in rural areas.

(6) TELECOMMUNICATION TRANSMISSION FACILITIES.—The term ''telecommunications transmission facilities'' means those facilities that transmit, receive, or carry data between the telecommunications terminal equipment at each end of a telecommunications circuit or path. Such facilities include microwave antennae, relay stations and towers, other telecommunications antennae, fiber-optic cables and repeaters, coaxial cables, communication satellite ground station complexes, copper cable electronic equipment associated with telecommunications transmissions, and similar items as defined by the Secretary.

(7) TELECOMMUNICATION TERMINAL EQUIPMENT.—The term ''telecommunications terminal equipment'' means the assembly of telecommunications equipment at the end of a circuit, normally

located on the premises of the end user, that interfaces with telecommunications transmission facilities, and that is used to modify, convert, encode, or otherwise prepare signals to be transmitted via such telecommunications facilities, or that is used to modify, reconvert or carry signals received from such facilities, the purpose of which is to accomplish the goal for which the circuit was established.

Subtitle E—Health Services for Medically Underserved Populations

PART 1—INITIATIVES FOR ACCESS TO HEALTH CARE

Subpart A—Authorization of Appropriations

SEC. 3411. AUTHORIZATIONS OF APPROPRIATIONS.

(a) IMPROVING ACCESS TO HEALTH SERVICES.—

(1) SUBPART B.—

(A) Except as provided in subparagraph (B), for the purpose of carrying out subpart B, there are authorized to be appropriated $105,000,000 for fiscal year 1995, $245,000,000 for fiscal year 1996, $385,000,000 for fiscal year 1997, $315,000,000 for fiscal year 1998,

$245,000,000 for fiscal year 1999, and $105,000,000 for fiscal year 2000.

(B) With respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) and rural health clinics under subpart B, there are authorized to be appropriated $45,000,000 for fiscal year 1995, $105,000,000 for fiscal year 1996, $165,000,000 for fiscal year 1997, $135,000,000 for fiscal year 1998, $105,000,000 for fiscal year 1999, and $45,000,000 for fiscal year 2000.

(2) SUBPART C.—

(A) For the purpose of providing loans under subpart C, there are authorized to be appropriated such sums as may be necessary to support a loan level of $200,000,000 for each of the fiscal years 1995 through 2000.

(B) For the purpose of making grants under subpart C, there are authorized to be appropriated $35,000,000 for each of the fiscal year 1995 through 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations

that are available for the purpose described in such subsection.

(c) ELIGIBLE ENTITIES.—For purposes of this part, the term ''eligible entities'' means—

(1) covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), except that subsection (a)(4)(L)(iii) and (a)(7) of such section shall not apply;

(2) school health service sites under title III of this Act;

(3) nonprofit hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act, except that subsection (a)(4)(L)(iii) of such section shall not apply, and children's hospitals meeting comparable criteria as determined appropriate by the Secretary;

(4) public and private, nonprofit community mental health centers and substance abuse treatment providers receiving funds from the Substance Abuse and Mental Health Services Administration;

(5) runaway homeless youth centers or transitional living programs for homeless youth for the provision of health services under the Runaway

Homeless Youth Act of 1974 (42 U.S.C. 5701 et seq.);

(6) rural referral centers under section 1886(d)(5)(C) of the Social Security Act, except that such eligibility is restricted to the receipt of grants under section 3441; and

(7) public or nonprofit entities in nonmetropolitan areas (as defined by the Department of Commerce) in a consortium of community-based providers that includes at least three of the following:

(A) community or migrant health centers;

(B) local health departments;

(C) community mental health centers;

(D) nonprofit hospitals;

(E) private practice health professionals, including rural health clinics; or

(F) other publicly funded health or social services agencies;

except that such eligibility is restricted to the receipt of grants or contracts under section 3421(a).

(d) PRIORITY.—In making awards from amounts appropriated under subsection (a)(1)(B) and section 3462, the Secretary shall give the highest priority to providing adequate assistance to federally qualified health centers

in order to ensure the provision of comprehensive primary health care services, other covered services and benefits, and enabling services to medically underserved populations that were served by such centers prior to the date of enactment of this Act, except that such federally qualified health centers must continue to meet the requirements for designation under section 1861(aa)(4) of the Social Security Act.

(e) EQUITABLE DISTRIBUTION.—The Secretary shall, in awarding grants, entering into contracts, and making loans under this part, assure an equitable distribution of funds between rural and urban areas.

Subpart B—Development of Community Health Groups and Health Care Sites and Services

SEC. 3421. GRANTS AND CONTRACTS FOR DEVELOPMENT OF PLANS AND NETWORKS AND THE EXPANSION AND DEVELOPMENT OF HEALTH CARE SITES AND SERVICES.

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary may make grants to and enter into contracts with eligible entities described in section 3411(c) for—

(A) the development of community health groups whose principal purpose is to provide the comprehensive benefit package under title I

in one or more health professional shortage areas or to provide such items and services to a significant number of individuals who are members of a medically underserved population; and

(B) the expansion of existing health delivery sites and services and the development of new health delivery sites and services.

(2) CONSIDERATION BY SECRETARY.—In awarding grants or contracts under paragraph (1), the Secretary shall give consideration to—

(A) the geographic proximity of the grant applicants and recipients;

(B) cultural and language differences existing within the communities to be served under the grants or contracts; and

(C) the capacity needs of the communities to be served.

(b) SERVICE AREA.—In making an award under subsection (a), the Secretary shall designate the geographic area with respect to which the community health group involved is to provide health services.

(c) PRIORITY.—In making awards under subsection (a)(1), the Secretary shall give priority to proposals in which a greater number of eligible entities and other

health care providers, especially providers in community- and provider-based health plans under section 1651(d), are participants in the community health group, except in areas such as rural areas, where providers are severely limited in number.

(d) LIMITATION ON AWARDS.—The Secretary may not make awards under subsection (a)(1) for more than 5 years to the same community health group.

(e) DEFINITIONS.—For purposes of this subpart:

(1) The term ''community health group'' means—

(A) a community health network that—

(i) is a public or nonprofit private consortium of health care providers that principally provides some of the items and services of the standard benefit package to medically underserved populations, and residents of health professional shortage areas;

(ii) has an agreement with one or more health plans; and

(iii) has a written agreement governing the participation of health care providers in the consortium to which each participating provider is a party; or

(B) a community health plan that—

(i) is a public or nonprofit private entity that principally provides all of the items and services of the standard benefit package to medically underserved populations, and residents of health professional shortage areas;

(ii) is a participant in one or more health alliances; and

(iii) has a written agreement governing the participation of health care providers in the consortium to which each participating provider is a party.

(2) The term ''health professional shortage areas'' means health professional shortage areas designated under section 332 of the Public Health Service Act.

(3) The term ''medically underserved population'' means a medically underserved population designated under section 330(b)(3) of the Public Health Service Act, populations residing in health professional shortage areas under section 332 of the Public Health Service Act, and populations eligible for premium subsidies and cost sharing reductions based on income under title I.

SEC. 3422. CERTAIN USES OF AWARDS.

(a) IN GENERAL.—Amounts awarded under section 3421 may be expended for—

(1) the development of a community health group, including entering into contracts between the recipient of the award and health care providers who are to participate in the group;

(2) the expansion, development and on-going operation of health delivery sites and services; and

(3) activities under paragraphs (1) and (2) which include—

(A) the recruitment, compensation, and training of health professionals and administrative staff;

(B) the purchase and upgrading of equipment, supplies, and information systems including telemedicine systems; and

(C) the establishment of reserves required for furnishing services on a prepaid or capitated basis, except that eligible entities may use non-cash mechanisms (including bonds, letters of credit and federally guaranteed reinsurance pools) for establishing and maintaining financial reserves.

(b) LOANS AND GRANTS.—The Secretary may expend, in any fiscal year, not to exceed 10 percent of the

amounts appropriated to carry out this subpart to make loans and grants to eligible entities to support the types of activities described in section 3441, subject to the requirements of subpart C, except that, with respect to amounts available for non-federally qualified health center activities, such funds may be used to convert facilities from providers of acute care service to providers of primary, emergency or long-term care.

SEC. 3423. APPLICATION.

The Secretary may not make an award to an entity under section 3421 until such entity submits and application to the Secretary, in such form and containing such assurances and information as the Secretary determines appropriate, including—

(1) an assessment of the need that the medically underserved population or populations proposed to be served by the applicant have for health services and for enabling services (as defined in section 3461);

(2) a description of how the applicant will design the proposed community health plan or practice network (including the service sites involved) for such populations based on the assessment of need;

(3) a description of efforts to secure financial and professional assistance and support for the project; and

(4) evidence of significant community involvement in the initiation, development and ongoing operation of the project.

SEC. 3424. PURPOSES AND CONDITIONS.

Grants shall be made under this subpart for the purposes and subject to all of the conditions under which eligible entities otherwise receive funding to provide health services to medically underserved populations under the Public Health Service Act. The Secretary shall prescribe comparable purposes and conditions for eligible entities not receiving funding under the Public Health Service Act.

Subpart C—Capital Cost of Development of Community Health Groups and Other Purposes

SEC. 3441. DIRECT LOANS AND GRANTS.

(a) IN GENERAL.—The Secretary shall make grants and loans to—

(1) eligible entities (as defined in section 3412(c));

(2) hospitals designated by the Secretary as essential access community hospitals under section 1820(i)(1) of the Social Security Act; or

(3) rural primary care hospitals under section 1820(i)(2) of such Act;

for the capital costs of developing community health groups (as defined in section 3421(e)) and expanding existing health delivery sites or developing new health delivery sites.

(b) USE OF ASSISTANCE.—

(1) IN GENERAL.—The capital costs for which grants and loans made pursuant to subsection (a) may be expended are, subject to paragraphs (2) and (3), the following:

(A) The acquisition, modernization, expansion or construction of facilities, or the conversion of unneeded hospital facilities to facilities that will assure or enhance the provision and accessibility of health care and enabling services to medically underserved populations.

(B) The purchase of major equipment, including equipment necessary for the support of external and internal information systems.

(C) The establishment of reserves required for furnishing services on a prepaid or capitated basis.

(D) Such other capital costs as the Secretary may determine are necessary to achieve the objectives of this section.

(2) PRIORITIES REGARDING USE OF FUNDS.—In providing grants and loans under subsection (a) for an entity, the Secretary shall give priority to authorizing the use of amounts for projects for the renovation and modernization of medical facilities necessary to prevent or eliminate safety hazards including asbestos removal, avoid noncompliance with licensure or accreditation standards, or projects to replace obsolete facilities.

(3) LIMITATION.—The Secretary may authorize the use of grants and loans under subsection (a) for the construction of new buildings only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding or converting existing buildings, or that construction new buildings will cost less.

(c) AMOUNT OF ASSISTANCE.—

(1) IN GENERAL.—The principal amount of loans under subsection (a) may cover up to 90 percent of the costs involved.

(2) GRANTS.—Grants under this subsection may not exceed 75 percent of the costs involved.

(d) INTEREST SUBSIDIES.—Amounts provided under this section may be used to provide interest subsidies for loans provided under this section where such subsidies are necessary to make a project financial feasible.

SEC. 3442. CERTAIN REQUIREMENTS.

(a) IN GENERAL.—The Secretary may approve a loan under section 3441 only if—

(1) the Secretary is reasonably satisfied that the applicant for the project for which the loan would be made will be able to make payments of principal and interest thereon when due; and

(2) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(b) TERMS AND CONDITIONS.—Any loan made under section 3441 shall, subject to the Federal Credit Reform Act of 1990, meet such terms and conditions (including provisions for recovery in case of default) as the Secretary, in consultation with the Secretary of the Treasury, determines to be necessary to carry out the purposes of such section while adequately protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

(1) Security.

(2) Maturity date.

(3) Amount and frequency of installments.

(4) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

SEC. 3443. DEFAULTS; RIGHT OF RECOVERY.

(a) DEFAULTS.—

(1) IN GENERAL.—The Secretary may take such action as may be necessary to prevent a default on loans under section 3441, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes.

(2) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to section 3441, including selling real property pledged as security for such a loan and for a reasonable period of time taking possession of, holding,

and using real property pledged as security for such a loan.

(3) WAIVERS.—The Secretary may, for good cause, but with due regard to the financial interests of the United States, waive any right of recovery which the Secretary has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made pursuant to section 3441, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(b) TWENTY-YEAR OBLIGATION; RIGHT OF RECOVERY; SUBORDINATION; WAIVERS.—

(1) IN GENERAL.—With respect to an eligible entity for which a grant or loan was made under section 3441, the Secretary may award the grant or loan only if the applicant involved agrees that the applicant will be liable to the United States for the amount of the grant or loan, together with an amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the entity—

(A) ceases to be an eligible entity utilized by a community health group, or by another

public or nonprofit private entity that provides health services in one or more health professional shortage areas or that provides such services to a significant number of individuals who are members of a medically underserved population; or

(B) is sold or transferred to any entity other than an entity that is—

(i) a community health group or other entity described in subparagraph (A); and

(ii) approved by the Secretary as a purchaser or transferee regarding the facility.

(2) SUBORDINATION; WAIVERS.—With respect to essential community providers, the Secretary may subordinate or waive the right of recovery under paragraph (1), and any other Federal interest that may be derived by virtue of a grant or loan under section 3441, if the Secretary determines that subordination or waiver will further the objectives of this part.

SEC. 3444. PROVISIONS REGARDING CONSTRUCTION OR EXPANSION OF FACILITIES.

(a) SUBMISSION OF INFORMATION.—In the case of a project for construction, conversion, expansion or mod-

ernization of a facility, the Secretary may provide loans under section 3441 only if the applicant submits to the Secretary the following:

(1) A description of the site.

(2) Plans and specifications which meet requirements prescribed by the Secretary.

(3) Information reasonably demonstrating that title to such site is vested in one or more of the entities filing the application (unless the agreement described in subsection (b)(1) is made).

(4) A specification of the type of assistance being requested under section 3441.

(b) AGREEMENTS.—In the case of a project for construction, conversion, expansion or modernization of a facility, the Secretary may provide loans under section 3441 only if the applicant makes the following agreements:

(1) Title to such site will be vested in one or more of the entities filing the application (unless the assurance described in subsection (a)(3) has been submitted under such subsection).

(2) Adequate financial support will be available for completion of the project and for its maintenance and operation when completed.

(3) All laborers and mechanics employed by contractors or subcontractors in the performance of

work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a et seq.; commonly known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Appendix) and section 276c of title 40.

(4) The facility will be made available to all persons seeking service regardless of their ability to pay.

SEC. 3445. APPLICATION FOR ASSISTANCE.

The Secretary may provide loans under section 3441 only if an application for such assistance is submitted to the Secretary, the application contains each agreement described in this subpart, the application contains the information required in section 3444(a), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

SEC. 3446. ADMINISTRATION OF PROGRAMS.

This subpart, and any other program of the Secretary that provides loans, shall be carried out by a centralized loan unit established within the Department of Health and Human Services.

Subpart D—Enabling and Supplemental Services

SEC. 3461. GRANTS AND CONTRACTS FOR ENABLING AND SUPPLEMENTAL SERVICES.

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary may make grants to and enter into contracts with eligible entities to assist such entities in providing the services described in subsections (b) and (c) for the purpose of increasing the capacity of individuals to utilize the items and services included in the comprehensive benefits package under title I, and to provide access to essential supplemental services that are not fully reimbursable under title I prior to January 2001.

(2) CONSIDERATION BY SECRETARY.—In awarding grants or contracts under paragraph (1), the Secretary shall give consideration to—

(A) the geographic proximity of the grant applicants and recipients;

(B) cultural and language differences existing within the communities to be served under the grants or contracts; and

(C) the capacity needs of the communities to be served.

(b) ENABLING SERVICES.—Enabling services shall include transportation, community and patient outreach, patient and family education, translation services, case management, home visiting, and such other services as the Secretary determines to be appropriate in carrying out the purpose described in such subsection.

(c) SUPPLEMENTAL SERVICES.—Supplemental services shall include items or services described in section 1106 or section 1118 of this Act that would otherwise be excluded from coverage prior to January 1, 2001.

(d) CERTAIN REQUIREMENTS REGARDING PROJECT AREA.—The Secretary may make an award of a grant or contract under subsection (a) only if the applicant involved—

(1) submits to the Secretary—

(A) information demonstrating that the medically underserved populations in the community to be served under the award have a need for enabling services; and

(B) a proposed budget for providing such services;

(2) the applicant for the award agrees that the medically underserved residents of the community

will be consulted with respect to the design and implementation of the project carried out with the award;

(3) agrees that the services will not be denied because the individual is unable to pay for such services; and

(4) agrees that the applicant will utilize existing resources to the maximum extent practicable.

(e) APPLICATION FOR AWARDS OF ASSISTANCE.—The Secretary may make an award of a grant or contract under subsection (a) only if an application for the award is submitted to the Secretary, the application contains each agreement described in this subpart, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

SEC. 3462. AUTHORIZATIONS OF APPROPRIATIONS.

(a) ENABLING SERVICES.—For the purpose of carrying out section 3461(b), there are authorized to be appropriated $17,200,000 for fiscal year 1996, $68,900,000 for each of the fiscal years 1997 through 1999, $68,900,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

(b) SUPPLEMENTAL SERVICES.—For the purpose of carrying out section 3461(c), there are authorized to be appropriated $82,000,000 for fiscal year 1996, $123,000,000 for each of the fiscal years 1997 through 1999, $205,000,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

(c) FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—With respect to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) and rural health clinics—

(1) for the purpose of carrying out section 3461(b), there are authorized to be appropriated $40,000,000 for fiscal year 1996, $161,000,000 for each of the fiscal years 1997 through 1999, $201,000,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004; and

(2) for the purpose of carrying out section 3461(c), there are authorized to be appropriated $24,600,000 for fiscal year 1996, $36,900,000 for each of the fiscal years 1997 through 1999, $61,500,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004; and

(d) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations

that are available for the purpose described in such subsection.

PART 2—NATIONAL HEALTH SERVICE CORPS

SEC. 3471. AUTHORIZATIONS OF APPROPRIATIONS.

(a) ADDITIONAL FUNDING; GENERAL CORPS PROGRAM; ALLOCATIONS REGARDING NURSES.—For the purpose of carrying out subpart II of part D of title III of the Public Health Service Act, and for the purpose of carrying out section 3472, there are authorized to be appropriated $123,000,000 for each of the fiscal years 1996 and 1997, and $201,000,000 for each of the fiscal years 1998 through 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 3472. ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Of the amounts appropriated under section 3471, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program under section

338A of the Public Health Service Act, or in the Loan Repayment Program under section 338B of such Act, the total number who are being educated as nurse practitioners, nurse midwives, or nurse anesthetists or are serving as nurse practitioners, nurse midwives, or nurse anesthetists, respectively, is increased to 20 percent.

SEC. 3473. ALLOCATION FOR PARTICIPATION OF PSYCHIATRISTS, PSYCHOLOGISTS, AND CLINICAL SOCIAL WORKERS IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Of the amounts appropriate under section 3471, the Secretary shall reserve such amounts as may be necessary to ensure that of the aggregate number of individuals who are participants in the scholarship program under section 338A of the Public Health Service Act, the number who are being educated as psychiatrists, psychologists, and clinical social workers or are serving as psychiatrists, psychologists, and clinical social workers, respectively, is increased to 15 percent.

PART 3—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

SEC. 3481. PAYMENTS TO HOSPITALS.

(a) ENTITLEMENT STATUS.—The Secretary shall make payments in accordance with this part to eligible

hospitals described in section 3482. The preceding sentence—

(1) is an entitlement in the Secretary on behalf of such eligible hospitals (but is not an entitlement in the State in which any such hospital is located or in any individual receiving services from any such hospital); and

(2) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the fiscal years, specified in subsection (b).

(b) APPROPRIATIONS.—

(1) IN GENERAL.—For purposes of subsection (a)(2), the amounts and fiscal years specified in this subsection are (in the aggregate for all eligible hospitals) $1,300,000,000 for the fiscal year in which the general effective date occurs and for each subsequent fiscal year.

(2) SPECIAL RULE FOR YEARS BEFORE GENERAL EFFECTIVE DATE.—

(A) IN GENERAL.—For each of the fiscal years 1996 and 1997, the amount specified in this subsection for purposes of subsection (a)(2) shall be equal to the aggregate DSH percentage

of the amount otherwise determined under paragraph (1).

(B) AGGREGATE DSH PERCENTAGE DEFINED.—In subparagraph (A), the ''aggregate DSH percentage'' for a year is the amount (expressed as a percentage) equal to—

(i) the total amount of payment made by the Secretary under section 1903(a) of the Social Security Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in the States in which eligible hospitals for the year are located; divided by

(ii) the total amount of payment made by the Secretary under section 1903(a) of such Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in all States.

(c) PAYMENTS MADE ON QUARTERLY BASIS.—Payments to an eligible hospital under this section for a year shall be made on a quarterly basis during the year.

SEC. 3482. IDENTIFICATION OF ELIGIBLE HOSPITALS.

(a) STATE IDENTIFICATION.—In accordance with the criteria described in subsection (b) and such procedures as the Secretary may require, each State shall identify the hospitals in the State that meet such criteria and provide the Secretary with a list of such hospitals.

(b) CRITERIA FOR ELIGIBILITY.—A hospital meets the criteria described in this subsection if the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act) is not less than 25 percent.

SEC. 3483. AMOUNT OF PAYMENTS.

(a) DISTRIBUTION OF ALLOCATION FOR LOW-INCOME ASSISTANCE.—

(1) ALLOCATION FROM TOTAL AMOUNT.—Of the total amount available for payments under this section in a year, 66.66 percent shall be allocated to hospitals for low-income assistance in accordance with this subsection.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital from the allocation made under paragraph (1) during a year shall be the equal to the hospital's low-income percentage of the allocation for the year.

(b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE FOR UNCOVERED SERVICES.—

(1) ALLOCATION FROM TOTAL AMOUNT; DETERMINATION OF STATE-SPECIFIC PORTION OF ALLOCATION.—Of the total amount available for payments under this section in a year, 33.33 percent shall be allocated to hospitals for assistance in furnishing hospital services that are not covered services under title I (in accordance with regulations of the Secretary) or in furnishing hospital services to individuals, including those residing in Southwestern border States, who are not eligible individuals under title I, in accordance with this subsection. The amount available for payments to eligible hospitals in a State shall be equal to an amount determined in accordance with a methodology specified by the Secretary that shall take into consideration the volume of such services provided by hospital in the State as compared to the volume of such services provided by all eligible hospitals.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital in a State from the amount available for payments to eligible hospitals in the State under paragraph (1) during a year shall be the equal to

the hospital's low-income percentage of such amount for the year.

(c) LOW-INCOME PERCENTAGE DEFINED.—

(1) IN GENERAL.—In this subsection, an eligible hospital's ''low-income percentage'' for a year is equal to the amount (expressed as a percentage) of the total low-income days for all eligible hospitals for the year that are attributable to the hospital.

(2) LOW-INCOME DAYS DESCRIBED.—For purposes of paragraph (1), an eligible hospital's low-income days for a year shall be equal to the product of—

(A) the total number of inpatient days for the hospital for the year (as reported to the Secretary by the State in which the hospital is located, in accordance with a reporting schedule and procedures established by the Secretary); and

(B) the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act).

SEC. 3484. BASE YEAR.

In this part, the ''base year'' is, with respect to a State and hospitals in a State, the year immediately prior to the year in which the general effective date occurs.

Subtitle F—Mental Health; Substance Abuse

PART 1—AUTHORITIES REGARDING PARTICIPATING STATES

SEC. 3510. INTEGRATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS.

(a) IN GENERAL.—As a condition of being a participating State under title I, each State shall, not later than January 1, 2001, achieve the integration of the mental illness and substance abuse services of the State and its political subdivisions with the mental illness and substance abuse services offered by health plans pursuant to title I of this Act. A State may petition the Secretary for a waiver of the requirement of this subsection under the circumstances described in section 3511(b)(7).

(b) CERTIFICATION OF READINESS.—

(1) PETITION.—A State may petition the Secretary to integrate the mental illness and substance abuse services of the State and its political subdivisions with the mental illness and substance abuse services offered by health plans pursuant to title I of this Act prior to January 1, 2001.

(2) STATE READINESS TO INTEGRATE.—Upon receiving such a petition, the Secretary shall, based on the reports submitted pursuant to subsections (b) and (c) of section 3511 and the criteria promulgated pursuant to paragraph (3), ascertain the State's readiness to integrate its mental illness and substance abuse services with the mental illness and substance abuse services offered by health plans pursuant to title I of this Act and certify whether the State is prepared to conduct such an integration.

(3) CRITERIA.—The certification by the Secretary of a State's readiness to integrate under paragraph (2) shall be based on objective criteria promulgated by the Secretary after consultation with the States.

(c) APPLICATION OF PROVISIONS.—Upon the issuance of a certification of readiness by the Secretary for a State, the limits set forth in subsections (d)(2)(B) and (e)(2)(A) of section 1106 shall not apply to the provision of mental illness and substance abuse services in the State.

SEC. 3511. REPORT ON INTEGRATION OF MENTAL HEALTH SYSTEMS.

(a) IN GENERAL.—As a condition of being a participating State under title I, each State shall, not later than October 1, 1998, submit to the Secretary a report contain-

ing the information described in subsection (b) on (including a plan for) the measures to be implemented by the State to achieve the integration of the mental illness and substance abuse services of the State and its political subdivisions with the mental illness and substance abuse services that are included in the comprehensive benefit package under title I. The plan required in the preceding sentence shall meet the conditions described in section 3083(b). In addition, each State shall submit to the Secretary a report containing the information described in subsection (c) for each year in which the State participates under title I up to and including the year 2001 or the date on which an unlimited benefit for mental illness and substance abuse services is provided, whichever occurs later.

(b) REQUIRED CONTENTS OF INTEGRATION REPORT.—With respect to the provision of items and services relating to mental illness and substance abuse, the report of a State under subsection (a) shall, at a minimum, contain the following information:

(1) Information on the number of individuals served by or through mental illness and substance abuse programs administered by State and local agencies and the proportion who are eligible persons under title I.

(2) Information on the extent to which each health provider furnishing mental illness and substance abuse services under a State program participates or will participate in one or more regional or corporate alliance health plans, and, in the case of providers that do not so participate, the reasons for the lack of participation.

(3) With respect to the two years preceding the year in which the State becomes a participating State under title I—

(A) the amount of funds expended by the State and its political subdivisions for each of such years for items and services that are included in the comprehensive benefit package under such title;

(B) the amount of funds expended for medically necessary and appropriate items and services not included in such benefit package, including medical care, other health care, and supportive services related to the provision of health care.

(4) An estimate of the amount that the State will expend to furnish items and services not included in such package once the expansion of cov-

erage for mental illness and substance abuse services is implemented in the year 2001.

(5) A description of how the State will assure that all individuals served by mental illness and substance abuse programs funded by the State will be enrolled in a health plan and how mental illness and substance abuse services not covered under the benefit package will continue to be furnished to such enrollees.

(6) A description of the conditions under which the integration of mental illness and substance abuse providers into regional and corporate alliances can be achieved, and an identification of changes in participation and certification requirements that are needed to achieve the integration of such programs and providers into health plans.

(7) If the integration of mental illness and substance abuse programs operated by the State into one or more health plans is not medically appropriate or feasible for one or more groups of individuals treated under State programs, a description of the reasons that integration is not feasible or appropriate and a plan for assuring the coordination for such individuals of the care and services covered under the comprehensive benefit package with the

additional items and services furnished by such programs.

(8) A description of the manner in which the resources that the State and its political subdivisions currently spend on mental health and substance abuse services will be used to facilitate integration.

(c) REQUIRED CONTENTS OF TRANSITION REPORT.—With respect to the a report required under this subsection, the report shall, at a minimum, contain the following information:

(1) The amount of funds expended for substance abuse and mental health services by the source of revenue, including, Federal block grant funds, under title XIX of the Public Health Service Act, Federal categorical grant funds, State and local revenues and health plan payments.

(2) The amount of funds expended for supportive services to individuals enrolled in substance abuse and mental health treatment programs, including transportation, child care, educational and vocational training and coordination with other public systems such as the social service, child welfare and juvenile and criminal justice systems, by source of revenue.

(3) The amount of funds expended on medically necessary and appropriate items and services not covered or reimbursed in the comprehensive benefit package by source of revenue.

(4) The amount of funds expended by the State on substance abuse and mental illness services for individuals who are not eligible to receive the comprehensive benefit package pursuant to this Act, and the source of revenue for such services.

(d) GENERAL PROVISIONS.—Reports under subsections (b) and (c) shall be provided at the time and in the manner prescribed by the Secretary. The Secretary shall also determine what, if any, reports shall be submitted in years following the implementation of an unlimited benefit for mental illness and substance abuse services.

(e) REPORTING REQUIREMENT.—Each State shall report annually to the Secretary on the incidence and prevalence of mental illness and substance abuse disorders in the prison population, changes in such incidence and prevalence in the prison population, and potential causative factors with respect to such changes, including an estimate of the extent to which the denial of treatment, or the provision of inadequate treatment, to individuals with mental illness and substance abuse disorders is contributing to the criminal activity of such individuals.

PART 2—ASSISTANCE FOR STATE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

SEC. 3531. AVAILABILITY OF ASSISTANCE.

(a) IN GENERAL.—The Secretary shall make grants to States for the development and operation of comprehensive managed mental health and substance abuse programs that are integrated with the health delivery system established under this Act. Such programs shall—

(1) promote the development of integrated delivery systems for the management of the mental health and substance abuse services provided under the comprehensive benefits package;

(2) give priority to providing services to low-income adults with serious mental illness or substance abuse disorders and children with serious emotional disturbance or substance abuse disorders and provide for the phase-in of such services for all eligible persons within 5 years;

(3) ensure that individuals participating in the program have access to all medically necessary mental health and substance abuse services;

(4) promote the linkage of mental health and substance abuse services with primary and preventive health care services; and

(5) meet such other requirements as the Secretary may impose.

(b) EXCEPTION.—Nothing in this part shall be construed as preventing States that have separate administrative entities for mental health and for substance abuse services from establishing separate comprehensive managed care programs for such services and receiving assistance under this part for either or both programs.

SEC. 3532. PLAN REQUIREMENTS.

In order to receive a grant under this part, a State must have a plan for a comprehensive managed mental health and substance abuse program which is approved by the Secretary. Such plan shall—

(1) describe the management, access, and referral structure that the State will use to promote and achieve integration of mental health and substance abuse services with the health delivery system established under this Act for eligible individuals in the State;

(2) describe how the State will ensure that providers of specialized services will meet appropriate standards and provide assurances that the State has complied with section 1504 as it affects mental health and substance abuse services;

(3) describe payment, utilization review, and other mechanisms that the State will use to encourage appropriate service delivery and management of costs;

(4) describe uniform patient placement criteria that the State will use to ensure placement in appropriate substance abuse treatment programs;

(5) describe the processes the State will use to ensure that individuals will continue to have access to treatment through referrals from nonhealth public entities, such the juvenile or criminal justice systems, or social service systems;

(6) specify the methods the State will use to ensure that individuals receiving services under the program have access to all medically necessary and appropriate mental health and substance abuse services;

(7) define terms that will be used by the State in determining the eligibility of individuals for services under the program;

(8) describe how health plans will use services under the comprehensive managed mental health and substance abuse programs established under this part;

(9) describe the role of local government in financing and managing the integrated mental illness and substance abuse treatment system;

(10) describe the sources of funding, including Medicaid and the block grants authorized by title XIX of the Public Health Service Act, that will be used by the State, other than the grant received under this part, to operate the program, and provide the status of any request for a Medicaid waiver made by the State to the Secretary;

(11) describe how the State provided for broad-based public input in the development of the plan, and the mechanism that will be used for ongoing public comment on and review of amendments to the plan; and

(12) describe grievance procedures that will be available for individuals dissatisfied with their health plan's participation in the comprehensive managed mental health and substance abuse program, and mechanisms that will be available to review the performance of health plans and fee-for-service arrangements to ensure against under treatment.

SEC. 3533. ADDITIONAL FEDERAL RESPONSIBILITIES.

The Secretary shall, upon the submission of a State's plan under section 3532, ensure the timely consideration

of any Medicaid waiver requests submitted by the State, affirm that section 1504 has been implemented, and ensure the timely implementation of section 1641(b)(5).

SEC. 3534. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this part, $82,000,000 for each of the fiscal years 1995 through 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

Subtitle G—Comprehensive School Health Education; School-Related Health Services

PART 1—HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS FOR SCHOOL HEALTH EDUCATION

SEC. 3601. PURPOSES.

It is the purpose of this part—

(1) to support the development and implementation of comprehensive age appropriate health education programs in public schools for children and youth kindergarten through grade 12; and

(2) to increase access to preventive and primary health care services for children and youth through school-based or school-linked health service sites in accordance with locally determined needs.

SEC. 3602. HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Education, shall award grants to State educational agencies in eligible States to integrate comprehensive school health education in schools within the State, with priority given within States to those communities in greatest need as defined by section 3683(a).

(b) ELIGIBLE USES OF FUNDS.—Funds made available under this section shall be used—

(1) to implement comprehensive school health education programs, as defined in subsection (f)(1) through grants to local educational agencies;

(2) to provide staff development and technical assistance to local educational agencies, schools, local health agencies, and other community organizations involved in providing comprehensive school health education programs;

(3) to evaluate and report to the Secretary on the progress made towards attaining the goals and objectives described under subsection (c)(1)(A); and

(4) to conduct such other activities to achieve the objectives of this subpart as the Secretary may require.

(c) APPLICATION.—An application for a grant under subsection (a), shall be jointly developed by the State edu-

cational agency and the State health agencies of the State involved, and shall contain—

(1) a State plan for comprehensive school health education programs, that outlines—

(A) the goals and objectives of the State for school health education programs, and the manner in which the State will allocate funds to local educational agencies in order to achieve these goals and objectives;

(B) the manner in which the State will coordinate programs under this part with other Federal, State and local health education programs and resources, and school health services;

(C) the manner in which comprehensive school health education programs will be coordinated with other Federal, State and local education programs (such as programs under titles I, II, and IV of the Elementary and Secondary Education Act of 1965), with the school improvement plan of the State, if any, under title III of the Goals 2000: Educate America Act, and with any similar programs;

(D) the manner in which the State shall work with State and local educational agencies

and with State and local health agencies to reduce barriers to implementing school health education programs;

(E) the manner in which the State will monitor the implementation of such programs by local educational agencies and establish outcome criteria by which to evaluate their effectiveness in achieving progress towards the goals and objectives described in subparagraph (A);

(F) the manner in which the State will provide staff development and technical assistance to local educational agencies, and build capacity for professional development of health educators; and

(G) the manner in which such school health education programs will be, to the extent practicable, culturally competent and linguistically appropriate and responsive to the diverse needs of the students served;

(2) a description of the respective roles of the State educational agency, local educational agencies, the State health agency and local health agencies in developing and implementing the State's school health education plan and resulting programs;

(3) a description of the input of the local community (including students and parents) in the development and operation of comprehensive school health education programs;

(4) an assurance that communities identified in section 3683(a) receive priority as locations for comprehensive school health education programs for all grades to the extent that a State does not implement a statewide program; and

(5) an assurance that grants to local educational agencies under subsection (b)(1) are contingent upon submission by such agencies of a plan consistent with the requirements for the State plan as required under this subsection.

(d) WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS.—

(1) WAIVERS.— Except as provided in paragraph (4), upon the request of an entity and under a relevant program described in paragraph (2), the Secretary of Health and Human Services and the Secretary of Education may grant to the entity a waiver of any requirement of such program regarding the use of funds, or of the regulations issued for the program by the Secretary involved, if the following conditions are met with respect to such program:

(A) The Secretary involved determines that the requirements of such program impede the ability of the State educational agency to achieve more effectively the purposes described in section 3601.

(B) The Secretary involved determines that, with respect to the use of funds under such program, the requested use of the funds by the entity would be consistent with the purposes described in section 3601.

(C) The State educational agency provides all interested local educational agencies in the State with notice and an opportunity to comment on the proposal and makes these comments available to the Secretary.

(2) RELEVANT PROGRAMS.—For purposes of paragraph (1), the programs described in this subparagraph are the following:

(A) In the case of programs administered by the Secretary of Health and Human Services, the following:

(i) The program known as the Prevention, Treatment, and Rehabilitation Model Projects for High Risk Youth, carried out

under section 517 of the Public Health Service Act.

(ii) The program known as the State and Local Comprehensive School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes, carried out under such Act.

(B) In the case of programs administered by the Secretary of Education, any program carried out under part B of the Drug-Free Schools and Communities Act of 1986, except that a component of such comprehensive school health education must be consistent with the statutory intent and purposes of such Act.

(3) WAIVER PERIOD.—A waiver under this paragraph shall be for a period not to exceed 3 years, unless the Secretary involved determines that—

(A) the waiver has been effective in enabling the State to carry out the activities for which it was requested and has contributed to improved performance of comprehensive health education programs; and

(B) such extension is in the public interest;

(4) WAIVERS NOT AUTHORIZED.—The Secretary involved under paragraph (1), may not waive, under this section, any statutory or regulatory requirements relating to—

(A) comparability of services;

(B) maintenance of effort;

(C) parental participation and involvement;

(D) the distribution of funds to States or to local educational agencies or other recipients of funds under the programs described in paragraph (2);

(E) maintenance of records;

(F) applicable civil rights requirements; or

(G) the requirements of sections 438 and 439 of the General Education Provisions Act.

(5) TERMINATION OF WAIVER.—The Secretary involved under paragraph (1) shall terminate a waiver under this subsection if the Secretary determines that the performance of the State affected by the waiver has been inadequate to justify a continuation of the waiver or if it is no longer necessary to achieve its original purpose.

(e) DEFINITIONS.—As used in this section:

(1) COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The term ''comprehensive school health

education'' means a planned, sequential program of health education that addresses the physical, emotional and social dimensions of student health in kindergarten through grade 12. Such program shall—

(A) be designed to assist students in developing the knowledge and behavioral skills needed to make positive health choices and maintain and improve their health, prevent disease and injuries, and reduce risk behaviors which adversely impact health;

(B) be comprehensive and include a variety of components addressing personal health, community and environmental health, injury prevention and safety, nutritional health, the effects of substance use and abuse, consumer health regarding the benefits and appropriate use of medical services including immunizations and other clinical preventive services, and other components deemed appropriate by the local educational agencies;

(C) be designed to be linguistically and culturally competent and responsive to the needs of the students served; and

(D) address locally relevant priorities as determined by parents, students, teachers, and school administrators and health officials.

(2) ELIGIBLE STATE.—The term ''eligible State'' means a State with a memorandum of understanding or a written cooperative agreement entered into by the agencies responsible for health and education concerning the planning and implementation of comprehensive school health education programs. Among these States a priority shall be given to qualified States as defined in section 3682(c).

(3) STATE EDUCATIONAL AGENCY.—The term ''State educational agency'' means the officer or agency primarily responsible for the State supervision of public elementary and secondary schools.

(4) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' means a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or such combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or

secondary schools. Such term includes any other public institution or agency having administrative control and direction of a public elementary or secondary school.

(f) AUTHORIZED FUNDING.—For the purpose of carrying out this section, out of the funds available under section 3695(b)(2), there are made available, not to exceed $15,000,000 for fiscal year 1995, $20,000,000 for fiscal year 1996, $25,000,000 for fiscal year 1997, $30,000,000 for fiscal year 1998, $40,000,000 for fiscal year 1999, and $50,000,000 for fiscal year 2000.

SEC. 3603. HEALTHY STUDENTS-HEALTHY SCHOOLS INTERAGENCY TASK FORCE.

(a) ESTABLISHMENT.—Not later than 120 days after the date of enactment of this Act, the Secretary shall establish a Healthy Students-Healthy Schools Interagency Task Force to be composed of representatives of the Office of Disease Prevention and Health Promotion, the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Office of School Health Education within the Department of Education, and other Federal agencies and departments which have responsibility for components of school health and education.

(b) CO-CHAIRPERSONS.—The Assistant Secretary for Health and the Assistant Secretary for Elementary and Secondary Education shall serve as co-chairpersons of the task force established under subsection (a).

(c) FUNCTIONS AND ACTIVITIES.—The task force established under subsection (a) shall—

(1) review and coordinate all Federal efforts in school health education and health services;

(2) provide scientific and technical advice concerning the development and implementation of model comprehensive school health education programs and curricula;

(3) develop model student learning objectives and assessment instruments that shall be made available to all States;

(4) develop a uniform grant application form (a form that serves as the principal document containing the core information concerning a particular entity) and procedures that may be used with respect to all school health education-related programs (including supplementary information procedures to be implemented when an entity that has already submitted an application form is applying for additional assistance) that require the submission of an application; and

(5) recommend to the Secretary, for inclusion in the biennial report required by section 3604(2), methods for effectively linking school health education and health services research findings at the Federal level with implementation at the State and local levels.

(d) CONSOLIDATION OF INITIATIVES.—Not later than 12 months after the date of enactment of this Act, the task force established under subsection (a) shall prepare and submit to the Congress a report containing the recommendations of the task force for the consolidation of Federal school health education initiatives.

SEC. 3604. DUTIES OF THE SECRETARY.

The Secretary shall—

(1) establish and maintain a national clearinghouse, using advanced technologies to the maximum extent practicable, and mechanisms for the diverse dissemination of school health education material, including written, audio-visual, and electronically conveyed information to educators, schools, health care providers, and other individuals, organizations, and governmental entities;

(2) submit a biennial report to the Committee on Labor and Human Resources of the Senate and the appropriate committees of the House of Rep-

resentatives on the implementation and contribution of comprehensive school health education programs funded under this part toward achieving relevant National Healthy People 2000 objectives established by the Secretary; and

(3) encourage coordination among Federal agencies, State and local governments, educators, school health providers, community-based organizations, and private sector entities to support development of comprehensive school health education programs and school health services.

PART 5—SCHOOL-RELATED HEALTH SERVICES

Subpart A—Development and Operation

SEC. 3681. AUTHORIZATION OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subpart, there are authorized to be appropriated $82,000,000 for fiscal year 1995, $164,000,000 for fiscal year 1996, $266,500,000 for fiscal year 1997, and $369,000,000 for fiscal year 1998, $471,500,000 for fiscal year 1999, $574,000,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

(b) FUNDING FOR PLANNING AND DEVELOPMENT GRANTS.—Of amounts made available under this section,

not to exceed $10,000,000 for each of fiscal years 1995 and 1996 may be utilized to carry out section 3684.

SEC. 3682. ELIGIBILITY FOR GRANTS.

(a) IN GENERAL.—

(1) PLANNING AND DEVELOPMENT GRANTS.—Entities eligible to apply for and receive grants under section 3684 are—

(A) State health agencies that apply on behalf of local community partnerships; or

(B) local community partnerships in States in which health agencies have not successfully applied.

(2) OPERATIONAL GRANTS.—Entities eligible to apply for and receive grants under section 3685 are—

(A) a qualified State as designated under subsection (c) that apply on behalf of local community partnerships; or

(B) local community partnerships in States that are not designated under subparagraph (A).

(b) LOCAL COMMUNITY PARTNERSHIPS.—

(1) IN GENERAL.—A local community partnership under subsection (a)(1)(B) and (a)(2)(B) is an entity that, at a minimum includes—

(A) a local health care provider, which may be a local public health department, with experience in delivering services to children and youth or medically underserved populations;

(B) local educational agency on behalf of one or more public schools; and

(C) one community based organization located in the community to be served that has a history of providing services to at-risk children and youth.

(2) RURAL COMMUNITIES.—In rural communities, local partnerships should seek to include, to the fullest extent practicable, providers and community based organizations with experience in serving the target population.

(3) PARENT AND COMMUNITY PARTICIPATION.—An applicant described in subsection (a) shall, to the maximum extent feasible, involve broad-based community participation (including parents of the youth to be served).

(c) QUALIFIED STATE.—A qualified State under subsection (a)(2)(A) is a State that, at a minimum—

(1) demonstrates an organizational commitment (including a strategic plan) to providing a broad

range of health, health education and support services to at-risk youth; and

(2) has a memorandum of understanding or cooperative agreement jointly entered into by the State agencies responsible for health and education regarding the planned delivery of health and support services in school-based or school-linked centers.

SEC. 3683. PREFERENCES.

In making grants under sections 3684 and 3685, the Secretary shall give priority to applicants whose-communities to be served show the most substantial level of need for health services among children and youth.

SEC. 3684. PLANNING AND DEVELOPMENT GRANTS.

(a) IN GENERAL.—The Secretary may make grants during fiscal years 1995 and 1996 to entities eligible under section 3862 to develop school-based or school-linked health service sites.

(b) USE OF FUNDS.—Amounts provided under a grant under this section may be used for the following:

(1) Planning for the provision of school health services, including—

(A) an assessment of the need for health services among youth in the communities to be served;

(B) the health services to be provided and how new services will be integrated with existing services;

(C) assessing and planning for the modernization and expansion of existing facilities and equipment to accommodate such services; and

(D) an affiliation with relevant health plans.

(2) recruitment and training of staff for the administration and delivery of school health services;

(3) the establishment of local community partnerships as described in section 3682 (b);

(4) in the case of States, the development of memorandums of understanding or cooperative agreements for the coordinated delivery of health and support services through school health service sites; and

(5) other activities necessary to assume operational status.

(c) APPLICATION FOR GRANTS.—To be eligible to receive a grant under this section an entity described in section 3682 (a) shall submit an application in a form and manner prescribed by the Secretary.

(d) NUMBER OF GRANTS.—Not more than one planning grant may be made to a single applicant. A planning grant may not exceed 2 years in duration.

(e) AMOUNT AVAILABLE FOR DEVELOPMENT GRANT.—The Secretary may award not to exceed—

(1) $150,000 to entities under section 3682(a)(1)(A) and to localities planning for a city-wide or countywide school health services delivery system; and

(2) $50,000 to entities under section 3682(a)(1)(B).

SEC. 3685. GRANTS FOR OPERATION OF SCHOOL HEALTH SERVICES.

(a) IN GENERAL.—The Secretary may make grants to eligible entities described in section 3682(a)(2) that submit applications consistent with the requirements of this section, to pay the cost of operating school-based or school-linked health service sites.

(b) USE OF GRANT.—Amounts provided under a grant under this section may be used for the following—

(1) health services, including diagnosis and treatment of simple illnesses and minor injuries;

(2) preventive health services, including health screenings follow-up health care, mental health, and preventive health education;

(3) enabling services, as defined in section 3461(b), and other necessary support services;

(4) training, recruitment, and compensation of health professionals and other staff necessary for the administration and delivery of school health services; and

(5) referral services, including the linkage of individuals to health plans, and community-based health and social service providers.

(c) APPLICATION FOR GRANT.—To be eligible to receive a grant under this section an entity described in section 3682(a)(2) shall submit an application in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant must include in the application the following information—

(1) a description of the services to be furnished by the applicant;

(2) the amounts and sources of funding that the applicant will expend, including estimates of the amount of payments the applicant will receive from health plans and other sources;

(3) a description of local community partnerships, including parent and community participation;

(4) a description of the linkages with other health and social service providers; and

(5) such other information as the Secretary determines to be appropriate.

(d) ASSURANCES.—In order to receive a grant under this section, an applicant must meet the following conditions—

(1) school health service sites will, directly or indirectly, provide a broad range of health services, in accordance with the determinations of the local community partnership, that may include—

(A) diagnosis and treatment of simple illnesses and minor injuries;

(B) preventive health services, including health screenings and follow-up health care, mental health and preventive health education;

(C) enabling services, as defined in section 3461(b);

(D) referrals (including referrals regarding mental health and substance abuse) with follow-up to ensure that needed services are received;

(2) the applicant provides services recommended by the health provider, in consultation with the local community partnership, and with the approval of the local education agency;

(3) the applicant provides the services under this subsection to adolescents, and other school age

children and their families as deemed appropriate by the local partnership;

(4) the applicant maintains agreements with community-based health care providers with a history of providing services to such populations for the provision of health care services not otherwise provided directly or during the hours when school health services are unavailable;

(5) the applicant establishes an affiliation with relevant health plans and will establish reimbursement procedures and will make every reasonable effort to collect appropriate reimbursement for services provided; and

(6) the applicant agrees to supplement and not supplant the level of State or local funds under the direct control of the applying State or participating local education or health authority expended for school health services as defined by this Act;

(7) services funded under this Act will be coordinated with existing school health services provided at a participating school; and

(8) for applicants in rural areas, the assurances required under paragraph (4) shall be fulfilled to the maximum extent possible.

(e) STATE LAWS.—Notwithstanding any other provision in this part, no school based health clinic may provide services, to any minor, when to do so is a violation of State laws or regulations pertaining to informed consent for medical services to minors.

(f) LIMITATION ON ADMINISTRATIVE FUNDS.—In the case of a State applying on behalf of local educational partnerships, the applicant may retain not more than 5 percent of grants awarded under this subpart for administrative costs.

(g) DURATION OF GRANT.—A grant under this section shall be for a period determined appropriate by the Secretary.

(h) AMOUNT OF GRANT.—The annual amount of a grant awarded under this section shall not be more than $200,000 per school-based or school-linked health service site.

(i) FEDERAL SHARE.—

(1) IN GENERAL.—Subject to paragraph (3), a grant for services awarded under this section may not exceed—

(A) 90 percent of the non-reimbursed cost of the activities to be funded under the program for the first 2 fiscal years for which the program receives assistance under this section; and

(B) 75 percent of the non-reimbursed cost of such activities for subsequent years for which the program receives assistance under this section.

The remainder of such costs shall be made available as provided in paragraph (2).

(2) FORM OF NON-FEDERAL SHARE.—The non-Federal share required by paragraph (1) may be in cash or in-kind, fairly evaluated, including facilities, equipment, personnel, or services, but may not include amounts provided by the Federal Government. In-kind contributions may include space within a school facilities, school personnel, program use of school transportation systems, outposted health personnel, and extension of health provider medical liability insurance.

(3) WAIVER.—The Secretary may waive the requirements of paragraph (1) for any year in accordance with criteria established by regulation. Such criteria shall include a documented need for the services provided under this section and an inability of the grantee to meet the requirements of paragraph (1) despite a good faith effort.

(j) TRAINING AND TECHNICAL ASSISTANCE.—Entities that receive assistance under this section may use not

to exceed 10 percent of the amount of such assistance to provide staff training and to secure necessary technical assistance. To the maximum extent feasible, technical assistance should be sought through local community-based entities. The limitation contained in this subsection shall apply to individuals employed to assist in obtaining funds under this part. Staff training should include the training of teachers and other school personnel necessary to ensure appropriate referral and utilization of services, and appropriate linkages between class-room activities and services offered.

(k) REPORT AND MONITORING.—The Secretary will submit to the Committee on Labor and Human Resources in the Senate and the Committee on Energy and Commerce in the House of Representatives a biennial report on the activities funded under this Act, consistent with the ongoing monitoring activities of the Department. Such reports are intended to advise the relevant Committees of the availability and utilization of services, and other relevant information about program activities.

Subpart B—Capital Costs of Developing Projects

SEC. 3691. FUNDING.

Amounts available to the Secretary under section 3412 for the purpose of carrying out subparts B and C of part 2 of subtitle E are, in addition to such purpose,

available to the Secretary for the purpose of carrying out this subpart.

Subtitle H—Public Health Service Initiative

SEC. 3695. PUBLIC HEALTH SERVICE INITIATIVE.

(a) IN GENERAL.—Subject to subsection (c), the Secretary of Health and Human Services shall pay, from funds in the Treasury not otherwise appropriated, individuals and entities that are eligible to receive assistance pursuant to the provisions referred to in paragraphs (1) through (13) of subsection (b), to the extent of the amounts specified under subsection (b).

(b) AMOUNTS SPECIFIED.—The amounts specified in subsection (a) with respect to a fiscal year shall be—

(1) with respect to the core functions of public health programs authorized under part 2 of subtitle D of title III, $123,000,000 for fiscal year 1995, $184,500,000 for fiscal year 1996, $266,500,000 for fiscal year 1997, $348,500,000 for fiscal year 1998, $410,000,000 for fiscal year 1999, $512,500,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(2) with respect to the national initiatives regarding health promotion and disease prevention under part 3 of subtitle D of title III, $102,500,000

for each of the fiscal years 1996 through 1998, $123,000,000 for each of the fiscal years 1999 and 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(3) with respect to occupational injury and illness prevention under section 3903, $92,250,000 for each of the fiscal years 1995 through 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(4) with respect to activities for the development of plans and networks under subpart B of part 2 of subtitle E of title III—

(A) $43,050,000 for fiscal year 1995, $100,450,000 for fiscal year 1996, $157,850,000 for fiscal year 1997, $129,150,000 for fiscal year 1998, $100,450,000 for fiscal year 1999, $43,050,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004; and

(B) with respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) and rural health clinics under such subpart, $79,950,000 for fiscal year 1995, $186,550,000 for fiscal year 1996, $293,150,000 for fiscal

year 1997, $239,850,000 for fiscal year 1998, $186,550,000 for fiscal year 1999, $79,950,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(5) with respect to capital costs under subpart C of part 2 of subtitle E of title III, $41,000,000 for each of the fiscal years 1995 through 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(6) with respect to enabling services under subpart D of part 2 of subtitle E of title III—

(A) $17,200,000 for fiscal year 1996, $68,900,000 for each of the fiscal years 1997 through 1999, $68,900,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004; and

(B) with respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) and rural health clinics under such subpart, $40,000,000 for fiscal year 1996, $161,000,000 for each of the fiscal years 1997 through 1999, $201,000,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(7) with respect to supplemental services under subpart D of part 1 of subtitle E of title III—

(A) $24,600,000 for fiscal year 1996, $36,900,000 for each of the fiscal years 1997 through 1999, $61,500,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004; and

(B) with respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) and rural health clinics under such subpart, $57,400,000 for fiscal year 1996, $86,100,000 for each of the fiscal years 1997 through 1999, and $143,500,000 for fiscal year 2000 and $2,000,000 for each of the fiscal years 2001 through 2004;

(8) with respect to the National Health Service Corps program referred to under section 3471, $123,000,000 for each of the fiscal years 1996 and 1997, and $201,000,000 for each of the fiscal years 1998 through 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(9) with respect to school-related health service programs under subpart A of part 5 of subtitle G of title III, $82,000,000 for fiscal year 1995,

$164,000,000 for fiscal year 1996, $266,500,000 for fiscal year 1997, and $369,000,000 for fiscal year 1998, $471,500,000 for fiscal year 1999, $574,000,000 for fiscal year 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(10) with respect to the development and operation of comprehensive managed mental health and substance abuse programs under section 3534, $82,000,000 for each of the fiscal years 1995 through 2000, and $2,000,000 for each of the fiscal years 2001 through 2004;

(11) with respect to programs of the Secretary of Health and Human Services under section 3081, $82,000,000 for each of the fiscal years 1995 and 1996, $123,000,000 for each of the fiscal years 1997 through 2000 and $2,000,000 for each of the fiscal years 2001 through 2004;

(12) with respect to programs of the Secretary of Labor under section 3082, $164,000,000 for each of the fiscal years 1995 through 2000 and $2,000,000 for each of the fiscal years 2001 through 2004; and

(13) with respect to programs of the Indian Health Service under subtitle D of title VIII, $164,000,000 for each of the fiscal years 1995

through 2000 and $2,000,000 for each of the fiscal years 2001 through 2004.

(c) AUTHORITY TO TRANSFER FUNDS.—The Committee on Appropriations of the House of Representatives and the Committee on Appropriations of the Senate, acting through appropriations Acts, may transfer the amounts specified under subsection (b) in each fiscal year among the programs referred to in such subsection.

(d) REPORT.—The Secretary shall review the effectiveness of the programs included in the Public Health Initiative. Not later than October 1, 1998, the Secretary shall prepare and submit to Congress a report concerning such review. Such report shall include recommendations concerning whether Congress should increase the program funding levels described in subsection (b) in fiscal years 2001 through 2004 to a level equal to that of prior fiscal years.

Subtitle I—Additional Provisions Regarding Public Health

SEC. 3901. CURRICULUM DEVELOPMENT AND IMPLEMENTATION REGARDING DOMESTIC VIOLENCE AND WOMEN'S HEALTH.

(a) IN GENERAL.—The Secretary shall make grants to eligible entities for the purpose of implementing and developing for trainees a curriculum that includes training

in identification, treatment and referral of victims of domestic violence and women's health needs.

(b) ELIGIBLE ENTITIES.—For purposes of subsection (a), eligible entities are any school of medicine, school of osteopathic medicine, school of public health, graduate program in mental health practice, school of nursing as defined in section 853 of the Public Health Service Act, a program to train physician assistants, a program for training allied health professionals, and a program for training of family medicine physicians, general internists, general pediatricians, geriatricians, and obstetrician/gynecologists.

(c) CURRICULUM.—A curriculum developed under this section shall include—

(1) identification of victims of domestic violence and maintaining complete medical records that include documentation of the examination, treatment provided, and referral made and recording the location and nature of the victim's injuries;

(2) examining and treating such victims within the scope of the health professional's discipline, training, and practice, including at a minimum providing medical advice regarding the dynamics and nature of domestic violence;

(3) referring the victims to public and nonprofit entities that provide support services for such victims;

(4) training in the identification and diagnosis of diseases afflicting women and other medical disorders as they affect women;

(5) training in the treatment of such diseases and disorders with emphasis on the unique needs of women; and

(6) research into the causes of such diseases and disorders, including determination of appropriate means of prevention.

(d) ALLOCATION OF APPROPRIATIONS.—Of the amounts made available under section 3301(b) for a fiscal year, the Secretary shall reserve not to exceed $20,000,000 for a fiscal year for carrying out this section.

SEC. 3902. COMMUNITY SCHOLARSHIP PROGRAMS.

Section 338L of the Public Health Service Act (42 U.S.C. 254t) is amended—

(1) in the section heading, by striking ''DEMONSTRATION'';

(2) in subsection (a)—

(A) by striking ''for the purpose of carrying out demonstration programs''; and

(B) by striking ''health manpower shortage areas'' and inserting ''Federally-designated health professional shortage areas'';

(3) in subsection (c)—

(A) by striking ''health manpower shortage areas'' and inserting ''Federally-designated health professional shortage areas'' in the matter preceding paragraph (1); and

(B) by striking ''in the health manpower shortage areas in which the community organizations are located,'' and inserting ''in a Federally-designated health professional shortage area that is served by the community organization awarding the scholarship,'' in paragraph (2);

(4) in subsection (e)(1)—

(A) by striking ''health manpower shortage area'' and inserting ''a Federally-designated health professional shortage area''; and

(B) by striking ''in which the community'' and all that follows through ''located'';

(5) in subsection (k)(2), by striking ''internal medicine'' and all that follows through the end thereof and inserting ''general internal medicine, general pediatrics, obstetrics and gynecology, den-

tistry, or mental health, that are provided by physicians or other health professionals.''; and

(6) in subsection (l)(1), by striking ''$5,000,000'' and all that follows through ''1993'' and inserting ''$1,000,000 for fiscal year 1994, and such sums as may be necessary for each fiscal year thereafter''.

Subtitle J—Occupational Safety and Health

SEC. 3903. OCCUPATIONAL INJURY AND ILLNESS PREVENTION.

(a) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall work together to develop and implement a comprehensive program to expand and coordinate initiatives to prevent occupational injuries and illnesses.

(b) SECRETARY OF LABOR.—The Secretary of Labor after consultation with the Secretary of Health and Human Services shall directly or by grants or contracts—

(1) provide for training and education programs for employees and employers in the recognition and control of workplace hazards and methods and measures to prevent occupational injuries and illnesses;

(2) develop model educational materials for training and educating employees and employers on

the recognition and control of workplace hazards, including a core curriculum for general safety and health training and materials related to specific safety and health hazards; and

(3) provide programs and services for technical assistance to employers and employees on the recognition and control of workplace safety and health hazards including programs for onsite consultation.

Technical assistance and consultative services under paragraph (3) shall be provided in a manner that is separate from the enforcement programs conducted by the Secretary of Labor.

(c) SECRETARY OF HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services after consultation with the Secretary of Labor shall directly or by grants or contracts—

(1) provide education programs for training occupational safety and health professionals including professionals in the fields of occupational medicine, occupational health nursing, industrial hygiene, safety engineering, toxicology and epidemiology;

(2) provide education programs for other health professionals and health care providers and the public to improve the recognition, treatment and prevention of occupationally related injuries and illnesses;

(3) conduct surveillance programs to identify patterns and to determine the prevalence of occupational illnesses, injuries and deaths related to exposure to particular safety and health hazards;

(4) conduct investigations and evaluations to determine if workplace exposures to toxic chemicals, harmful physical agents or potentially hazardous conditions pose a risk to exposed employees; and

(5) conduct research, demonstrations and experiments relating to occupational safety and health to identify the causes of and major factors contributing to occupational illnesses and injuries.

(d) NATIONAL ADVISORY BOARD.—

(1) ESTABLISHMENT.—There is established a National Advisory Board for Occupational Injury and Illness Prevention to provide oversight, advice and direction on the occupational injury and illness prevention programs and initiatives conducted by the Secretary of Labor and Secretary of Health and Human Services.

(2) COMPOSITION.—The Board shall be composed of 10 members appointed by the Secretary of Labor, 5 of whom are to be designated by the Secretary of Health and Human Services. Such members shall be composed of representatives of employ-

ers, employees, and occupational safety and health professionals.

(e) DIRECTOR OF NIOSH.—The responsibilities of the Secretary of Health and Human Services established under this section shall be carried out by the Director of the National Institute for Occupational Safety and Health.

(f) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section there are authorized to be appropriated $92,250,000 for each of the fiscal years 1995 through 2000, and $2,000,000 for each of the fiscal years 2001 through 2004.

Subtitle K—Full Funding for WIC

SEC. 3905. FULL FUNDING FOR WIC.

Section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) is amended—

(1) in the second sentence of subsection (a)—

(A) by striking ''authorized'' and inserting ''established''; and

(B) by striking '', up to the authorization levels set forth in subsection (g) of this section,'' and inserting '', up to the levels made available under this section,'';

(2) in subsection (c)—

(A) in the first sentence of paragraph (1), by striking ''may'' and inserting ''shall'';

(B) in paragraph (2), by striking ''appropriated'' and inserting ''made available'';

(3) in subsection (g)—

(A) by striking paragraph (1) and inserting the following new paragraph:

''(1)(A) There are authorized to be —

''(i) appropriated to carry out this section such amounts as are necessary for each of fiscal years 1995 through 2000; and

''(ii) made available such amounts as are necessary for the Secretary of the Treasury to fulfill the requirements of subparagraph (B).

''(B)(i) Out of any money in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide to the Secretary of Agriculture, on January 1 of each fiscal year, to carry out this subsection—

''(I) $444,000,000 for fiscal year 1996;

''(II) $696,000,000 for fiscal year 1997;

''(III) $775,000,000 for fiscal year 1998;

''(IV) $924,000,000 for fiscal year 1999; and

''(V) $1,077,000,000 for fiscal year 2000.

''(ii) The Secretary of Agriculture shall be entitled to receive the funds and shall accept the funds.

''(C) In lieu of obligating the funds made available under subparagraph (B) to carry out this subsection, if

the amount appropriated (in addition to the amount appropriated under subparagraph (B)(i)) to carry out this subsection for—

''(i) fiscal year 1996 is less than $3,470,000,000, the amount referred to in subparagraph (B)(i)(I) shall be obligated by the Secretary, during the period beginning December 31, 1995, and ending June 30, 1996, to increase the special assistance factor prescribed under section 11(a) of the National School Lunch Act (42 U.S.C. 1759a(a)) for free lunches served under the school lunch program (as established under section 4 of such Act (42 U.S.C. 1753));

''(ii) fiscal year 1997 is less than $3,470,000,000, the amount referred to in subparagraph (B)(i)(II) shall be obligated by the Secretary, during the period beginning December 31, 1996, and ending June 30, 1997, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act);

''(iii) fiscal year 1998 is less than $3,470,000,000, the amount referred to in subparagraph (B)(i)(III) shall be obligated by the Secretary,

during the period beginning December 31, 1997, and ending June 30, 1998, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act);

''(iv) fiscal year 1999 is less than $3,470,000,000, the amount referred to in subparagraph (B)(i)(IV) shall be obligated by the Secretary, during the period beginning December 31, 1998, and ending June 30, 1999, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act); and

''(v) fiscal year 2000 is less than $3,470,000,000, the amount referred to in subparagraph (B)(i)(V) shall be obligated by the Secretary, during the period beginning December 31, 1999, and ending June 30, 2000, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act).

''(D) Any increase in the special assistance factor prescribed under section 11(a) of such Act as a result of subparagraph (C) shall not affect any annual adjustment in the factor under section 11(a)(3) of such Act.

''(E) Notwithstanding any other provision of law, no additional amounts shall be made available under this paragraph for any fiscal year after fiscal year 2000.'';

(B) in the first sentence of paragraph (4), by striking ''appropriated'' and inserting ''made available''; and

(C) in paragraph (5), by striking ''appropriated'' and inserting ''made available'';

(4) in subsection (h)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking ''appropriated'' both places it appears and inserting ''made available''; and

(ii) in subparagraph (C), by striking ''appropriated'' both places it appears and inserting ''made available''; and

(B) in the first sentence of paragraph (2)(A), by striking ''1990, 1991, 1992, 1993 and 1994'' and inserting ''1990 through 2000''; and

(5) in subsection (l), by striking ''funds appropriated'' and inserting ''funds made available''.

Subtitle L—Border Health Improvement

SEC. 3908. BORDER HEALTH COMMISSION.

(a) ESTABLISHMENT.—The President is authorized and encouraged to conclude an agreement with Mexico to establish a binational commission to be known as the United States-Mexico Border Health Commission.

(b) DUTIES.—It should be the duty of the Commission—

(1) to conduct a comprehensive needs assessment in the United States-Mexico Border Area for the purposes of identifying, evaluating, preventing, and resolving health problems and potential health problems that affect the general population of the area;

(2) to develop and implement a comprehensive plan for carrying out the actions recommended by the needs assessment through—

(A) assisting in the coordination of public and private efforts to prevent potential health problems and resolve existing health problems,

(B) assisting in the coordination of public and private efforts to educate the population, in

a culturally competent manner, concerning such potential and existing health problems; and

(C) developing and implementing culturally competent programs to prevent and resolve such health problems and to educate the population, in a culturally competent manner, concerning such health problems where a new program is necessary to meet a need that is not being met through other public or private efforts; and

(3) to formulate recommendations to the Governments of the United States and Mexico concerning a fair and reasonable method by which the government of one country could reimburse a public or private person in the other country for the cost of a health care service that such person furnishes to a citizen or resident alien of the first country who is unable, through insurance or otherwise, to pay for the service.

(c) OTHER AUTHORIZED FUNCTIONS.—In addition to the duties described in subsection (b), the Commission should be authorized to perform the following functions as the Commission determines to be appropriate—

(1) to conduct or support investigations, research, or studies designed to identify, study, and

monitor, on an on-going basis, health problems that affect the general population in the United States-Mexico Border Area;

(2) to conduct or support a binational, public-private effort to establish a comprehensive and co-ordinated system, which uses advanced technologies to the maximum extent possible, for gathering health-related data and monitoring health problems in the United States-Mexico Border Area; and

(3) to provide financial, technical, or administrative assistance to public or private persons who act to prevent or resolve such problems or who educate the population concerning such health problems.

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT OF UNITED STATES SECTION.—The United States section of the Commission should be composed of 13 members. The section should consist of the following members:

(A) The Secretary of Health and Human Services or the Secretary's delegate.

(B) The commissioners of health or chief health officer from the States of Texas, New Mexico, Arizona, and California or such commissioners' delegates.

(C) Two individuals residing in United States-Mexico Border Area in each of the States of Texas, New Mexico, Arizona, and California who are nominated by the chief executive officer of the respective States and appointed by the President from among individuals—

(i) who have a demonstrated interest or expertise in health issues of the United States-Mexico Border Area; and

(ii) whose name appears on a list of 6 nominees submitted to the President by the chief executive officer of the State where the nominees resides.

(2) COMMISSIONER.—The Commissioner of the United States section of the Commission should be the Secretary of Health and Human Services or such individual's delegate to the Commission. The Commissioner should be the leader of the section.

(3) COMPENSATION.—Members of the United States section of the Commission who are not employees of the United States—

(A) shall each receive compensation at a rate of not to exceed the daily equivalent of the annual rate of basic pay payable for positions

at GS–15 of the General Schedule under section 5332 of title 5, United States Code, for each day such member is engaged in the actual performance of the duties of the Commission; and

(B) shall be allowed travel expenses, including per diem in lieu of subsistence at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services of the Commission.

(e) REGIONAL OFFICES.—The Commission should designate or establish one border health office in each of the States of Texas, New Mexico, Arizona, and California. Such office should be located within the United States-Mexico Border Area, and should be coordinated with—

(1) State border health offices; and

(2) local nonprofit organizations designated by the State's governor and directly involved in border health issues.

If feasible to avoid duplicative efforts, the Commission offices should be located in existing State or local nonprofit offices. The Commission should provide adequate compensation for cooperative efforts and resources.

(f) REPORTS.—Not later than February 1 of each year that occurs more than 1 year after the date of the establishment of the Commission, the Commission should submit an annual report to both the United States Government and the Government of Mexico regarding all activities of the Commission during the preceding calendar year.

(g) DEFINITIONS.—As used in this section:

(1) COMMISSION.—The term ''Commission'' means the United States-Mexico Border Health Commission.

(2) HEALTH PROBLEM.—The term ''health problem'' means a disease or medical ailment or an environmental condition that poses the risk of disease or medical ailment. Such term includes diseases, ailments, or risks of disease or ailment caused by or related to environmental factors, control of animals and rabies, control of insect and rodent vectors, disposal of solid and hazardous waste, and control and monitoring of air quality.

(3) RESIDENT ALIEN.—The term ''resident alien'', when used in reference to a country, means an alien lawfully admitted for permanent residence to the United States or otherwise permanently resid-

ing in the United States under color of law (including residence as an asylee, refugee, or parolee).

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

(5) UNITED STATES-MEXICO BORDER AREA.—The term ''United States-Mexico Border Area'' means the area located in the United States and Mexico within 100 kilometers of the border between the United States and Mexico.

TITLE IV—MEDICARE AND MEDICAID

SEC. 4000. REFERENCES IN TITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Rec-

onciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

Subtitle A—Medicare

PART 1—INTEGRATION OF MEDICARE BENEFICIARIES

SEC. 4001. INDIVIDUAL ELECTION TO REMAIN IN CERTAIN HEALTH PLANS.

(a) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k)(1) Notwithstanding any other provision of this section, each eligible organization with a risk-sharing contract (or which is eligible to enter into such a contract, as determined by the Secretary) that is the sponsor of a standard health plan under subtitle B of title I of the Health Security Act shall provide each individual who meets the requirements of paragraph (2) with the opportunity to elect (by submitting an application at such time and in such manner as specified by the Secretary) to continue enrollment in such plan (for the same benefits as other individuals enrolled in the plan) and to have payments made by the Secretary to the plan on the individual's behalf in accordance with paragraph (3). The premium imposed with respect to such an individual by the

plan shall be in an amount (determined in accordance with rules of the Secretary and notwithstanding other provisions of such Act) which reflects the difference between the premium otherwise established (adjusted by a factor to reflect the actuarial difference between medicare beneficiaries and other plan enrollees) and the amount payable under paragraph (3).

''(2) An individual meets the requirements of this paragraph if the individual is—

''(A) enrolled in the health plan of an eligible organization in a month in which the individual is either not entitled to benefits under part A, or is an employee (as defined in the Health Security Act) or the spouse or dependent of an employee,

''(B) entitled to benefits under part A and enrolled under part B in the succeeding month,

''(C) a community-rated individual under the Health Security Act in that succeeding month, and

''(D) not an experience-rated employee (as defined in the Health Security Act) or the spouse or dependent of an experience-rated employee in that succeeding month.

''(3) The Secretary shall make a payment to an eligible organization on behalf of each individual enrolled with the organization for whom an election is in effect under

this subsection in an amount determined by the rate specified by subsection (a)(1)(C) (notwithstanding the second sentence of paragraph (1)). Such payment shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as provided under subsection (a)(5) (other than as provided under subparagraph (B) of that paragraph).

''(4) The period for which payment may be made under paragraph (3)—

''(A) begins with the first month for which the individual meets the requirements of paragraph (2) (or a later month, in the case of a late application, as may be specified by the Secretary); and

''(B) ends with the earliest of—

''(i) the month following the month—

''(I) in which the individual notifies the Secretary that the individual no longer wishes to be enrolled in the health plan of the eligible organization and to have payment made on the individual's behalf under this subsection; and

''(II) which is a month specified by the Secretary as a uniform open enrollment period under subsection (c)(3)(A)(i), or

''(ii) the month in which the individual ceases to meet the requirements of paragraph (2).

''(5) Notwithstanding any other provision of this title, payments to an eligible organization under this subsection on behalf of an individual shall be the sole payments made with respect to items and services furnished to the individual during the period for which the individual's election under this subsection is in effect.''.

(b) CONFORMING AMENDMENT.—Section 1838(b) (42 U.S.C. 1395q(b)) is amended by inserting after ''section 1843(e)'' the following: '', 1876(c)(3)(B) or 1876(k)(4)(B)''.

SEC. 4002. ENROLLMENT AND TERMINATION OF ENROLLMENT.

(a) UNIFORM OPEN ENROLLMENT PERIODS.—

(1) FOR CAPITATED PLANS.—The first sentence of section 1876(c)(3)(A)(i) (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended by inserting ''(which may be specified by the Secretary)'' after ''open enrollment period''.

(2) FOR MEDIGAP PLANS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''paragraph (1), (2), or (3)'',

(B) by redesignating paragraph (3) as paragraph (4), and

(C) by inserting after paragraph (2) the following new paragraph:

''(3) Each issuer of a medicare supplemental policy shall have an open enrollment period (which shall be the period specified by the Secretary under section 1876(c)(3)(A)(i)), of at least 30 days duration every year, during which the issuer may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of age, health status, claims experience, receipt of health care, or medical condition. The policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods (except as provided by paragraph (2)(B)). The Secretary may require enrollment through a third party designated under section 1876(c)(3)(B).''.

(b) ENROLLMENTS FOR NEW MEDICARE BENEFICIARIES AND THOSE WHO MOVE.—Section 1876(c)(3)(A) (42 U.S.C. 1395mm(c)(3)(A)) is amended—

(1) in clause (i), by striking ''clause (ii)'' and inserting ''clauses (ii) through (iv)'', and

(2) by adding at the end the following:

''(iii) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) during any enrollment period specified by section 1837 that applies to that individual. Enrollment under this clause shall be effective as specified by section 1838.

''(iv) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) who has previously resided outside the geographic area which the organization serves. The enrollment period shall begin with the beginning of the month that precedes the month in which the individual becomes a resident of that geographic area and shall end at the end of the following month. Enrollment under this clause shall be effective as of the first of the month following the month in which the individual enrolls.''.

(c) ENROLLMENT THROUGH THIRD PARTY; UNIFORM TERMINATION OF ENROLLMENT.—The first sentence of section 1876(c)(3)(B) (42 U.S.C. 1395mm(c)(3)(B)) is amended—

(1) by inserting ''(including enrollment through a third party)'' after ''regulations'', and

(2) by striking everything after ''with the eligible organization'' and inserting ''during an annual period as prescribed by the Secretary, and as specified by the Secretary in the case of financial insolvency of the organization, if the individual moves from the geographic area served by the organization, or in other special circumstances that the Secretary may prescribe.''.

(d) EFFECTIVE DATE.—The amendments made by the previous subsections apply to enrollments and terminations of enrollments occurring after 1995 (but only after the Secretary of Health and Human Services has prescribed the relevant annual period), except that the amendments made by subsection (a)(2) apply to enrollments for a medicare supplemental policy made after 1995.

PART 2—PROVISIONS RELATING TO PART A

SEC. 4101. INPATIENT HOSPITAL SERVICES UPDATE FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by amending subclause (XII) to read as follows:

''(XII) for fiscal years 1997 through 2000, the market basket percentage minus 2.0 percentage points for hospitals in all areas, and''; and

(2) in subclause (XIII), by striking ''1998'' and inserting ''2001''.

SEC. 4102. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—

(1) REDUCTION IN BASE PAYMENT RATES FOR PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Health Security Act) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Health Security Act).''.

(2) REDUCTION IN UPDATE.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(A) in subparagraph (B)(i)—

(i) by striking ''and (II)'' and inserting ''(II)'', and

(ii) by striking the semicolon at the end and inserting the following: '', and (III) an annual update factor established for the prospective payment rates applicable to discharges in a fiscal year which (subject to reduction under subparagraph (C)) will be based upon such factor as the Secretary determines appropriate to take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality;'';

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

''(C)(i) With respect to payments attributable to portions of cost reporting periods or discharges occurring during each of the fiscal years 1996 through 2003, the Secretary shall include a reduction in the annual update factor established under subparagraph (B)(i)(III) for discharges in the year

equal to the applicable update reduction described in clause (ii) to adjust for excessive increases in capital costs per discharge for fiscal years prior to fiscal year 1992 (but in no event may such reduction result in an annual update factor less than zero).

''(ii) In clause (i), the term 'applicable update reduction' means, with respect to the update factor for a fiscal year—

''(I) 4.9 percentage points; or

''(II) if the annual update factor for the previous fiscal year was less than the applicable update reduction for the previous year, the sum of 4.9 percentage points and the difference between the annual update factor for the previous year and the applicable update reduction for the previous year.''.

(b) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is further amended by adding at the end the following new subparagraph:

''(T) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital

(as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during each of the fiscal years 1996 through 2003.''.

SEC. 4103. REDUCTIONS IN DISPROPORTIONATE SHARE PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''The amount'' and inserting ''Subject to clause (ix), the amount'';

(2) in clause (vi), by striking ''In'' and inserting ''Subject to clause (x), in''; and

(3) by adding at the end the following new clauses:

''(ix) Notwithstanding any other provision of this subparagraph, the Secretary shall reduce the amount of any additional payment made to a hospital under this subparagraph by an amount equal to the sum of—

''(I) for discharges occurring on or after the date on which the State in which such hospital is located becomes a participating State (as such term is defined in title I of the Health Security Act), 33 percent of such additional payment.''.

SEC. 4104. EXTENSION OF FREEZE ON UPDATES TO ROUTINE SERVICE COST LIMITS FOR SKILLED NURSING FACILITIES.

(a) PAYMENTS BASED ON COST LIMITS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''112 percent'' each place it appears and inserting ''100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(a)(1) of the Omnibus Budget Reconciliation Act of 1993)''.

(b) ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended by inserting the following sentence at the end: ''The effect of the amendment made by section 4104(a) of the Health Security Act shall not be considered by the Secretary in making adjustments pursuant to this subsection.''

(c) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Section 1888(d)(2)(B) (42 U.S.C. 1395yy(d)(2)(B)) is amended by striking ''105 percent'' and inserting ''100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(b) of the Omnibus Budget Reconciliation Act of 1993)''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall apply to cost reporting periods beginning on or after October 1, 1995.

SEC. 4105. MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.

(a) CLARIFICATION OF ADDITIONAL PAYMENT.—Section 1886(d)(5)(G)(ii)(I) (42 U.S.C. 1395ww(d)(5)(G)(ii)(I)) is amended by striking ''the first 3 12-month cost reporting periods that begin'' and inserting ''the 36-month period beginning with the first day of the cost reporting period that begins''.

(b) SPECIAL TREATMENT EXTENDED.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''October 1, 1994'' and inserting ''October 1, 1999''; and

(2) in clause (ii)(II), by striking ''October 1, 1994'' and inserting ''October 1, 1999''.

(c) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(1) in the matter preceding clause (i), by striking ''March 31, 1993'' and inserting ''September 30, 1999''; and

(2) by amending clause (iii) to read as follows:

''(iii) with respect to discharges occurring in fiscal years 1994 through 1999, the target amount for the cost reporting period beginning in the previous

fiscal year increased by the applicable percentage increase under subparagraph (B)(iv).''.

SEC. 4106. PROVISIONS RELATING TO RURAL HEALTH TRANSITION GRANT PROGRAM.

(a) ELIGIBILITY OF RURAL PRIMARY CARE HOSPITALS FOR GRANTS.—

(1) IN GENERAL.—Section 4005(e)(2) of the Omnibus Budget Reconciliation Act of 1987 is amended in the matter preceding subparagraph (A) by inserting ''any rural primary care hospital as defined in section 1861(mm)(1), or'' after ''means''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to grants made on or after October 1, 1993.

(b) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—Section 4005(e)(9) of Omnibus Budget Reconciliation Act of 1987 is amended—

(1) by striking ''1989 and'' and inserting ''1989,''; and

(2) by striking ''1992'' and inserting ''1992 and $30,000,000 for each of the fiscal years 1993 through 1999''.

(c) FREQUENCY OF REQUIRED REPORTS.—Section 4008(e)(8)(B) of the Omnibus Budget Reconciliation Act

of 1987 is amended by striking ''every 6 months'' and inserting ''every 12 months''.

SEC. 4107. PAYMENTS FOR SOLE COMMUNITY HOSPITALS WITH TEACHING PROGRAMS AND MULTIHOSPITAL CAMPUSES.

(a) IN GENERAL.—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended by adding at the end the following new clause:

''(vi) The Secretary shall determine payment under clause (i) for a sole-community hospital that is a part of a multi-campus hospital by making the determination under such clause for each facility of the multi-campus hospital if any facility of the hospital would have a value of 'r' greater than 0, as 'r' is defined in subparagraph (B)(ii). In making a determination for each such facility, the Secretary shall determine the DRG-specific rate applicable to the facility based on its location in accordance with paragraph (3)(D).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1993, from multi-campus hospitals that merged facilities on or after October 1, 1987.

SEC. 4108. MORATORIUM ON DESIGNATION OF NEW LONG-TERM HOSPITALS.

Notwithstanding clause (iv) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days shall not be treated as a hospital described in such clause for purposes of such title unless such hospital was treated as a hospital described in such clause for purposes of such title as of the date of the enactment of this Act.

SEC. 4109. REVISED PAYMENT METHODOLOGY FOR REHABILITATION AND LONG-TERM CARE HOSPITALS.

(a) REHABILITATION HOSPITALS AND DISTINCT PART UNITS.—

(1) DEFINITION.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: ''In defining a rehabilitation hospital and a rehabilitation unit of a hospital which is a distinct part of a hospital, the Secretary shall take into account the impact of new technologies, survival rates, and changes in the practice of rehabilitation medicine.''.

(2) TARGET AMOUNT CALCULATION FOR REHABILITATION HOSPITALS AND DISTINCT PART UNITS.—

(A) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(i) in subparagraph (A), by striking ''(D), and (E)'' and inserting ''(D), (E), and (F)'';

(ii) in subparagraph (B)(ii), by striking ''and (E)'' and inserting ''(E), and (F)''; and

(iii) by adding at the end the following new subparagraph:

''(F)(i) Subject to clause (ii), for cost reporting periods beginning on or after October 1, 1994, in the case of a hospital described in subsection (d)(1)(B)(ii) or a rehabilitation unit described in such subparagraph, the term 'target amount' means—

''(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital or unit—

''(aa) the allowable operating costs of inpatient hospital services (as

defined in subsection (a)(4)) recognized under this title for the hospital or unit for the 12-month cost reporting period (in this subparagraph referred to as the 'base cost reporting period') preceding the first cost reporting period for which this subparagraph was in effect with respect to such hospital, increased (in a compounded manner), by

''(bb) the applicable percentage increases applied to such hospital or unit under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

''(II) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B).

There shall be substituted for the allowable average costs of inpatient hospital services determined under subclause (I)(aa), the average of

the allowable average costs of inpatient hospital services (as so defined) recognized under this title for the hospital or unit for cost reporting periods beginning during fiscal years 1990 and 1991 (if any).

''(ii)(I) Notwithstanding the provisions of clause (i), in the case of a hospital or unit to which the last sentence of clause (i) applies, the hospital or unit's target amount under such clause for a cost reporting period shall be—

''(aa) not less than 70 percent of the national weighted average of all target amounts calculated under such clause for all hospitals and units described in such clause (as determined by the Secretary), and

''(bb) not less than the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) for such hospital or unit in the base cost reporting period (including any payments made to such hospital or unit pursuant to paragraph (1)(A)), multiplied by the applicable percentage increase for such cost reporting period under subparagraph (B).

"(II) Notwithstanding the provisions of clause (i), in the case of a hospital or unit that is not described in subclause (I), the hospital or unit's target amount under such clause for a cost reporting period shall be—

"(aa) not less than the amount described in subclause (I)(aa), and

"(bb) not greater than 110 percent of the national weighted average of all target amounts calculated under clause (i) for all hospitals and units described in such clause (as determined by the Secretary).".

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply with respect to cost reporting periods beginning on or after October 1, 1994.

(3) DEVELOPMENT OF NATIONAL PROSPECTIVE RATES FOR REHABILITATION HOSPITALS AND DISTINCT PART UNITS.—

(A) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary") shall develop a proposal to replace the current system under which rehabilitation hospitals and rehabilitation units of a hospital

which are a distinct part of a hospital (as described in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receive payment for the operating and capital-related costs of inpatient hospital services under part A of title XVIII of such Act with a prospective payment system. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall develop a system that provides for—

(i) a payment on a per-discharge basis, and

(ii) an appropriate weighting of such payment amount as it relates to the classification of the discharge.

(B) REPORTS.—Not later than October 1, 1996, the Secretary shall submit the proposal developed under subparagraph (A) to the Congress.

(b) ASSIGNMENT OF NEW BASE YEAR FOR CERTIFIED LONG-STAY HOSPITALS THAT ALSO SERVE A SIGNIFICANT PROPORTION OF LOW-INCOME PATIENTS.—

(1) REBASING FOR LONG-TERM HOSPITALS.—

(A) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by subsection (a), is further amended—

(i) in subparagraph (A), by striking ''(E), and (F)'' and inserting ''(E), (F), and (G)'';

(ii) in subparagraph (B)(ii), by striking ''(E), and (F)'' and inserting ''(E), (F), and (G)''; and

(iii) by inserting after subparagraph (F) the following new subparagraph:

''(G)(i) For cost reporting periods beginning on or after October 1, 1994, in the case of a hospital described in subsection (d)(1)(B)(iv) that—

''(I) has not received the additional payment amount described in paragraph (1)(A) for at least the preceding 2 consecutive 12-month cost reporting periods; and

''(II) for which the sum of the amounts described in subclauses (I) and (II) of subsection (d)(5)(F)(vi) during the period described in clause (I) exceeds 25 percent,

the term ‘target amount’ has the meaning given such term by clause (ii).

‘‘(ii) In the case of a hospital described in clause (i), the term ‘target amount’ means—

‘‘(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

‘‘(aa) the average allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital during cost reporting periods of the hospital beginning during fiscal years 1990 and 1991 for such hospital (in this subparagraph referred to as the ‘base cost reporting period’), increased (in a compounded manner), by

‘‘(bb) the applicable percentage increases applied to such hospital or under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting periods, or

''(II) with respect to a subsequent 12-month cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B).

''(iii) Notwithstanding clause (ii)(II), if, after 2 consecutive 12-month cost reporting periods, a hospital continues to be described in subclauses (I) and (II) of clause (i), there shall be substituted for the base cost reporting period described in clause (ii)(I)(aa) the most recent preceding 2 12-month cost reporting periods of the hospital for which data is available (as determined by the Secretary), but only if such substituting results in an increase in the target amount for the hospital. The substitution under the preceding sentence may not occur more often than every 2 years.

''(iv) Effective October 1, 1994, the Secretary shall take into account the enactment of this subparagraph in making available to the hospital the payments described in section 1815(e)(2), and, shall increase such payments as if the target amount of the hospital had been

established pursuant to this subparagraph as of such date.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall be effective with respect to cost reporting periods beginning on or after October 1, 1994.

SEC. 4110. TERMINATION OF INDIRECT MEDICAL EDUCATION PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended in the matter preceding clause (i) by striking ''The Secretary'' and inserting ''For discharges occurring before January 1, 1997, the Secretary''.

(b) ADJUSTMENT TO STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking ''excluding'' and inserting ''for discharges occurring before January 1, 1997, excluding''.

SEC. 4111. LIMITED SERVICE HOSPITAL PROGRAM.

(a) LIMITED SERVICE HOSPITAL PROGRAM.—Section 1820 (42 U.S.C. 1395*l*–4) is amended to read as follows:

''LIMITED SERVICE HOSPITAL PROGRAM

''SEC. 1820. (a) PURPOSE.—The purpose of this section is to—

''(1) make available alternative hospital models to small rural or isolated rural communities in which

facilities are relieved of the burden of selected regulatory requirements by limiting the scope of inpatient acute services required to be offered;

''(2) alter medicare reimbursement policy to support the financial viability of alternative facilities by limiting the financial risk faced by such small hospitals through the use of reasonable cost reimbursement; and

''(3) promote linkages between facilities designated by the State under this section and broader programs supporting the development of and transition to integrated provider networks.

''(b) IN GENERAL.—Any State that submits an application in accordance with subsection (c) may establish a limited service hospital program described in subsection (d).

''(c) APPLICATION.—A State may establish a limited service hospital program described in subsection (d) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(A) has developed, or is in the process of developing, a State rural health care plan that—

''(i) in the case of a State applying to establish a rural primary care hospital program (described in subsection (d)(1)(A)), provides for the creation of one or more rural health networks (as defined in subsection (e)) in the State,

''(ii) promotes regionalization of rural health services in the State, and

''(iii) improves access to hospital and other health services for rural residents of the State;

''(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that it will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan); and

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of designating, rural nonprofit or public hospitals or facili-

ties located in the State as rural primary care hospitals facilities or medical assistance facilities; and

''(3) such other information and assurances as the Secretary may require.

''(d) LIMITED SERVICE HOSPITAL PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (c), may establish a limited service hospital program that includes—

''(A) a rural primary care hospital program under which—

''(i) at least one facility in the State shall be designated as a rural primary care hospital in accordance with paragraph (2), and

''(ii) the State shall develop at least one rural health network (as defined in subsection (e)) in the State;

''(B) a medical assistance facility program under which at least one facility in the State shall be designated as a medical assistance facility in accordance with paragraph (2); or

''(C) both.

"(2) STATE DESIGNATION OF FACILITIES.—A State may designate one or more facilities as a rural primary care hospital or medical assistance facility in accordance with subparagraph (A) or (B).

"(A) CRITERIA FOR DESIGNATION AS RURAL PRIMARY CARE HOSPITAL.—A State may designate a facility as a rural primary care hospital only if the facility—

"(i) is located in a rural area (as defined in section 1886(d)(2)(D)), or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas;

"(ii) at the time such facility applies to the State for designation as a rural primary care hospital, is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed), with a participation agreement in effect under section 1866(a);

''(iii) has in effect an agreement to participate with other hospitals and facilities in a rural health network;

''(iv) provides 24-hour emergency services to ill or injured persons prior to admission to the facility or prior to their transportation to a full-service hospital;

''(v) provides not more than 15 inpatient beds (meeting such conditions as the Secretary may establish) for providing acute inpatient care;

''(vi) provides inpatient care for a period not to exceed an average length of 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions);

''(vii) meets such staffing requirements as would apply under section 1861(e), to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the fa-

cility must be open and fully staffed, except insofar as the facility is required to provide emergency care on a 24-hour basis under clause (v) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present,

''(II) the facility may provide any services otherwise required to be provided by a full-time, onsite dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, offsite basis under arrangements as defined in section 1861(w)(1), and

''(III) the inpatient care described in clause (vii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility, and

''(viii) meets the requirements of subparagraphs (C) through (I) of paragraph

(2) of section 1861(aa), and of clauses (ii) and (iv) of the second sentence of that paragraph, except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(B) CRITERIA FOR DESIGNATION AS MEDICAL ASSISTANCE FACILITY.—A State may designate a facility as a medical assistance facility only if the facility—

''(i) is located in a county (or equivalent unit of local government)—

''(I) with fewer than 6 residents per square mile; or

''(II) in a rural area (as defined in section 1886(d)(2)(D)) that is located more than a 35–mile or 45–minute drive from a hospital, a rural primary care hospital, or another facility described in this subsection;

"(ii) at the time such facility applies to the State for designation as a medical assistance facility—

"(I) is a hospital (or in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed), with a participation agreement in effect under section 1866(a); or

"(II) is licensed in accordance with applicable State and local laws and regulations;

"(iii) meets the requirements of clauses (iv), (vi), and (vii) of subparagraph (A); and

"(iv) meets the requirements of subparagraph (I) of paragraph (2) of section 1861(aa).

"(e) RURAL HEALTH NETWORK DEFINED.—For purposes of this section, the term 'rural health network' means, with respect to a State, an organization—

"(1) consisting of—

"(A) at least 1 facility that the State has designated or plans to designate as a rural primary care hospital, and

"(B) at least 1 hospital that furnishes services that a rural primary care hospital cannot furnish, and

"(2) the members of which have entered into agreements regarding—

"(A) patient referral and transfer,

"(B) the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data,

"(C) the provision of emergency and non-emergency transportation among the members, and

"(D) credentialing and quality assurance.

"(f) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a rural primary care hospital or medical assistance facility (as the case may be) if the facility—

"(1) is located in a State that has established a limited service hospital program in accordance with subsection (d);

1 ''(2) is designated as a rural primary care hos-
2 pital or medical assistance facility by the State in
3 which it is located; and
4 ''(3) meets such other criteria as the Secretary
5 may require.
6 ''(g) PERMITTING MAINTENANCE OF SWING BEDS.—
7 Nothing in this section shall be construed to prohibit a
8 State from designating or the Secretary from certifying
9 a facility as a rural primary care hospital or medical as-
10 sistance facility solely because, at the time the facility ap-
11 plies to the State for designation as a rural primary care
12 hospital or medical assistance facility, there is in effect
13 an agreement between the facility and the Secretary under
14 section 1883 under which the facility's inpatient hospital
15 facilities are used for the furnishing of extended care serv-
16 ices, except that the number of beds used for the furnish-
17 ing of such services may not exceed the total number of
18 licensed inpatient beds at the time the facility applies to
19 the State for such designation (minus the number of inpa-
20 tient beds used for providing inpatient care in a rural pri-
21 mary care facility pursuant to subsection (d)(2)(A)(vi)).
22 The Secretary may establish additional conditions of par-
23 ticipation for rural primary care hospitals with a substan-
24 tial number of such beds. For purposes of the first sen-
25 tence, the number of beds of the facility used for the fur-

nishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital or medical assistance facility.

''(h) GRANTS.—

''(1) LIMITED SERVICE HOSPITAL PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (c) for—

''(A) engaging in activities relating to planning and implementing a rural health care plan;

''(B) in the case of a rural primary care hospital program described in subsection (d)(1)(A), engaging in activities relating to planning and implementing rural health networks; and

''(C) designation of facilities as rural primary care hospitals or medical assistance facilities.

''(2) RURAL EMERGENCY MEDICAL SERVICES.—

''(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a pro-

gram for the provision of rural emergency medical services.

''(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (c)(1) and paragraph (3) of such subsection.

''(i) STUDY ON CLINICALLY BASED ALTERNATIVE TO 96-HOUR RULE.—The Secretary shall conduct a study on the feasibility of admitting patients to rural primary care hospitals and medical assistance facilities on a limited DRG basis instead of using the 96-hour average length of stay criteria described in subsection (d)(2)(A)(vii).

''(j) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund—

''(1) for making grants under subsection (h)(1) to States that have established a rural primary care

hospital program in the State under subsection (d)(1)(A), $15,000,000 for each of fiscal years 1993 through 1995; and

''(2) for making grants to all States under subsection (h), $25,000,000 in each of the fiscal years 1996 through 1999.''.

(b) PART A AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND MEDICAL ASSISTANCE FACILITIES.—

(1) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''MEDICAL ASSISTANCE FACILITY; MEDICAL ASSISTANCE FACILITY SERVICES

''(oo)(1) The term 'medical assistance facility' means a facility certified by the Secretary as a medical assistance facility under section 1820(f).

''(2) The term 'medical assistance facility services' means items and services, furnished to an inpatient for a medical assistance facility by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.''.

(2) COVERAGE AND PAYMENT.—(A)(i) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by striking ''inpatient hospital services'' the first place it appears and inserting '', inpatient hospital serv-

ices and inpatient medical assistance facility services''; and

(ii) by striking ''inpatient hospital services'' the second place it appears and inserting ''such services''.

(B) Section 1814 (42 U.S.C. 1395f) is amended—

(i) in subsection (b), by striking ''inpatient rural primary care hospital services,'' and inserting ''inpatient rural primary care hospital services, other than a medical assistance facility providing inpatient medical assistance facility services,''; and

(ii) by amending subsection (l) to read as follows:

''(l) PAYMENT FOR INPATIENT RURAL PRIMARY CARE SERVICES AND INPATIENT MEDICAL ASSISTANCE FACILITY SERVICES.—The amount of payment under this part for inpatient rural primary care services and inpatient medical assistance facility services is the reasonable costs of the rural primary care hospital or medical assistance facility in providing such services.''.

(3) TREATMENT OF MEDICAL ASSISTANCE FACILITIES AS PROVIDERS OF SERVICES.—(A) Section 1861(u) (42 U.S.C. 1395x(u)) is amended by insert-

ing ''medical assistance facility,''after ''rural primary care hospital,''.

(B) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by inserting ''a medical assistance facility, as defined in section 1861(oo)(1),'' after ''1861(mm)(1),''.

(C) The third sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by striking ''or 1861(mm)(1)'' and inserting ''1861(mm)(1), or 1861(oo)(1),''.

(4) CONFORMING AMENDMENTS.—(A) Section 1128A(b)(1) (42 U.S.C. 1320a–7a(b)(1)) is amended—

(i) by striking ''or a rural primary care hospital'' the first place it appears and inserting '', a rural primary care hospital, or a medical assistance facility''; and

(ii) by striking ''or a rural primary care hospital'' the second place it appears and inserting '', the rural primary care hospital, or the medical assistance facility''.

(B) Section 1128B(c) (42 U.S.C. 1320a–7b(c)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(C) Section 1134 (42 U.S.C. 1320b–4) is amended by striking ''or rural primary care hospitals'' each place it appears and inserting '', rural primary care hospitals, or medical assistance facilities''.

(D) Section 1138(a)(1) (42 U.S.C. 1320b–8(a)(1)) is amended—

(i) in the matter preceding subparagraph (A), by striking ''or rural primary care hospital'' and inserting '', rural primary care hospital, or medical assistance facility'', and

(ii) in the matter preceding clause (i) of subparagraph (A), by striking ''or rural primary care hospital'' and inserting '', rural primary care hospital, or medical assistance facility''.

(E) Section 1164(e) (42 U.S.C. 1320c–13(e)) is amended by inserting ''medical assistance facilities,'' after ''rural primary care hospitals,''.

(F) Section 1816(c)(2)(C) (42 U.S.C. 1395h(c)(2)(C)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(G) Section 1833 (42 U.S.C. 1395*l*) is amended—

(i) in subsection (h)(5)(A)(iii)—

(I) by striking ''or rural primary care hospital'' and inserting ''rural primary care hospital, or medical assistance facility''; and

(II) by striking ''to the hospital'' and inserting ''to the hospital or the facility'';

(ii) in subsection (i)(1)(A), by inserting ''medical assistance facility,'' after ''rural primary care hospital,'';

(iii) in subsection (i)(3)(A), by striking ''or rural primary care hospital services'' and inserting ''rural primary care hospital services, or medical assistance facility services'';

(iv) in subsection (*l*)(5)(A), by inserting ''medical assistance facility,'' after ''rural primary care hospital,'' each place it appears; and

(v) in subsection (*l*)(5)(C), by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(H) Section 1835(c) (42 U.S.C. 1395n(c)) is amended by adding at the end the following: ''A medical assistance facility shall be considered a hospital for purposes of this subsection.''.

(I) Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(J) Section 1861 (42 U.S.C. 1395x) is amended—

(i) in the last sentence of subsection (e), by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) or a medical assistance facility (as defined in section 1861(oo)(1)).'',

(ii) in subsection (w)(1) by inserting ''medical assistance facility,'' after ''rural primary care hospital,'', and

(iii) in subsection (w)(2), by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(K) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(L) Section 1866(a)(1) (42 U.S.C 1395cc(a)(1)) is amended—

(i) in subparagraph (F)(ii), by inserting ''medical assistance facilities,'' after ''rural primary care hospitals,'';

(ii) in subparagraph (H)—

(I) in the matter preceding clause (i), by inserting ''and in the case of medical assistance facilities which provide inpatient medical assistance facility services'' after ''rural primary care hospital services''; and

(II) in clauses (i) and (ii), by striking ''hospital'' each place it appears and inserting ''hospital or facility'';

(iii) in subparagraph (I)—

(I) in the matter preceding clause (i), by striking ''or rural primary care hospital'' and inserting '', a rural primary care hospital, or a medical assistance facility''; and

(II) in clause (ii), by striking ''the hospital'' and inserting ''the hospital or the facility''; and

(iv) in subparagraph (N)—

(I) in the matter preceding clause (i), by striking ''and rural primary hospitals''

and inserting ‘‘, rural primary care hospitals, and medical assistance facilities’’;

(II) in clause (i), by striking ‘‘or rural primary care hospital,’’ and inserting ‘‘, rural primary care hospital, or medical assistance facility,’’; and

(III) in clause (ii), by striking ‘‘hospital’’ and inserting ‘‘hospital or facility’’.

(M) Section 1866(a)(3) (42 U.S.C 1395cc(a)(3)) is amended—

(i) by striking ‘‘rural primary care hospital,’’ each place it appears in subparagraphs (A) and (B) and inserting ‘‘rural primary care hospital, medical assistance facility,’’, and

(ii) in subparagraph (C)(ii)(II), by striking ‘‘rural primary care hospitals,’’ each place it appears and inserting ‘‘rural primary care hospitals, medical assistance facilities’’.

(N) Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking ‘‘1861(mm)(1))’’ and inserting ‘‘1861(mm)(1)) or a medical assistance facility (as defined in section 1861(oo)(1)).’’.

(c) PART B AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND MEDICAL ASSISTANCE FACILITIES.—

(1) COVERAGE.—(A) Section 1861(oo) (42 U.S.C. 1395x(oo)) as added by subsection (b)(1), is amended by adding at the end the following new paragraph:

''(3) The term 'outpatient medical assistance facility services' means medical and other health services furnished by a medical assistance facility on an outpatient basis.''.

(B) Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(i) in subparagraph (I), by striking ''and'' at the end;

(ii) in subparagraph (J), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(K) outpatient medical assistance facility services (as defined in section 1861(oo)(3)).''.

(2) PAYMENT.—(A) Section 1833(a) (42 U.S.C. 1395*l*(a)) is amended—

(i) in paragraph (2), in the matter preceding subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

(ii) in paragraph (6), by striking ''and'' at the end;

(iii) in paragraph (7), by striking the period at the end and inserting ''; and''; and

(iv) by adding at the end the following new paragraph:

''(8) in the case of outpatient medical assistance facility services, the amounts described in section 1834(g).''.

(B) Section 1834(g) (42 U.S.C. 1395m(g)) is amended—

(i) in the subsection heading by inserting ''AND OUTPATIENT MEDICAL ASSISTANCE FACILITY SERVICES'' after ''SERVICES'';

(ii) in paragraph (1), by striking ''provided during a year before 1993 in a rural primary care hospital under this part shall be determined by one of the following methods as elected by the rural primary care hospital'' and inserting ''in a rural primary care hospital or medical assistance facility under this part shall be determined by one of the following methods

as elected by the rural primary care hospital or medical assistance facility''; (iii) in paragraph (1)(A)(ii), by striking ''outpatient rural primary care hospital services'' each place it appears and inserting ''outpatient rural primary care hospital services or outpatient medical assistance facility services''; and (iv) in paragraph (1)(B), by striking ''hospital'' and inserting ''hospital or facility''.

(d) PAYMENT CONTINUED TO DESIGNATED EACHs.—

(1) TERMINATION OF EACH DESIGNATION.—Section 1820(i)(1)(A) (42 U.S.C. 1395*l*(4)(i)(1)(A)) is amended by inserting at the end the following new flush sentence:

''The Secretary shall not designate any hospital as an essential access community hospital on or after July 1, 1994.''.

(2) PERMITTING PAYMENT TO PRIOR DESIGNATED EACHS.—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting ''as such section was in effect as of July 1, 1994'' before the period at the end; and

(B) in clause (v), by inserting ''as such section was in effect as of July 1, 1994'' after ''1820(i)(1).''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on July 1, 1994.

(e) TECHNICAL AMENDMENT RELATING TO PART A DEDUCTIBLE, COINSURANCE AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)), as amended by subsection (b)(2)(A), is amended—

(A) by striking ''inpatient medical assistance facility services'' and inserting ''inpatient medical assistance facility services, inpatient rural primary care hospital services, or inpatient medical assistance facility services''; and

(B) by striking ''and inpatient rural primary care hospital services''.

(2) Sections 1813(a) and 1813(b)(3)(A) (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking ''inpatient hospital services'' each place it appears and inserting ''inpatient hospital services, inpatient rural primary care hospital services, or inpatient medical assistance facility services,''.

(3) Section 1813(b)(3)(B) (42 U.S.C. 1395e(b)(3)(B)) is amended by striking ''inpatient hospital services'' and inserting ''inpatient hospital services,

inpatient rural primary care hospital services, inpatient medical assistance facility services,''.

(4) Section 1861(a) (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking ''inpatient hospital services'' and inserting ''inpatient hospital services, inpatient rural primary care hospital services, inpatient medical assistance facility services,''; and

(B) in paragraph (2), by striking ''hospital'' and inserting ''hospital, rural primary care hospital, or medical assistance facility''.

(f) REPEAL OF DEVELOPMENT OF PPS SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1814(l) (42 U.S.C. 1395f(l)) is amended by striking paragraph (2).

(2) CONFORMING AMENDMENTS.—Section 1814(l)(1) (42 U.S.C. 1395F(l)(1)) is amended—

(A) by striking ''(l)(1)'' and inserting ''(l)'';

(B) by redesignating subparagraphs (A) and (B) as paragraphs (1) and (2), respectively;

(C) in paragraph (2), as redesignated, by striking ''paragraph'' and inserting ''subsection''; and

(D) in the last sentence, by striking ''paragraph'' and inserting ''subsection''.

(g) REPEAL OF DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE PPS SYSTEM FOR OUTPATIENT RURAL PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by subsection (c)(2)(B), is amended by striking paragraph (2).

(2) CONFORMING AMENDMENTS.—Section 1834(g)(1) (42 U.S.C. 1395m(g)(1)) is amended—

(A) by striking ''(1) IN GENERAL.—''

(B) by redesignating subparagraph (A) and clauses (i) and (ii) of such subparagraph as paragraph (1) and subparagraphs (A) and (B) of such paragraph, respectively;

(C) by redesignating subparagraph (B) as paragraph (2);

(D) in paragraph (1)(A), as redesignated, by striking ''subparagraph (B)''; and

(E) in paragraph (1)(B), as so redesignated, by striking ''subparagraph'' and inserting ''paragraph''.

(h) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to services furnished on or after October 1, 1994.

SEC. 4112. SUBACUTE CARE STUDY.

(a) STUDY.—The Secretary of Health and Human Services (hereafter in this section referred to as the ''Secretary'') shall—

(1) define the level and type of care that should constitute subacute care;

(2) determine the appropriateness of furnishing subacute care in different settings by evaluating the quality of care and patient outcomes;

(3) determine the cost and effectiveness of providing subacute care under the medicare program under title XVIII of such Act to individuals who are eligible for benefits under part A of such title;

(4) determine the extent to which hospital DRG prospective payment rates under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) are appropriate for the less restrictive institutional settings that provide subacute care; and

(5) study the relationships between institutions and their payment methodologies in order to develop ways in which to maximize the continuity of care for

each patient episode in which subacute care is furnished.

(b) REPORT.—Not later than October 1, 1996, the Secretary shall submit to the Congress a report on the matters studied under subsection (a).

PART 3—PROVISIONS RELATING TO PART B

SEC. 4201. UPDATES FOR PHYSICIANS' SERVICES.

Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) in subparagraph (A), by inserting after ''subparagraph (B)'' the following: ''and, in the case of 1995, specified in subparagraph (C)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL PROVISION FOR 1995.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is—

''(i) in the case of physicians' services included in the category of primary care services (as defined for purposes of subsection (j)(1)), the conversion factor established under this subsection for 1994 re-

duced by 1 percent and adjusted by the update established under paragraph (3) for 1995; and

''(ii) in the case of any other physicians' services, the conversion factor established under this subsection for 1994 reduced by 4.0 percent and adjusted by the update established under paragraph (3) for 1995.''.

SEC. 4202. SUBSTITUTION OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY; REPEAL OF RESTRICTION ON MAXIMUM REDUCTION PERMITTED IN DEFAULT UPDATE.

(a) USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY.—Section 1848(f)(2)(A)(iii) (42 U.S.C. 1395w–4(f)(2)(A)(iii)) is amended to read as follows:

''(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the category of services consisting of primary care services), and''.

(b) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w–4(d)(3)(B)(ii)) is amended—

(1) in the heading, by inserting ''IN CERTAIN YEARS'' after ''ADJUSTMENT'';

(2) in the matter preceding subclause (I), by striking ''for a year'';

(3) in subclause (I), by adding ''and'' at the end;

(4) in subclause (II), by striking '', and'' and inserting a period; and

(5) by striking subclause (III).

(c) REPEAL OF PERFORMANCE STANDARD FACTOR.—

(1) IN GENERAL.—Section 1848(f)(2) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) CONFORMING AMENDMENT.—Section 1848(f)(2)(A) is amended in the matter following clause (iv) by striking ''1, multiplied by 100'' and all that follows through ''subparagraph (B))'' and inserting ''1 and multiplied by 100''.

(d) EFFECTIVE DATE.—

(1) VOLUME PERFORMANCE STANDARDS.—The amendments made by subsections (a) and (c) shall

apply with respect to volume performance standards established beginning with fiscal year 1995.

(2) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—The amendments made by subsection (b) shall apply to services furnished on or after January 1, 1997.

SEC. 4203. PAYMENT FOR PHYSICIANS' SERVICES RELATING TO INPATIENT STAYS IN CERTAIN HOSPITALS.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII (42 U.S.C. 1831 et seq.) is amended by inserting after section 1848 the following new section:

''LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES RELATING TO INPATIENT STAYS IN CERTAIN HOSPITALS

''SEC. 1849. (a) DEFINITIONS.—In this section, the following definitions apply:

''(1) HOSPITAL.—The term 'hospital' means a subsection (d) hospital as defined in section 1886(d)(1)(B).

''(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

''(A) if (in accordance with requirements for hospitals established by the Joint Commis-

sion on Accreditation of Health Organizations)—

''(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

''(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

''(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

''(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

''(3) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

''(4) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).

''(b) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (c)(2) for the following year; and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (c)(1).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (d)) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an indi-

vidual who is a member of the hospital's medical staff.

''(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff of such hospital under paragraph (1).

''(c) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

''(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

''(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for a year is equal to 125 percent (or 120 percent for years after 1999) of the median of 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

"(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

"(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific per admission

relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

''(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)); and

''(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second calendar year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall deter-

mine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

''(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

''(d) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (b) during a year shall be reduced by 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (b)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

"(e) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

"(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission relative value shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (c)(2)(C)).

"(2) RECONCILIATION WITH REDUCTIONS TAKEN.—

"(A) REIMBURSEMENT.—In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the

hospital were reduced under this section for a year—

''(i) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (c)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (d), including interest at an appropriate rate determined by the Secretary; and

''(ii) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) exceeded the allowable average per admission relative value applicable to the hospital's medical staff under subsection (c)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a

percent of the total amount of payment otherwise determined under this part for physicians' services furnished during the year to inpatients of the hospital by the hospital's medical staff (prior to the reduction under subsection (d)), the difference between 15 percentage points and the actual number of percentage points that the medical staff exceeded the allowable average per admission relative value, including interest at any appropriate rate determined by the Secretary.

''(B) NO REIMBURSEMENT.—The Secretary shall not pay the fiduciary agent for the medical staff of a hospital any amounts by which payments for physicians' services provided by the medical staff were reduced for a year under this section if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) exceeded the allowable average per admission relative value applicable to the hospital's medical staff under subsection (c)(1) for the year by 15 percentage points or more.

"(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have 1 year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate amounts withheld made by the carrier.

"(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(A)(ii) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

"(f) CLAIMS TO BE SUBMITTED NOT LATER THAN 90 DAYS AFTER END OF YEAR.—Notwithstanding any other provision of law, no payment may be made under this part for any physician's service furnished by a mem-

ber of the medical staff of a hospital to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for the payment for such service not later than 90 days after the last day of the year.''.

(2) CONFORMING AMENDMENTS.—(A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting ''(subject to reduction under section 1849)'' after ''1848(a)(1)''.

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w–4(a)(1)(B)) is amended by striking ''this subsection,'' and inserting ''this subsection and section 1849,''.

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w–4(g)(4)(A)(i)) is amended by striking ''beneficiary,'' and inserting ''beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 4204. CHANGES IN UNDERSERVED AREA BONUS PAYMENTS.

(a) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(1) by inserting ''(1)'' after ''(m)'',

(2) by inserting ''described in paragraph (2)'' after ''physicians' services'',

(3) by striking ''10 percent'' and inserting ''the applicable percent'',

(4) by striking ''service'' the last place it appears and inserting ''services'', and

(5) by adding at the end the following new paragraph:

''(2)(A) The applicable percent referred to in paragraph (1) is 20 percent in the case of primary care services, as defined in section 1842(i)(4), and 10 percent for services other than primary care services furnished in health professional shortage areas located in rural areas as defined in section 1886(d)(2)(D).

''(B) The Secretary shall reduce payments for all services (other than primary care services) for which payment may be made under this section by such percentage as the Secretary determines necessary so that, beginning on the date of the enactment of the Health Security Act, the amendments made by section 4204(e) of such Act would not result in expenditures under this section that

exceed the amount of such expenditures that would have been made if such amendment had not been made.''.

(b) EFFECTIVE DATE.—The amendments made by paragraph (1) are effective for services furnished on or after January 1, 1995.

SEC. 4205. CORRECTION OF MVPS UPWARD BIAS.

(a) IN GENERAL.—Section 1848(f)(2)(A)(iv) (42 U.S.C. 1395w–4(f)(2)(A)(iv)) is amended by striking ''including changes in law and regulations affecting the percentage increase described in clause (i)'' and inserting ''excluding anticipated responses to such changes''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to performance standard rates of increase determined for fiscal year 1995 and succeeding fiscal years.

SEC. 4206. DEMONSTRATION PROJECTS FOR MEDICARE STATE-BASED PERFORMANCE STANDARD RATE OF INCREASE.

Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by adding at the end the following new paragraph:

''(6) STATE-BASED PERFORMANCE STANDARD RATES OF INCREASE DEMONSTRATION PROJECTS.—The Secretary shall establish demonstration projects in not more than 3 States under which a State elects State-based performance standard rates of in-

crease to substitute for the national performance standard rates of increase established for the year under paragraph (2). The Secretary shall develop criteria for the establishment of such demonstration projects which shall include the requirement of budget-neutrality for payments made under this part with respect to physicians' services furnished in a State participating in the demonstration project.''.

SEC. 4207. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may

charge as described in clause (ii) of section 1866(a)(2)(A).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after July 1, 1994.

SEC. 4208. EYE OR EYE AND EAR HOSPITALS.

Section 1833(i)(4)(A) (42 U.S.C. 1395l(i)(4)(A)) is amended in the matter following clause (iii) by striking ''January 1, 1995'' and inserting ''September 30, 1997''.

SEC. 4209. IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

(a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

(1) by striking ''(or 100 percent'' and all that follows through ''the first opinion))''; and

(2) by striking ''100 percent of such negotiated rate'' and inserting ''80 percent of such negotiated rate''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1995.

SEC. 4210. APPLICATION OF COMPETITIVE ACQUISITION PROCESS FOR PART B ITEMS AND SERVICES.

(a) GENERAL RULE.—Part B of title XVIII is amended by inserting after section 1846 the following:

''COMPETITION ACQUISITION FOR ITEMS AND SERVICES

''SEC. 1847. (a) ESTABLISHMENT OF BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for the purpose of awarding a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1, 1995. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services under this part.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall—

''(A) initially be, or be within, metropolitan statistical areas; and

''(B) be chosen based on the availability and accessibility of suppliers and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

"(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

"(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any individual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity meets quality standards specified by the Secretary for the furnishing of such item or service.

"(3) CONTENTS OF CONTRACT.—A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1) shall specify (for all of the items and services within a class)—

"(A) the quantity of items and services the entity shall provide; and

"(B) such other terms and conditions as the Secretary may require.

"(c) SERVICES DESCRIBED.—The items and services to which the provisions of this section shall apply are as follows:

''(1) Magnetic resonance imaging tests and computerized axial tomography scans, including a physician's interpretation of the results of such tests and scans.

''(2) Enteral and parenteral nutrients and supplies.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting ''; or''; and

(3) by inserting after paragraph (16) the following new paragraph:

''(17) where such expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, unless the Secretary finds that such expenses were incurred in a case of urgent need.''.

(c) REDUCTION IN PAYMENT AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUCTION IN PAYMENTS.—Notwithstanding any other provision of title XVIII of the Social Security Act, if the establishment of competitive acquisition areas under section 1847 of such Act (as added by subsection (a)) and the limitation of coverage for items and services under part B of such title to items and services furnished by providers with competitive acquisition contracts under such section during 1996 does not result in a reduction of at least 10 percent in the projected payment amount that would have applied to the items or services under part B if the items or services had not been furnished through competitive acquisition under such section in such year, the Secretary shall reduce for such year the payment amount for all such services by such percentage as the Secretary determines necessary to result in such a reduction for such year.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished under part B of title XVIII of the Social Security Act on or after January 1, 1995.

SEC. 4211. APPLICATION OF COMPETITIVE ACQUISITION PROCEDURES FOR LABORATORY SERVICES.

(a) IN GENERAL.—Section 1847(c), as added by section 4210, is amended by inserting after paragraph (2) the following new paragraph:

''(3) Clinical diagnostic laboratory tests.''.

(b) REDUCTION IN FEE SCHEDULE AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE SAVINGS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

''(7) Notwithstanding any other provision of this subsection, if the Secretary applies the authority provided under section 1847 to establish competitive acquisition areas for the furnishing of clinical diagnostic laboratory tests during 1996 and the application of such authority does not result in a reduction of at least 10 percent in the projected payment amount that would have applied to such tests under this section in such year if the tests had not been furnished through competitive acquisition under section 1847, the Secretary shall reduce for such year each payment amount for all such tests otherwise determined under the fee schedules and negotiated rates established under this subsection by such percentage as the Secretary determines necessary to result in such a reduction for such year.''.

SEC. 4212. EXPANDED COVERAGE FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS.

(a) COVERAGE IN OUTPATIENT SETTINGS.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i)—

(A) by striking ''or'' at the end of subclause (II); and

(B) by inserting ''or (IV) in an outpatient setting as defined by the Secretary'' following ''shortage area,''; and

(2) in clause (ii), by striking ''section 1919(a)'' and inserting ''section 1919(a) or in an outpatient setting as defined by the Secretary''.

(b) PAYMENT BASED ON PHYSICIAN FEE SCHEDULE.—

(1) Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)) is amended—

(A) by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner and clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)'';

(B) by striking ''for services furnished on or after January 1, 1992,'' and inserting ''for services described in section 1861(s)(2)(K)(iii) furnished on or after January 1, 1992, and for services described in clauses (i), (ii), and (iv) of

section 1861(s)(2)(K) furnished on or after January 1, 1997,''; and

(C) by striking ''subsection (r)(2)'' and inserting ''subsection (r)(2) or subparagraph (A) or (B) of section 1842(b)(12)''.

(2) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended—

(A) by striking ''and'' at the end of clause (i);

(B) in clause (ii)(II), by inserting ''and before January 1, 1997,'' after ''January 1, 1992,'';

(C) by striking the period at the end of clause (ii)(II) and inserting ''; and''; and

(D) by inserting at the end the following clause:

''(iii) in the case of services furnished on or after January 1, 1997—

''(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, and

''(II) in the case of other services, 85 percent of the fee schedule amount provided under section 1848.''.

(c) RURAL NURSE PRACTITIONERS AS ASSISTANTS AT SURGERY IN URBAN AREAS.—Section 1861(s)(2)(K)(ii) (42 U.S.C. 1395x(s)(2)(K)(ii)), as amended by subsection (a)(2), is further amended by adding ''or services as an assistant at surgery furnished by a nurse practitioner whose primary practice location (as defined by the Secretary) is in a rural area (as defined in section 1886(d)(2)(D)) to an individual who resides in a rural area when the service is furnished to such individual in an urban area by such practitioner when such practitioner refers such individual to an urban area for the furnishing of services'' after ''as defined by the Secretary''.

(d) CONFORMING AMENDMENTS.—

(1) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''subsection (s)(2)(K)(i)'' and inserting ''subsection (s)(2)(K)''.

(2) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)), as amended by section4108(b)(4)(K), is amended by striking ''section 1861(s)(2)(K)(i)'' and inserting ''section 1861(s)(2)(K)''.

(3) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)), as amended by section 4108(b)(4)(L)(ii), is further amended by striking ''section 1861(s)(2)(K)(i)'' and inserting ''section 1861(s)(2)(K)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1997.

SEC. 4213. ELIMINATION OF BALANCE BILLING.

Effective January 1, 1996, notwithstanding any provision of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), a nonparticipating physician, or nonparticipating supplier or other person (as such terms are defined in section 1842(i)(2) of such Act (42 U.S.C. 1395u(i)(2)) may not receive payment for services or items under such title.

SEC. 4214. DEVELOPMENT AND IMPLEMENTATION OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES.

(a) DEVELOPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physician's service. The methodology utilized

shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

(2) REPORT.—The Secretary shall transmit a report by January 1, 1996, on the methodology developed under paragraph (1) to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in developing the methodology and an explanation of the methodology.

(b) IMPLEMENTATION.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w–4(c)(2)(C)(ii)) is amended—

(A) by inserting ''for the service for years before 1997'' before ''equal to'',

(B) by striking the period at the end of subclause (II) and inserting a comma, and

(C) by adding after and below subclause (II) the following:

''and for years beginning with 1997 based on the relative practice expense resources involved in furnishing the service.''.

(2) CONFORMING AMENDMENT.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w–4(c)(3)(C)(ii)) is amended by striking ''The practice'' and inserting ''For years before 1997, the practice''.

(3) APPLICATION OF CERTAIN PROVISIONS.—In implementing the amendment made by paragraph (1)(C), the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.

SEC. 4215. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Subparagraph (B) of section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended by striking the period at the end and inserting '', except that such percentage increase shall—

''(i) be reduced by 2 percentage points for each of years 1995 and 1996;

''(ii) be reduced by 1.5 percentage points for 1997;

''(iii) be reduced by 2 percentage points for 1998; and

''(iv) be reduced by 1 percentage points for 1999.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall be effective on the date of the enactment of this Act.

SEC. 4216. GENERAL PART B PREMIUM.

Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking ''and prior to January 1999''; and

(2) in paragraph (2), by striking ''prior to January 1998''.

PART 4—PROVISIONS RELATING TO PARTS A AND B

SEC. 4301. MEDICARE SECONDARY PAYER CHANGES.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended—

(1) in the heading, by striking ''SUNSET'' and inserting ''EFFECTIVE DATE''; and

(2) by striking '', and before October 1, 1998''.

(c) EXTENSION OF PERIOD FOR END STAGE RENAL DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking ''and on or before October 1, 1998,''.

SEC. 4302. INCREASE IN MEDICARE SECONDARY PAYER COVERAGE FOR END STAGE RENAL DISEASE SERVICES TO 24 MONTHS.

(a) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)), as amended by section 4301(c), is amended by striking the last sentence and inserting: ''Effective for items and services furnished on or after January 1, 1996 (with respect to periods beginning on or after July 1, 1994), this subparagraph shall be applied by substituting '24-month' for '12-month' each place it appears.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services provided on or after January 1, 1996.

SEC. 4303. EXPANSION OF CENTERS OF EXCELLENCE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall use a competitive process to contract with centers of excellence for cataract surgery, coronary artery by-pass surgery, and such other services as the Secretary determines to be appropriate. Payment under title XVIII of the Social Security Act will be made

for services subject to such contracts on the basis of negotiated or all-inclusive rates as follows:

(1) The center shall cover services provided in an urban area (as defined in section 1886(d)(2)(D) of the Social Security Act) for years beginning with fiscal year 1995.

(2) The amount of payment made by the Secretary to the center under title XVIII of the Social Security Act for services covered under the contract shall be less than the aggregate amount of the payments that the Secretary would have made to the center for such services had the contract not been in effect.

(3) The Secretary shall make payments to the center on such a basis for the following services furnished to individuals entitled to benefits under such title:

(A) Facility, professional, and related services relating to cataract surgery.

(B) Coronary artery bypass surgery and related services.

(C) Such other services as the Secretary and the center may agree to cover under the contract.

(b) REBATE OF PORTION OF SAVINGS.—In the case of any services provided under a contract conducted under subsection (a), the Secretary shall make a payment to each individual to whom such services are furnished (at such time and in such manner as the Secretary may provide) in an amount equal to 10 percent of the amount by which—

(1) the amount of payment that would have been made by the Secretary under title XVIII of the Social Security Act to the center for such services if the services had not been provided under the contract, exceeds

(2) the amount of payment made by the Secretary under such title to the center for such services.

SEC. 4304. REDUCTION IN ROUTINE COST LIMITS FOR HOME HEALTH SERVICES.

(a) REDUCTION IN UPDATE TO MAINTAIN FREEZE IN 1996.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (II), by striking ''or'' at the end;

(2) in subclause (III), by striking ''112 percent,'' and inserting ''and before July 1, 1996, 112 percent, or''; and

(3) by inserting after subclause (III) the following new subclause:

''(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),''.

(b) BASING LIMITS IN SUBSEQUENT YEARS ON MEDIAN OF COSTS.—

(1) IN GENERAL.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)), as amended by subsection (a), is amended in the matter following subclause (IV) by striking ''the mean'' and inserting ''the median''.

(2) ADJUSTMENT TO LIMITS.—Section 1861(v)(1)(L)(ii) (42 U.S.C. 1395x(v)(1)(L)(ii)) is amended by adding at the end the following new sentence: ''The effect of the amendments made by 656(b) of the Health Security Act shall not be considered by the Secretary in making adjustments pursuant to this clause.''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to cost reporting periods beginning on or after July 1, 1997.

SEC. 4305. IMPOSITION OF 20 PERCENT COINSURANCE ON HOME HEALTH SERVICES UNDER MEDICARE.

(a) PART A.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

''(5) The amount payable for a home health service furnished to an individual under this part shall be reduced by a copayment amount equal to 20 percent of the average of all the per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year).''.

(b) PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)), as amended by section 4108(c)(2), is amended—

(1) in subparagraph (A), by striking ''to home health services,'' and by striking the comma after ''opinion)'';

(2) in subparagraph (E), by striking ''and'' at the end;

(3) in subparagraph (F), by striking the semicolon at the end and inserting ''; and''; and

(4) by adding at the end the following new subparagraph:

''(G) with respect to any home health service—

''(i) the lesser of —

''(I) the reasonable cost of such service, as determined under section 1861(v), or

''(II) the customary charges with respect to such service,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), or

''(ii) if such service is furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2),

less a copayment amount equal to 20 percent of the average of all per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year);''.

(c) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(1) by striking ''deduction or coinsurance'' and inserting ''deduction, coinsurance, or copayment''; and

(2) by striking ''or (a)(4)'' and inserting ''(a)(4), or (a)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after July 1, 1995.

SEC. 4306. TERMINATION OF GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

''(6) TERMINATION OF PAYMENTS ATTRIBUTABLE TO COSTS OF TRAINING PHYSICIANS.—Notwithstanding any other provision of this section or section 1861(v), no payment may be made under this title for direct graduate medical education costs attributable to an approved medical residency training program for any cost reporting period (or portion thereof) beginning on or after January 1, 1997.''.

(b) PROHIBITION AGAINST RECOGNITION OF COSTS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 4102(b), is amended by adding at the end the following new subparagraph:

''(U) Such regulations shall not include any provision for specific recognition of the costs of graduate medical education for hospitals for any cost reporting period (or portion thereof) beginning on or after January 1, 1997. Nothing in the previous sentence shall be construed to affect in any way payments to hospitals for the costs of any approved educational activities that are not described in such sentence.''.

SEC. 4307. MEDICARE SELECT.

(a) AMENDMENTS TO PROVISIONS RELATING TO MEDICARE SELECT POLICIES.—

(1) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 is hereby repealed.

(2) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the requirements of the 1991 NAIC Model Regulation or 1991

Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those requirements if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

''(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

''(bb) out of area coverage under the policy,

''(cc) the policy's coverage of emergency services and urgently needed care, and

''(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(b) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

''(B)(i) In the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy; except that, if such individual moves to a geographic area where such issuer, or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(ii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I); and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

(5) by adding at the end the following new subparagraph:

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(d) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1995 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 9-month period specified in paragraph (1), the Secretary of Health and Human Services (hereafter in this subsection referred to as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective

for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1995 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1995 NAIC Model Regulation or the 1995 Federal Regulation, or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to

meet the 1995 NAIC Model Regulation or the 1995 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle B—Medicaid Program

PART 1—INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO REFORMED HEALTH CARE SYSTEM

SEC. 4601. LIMITING COVERAGE UNDER MEDICAID OF ITEMS AND SERVICES COVERED UNDER STANDARD BENEFIT PACKAGE.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section

1932 and by inserting after section 1930 the following new section:

"TREATMENT OF ITEMS AND SERVICES IN THE STANDARD BENEFIT PACKAGE

"SEC. 1931. (a) ITEMS AND SERVICES COVERED UNDER STANDARD BENEFIT PACKAGE.—Except as provided in subsection (c), a State plan under this part shall not provide medical assistance consisting of payment for items and services in the standard benefit package described in section 1201(a) of the Health Security Act.

"(b) MEDICAL ASSISTANCE NOT AFFECTED.—Subsection (a) shall not be construed as—

"(1) affecting the eligibility of any individual for medical assistance consisting of payment for items and services not covered under the standard benefits package;

"(2) affecting the amount, duration, and scope of any medical assistance consisting of payment for the items and services described in paragraph (1); or

"(3) prohibiting payment of medical assistance for items and services covered under the standard benefits package to the extent that the items and services under this part exceed the items and services covered under such package with respect to amount, duration, and scope.

"(c) EXCEPTIONS.—Subsection (a) shall not affect the provision of medical assistance consisting of payment for items and services in the standard benefits package—

"(1) which are provided to—

"(A) an individual eligible for medical assistance under the State plan who is not a premium subsidy eligible individual (as defined in 6002(a)(2) of the Health Security Act);

"(B) an individual with respect to whom supplemental security income benefits are being paid under title XVI; and

"(C) an individual who is eligible for benefits under part A of title XVIII; or

"(2) which consist of emergency services to certain aliens under section 1903(v)(2).

"(d) STATE MAINTENANCE OF EFFORT.—

"(1) IN GENERAL.—

"(A) REDUCTION IN QUARTERLY PAYMENTS.—For any calendar quarter in an applicable year (as defined in subparagraph (B)), the amount otherwise payable to a State under section 1903 for the quarter shall be reduced by the State maintenance of effort amount for the quarter determined under paragraph (2).

"(B) APPLICABLE YEAR.—For purposes of this paragraph, the term 'applicable year' means 1997 and any succeeding year.

"(2) MAINTENANCE OF EFFORT AMOUNT.—

"(A) IN GENERAL.—The maintenance of effort amount for a State for a calendar quarter in an applicable year shall be equal to 25 percent of the sum of—

"(i) the State's AFDC eligibles payment amount for the year determined under paragraph (3); and

"(ii) the State's non-cash eligibles payment amount for the year determined under paragraph (4).

"(3) STATE AFDC ELIGIBLES PAYMENT AMOUNT.—

"(A) IN GENERAL.—The AFDC eligibles payment amount for a State for a year is an amount equal to the product of—

"(i) the adjusted State per capita amount for the year determined under subparagraph (B); multiplied by

"(ii) the number of AFDC eligible individuals receiving premium assistance under section 6002 of the Health Security

Act during the year (as estimated by the Secretary).

"(B) ADJUSTED STATE PER CAPITA AMOUNT.—

"(i) IN GENERAL.—The adjusted State per capita amount for a year is the base State per capita amount determined under clause (ii) updated by the percentage change in per capita health expenditures index (as described in paragraph (5)(B)) during the period beginning on October 1, 1994, and ending on December 31 of the year preceding the applicable year (as determined by the Secretary).

"(ii) BASE STATE PER CAPITA AMOUNT.—The base per capita amount for a State shall be an amount, as determined by the Secretary, equal to the quotient of—

"(I) the total expenditures from State funds made under the State plan during fiscal year 1994 with respect to medical assistance consisting of items and services of the type included in the standard benefit pack-

age for AFDC eligible individuals; divided by

''(II) the average total number of AFDC eligible individuals who received such medical assistance under the State plan in any month during fiscal year 1994.

''(iii) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—In applying clause (ii), payments made under section 1923 shall not be counted in the gross amount of payments.

''(C) AFDC ELIGIBLE DEFINED.—For purposes of this paragraph, the term 'AFDC eligible' means an individual who receives aid or assistance under any plan of the State approved under part A or part E of title IV.

''(4) NON-CASH ELIGIBLES PAYMENT AMOUNT.—

''(A) IN GENERAL.—The non-cash eligibles payment amount for a State for a year is an amount equal to the State's base payment amount (determined under subparagraph (B)) for the applicable year updated by the percentage change in the health expenditures index (as

described in paragraph (5)(A)) and the State population index (as described in paragraph (5)(C)) during the period beginning on October 1, 1994, and ending on December 31 of the year preceding the applicable year (as determined by the Secretary).

''(B) STATE BASE PAYMENT AMOUNT.—

''(i) IN GENERAL.—The base payment amount for a State for an applicable year shall be an amount, as determined by the Secretary, equal to the total expenditures from State funds made under the State plan during fiscal year 1994 with respect to medical assistance consisting of items and services of the type included in the standard benefit package for non-cash eligible individuals who would not have received such medical assistance if the provisions of this section and subtitle A of title VI of the Health Security Act had been in effect in fiscal year 1994.

''(ii) DISPROPORTIONATE SHARE PAYMENTS INCLUDED.—In applying clause (i), payments made under section 1923 shall

be counted in the gross amount of payments.

''(C) NON-CASH ELIGIBLE DEFINED.—For purposes of this paragraph, the term 'non-cash eligible' means any individual who received medical assistance under the State plan during fiscal year 1994 other than an AFDC eligible individual or an individual described in subsection (b).

''(5) INDEXES.—

''(A) HEALTH EXPENDITURES INDEX.—The Secretary shall establish a health expenditures index which measures the change in national health expenditures from year to year.

''(B) PER CAPITA HEALTH EXPENDITURES INDEX.—The Secretary shall establish a per capita health expenditures index which measures the change in national per capita health expenditures from year to year.

''(C) STATE POPULATION INDEX.—The Secretary shall establish a State population index which measures the change in the number of individuals residing in a State from year to year.''.

(b) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following new paragraph:

''(16) with respect to items and services covered under the standard benefit package described in section 1201(a) of the Health Security Act for individuals to whom section 1931(a) applies.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1, 1997.

PART 2—COORDINATED CARE SERVICES FOR DISABLED MEDICAID ELIGIBLES

SEC. 4605. COORDINATED CARE SERVICES FOR DISABLED MEDICAID ELIGIBLES.

(a) STATE EXPENDITURES LIMITED TO CERTIFIED HEALTH PLANS.—Section 1903(m) (42 U.S.C. 1396b) is amended by adding at the end the following new paragraph:

''(7) No payment shall be made under this part to a State with respect to expenditures incurred by

the State for payment for services provided by an entity with a contract under this subsection unless such entity is a standard health plan (as defined in section 1011(2)(B) of the Health Security Act).''.

(b) MODIFICATION TO 75/25 RULE.—Section 1903(m)(2)(A)(ii) (42 U.S.C. 1396b(m)(2)(A)(ii)) is amended by striking ''75 percent'' and inserting ''50 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to payments for calendar quarters beginning on or after January 1, 1997.

PART 3—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

SEC. 4611. REPLACEMENT OF DSH PAYMENT PROVISIONS WITH PROVISIONS RELATING TO PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.

(a) AMENDMENTS TO PROVISIONS REQUIRING STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—

(1) ADJUSTMENTS TO NATIONAL DSH PAYMENT LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r–4(f)(1)(B)) is amended to read as follows:

''(B) NATIONAL DSH PAYMENT LIMIT.—

"(i) IN GENERAL.—Except as provided in clause (ii), the national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under the State plans under this part for medical assistance during the fiscal year.

"(ii) REDUCTION IN LIMIT.—For fiscal years ending in a calendar year during which the percentage of individuals covered by insurance, as determined by the National Health Care Cost and Coverage Commission established under section 10001 of the Health Security Act—

"(I) equals or exceeds 85 percent but is less than 88 percent, '10 percent' shall be substituted for '12 percent' in clause (i);

"(II) equals or exceeds 88 percent but is less than 90 percent, '8 percent' shall be substituted for '12 percent' in clause (i);

"(III) equals or exceeds 90 percent but is less than 92 percent, '6 percent' shall be substituted for '12 percent' in clause (i); and

''(IV) equals or exceeds 92 percent, '4 percent' shall be substituted for '12 percent' in clause (i).

(2) ADJUSTMENTS TO STATE ALLOTMENT LIMITS.—Section 1923(f)(2)(B) (42 U.S.C. 1396r–4(f)(2)(B)) is amended to read as follows:

''(B) EXCEPTIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), a State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

''(ii) REDUCTION IN LIMIT.—For fiscal years ending in a calendar year during which the percentage of individuals covered by insurance, as determined by the National Health Care Cost and Coverage Commission established under section 10001 of the Health Security Act—

''(I) equals or exceeds 85 percent but is less than 88 percent, '10 percent' shall be substituted for '12 percent' in clause (i);

''(II) equals or exceeds 88 percent but is less than 90 percent, '8 percent' shall be substituted for '12 percent' in clause (i);

''(III) equals or exceeds 90 percent but is less than 92 percent, '6 percent' shall be substituted for '12 percent' in clause (i); and

''(IV) equals or exceeds 92 percent, '4 percent' shall be substituted for '12 percent' in clause (i).

(3) ELIMINATION OF HIGH DSH STATES AND STATE SUPPLEMENTAL AMOUNTS.—

(A) IN GENERAL.—Section 1923(f)(2)(A) (42 U.S.C. 1396r–4(f)(2)(A)) is amended to read as follows:

''(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year increased by the State growth factor (as defined in paragraph (3)(B)) for the fiscal year.''.

(B) CONFORMING AMENDMENTS.—(i) Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended

by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(ii) Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)), as redesignated by clause (i), is amended by striking subparagraphs (A) and (C) and redesignating subparagraphs (B), (D), and (E) as subparagraphs (A), (B), and (C).

(iii) Section 1923(f)(3)(B) (42 U.S.C. 1396r–4(f)(3)(B)), as redesignated by clauses (i) and (ii), is amended to read as follows:

''(B) STATE GROWTH AMOUNT.—The term 'State growth amount' means, with respect to a State for a fiscal year, the product of the State growth factor and the State DSH payment limit for the previous fiscal year.''.

(iv) Section 1923(f)(1)(A) (42 U.S.C. 1396r–4(f)(1)(A) is amended by striking ''(as defined in paragraph (4)(B))'' and inserting ''(as defined in paragraph (3)(A))''.

(3) TERMINATION OF REQUIREMENT ON STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(h) TERMINATION OF REQUIREMENT TO MAKE PAYMENT ADJUSTMENTS.—

''(1) IN GENERAL.—Any requirement imposed by this section on a State to increase the rate or amount of payment for inpatient hospital services provided by a hospital which serves a disproportionate number of low income patients with special needs shall terminate in the year described in paragraph (2).

''(2) YEAR DESCRIBED.—The year described in this paragraph is the first year beginning after the year during which the percentage of individuals covered by insurance, as determined by the National Health Care Cost and Coverage Commission established under section 100001 of the Health Security Act, equals or exceeds 92 percent.''.

(4) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by section 4601(b), is amended—

(A) by striking ''or'' at the end of paragraph (15),

(B) by striking the period at the end of paragraph (16) and inserting ''; or'', and

(C) by inserting after paragraph (16) the following new paragraph:

''(17) during or after the year described in section 1923(h)(2) with respect to any payment made

by a State to a hospital which serves a disproportionate number of low income patients with special needs that is in excess of the payment otherwise required under this part.''.

(5) EFFECTIVE DATE.—The amendments made by this section shall be effective for calendar quarters beginning on or after January 1, 1997.

(b) PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.—Title XIX (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new part:

''PART B—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

''SEC. 1951. PAYMENTS TO HOSPITALS.

''(a) ENTITLEMENT STATUS.—The Secretary shall make payments in accordance with this part to eligible hospitals described in section 1952. The preceding sentence constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the fiscal years, specified in subsection (b).

''(b) AMOUNT OF ENTITLEMENT.—For purposes of subsection (a), the amounts and fiscal years specified in this subsection are (in the aggregate for all eligible hospitals) $2,500,000,000 for the first applicable fiscal year

(as defined in section 1954) and for each subsequent fiscal year.

''(c) PAYMENTS MADE ON QUARTERLY BASIS.—Payments to an eligible hospital under this section for a year shall be made on a quarterly basis during the year.

"SEC. 1952. IDENTIFICATION OF ELIGIBLE HOSPITALS.

''(a) HOSPITALS IN PARTICIPATING STATES.—In order to be an eligible hospital under this part, a hospital must be located in a State that is a participating State under title I of the Health Security Act.

''(b) STATE IDENTIFICATION.—In accordance with the criteria described in subsection (c) and such procedures as the Secretary may require, each State shall identify the hospitals in the State that meet such criteria and provide the Secretary with a list of such hospitals.

''(c) CRITERIA FOR ELIGIBILITY.—A hospital meets the criteria described in this subsection if the hospital's low-income utilization rate for the base year under section 1923(b)(3) (as such section is in effect on the day before the date of the enactment of this part) is not less than 25 percent.

"SEC. 1953. AMOUNT OF PAYMENTS.

''(a) IN GENERAL.—The total amount available for payments under this part in a year shall be allocated to

hospitals for low-income assistance in accordance with this subsection.

''(b) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital during a year shall be the equal to the hospital's low-income percentage (as defined in subsection (c)) of the total amount available for payments under this part for the year.

''(c) LOW-INCOME PERCENTAGE DEFINED.—

''(1) IN GENERAL.—For purposes of this section, an eligible hospital's 'low-income percentage' for a year is equal to the amount (expressed as a percentage) of the total low-income days for all eligible hospitals for the year that are attributable to the hospital.

''(2) LOW-INCOME DAYS DESCRIBED.—For purposes of paragraph (1), an eligible hospital's low-income days for a year shall be equal to the product of—

''(A) the total number of inpatient days for the hospital for the year (as reported to the Secretary by the State in which the hospital is located, in accordance with a reporting schedule and procedures established by the Secretary); and

''(B) the hospital's low-income utilization rate for the base year under section 1923(b)(3) (as such section is in effect on the day before the date of the enactment of this part).

"SEC. 1954. DEFINITIONS.

''For purposes of this part:

''(1) BASE YEAR.—The term 'base year' means 1996.

''(2) FIRST APPLICABLE FISCAL YEAR—The term 'first applicable fiscal year' means first fiscal year that begins after the fiscal year ending in the calendar year during which the percentage of individuals covered by insurance, as determined by the National Health Care Cost and Coverage Commission established under section 10001 of the Health Security Act, equals or exceeds 92 percent.''.

(c) CONFORMING AMENDMENTS.—(1) Title XIX (42 U.S.C. 1396 et seq.) is amended by striking the title and inserting the following:

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS AND PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS"

"PART A—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS".

(2) Title XIX (42 U.S.C. 1396 et seq.) is amended by striking each reference to ''this title'' and inserting ''this part''.

PART 4—MEDICAID LONG-TERM CARE PROVISIONS

SEC. 4615. INCREASED RESOURCE DISREGARD FOR INDIVIDUALS RECEIVING CERTAIN SERVICES.

(a) IN GENERAL.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by adding ''and'' at the end of subparagraph (F); and

(3) by adding at the end the following new subparagraph:

''(G) provide that, in determining the eligibility of any unmarried individual who has applied for or is receiving medical assistance con-

sisting of community-based services furnished under a waiver under subsection (c) or (d) of section 1915, personal care services described in section 1905(a)(24), or home and community care for functionally disabled elderly individuals under section 1929, the first $4,000 of resources may, at the option of the State, be disregarded.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for medical assistance for calendar quarters beginning on or after January 1, 1995.

SEC. 4616. FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.

(a) EXPANSION OF NUMBER OF WAIVERS.—Section 9412(b)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking ''15'' and inserting ''40''.

(b) DEVELOPMENT OF PROTOCOLS AND MODEL CERTIFICATION GUIDELINES.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 is amended by adding at the end the following new paragraphs:

''(5) The Secretary, in consultation with the States and organizations operating projects in accordance with waivers under this subsection shall develop and publish a waiver protocol that will estab-

lish minimum standard requirements that an organization must meet to be eligible for a waiver under this subsection. In developing the protocol under the preceding sentence, the Secretary shall incorporate standards for organizations to deliver integrated acute and long-term care services for the elderly, children, and young adults.

''(6) The Secretary shall develop model guidelines that shall be available to States that choose to establish a comprehensive procedure for the licensure and certification of an organization operating a demonstration project under a waiver granted pursuant to this subsection. Such guidelines shall encompass the range of services provided by such an organization.''.

(c) EVALUATIONS AND REPORTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by subsection (b), is amended by adding at the end the following new paragraph:

''(7)(A) The Secretary shall develop standard evaluation protocols to assess the cost-effectiveness and quality of service provided under—

''(i) demonstration projects operating on the date of the enactment of this paragraph

under waivers granted pursuant to this subsection; and

''(ii) demonstration projects granted waivers after the date of the enactment of this paragraph.

''(B) The Secretary shall conduct evaluations of the demonstration projects in accordance with the protocols developed under subparagraph (A) and based on the results of such evaluations, report to the Committee on Finance of the Senate, the Committee on Ways and Means of the House of Representatives, and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce of the House of Representatives by—

''(i) not later than January 1, 1998, with respect to demonstration projects described in subparagraph (A)(i); and

''(ii) not later than January 1, 2003, with respect to demonstration projects described in subparagraph (A)(ii);

on the desirability of granting permanent status under titles XVIII and XIX of the Social Security Act to such demonstration projects that the Secretary has determined to be successful.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4617. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended in the matter preceding subparagraph (A) by striking ‘‘, with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded’’.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1995.

SEC. 4618. ELIMINATION OF RULE REGARDING AVAILABILITY OF BEDS IN CERTAIN INSTITUTIONS.

(a) IN GENERAL.—The first sentence of section 1915(c)(1) (42 U.S.C. 1396n(c)(1)) is amended by inserting the following before the end period: ‘‘(at the option of the State, such determination may be made without regard to the availability of beds in such a hospital, nursing facility, or intermediate care facility for the mentally retarded located in the State)’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective with respect to waivers granted or renewed on or after January 1, 1995.

SEC. 4619. PREADMISSION SCREENING FOR MENTALLY RETARDED INDIVIDUALS.

(a) IN GENERAL.—Section 1919(b)(3)(F)(ii) (42 U.S.C. 1396r(b)(3)(F)(ii)) is amended by striking ''that, because'' and all that follows through the period at the end and inserting ''that the individual's primary need is for medical services that are at the level provided by the nursing facility and that the nursing facility has the capability to provide any specialized services necessary for habilitation of the individual.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to admissions on or after July 1, 1995.

PART 5—MISCELLANEOUS

SEC. 4621. MEDICAID COVERAGE OF ALL CERTIFIED NURSE PRACTITIONER AND CLINICAL NURSE SPECIALIST SERVICES.

(a) IN GENERAL.—Paragraph (21) of section 1905(a) (42 U.S.C. 1396d(a)) is amended to read as follows:

''(21) services furnished by all certified nurse practitioners (as defined by the Secretary) or clinical

nurse specialists (as defined in subsection (t)) which the certified nurse practitioner or clinical nurse specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified nurse practitioner or clinical nurse specialist is under the supervision of, or associated with, a physician or other health care provider;''.

(b) CLINICAL NURSE SPECIALIST DEFINED.—Section 1905 (42 U.S.C. 1396) is amended by adding at the end the following new subsection:

''(t) The term 'clinical nurse specialist' means an individual who—

''(1) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(2) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

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

SEC. 4622. RELIEF FROM THIRD PARTY LIABILITY REQUIREMENTS WHEN COST-EFFECTIVE.

(a) IN GENERAL.—Section 1902(a)(25)(B) (42 U.S.C. 1396a(a)(25)(B)) is amended to read as follows—

''(B) that in any case where such a legal liability is found to exist after medical assistance has been made available, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability, unless—

''(i) the amount of reimbursement the State can reasonably expect to recover for medical assistance furnished to an individual does not exceed the costs of such recovery, or

''(ii) with respect to case management services (as defined in section 1915(g)(2)), the State demonstrates to the satisfaction of the Secretary (using the methods specified by the Secretary under subsection (aa)) that it is not cost-effective in the aggregate to seek such recovery with respect to such services furnished to individuals covered under the State plan;''.

(b) METHODS FOR DEMONSTRATION.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended by adding at the end the following new subsection:

''(aa) The Secretary shall specify in regulations the methods by which a State may demonstrate that it is not

cost-effective in the aggregate to seek reimbursement for medical assistance paid for case management services under subsection (a)(25)(B)(ii). The methods specified by the Secretary under the preceding sentence shall include allowing a State to demonstrate that case management services are not generally covered by health insurers in the State.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments for medical assistance for calendar quarters beginning on or after January 1, 1995.

TITLE V—QUALITY AND CONSUMER PROTECTION

Subtitle A—Quality Management and Improvement

SEC. 5001. NATIONAL QUALITY COUNCIL.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a council to be known as the National Quality Council to oversee a program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services and access to such services.

(b) APPOINTMENT.—The National Quality Council shall consist of 15 members appointed by the President,

with the advice and consent of the Senate, who are broadly representative of the population of the United States and shall include the following:

(1) Individuals and health care providers distinguished in the fields of medicine, public health, health care quality, and related fields of health services research. Such members shall constitute at least one-third of the Council's membership.

(2) Individuals representing consumers of health care services. Such members shall constitute at least one-third of the Council's membership.

(3) Other individuals representing purchasers of health care, health plans, States, and nationally recognized health care accreditation organizations.

(c) DUTIES.—The National Quality Council shall—

(1) develop national goals and performance measures of quality;

(2) develop uniform quality goals and performance measures for plans;

(3) oversee the design and implementation of a program of national surveys of plans and consumers;

(4) oversee the design and production of Consumer Report Cards;

(5) oversee Quality Improvement Foundations;

(6) oversee National and State-based Consumer Information and Advocacy Centers; and

(7) oversee the evaluation of the impact of the implementation of this Act on the quality of health care services in the United States and the access of consumers to such services.

(d) CONSULTATION.—In carrying out these duties, the National Quality Council shall establish a process of consultation with appropriate interested parties.

(e) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council shall serve for a term of 4 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (b), the President shall appoint members to serve for a term of between 1 and 4 years so that no more than one third of the Council seats are vacated each year.

(3) SERVICE BEYOND TERM.—A member of the Council may continue to serve after the expiration of the term of the member until a successor is appointed.

(f) VACANCIES.—If a member of the Council does not serve the full term applicable under subsection (e), the individual appointed to fill the resulting vacancy shall be ap-

pointed for the remainder of the term of the predecessor of the individual.

(g) CHAIR.—The President shall designate an individual to serve as the chair of the Council.

(h) MEETINGS.—The Council shall meet not less than once during each 4-month period and shall otherwise meet at the call of the President or the chair.

(i) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Council shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(j) CONFLICTS OF INTEREST.—Members of the Council shall disclose upon appointment to the Council or at any subsequent time that it may occur, conflicts of interest.

(k) EXECUTIVE DIRECTOR; STAFF.—

(1) EXECUTIVE DIRECTOR.—

(A) IN GENERAL.—The Council shall, without regard to section 5311(b) of title 5, United States Code, appoint an Executive Director.

(B) PAY.—The Executive Director shall be paid at a rate equivalent to a rate for the Senior Executive Service.

(2) STAFF.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Executive Director, with the approval of the Council, may appoint and fix the pay of additional personnel.

(B) PAY.—The Executive Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of 120 percent of the annual rate of basic pay payable for GS–15 of the General Schedule.

(C) DETAILED PERSONNEL.—Upon request of the Executive Director, the head of any Federal department or agency may detail any of the personnel of that department or agency

to the Council to assist the Council in carrying out its duties under this Act.

(l) CONTRACT AUTHORITY.—To the extent provided in advance in appropriations Acts, the Council may contract with any person (including an agency of the Federal Government) for studies and analysis as required to execute its functions. Any employee of the Executive Branch may be detailed to the Council to assist the Council in carrying out its duties.

(m) CONSULTATIONS WITH EXPERTS.—The Council may consult with any outside expert individuals or groups that the Council determines appropriate in performing its duties under this section. The Council may establish advisory committees.

(n) ACCESS TO INFORMATION.—The Council may secure directly from any department or agency of the United States information necessary to enable it to carry out its functions, to the extent such information is otherwise available to a department or agency of the United States. Upon request of the chair, the head of that department or agency shall furnish that information to the Council.

(o) DELEGATION OF AUTHORITY.—Except as otherwise provided, the Council may delegate any function to such officers and employees as the Council may designate and may authorize such successive redelegations of such

functions with the Council as the Council deems to be necessary or appropriate. No delegation of functions by the Council shall relieve the Council of responsibility for the administration of such functions.

(p) RULEMAKING.—The Council is authorized to establish such rules as may be necessary to carry out this section.

(q) HEALTH CARE PROVIDER.—For purposes of this subtitle, the term ''health care provider'' means an individual who, or entity that, provides an item or service to an individual that is covered under the health plan (as defined in section 1111) in which the individual is enrolled.

SEC. 5002. NATIONAL GOALS AND PERFORMANCE MEASURES OF QUALITY.

(a) IN GENERAL.—The National Quality Council shall develop a set of national quality goals and performance measures of quality for both the general population and for population subgroups defined by demographic characteristics and health status. The goals and measures shall incorporate goals identified by the Secretary of Health and Human Services for meeting public health objectives utilizing, but not limited to, goals delineated in Healthy People 2000.

(b) SUBJECT OF MEASURES.—National measures of quality performance shall be developed under subsection

(a) in a manner that provides statistical and other information on at least the following subjects:

(1) Outcomes of health care services and procedures.

(2) Population health status.

(3) Health promotion.

(4) Prevention of diseases, disorders, disabilities, injuries, and other health conditions.

(5) Access to care and appropriateness of care.

(6) Consumer satisfaction.

SEC. 5003. STANDARDS AND PERFORMANCE MEASURES FOR HEALTH PLANS.

(a) DEVELOPMENT.—

(1) IN GENERAL.—The National Quality Council shall establish national standards and performance measures for health plans, which may be used to assess the provision of health care services and access to such services, both for the general population and population subgroups defined by demographic characteristics and health status. In subject matter areas with which the National Quality Council determines that sufficient information and consensus exist, the Council shall establish goals for performance by health plans consistent with the na-

tional goals and performance measures established under section 5002.

(2) MEASURES AND STANDARDS.—

(A) MEASURES.—Quality measures under this section shall relate, at a minimum, to:

(i) Access by consumers to health care services and providers.

(ii) Appropriateness of health care services.

(iii) Consumer satisfaction.

(iv) Outcomes of care.

(v) Disease prevention and health promotion.

(B) STANDARDS.—Quality standards under this section at a minimum shall relate to:

(i) Health plan compliance with members' rights under this Act.

(ii) Quality improvement and accountability.

(iii) Documentation and review of provider credentialing and competency.

(iv) Management of clinical, and administrative and financial information.

(b) CERTIFICATION OF PLANS.—The National Quality Council shall provide information and technical assist-

ance to the Secretary and the States concerning the use of national standards and performance measures developed under this section for State certification of health plans.

SEC. 5004. PLAN DATA ANALYSIS AND CONSUMER SURVEYS.

(a) IN GENERAL.—The National Quality Council shall oversee the design and conduct of periodic surveys of health care consumers and plans to gather information concerning the quality measures established under sections 5002 and 5003. The surveys shall monitor consumer reaction to the implementation of this Act and, in coordination with relevant data from health plans and other sources, be designed to assess the impact of this Act both for the general population of the United States and for populations vulnerable to discrimination or to receiving inadequate care due to health status, demographic characteristics, or geographic location.

(b) SURVEY ADMINISTRATION AND DATA ANALYSIS.—The National Quality Council shall approve a standard design for the consumer surveys and sampling of relevant plan data described in subsection (a) which shall be administered by the Administrator of the Agency for Health Care Policy and Research or such other appropriate entity as the Council shall designate on a plan-by-plan and State-by-State basis. Sufficient consumer survey

and plan data shall be collected and verified to provide for reliable and valid analysis. A State may add survey questions on quality measures of local interest to surveys conducted in the State. The plan-level survey shall include a subset of consumer survey questions related to consumer satisfaction, perceived health status, access, and such other survey items designated by the Council.

(c) SAMPLING STRATEGIES.—The National Quality Council shall approve sampling strategies under subsection (a) that ensure that appropriate survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care or may be difficult to reach through consumer-sampling methods, including individuals who—

(1) fail to enroll in a health plan;

(2) resign from a plan; or

(3) are vulnerable to discrimination or to receiving inadequate care due to health status, demographic characteristics, or geographic location.

(d) SURVEY INTEGRATION.—To the extent feasible, the consumer and plan surveys developed under this section shall be integrated with existing Federal surveys.

SEC. 5005. EVALUATION AND REPORTING OF QUALITY PERFORMANCE.

(a) HEALTH PLAN REPORTS.—Each State annually shall publish and make available to the public and Consumer Information and Advocacy Centers a performance report, in a standard format designated by the National Quality Council, outlining the performance of each health plan offered in the State with respect to the set of national measures of quality performance developed under sections 5002 and 5003. The report shall include—

(1) the results of a smaller number of such measures for health care providers if the available information is statistically meaningful; and

(2) the results of consumer surveys and an analysis of the plan data collected in section 5004.

(b) CONSUMER REPORT CARDS.—The health plan reports under subsection (a) shall be summarized in a consumer report card as specified by the National Quality Council and made available by the State through the Consumer Information and Advocacy Centers to all individuals in the State.

(c) QUALITY REPORTS.—The National Quality Council annually shall provide recommendations to the Congress, the National Health Benefits Board, and the Secretary in the form of a summary report that—

(1) outlines in a standard format the performance of each State;

(2) discusses State-level and national trends relating to health care quality; and

(3) presents data for each State from health plan reports and consumer surveys that were conducted during the year.

SEC. 5006. DEVELOPMENT AND DISSEMINATION OF PRACTICE GUIDELINES.

The National Quality Council may advise the Secretary and the Administrator of the Agency for Health Care Policy and Research concerning priorities for the development and periodic review and updating of clinically relevant guidelines established under section 912 of the Public Health Service Act.

SEC. 5007. RESEARCH ON HEALTH CARE QUALITY.

The National Quality Council may make recommendations to the Secretary and the Administrator of the Agency for Health Care Policy and Research concerning priorities for research with respect to the quality, appropriateness, and effectiveness of health care.

SEC. 5008. QUALITY IMPROVEMENT FOUNDATIONS.

(a) ESTABLISHMENT.—The National Quality Council shall oversee the operation of quality improvement foundations in performing the duties specified in subsection (c).

(b) STRUCTURE AND MEMBERSHIP.—

(1) GRANT PROCESS.—The Secretary, in consultation with the Council, shall, through a competitive grantmaking process, award grants for the establishment and operation of a quality improvement foundation in each State or region (as defined in paragraph (2)(B)).

(2) ESTABLISHMENT OF GEOGRAPHIC AREAS.—The Secretary shall establish throughout the United States geographic areas with respect to which grants under this section will be made. In establishing such areas, the Secretary shall take into account the following criteria:

(A) STATE AREAS.—Each State shall generally be designated as a geographic area for purposes of this paragraph.

(B) MULTI-STATE AREAS.—The Secretary may establish geographic areas comprised of multiple contiguous States only where the Secretary determines that volume of activity or other relevant factors justifies such an establishment.

(3) ELIGIBLE APPLICANTS.—To be eligible to receive a grant for the establishment of a quality im-

provement foundation under paragraph (1), an applicant entity shall meet the following conditions:

(A) NOT-FOR-PROFIT.—The entity shall be a not-for-profit entity operating within the State or region involved.

(B) BOARD.—The entity shall have a board which includes—

(i) representatives of health care providers from throughout the State or region involved, including both practicing providers and experts in the field of quality measurement and improvement, which together shall comprise at least one-fourth of the advisory board's membership;

(ii) at least one representative of Academic Health Centers or Schools of Public Health as defined in section 799 of the Public Health Service Act operating within the State or region involved (or operating outside of the State or region if no such Centers or schools operate within the State or region), which shall comprise up to one-fourth of the membership;

(iii) representatives of consumers residing within the State or region involved,

who shall comprise one-fourth of the membership; and

(iv) representatives of purchasers of health care, health plans, and other interested parties residing within the State or region involved, and representatives of the State or States within a region.

(C) STAFFING.—Each entity shall have sufficient, competent staff of experts possessing the skills and knowledge necessary to enable the foundation to perform its duties.

(c) DUTIES.—

(1) IN GENERAL.—Each quality improvement foundation shall carry out the duties described in paragraph (2) for the State or region in which the foundation is located. The foundation shall establish a program of activities incorporating such duties and shall be able to demonstrate the involvement of a broad cross-section of the providers and health care institutions throughout the State or region. A foundation may apply for and conduct research described in section 5007.

(2) DUTIES DESCRIBED.—The duties described in this paragraph include the following:

(A) Collaboration with and technical assistance to providers and health plans in ongoing efforts to improve the quality of health care provided to individuals in the State.

(B) Population-based monitoring of practice patterns and patient outcomes,on an other than a case-by-case basis.

(C) Developing programs in lifetime learning for health professionals to improve the quality of health care by ensuring that health professionals remain informed about new knowledge, acquire new skills, and adopt new roles as technology and societal demands change.

(D) Disseminating information about successful quality improvement programs, practice guidelines, and research findings, including information on innovative staffing of health professionals.

(E) Assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their health care, including an emphasis on shared decisionmaking between patients and health care providers.

(F) Issuing a report to the public regarding the foundation's activities for the previous

year including areas of success during the previous year and areas for opportunities in improving health outcomes for the community, and the adoption of guidelines.

(G) Providing notice to the State or appropriate entity if the foundation determines, after reasonable opportunities for improvement, that the quality of a provider or plan remains so inadequate that the patients or enrollees of such a provider or plan are subject to potential harm in utilizing the services of such provider or services under such plan.

(d) RESTRICTIONS ON DISCLOSURE.—The restrictions on disclosure of information under section 1160 of the Social Security Act shall apply to quality improvement foundations under this section, except that—

(1) such foundations shall make data available to qualified organizations and individuals for research for public benefit;

(2) individuals and qualified organizations shall meet standards consistent with the Public Health Service Act and policies regarding the conduct of scientific research, including provisions related to confidentiality, privacy, protection of humans and shall pay reasonable costs for data; and

(3) such foundations may exchange information with other quality improvement foundations.

SEC. 5009. CONSUMER INFORMATION AND ADVOCACY.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish (by grant or contract) and oversee a National Center of Consumer Information and Advocacy to provide technical assistance, adequate training and support to States and Consumer Information and Advocacy Centers in each State (hereafter referred to in this section as the ''Center'') to carry out the duties of this section, including providing public education to consumers concerning this Act.

(2) REQUIREMENTS FOR NATIONAL CENTER.—The National Center of Consumer Information and Advocacy shall be a national non-profit organization with public education and health policy expertise and shall have sufficient staff to carry out its duties and a demonstrated ability to represent and work with a broad spectrum of consumers, including vulnerable and underserved populations.

(3) STATE-BASED CENTERS.—The Consumer Information and Advocacy Center in each State shall disseminate State reports on quality performance (as defined in section 5005(4)) and health plan

consumer report cards (as defined in section 5005(2)) in order to facilitate consumer choice of health plans, perform public outreach and provide education and assistance regarding consumer rights and responsibilities under this Act, and assist consumers in dealing with problems that arise with consumer purchasing cooperatives, large group purchasers, health plans, insurance agencies, and health care providers operating in such State.

(b) CONTRACTS.—

(1) SOLICITATION.—The Secretary shall solicit contracts from private non-profit organizations based in each State to fulfill the duties of the Center in the State. The Secretary may develop such regulations and guidelines as necessary to oversee the process of considering and awarding competitive contracts under this section. In awarding such contracts, the Secretary shall consult with the National Center of Consumer Information and Advocacy and shall, at a minimum, consider the demonstrated ability of the organization to represent and work with a broad spectrum of consumers, including vulnerable and underserved populations.

(2) CONTRACT PERIOD.—The contract period for the State-based Consumer Information and Ad-

vocacy Centers and the National Center of Consumer Information and Advocacy under this section shall be not less than 4 years and not more than 7 years.

(c) FUNCTIONS AND RESPONSIBILITIES.—

(1) DISSEMINATION OF REPORTS.—Each Center shall disseminate State reports on quality performance (as defined in section 5005(2)) and health plan consumer report cards (as defined in section 5005(2)) in order to facilitate consumer choice of health plans.

(2) STAFF, OFFICES AND HOTLINES.—Each Center shall have sufficient staff, local offices throughout the State, and a State-wide toll-free hotline to carry out the advocacy duties of this section. Through direct contact and the hotline, the Center shall provide the following services in the State, including appropriate assistance to individuals with limited English language ability—

(A) outreach and education relating to consumer rights and responsibilities under this Act, including such rights and services available through the Center;

(B) assistance with enrollment in health plans, or obtaining services or reimbursement from health plans;

(C) assistance with filing an application for premium or cost sharing subsidies;

(D) information to enrollees about existing grievance procedures and coordination with other entities to assist in identifying, investigating, and resolving enrollee grievances under this Act (including grievances before State medical boards);

(E) referrals to appropriate local providers of legal assistance and to appropriate State and Federal agencies which may be of assistance to aggrieved individuals in the area; and

(F) conduct public hearings no less frequently than once a year to identify and address community health care needs.

(d) ACCESS TO INFORMATION.—The Secretary and the States shall ensure that, for purposes of carrying out the Center's duties under this section, the Center (and officers and employees of the Center in local offices) have appropriate access to necessary information subject to protections for confidentiality of enrollee information.

1 Each Center shall have the capability to accept electronic
2 quality data from plans as required under subtitle B.
3 (e) EVALUATION AND REPORT.—The Secretary shall
4 have the right to evaluate the quality and effectiveness of
5 the organization in carrying out the functions specified in
6 the contract. The Center shall report to the Secretary and
7 the State annually on the nature and patterns of consumer
8 complaints received in the Center and its local offices dur-
9 ing each year and any policy, regulatory, and legislative
10 recommendations for needed improvements together with
11 a record of the activities of the Center.
12 (f) CONFLICTS OF INTEREST.—The Secretary shall
13 ensure that no individual involved in the designation of
14 a State Center, the Center itself, or of any delegate thereof
15 is subject to a conflict of interest, including affiliation with
16 (through ownership or common control) a health care fa-
17 cility, managed care organization, health insurance com-
18 pany or association of health care facilities or providers.
19 No grantee under this section may have a direct involve-
20 ment with the licensing, certification, or accreditation of
21 a health care facility, a health care plan, or a provider
22 of health care services .
23 (g) LEGAL COUNSEL.—The Secretary shall ensure
24 that adequate legal counsel is available, and is able, with-

out conflict of interest, to assist the Center, and the local offices thereof in the performance of their official duties.

(h) COORDINATION.—The Center shall coordinate its activities with all appropriate entities including Quality Improvement Foundations (established under section 5008) and the State agencies designated to carry out client advocacy activities pursuant to section 2106.

(i) CONSTRUCTION.—Nothing in this section shall replace grievance procedures established or otherwise required under this Act.

SEC. 5010. AUTHORIZATION OF APPROPRIATIONS.

(a) NATIONAL QUALITY COUNCIL.—For the purpose of carrying out this subtitle with respect to the establishment and activities of the National Quality Council, there are authorized to be appropriated $4,000,000 for each of the fiscal years 1995 through 2000.

(b) QUALITY IMPROVEMENT FOUNDATIONS.—For the purpose of carrying out section 5008, the are authorized to be appropriated $100,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997, and $300,000,000 for each of the fiscal years 1998 through 2000.

(c) CONSUMER INFORMATION AND ADVOCACY CENTERS.—For the purpose of carrying out section 5009, the are authorized to be appropriated $100,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997,

$300,000,000 for each of the fiscal years 1998 through 2000, of which $4,000,000 for each fiscal year shall be made available to the National Center of Consumer Information and Advocacy.

SEC. 5011. ROLE OF HEALTH PLANS IN QUALITY MANAGEMENT.

Each health plan shall—

(1) measure and disclose performance on quality measures as designated by this Act;

(2) furnish information required under subtitles B and of this title and provide such other reports and information on the quality of care delivered by health care providers who are members of a provider network of the plan as may be required under this Act; and

(3) maintain quality management systems that—

(A) use the national measures of quality performance developed by the National Quality Council under section 5003; and

(B) measure the quality of health care furnished to enrollees under the plan by all health care providers of the plan where practical.

SEC. 5012. INFORMATION ON HEALTH CARE PROVIDERS.

(a) STATE OBLIGATIONS.—Each State shall make available to consumers, upon request, information concerning providers of health care services or supplies. Such information shall include—

(1) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply;

(2) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

(3) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and

(4) the identity of any provider whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional per-

formance, or financial integrity, or any provider who surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(b) PUBLIC AVAILABILITY OF INFORMATION IN NATIONAL PRACTITIONER DATA BANK ON DEFENDANTS, AWARDS, AND SETTLEMENTS.—

(1) IN GENERAL.—Section 427(a) of the Health Care Quality Improvement Act (42 U.S.C. 11137 (a)) is amended by adding at the end the following new sentence: ''Not later the January 1, 1996, the Secretary shall promulgate regulations under which individuals seeking to enroll in health plans under the Health Security Act shall be able to obtain information reported under this part with respect to physicians and other licensed health practitioners participating in such plans for whom information has been reported under this part on repeated occasions.''.

(2) ACCESS TO DATA BANK FOR POINT-OF-SERVICE CONTRACTORS UNDER MEDICARE.—Section 427(a) of such Act (42 U.S.C. 11137(a)) is amended—

(A) by inserting ''to sponsors of point-of-service networks under section 1990 of the Social Security Act,'', and

(B) in the heading, by inserting ''RELATED'' after ''CARE''.

SEC. 5013. CONFORMING AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act is amended—

(1) in section 903(a)(4) (42 U.S.C. 299a–1(a)(4)), by inserting ''and Quality Improvement Foundations'' after ''health agencies'';

(2) in section 904(c)(1) (42 U.S.C. 299a–2(c)(1)), by inserting ''the National Quality Council and'' after ''in consultation with'';

(3) in section 912(b)(4) (42 U.S.C. 299b–1(b)(4))—

(A) by inserting ''outcomes,'' before ''risks''; and

(B) by inserting before the semicolon ''to the extent feasible given the availability of unbiased, reliable, and valid data'';

(4) in section 914 (42 U.S.C. 299b–3)—

(A) in subsection (a)(2)(B)—

(i) by inserting ''the National Quality Council,'' after ''shall consult with''; and

(ii) by inserting before the period ''and relevant sections of the Health Security Act'';

(B) in subsection (c), by inserting ''Quality Improvement Foundations and other'' after ''carried out through''; and

(C) in subsection (f)—

(i) by striking ''TO ADMINISTRATOR'' in the subsection heading;

(ii) by striking ''Administrator'' and inserting ''National Quality Council and the''; and

(5) in section 927 (42 U.S.C. 299c–6), by adding at the end thereof the following new paragraphs:

''(5) The term 'National Quality Council' means the Council established under section 5001 of the Health Security Act.

''(6) The term ''Quality Improvement Foundations'' means the Foundations established under section 5008 of the Health Security Act.''.

Subtitle B—Administrative Simplification

PART 1—PURPOSE AND DEFINITIONS

SEC. 5101. PURPOSE.

It is the purpose of this subtitle to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act, by encouraging the development of a health information network through the establishment of standards and requirements for the electronic transmission of certain health information.

SEC. 5102. DEFINITIONS.

For purposes of this subtitle:

(1) CODE SET.—The term ''code set'' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) COORDINATION OF BENEFITS.—The term ''coordination of benefits'' means determining and coordinating the financial obligations of health plans when health care benefits are payable under 2 or more health plans.

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a provider of services

(as defined in section 1861(u) of the Social Security Act), a provider of medical or other health services (as defined in section 1861(s) of the Social Security Act), and any other person furnishing health care services or supplies.

(4) HEALTH INFORMATION.—The term ''health information'' means any information, whether oral or recorded in any form or medium that—

(A) is created or received by a health care provider, health plan, health oversight agency (as defined in section 5202), health researcher, public health authority (as defined in section 5202), employer, life insurer, school or university, or health information network service certified under section 5141; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(5) HEALTH INFORMATION NETWORK.—The term ''health information network'' means the health information system that is formed through the application of the requirements and standards established under this subtitle.

(6) HEALTH INFORMATION PROTECTION ORGANIZATION.—The term ''health information protection organization'' means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network, processes such information into non-identifiable health information, and may store such information.

(7) HEALTH INFORMATION NETWORK SERVICE.—The term ''health information network service''—

(A) means a private entity or an entity operated by a State that enters into contracts to—

(i) process or facilitate the processing of nonstandard data elements of health information into standard data elements;

(ii) provide the means by which persons are connected to the health information network for purposes of meeting the requirements of this subtitle, including the holding of standard data elements of health information;

(iii) provide authorized access to health information through the health information network; or

(iv) provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

(B) includes a health information protection organization.

(8) HEALTH PLAN.—The term ''health plan'' has the meaning given such term in section 1011(1)(A) except that such term shall include clauses (iii), (iv), (v), (vi), and (viii) of such section.

(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term ''non-identifiable health information'' means health information that is not protected health information as defined in section 5202.

(10) HEALTH RESEARCHER.—The term ''health researcher'' shall have the meaning given such term under section 5202.

(11) PATIENT MEDICAL RECORD INFORMATION.—The term ''patient medical record information'' means health information derived from a clinical encounter that relates to the physical or mental condition of an individual.

(12) STANDARD.—The term ''standard'' when referring to an information transaction or to data elements of health information means the transaction or data elements meet any standard adopted by the Secretary under part 2 that applies to such information transaction or data elements.

PART 2—STANDARDS FOR DATA ELEMENTS AND INFORMATION TRANSACTIONS

SEC. 5111. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this subtitle that are—

(1) consistent with the objective of reducing the costs of providing and paying for health care; and

(2) in use and generally accepted or developed or modified by the standards setting organizations accredited by the American National Standard Institute (ANSI).

(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this subtitle.

(c) FAILSAFE.—If the Secretary is unable to adopt standards or modified standards in accordance with subsection (a) that meet the requirements of this subtitle—

(1) the Secretary may develop or modify such standards and, after providing public notice and after an adequate period for public comment, adopt such standards; and

(2) if the Secretary adopts standards under paragraph (1), the Secretary shall submit a report to the appropriate committees of Congress on the actions taken by the Secretary under this subsection.

(d) PAPER FORMATS.—The Secretary may develop methods by which a person may use the standards adopted by the Secretary under this subtitle with respect to health information that is in written rather than electronic form.

SEC. 5112. STANDARDS FOR DATA ELEMENTS OF HEALTH INFORMATION.

(a) IN GENERAL.—The Secretary shall adopt standards necessary to make data elements of the following health information uniform and compatible for electronic transmission through the health information network:

(1) the health information that is appropriate for transmission in connection with transactions described in subsections (a), (b), and (d) of section 5121;

(2) the quality information required to be submitted by a health plan under title I and subtitle A of this title; and

(3) patient medical record information.

(b) ADDITIONS.—The Secretary may make additions to the sets of data elements adopted under subsection (a) as the Secretary determines appropriate in a manner that minimizes the disruption and cost of compliance with such additions.

(c) CERTAIN DATA ELEMENTS.—

(1) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall establish a system to provide for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. The personal health identifier for an individual shall be an encrypted form of the social security account number assigned to the individual by the Secretary under section 205(c)(2) of the Social Security Act.

(2) CODE SETS.—

(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to such code sets under section 5115(c).

SEC. 5113. INFORMATION TRANSACTION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt technical standards relating to the method by which data elements of health information that have been standardized under section 5112 may be transmitted electronically, including standards with respect to the format in which such data elements shall be transmitted.

(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standards adopted by the Secretary under paragraph (1) that relate to coordination of benefits shall provide that a claim for reimbursement for medical services furnished is tested by an algorithm specified by the Secretary against all records of enrollment and eligibility for the individual who received such services to determine any primary and secondary obligors for payment.

(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic

transmission and authentication of signatures, compliance with which will be deemed to satisfy State and Federal statutory requirements for written signatures with respect to information transactions required by this Act and written signatures on medical records and prescriptions.

SEC. 5114. STANDARDS RELATING TO WRITTEN CLAIMS SUBMITTED BY INDIVIDUALS AND WRITTEN EXPLANATIONS OF BENEFITS.

The Secretary shall adopt standard methods and formats which—

(1) may be used by an individual to submit a written claim when the individual's health care provider does not submit the claim; and

(2) shall be used by health plans to submit a written explanation of benefits to an enrollee.

SEC. 5115. TIMETABLES FOR ADOPTION OF STANDARDS.

(a) INITIAL STANDARDS FOR DATA ELEMENTS.—The Secretary shall adopt standards relating to—

(1) the data elements for the information described in section 5112(a)(1) not later than 9 months after the date of the enactment of this subtitle (except in the case of standards with respect to data elements for claims attachments which shall be adopted not later than 24 months after the date of the enactment of this subtitle);

(2) the data elements for the information described in section 5112(a)(2) not later than 9 months after the date of the enactment of this subtitle;

(3) data elements for patient medical record information not earlier than 24 months and not later than 7 years after the date of the enactment of this subtitle; and

(4) any addition to a set of data elements, in conjunction with making such an addition.

(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 5113 not later than 9 months after the date of the enactment of this subtitle (except in the case of standards for claims attachments which shall be adopted not later than 24 months after the date of the enactment of this subtitle).

(c) STANDARDS FOR WRITTEN CLAIMS AND EXPLANATIONS OF BENEFITS.—The Secretary shall adopt standard methods and formats described in section 5114 not later than 9 months after the date of the enactment of this subtitle.

(d) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards

adopted under this subtitle and shall adopt modified standards as determined appropriate, but no more frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption and cost of compliance.

(2) SPECIAL RULES.—

(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary shall not adopt any modifications to standards adopted under this subtitle during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with requirements relating to the standards.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets to accommodate

changes in biomedical science and health care delivery.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

(e) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this subtitle. Such process may include demonstration projects and analysis of the cost of implementing such standards and modifications.

PART 3—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

SEC. 5121. REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION.

(a) REQUIREMENTS ON PLANS AND PROVIDERS RELATING TO FINANCIAL AND ADMINISTRATIVE TRANS-

ACTIONS.—If a health care provider or a health plan conducts any of the following transactions, such transactions shall be standard transactions and the information transmitted or received in connection with such transaction shall be in the form of standard data elements:

(1) Claims (including coordination of benefits).

(2) Claims attachments.

(3) Responses to research inquiries by a health researcher.

(4) Other transactions determined appropriate by the Secretary consistent with the goal of reducing administrative costs.

(b) REQUIREMENT ONLY ON PLANS RELATING TO FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a person desires to conduct any of the following transactions with a health plan as a standard transaction, the health plan shall conduct such standard transaction and the information transmitted or received in connection with such transaction shall be in the form of standard data elements:

(1) Enrollment and disenrollment.

(2) Eligibility.

(3) Payment and remittance advice.

(4) Premium payments.

(5) First report of injury.

(6) Claims status.

(7) Referral certification and authorization.

(8) Other transactions determined appropriate by the Secretary consistent with the goal of reducing administrative costs.

(c) REQUIREMENT ON PLANS RELATING TO QUALITY INFORMATION.—Any quality information required to be submitted by a health plan under title I or subtitle A of this title shall be in the form of standard data elements and the transmission of such data shall be in the form of a standard transaction.

(d) REQUIREMENT ONLY ON PURCHASING COOPERATIVES.—If a person desires to conduct any of the following transactions with a purchasing cooperative (as defined in section 1013(12)) as a standard transaction, the cooperative shall conduct such standard transaction and the information transmitted or received in connection with such transaction shall be in the form of standard data elements:

(1) Enrollment and disenrollment.

(2) Premium payments.

(e) REQUIREMENT WITH RESPECT TO DISCLOSURE OF INFORMATION.—

(1) IN GENERAL.—A health plan or health care provider shall make the standard data elements transmitted or received by such plan or provider in connection with the transactions described in sub-

sections (a), (b), and (c) or acquired under section 5164(a) available for disclosure as authorized by this subtitle.

(2) SPECIAL RULE.—In the case of a health care provider that does not file claims, such provider shall be responsible for making standard data elements for encounter information available for disclosure as authorized by this subtitle.

(f) SATISFACTION OF REQUIREMENTS.—A health care provider, health plan, or consumer purchasing cooperative may satisfy the requirement imposed on such provider, plan, or cooperative under subsection (a), (b), (c), (d), or (e) by—

(1) directly transmitting standard data elements;

(2) submitting nonstandard data elements to a health information network service certified under section 5141 for processing into standard data elements and transmission; or

(3) in the case of a provider, submitting data elements to a plan which satisfies the requirements imposed on such provider on the provider's behalf.

(g) TIMELINESS.—A health care provider or health plan shall be determined to have satisfied a requirement imposed under this section only if the action required is

completed in a timely manner, as determined by the Secretary. In setting standards for timeliness, the Secretary shall take into consideration the age and the amount of information being requested.

SEC. 5122. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

(a) INITIAL COMPLIANCE.—

(1) IN GENERAL.—Not later than 12 months after the date on which standards are adopted under part 2 with respect to a type of transaction or data elements for a type of health information, a health plan, health care provider, or purchasing cooperative shall comply with the requirements of this subtitle with respect to such transaction or information.

(2) ADDITIONAL DATA ELEMENTS.—Not later than 12 months after the date on which the Secretary adopts an addition to a set of data elements for health information under part 2, a health plan, health care provider, or purchasing cooperative shall comply with the requirements of this subtitle using such data elements.

(b) COMPLIANCE WITH MODIFIED STANDARDS.—

(1) IN GENERAL.—If the Secretary adopts a modified standard under part 2, a health plan, health care provider, or purchasing cooperative shall

be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification.

(2) SPECIAL RULE.—In the case of modifications to standards that do not occur within the 12-month period beginning on the date such standards are adopted, the time determined appropriate by the Secretary under paragraph (1) shall be no sooner than the last day of the 90-day period beginning on the date such modified standard is adopted and no later than the last day of the 12 month period beginning on the date such modified standard is adopted.

PART 4—ACCESSING HEALTH INFORMATION

SEC. 5131. ACCESSING HEALTH INFORMATION FOR AUTHORIZED PURPOSES.

(a) IN GENERAL.—The Secretary shall adopt technical standards for appropriate persons, including health plans, health care providers, health information network services certified under section 5141, health researchers, and Federal and State agencies, to locate and access the health information that is available through the health information network due to the requirements of this subtitle. Such technical standards shall ensure that any request to

locate or access information shall be authorized under subtitle C.

(b) PROCUREMENT RULE FOR GOVERNMENT AGENCIES.—

(1) IN GENERAL.—Health information protection organizations certified under section 5141 shall make available to a Federal or State agency pursuant to a Federal Acquisition Regulation (or an equivalent State system), any non-identifiable health information that is requested by such agency.

(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection organization described in paragraph (1) needs information from a health plan or health care provider in order to comply with a request of a Federal or State agency that is necessary to comply with a requirement under this Act, such plan or provider shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information. If requested, a health information protection organization that receives information under the preceding sentence must make such information available to any other such organization that is certified under section 5141 for a

charge that does not exceed the reasonable cost of transmitting the information.

(c) FUNCTIONAL SEPARATION.—The standards adopted by the Secretary under subsection (a) shall ensure that any health information disclosed under such subsection shall not, after such disclosure, be used or released for an administrative, regulatory, or law enforcement purpose unless such disclosure was made for such purpose.

(d) PUBLIC USE FUNCTIONS.—Nothing in this subtitle shall be construed to limit the authority of a Federal or State agency to make non-identifiable health information available for public use functions.

SEC. 5132. RESPONDING TO ACCESS REQUESTS.

(a) IN GENERAL.—The Secretary may adopt, and modify as appropriate, standards under which a health care provider or health plan shall respond to requests for access to health information consistent with this subtitle and subtitle C.

(b) STANDARDS DESCRIBED.—The standards under subsection (a) shall provide—

(1) for a standard format under which a provider or plan will respond to each request either by satisfying the request or responding with an explanation of the specific restriction which results in a failure to satisfy the request; and

(2) that any restrictions will not prevent a plan or provider from responding to a request in a timely manner taking into account the age and amount of the information being requested.

(c) CONSTRUCTION.—Nothing in this section shall be construed as permitting a health care provider or health plan to refuse to disclose any health information that is required to be disclosed by law.

SEC. 5133. LENGTH OF TIME INFORMATION SHOULD BE ACCESSIBLE.

The Secretary shall adopt standards with respect to the length of time any standard data elements for a type of health information should be accessible through the health information network.

SEC. 5134. TIMETABLES FOR ADOPTION OF STANDARDS AND COMPLIANCE.

(a) INITIAL STANDARDS.—The Secretary shall adopt standards under this part not later than 9 months after the date of the enactment of this subtitle and such standards shall be effective upon adoption.

(b) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this part and shall adopt modified standards as determined appropriate, but no more

frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption and cost of compliance. Any modifications to standards adopted under this part shall be effective upon adoption.

(2) SPECIAL RULE.—The Secretary shall not adopt modifications to any standards adopted under this part during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with the requirements of this part.

PART 5—STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK

SEC. 5141. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

(a) STANDARDS FOR OPERATION.—The Secretary shall establish standards with respect to the operation of health information network services, including standards ensuring that—

(1) such services develop, operate, and cooperate with one another to form the health information network;

(2) such services meet all of the requirements under subtitle C that are applicable to such services;

(3) such services make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary;

(4) such services have security procedures that are consistent with the privacy requirements under subtitle C, including secure methods of access to and transmission of data;

(5) such services, if they are part of a larger organization, have policies and procedures in place which isolate their activities with respect to processing information in a manner that prevents access to such information by such larger organization.

(b) CERTIFICATION BY THE SECRETARY.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this subtitle, the Secretary shall establish a certification procedure for health information network services which ensures that certified services are qualified to meet the requirements of this subtitle and the standards established by the Secretary under this section. Such certification procedure shall be implemented in a

manner that minimizes the costs and delays of operations for such services.

(2) APPLICATION.—Each entity desiring to be certified as a health information network service shall apply to the Secretary for certification in a form and manner determined appropriate by the Secretary.

(3) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits by the Secretary and reports by an entity certified under this section as the Secretary determines appropriate in order to monitor such entity's compliance with the requirements of this subtitle, subtitle C, and the standards established by the Secretary under this section.

(4) RECERTIFICATION.—A health information network service must be recertified under this subsection at least every 3 years.

(c) LOSS OF CERTIFICATION.—

(1) MANDATORY TERMINATION.—Except as provided in paragraph (3), if a health information network service violates a requirement imposed on such service under subtitle C, its certification under this section shall be terminated unless the Secretary

determines that appropriate corrective action has been taken.

(2) DISCRETIONARY TERMINATION.—If a health information network service violates a requirement or standard imposed under this subtitle and a penalty has been imposed under section 5151, the Secretary shall review the certification of such service and may terminate such certification.

(3) CONDITIONAL CERTIFICATION—The Secretary may establish a procedure under which a health information network service may remain certified on a conditional basis if the service is operating consistently with a plan intended to correct any violations described in paragraphs (1) or (2). Such procedure may provide for the appointment of a trustee to continue operation of the service until the requirements for full certification are met.

(d) CERTIFICATION BY PRIVATE ENTITIES.—The Secretary may designate private entities to conduct the certification procedures established by the Secretary under this section. A health information network service certified by such an entity in accordance with such designation shall be considered to be certified by the Secretary.

SEC. 5142. ENSURING AVAILABILITY OF INFORMATION.

The Secretary shall establish a procedure under which a health plan or health care provider which does not have the ability to transmit standard data elements directly or does not have access to a health information network service certified under section 5141 shall be able to make health information available for disclosure as authorized by this subtitle.

PART 6—PENALTIES

SEC. 5151. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

(a) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person that violates a requirement or standard imposed under this subtitle a penalty of not more than $1,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under section 1128A of such Act.

(b) LIMITATIONS.—

(1) NONCOMPLIANCE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—A penalty may not be imposed under subsection (a) if it is established to the satisfaction of the Secretary that the

person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in subsection (a).

(2) FAILURES DUE TO REASONABLE CAUSE.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), a penalty may not be imposed under subsection (a) if—

(i) the failure to comply was due to reasonable cause and not to willful neglect; and

(ii) the failure to comply is corrected during the 30-day period beginning on the 1st date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(B) EXTENSION OF PERIOD.—

(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

(ii) ASSISTANCE.—If the Secretary determines that a health plan, health care

provider, or purchasing cooperative failed to comply because such person was unable to comply, the Secretary may provide technical assistance to such person. Such assistance shall be provided in any manner determined appropriate by the Secretary.

(3) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (2) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

PART 7—MISCELLANEOUS PROVISIONS

SEC. 5161. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) DATA ELEMENT STANDARDS.—A person may not impose a standard on another person that is in addition to the standards adopted by the Secretary under section 5112 unless—

(1) such person voluntarily agrees to such standard; or

(2) a waiver is granted under subsection (c) to impose such standard.

(b) TRANSACTIONS AND ACCESS STANDARDS.—A person may not impose a standard on another person that

is in addition to the standards adopted by the Secretary under section 5113 or 5131 unless such person voluntarily agrees to such standard.

(c) CONDITIONS FOR WAIVERS.—

(1) IN GENERAL.—A person may request a waiver from the Secretary in order to require another person to comply with a standard that is in addition to the standards adopted by the Secretary under section 5112.

(2) CONSIDERATION OF WAIVER REQUESTS.—No waiver may be granted unless the Secretary determines that the value of the data to be exchanged for research or other purposes significantly outweighs the administrative cost of the additional standard taking into consideration the burden of the timing of the imposition of the additional standard.

(3) ANONYMOUS REPORTING.—If a person attempts to impose a standard in addition to the standards adopted by the Secretary under section 5112, the person on whom such additional standard is being imposed may contact the Secretary. The Secretary shall develop a procedure under which the contacting person shall remain anonymous. The Secretary shall notify the person imposing the additional standard that the additional standard may not

be imposed unless the other person voluntarily agrees to such standard or a waiver is obtained under this subsection.

SEC. 5162. EFFECT ON STATE LAW.

(a) IN GENERAL.—A provision, requirement, or standard under this subtitle shall supersede any contrary provision of State law, including—

(1) a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form, and

(2) a provision of State law which provides for requirements or standards that are more stringent than the requirements or standards under this subtitle;

except where the Secretary determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

(b) PUBLIC HEALTH REPORTING.—Nothing in this subtitle shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

SEC. 5164. HEALTH INFORMATION CONTINUITY.

(a) INFORMATION HELD BY HEALTH PLANS AND PROVIDERS.—If a health plan or health care provider takes any action that would threaten the continued availability of the standard data elements of health information held by such plan or provider, such data elements shall be obtained by the State in which such plan or provider is located. The State shall ensure that such data elements are transferred to a health plan or health care provider in accordance with procedures established by the Secretary.

(b) INFORMATION HELD BY HEALTH INFORMATION NETWORK SERVICES.—If a health information network service certified under section 5141 loses its certified status or takes any action that would threaten the continued availability of the standard data elements of health information held by such service, such data elements shall be transferred to another health information network service certified under section 5141, as designated by the Secretary.

SEC. 5165. PROTECTION OF COMMERCIAL INFORMATION.

In adopting standards under this subtitle, the Secretary shall not require disclosure of trade secrets and confidential commercial information by entities operating in the health information network except as required by law.

SEC. 5166. PAYMENT FOR HEALTH CARE SERVICES OR HEALTH PLAN PREMIUMS.

Nothing in this subtitle shall be construed to prohibit payments for health care services or health plan premiums from being made by debit, credit, or other payment cards or numbers or other electronic payment means.

SEC. 5167. HEALTH SECURITY CARDS.

(a) IN GENERAL.—The Secretary shall establish standards relating to the form of health security cards issued by health plans and the information to be encoded electronically on such cards.

(b) FORM DESCRIBED.—The standard form for a health security card shall be a card which—

(1) is made of plastic or a similar durable material with a useful life of at least 5 years;

(2) is resistant to counterfeiting;

(3) can store information that can be encoded and retrieved electronically;

(4) can be produced in a cost-effective manner and used in all types of health care locations; and

(5) specifies on its face the social security account number assigned to the individual who is the cardholder by the Secretary under section 205(c)(2) of the Social Security Act.

(b) INFORMATION DESCRIBED.—The information electronically encoded on a health security card shall in-

clude the identity of the individual to whom the card was issued, including such individual's personal health identifier specified under section 5112(c)(1), and may include any other information that the Secretary determines may be useful in order for the card to serve the purpose of easing access to and paying for health care services. A health plan shall make available to an individual cardholder, upon demand by such individual, a printed copy of all information electronically encoded on such individual's health security card.

SEC. 5168. MISUSE OF HEALTH SECURITY CARD OR PERSONAL HEALTH IDENTIFIER.

(a) HEALTH SECURITY CARD.—A person who—

(1) requires the display of, requires the use of, or uses a health security card for any purpose other than obtaining or paying for health care;

(2) falsely makes, forges, counterfeits or alters a health security card;

(3) without lawful authority prints, photographs, or makes any impression in the likeness of any health security card; or

(4) sells, transfers, or otherwise delivers a false, forged, counterfeited, or altered health security card knowing that the card is false, forged, counterfeited, or altered;

shall be fined not more than $25,000, imprisoned not more than 2 years, or both.

(b) PERSONAL HEALTH IDENTIFIER.—A person who requires the disclosure of, requires the use of, or uses an individual's personal health identifier for any purpose that is not authorized by the Secretary, shall be fined not more than $25,000, imprisoned not more than 2 years, or both.

SEC. 5169. DIRECT BILLING FOR CLINICAL LABORATORY SERVICES.

(a) IN GENERAL.—

(1) REQUIREMENT.—Except as provided in paragraph (2), in the case of a claim for payment for a clinical diagnostic laboratory test for which payment may otherwise be made, payment may be made only to the person who, or entity which, performed or supervised the test.

(2) EXCEPTION.—Payment for a clinical diagnostic laboratory test may be made to a physician with whom the physician who performed the test shares a practice.

(b) ADDITIONAL EXCEPTIONS.—The Secretary may, by regulation, establish exceptions to the requirement under subsection (a)(1) that are in addition to the exception under subsection (a)(2). In establishing such exceptions the Secretary shall take into account—

(1) circumstances in which an individual's privacy might be violated; or

(2) the need for confidentiality on the part of the person furnishing the test.

SEC. 5170. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subtitle.

PART 8—ASSISTANCE TO THE SECRETARY

SEC. 5171. GENERAL REQUIREMENT ON SECRETARY.

In complying with any requirements imposed under this subtitle, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 5172 and shall consult with appropriate Federal agencies.

SEC. 5172. HEALTH INFORMATION ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Information Advisory Committee.

(b) DUTY.—

(1) IN GENERAL.—The committee shall—

(A) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this subtitle and subtitle C;

(B) be generally responsible for advising the Secretary and the Congress on the status of the health information network; and

(C) make recommendations to correct any problems that may occur in the network's implementation and ongoing operations and to refine and improve the network.

(2) TECHNICAL ASSISTANCE.—In performing its duties under this subsection, the committee shall receive technical assistance from appropriate Federal agencies.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The committee shall consist of 15 members to be appointed by the President not later than 60 days after the date of the enactment of this subtitle. The President shall designate 1 member as the Chair.

(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the committee.

(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered

terms such that the terms of no more than 3 members expire at one time.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

(d) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the commit-

tee have been appointed, the committee shall hold its first meeting.

(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the committee considers advisable to carry out the purposes of this section.

(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) of the Social Security Act shall apply to the committee in the same manner as they apply to the Prospective Payment Assessment Commission.

(g) REPORTS.—

(1) IN GENERAL.—The committee shall annually prepare and submit to Congress and the Secretary a report including at least an analysis of—

(A) the status of the health information network established under this subtitle, including whether the network is fulfilling the purpose described in section 5101;

(B) the savings and costs of the network;

(C) the activities of health information network services certified under section 5141, health care providers, health plans, and other entities using the network to exchange health information;

(D) the extent to which entities described in subparagraph (C) are meeting the standards adopted under this subtitle and working together to form an integrated network that meets the needs of its users;

(E) the extent to which entities described in subparagraph (C) are meeting the privacy and security protections of subtitle C;

(F) the number and types of penalties assessed for noncompliance with the standards adopted under this subtitle;

(G) whether the Federal Government and State Governments are receiving information of sufficient quality to meet their responsibilities under the Health Security Act;

(H) any problems with respect to implementation of the network;

(I) the extent to which timetables under this subtitle for the adoption and implementation of standards are being met; and

(J) any legislative recommendations related to the health information network.

(2) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under paragraph (1) shall be made available to the public unless such information may not be disclosed by law.

(h) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the committee shall continue in existence until otherwise provided by law.

(i) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until expended.

PART 9—DEMONSTRATION PROJECTS FOR COMMUNITY-BASED CLINICAL INFORMATION SYSTEMS

SEC. 5181. GRANTS FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary may make grants for demonstration projects to promote the development and use of electronically integrated community-based clini-

cal information systems and computerized patient medical records.

(b) APPLICATIONS.—

(1) SUBMISSION.—To apply for a grant under this part for any fiscal year, an applicant shall submit an application to the Secretary in accordance with the procedures established by the Secretary.

(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Secretary regarding the following:

(A) USE OF EXISTING TECHNOLOGY.—Funds received under this part will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

(B) USE OF EXISTING INFORMATION SYSTEMS.—Funds received under this part will be used—

(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

(C) MATCHING FUNDS.—The applicant shall make available funds for the demonstration project in an amount that equals at least 20 percent of the cost of the project.

(c) GEOGRAPHIC DIVERSITY.—In making any grants under this part, the Secretary shall, to the extent practicable, make grants to persons representing different geographic areas of the United States, including urban and rural areas.

(d) REVIEW AND SANCTIONS.—The Secretary shall review at least annually the compliance of a person receiving a grant under this part with the provisions of this part. The Secretary shall establish a procedure for determining whether such a person has failed to comply sub-

stantially within the provisions of this part and the sanctions to be imposed for any such noncompliance.

(e) ANNUAL REPORT.—The Secretary shall submit an annual report to the President for transmittal to Congress containing a description of the activities carried out under this part.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

PART 10—MEDICARE AND MEDICAID COVERAGE DATA BANK

SEC. 5191. REPEAL OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

(a) REPEAL OF DATA BANK.—Section 1144 of the Social Security Act (42 U.S.C. 1320b–14), as added by section 13581 of the Omnibus Budget Reconciliation Act of 1993, is repealed.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1862(b)(5) of such Act (42 U.S.C. 1395y(b)(5)) is amended—

(A) in subparagraph (B), by striking ''the information received under'' and all that follows and inserting ''the information received under subparagraph (A) for the purposes of carrying out this subsection.''; and

(B) in subparagraph (C)(i), by striking ''subparagraph (B)(i)'' and inserting ''subparagraph (B)''.

(2) MEDICAID.—Section 1902(a)(25)(A)(i) of such Act (42 U.S.C. 1396(a)(25)(A)(i)) is amended by striking ''(including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1144 and any additional measures as specified'' and inserting ''(as specified''.

(3) CONFORMING AMENDMENT RELATED TO DATA MATCHES.—Subsection (a)(8)(B) of section 552a of title 5, United States Code, is amended—

(A) in clause (v), by adding ''; or'' at the end;

(B) in clause (vi), by striking ''; or'' and inserting a semicolon; and

(C) by striking clause (vii).

(4) CONFORMING AMENDMENT TO ERISA.—

(A) Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1031) is amended—

(i) by striking subsection (f); and

(ii) by redesignating subsection (g) as subsection (f).

(B) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(i) in paragraph (6), by striking the semicolon at the end and inserting ''; or'';

(ii) in paragraph (7), by striking ''; or'' and inserting a period; and

(iii) by striking paragraph (8).

(C) Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by striking paragraph (4).

(D) Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended by striking ''fiduciary, or any person referred to in section 101(f)(1)'' and inserting ''or fiduciary''.

Subtitle C—Privacy of Health Information

PART 1—FINDINGS AND DEFINITIONS

SEC. 5201. FINDINGS AND PURPOSES.

(a) FINDINGS.—The Congress finds as follows:

(1) The improper disclosure of individually identifiable health care information may cause significant harm to an individual's interests in privacy, health care, and reputation and may unfairly affect the ability of an individual to obtain employment, education, insurance, and credit.

(2) The movement of people and health care related information across State lines, the availability of, access to, and exchange of health care related information with Federally funded health care systems, the medicare program under title XVIII of the Social Security Act, and the medicaid program under title XIX of such Act, through automated data banks and networks, and the emergence of other multistate health care providers and payors create a need for a uniform Federal law governing the disclosure of health care information.

(b) PURPOSE.—The purpose of this subtitle is to establish effective mechanisms to protect the privacy of individuals with respect to individually identifiable health care information that is created or maintained as part of health treatment, enrollment, payment, testing, or research processes.

SEC. 5202. DEFINITIONS.

(a) TERMS RELATING TO PROTECTED HEALTH INFORMATION.—In this subtitle:

(1) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' means any information, including demographic information collected from an individual, whether oral or recorded in any form or medium, that—

(A) is created or received by a health care provider, health plan, health oversight agency, health researcher, public health authority, employer, life insurer, school or university, or certified health information network service; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies an individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.

(2) DISCLOSE.—The term ''disclose'', when used with respect to protected health information, means to provide access to the information, but only if such access is provided to a person other than the individual who is the subject of the information.

(b) TERMS RELATING TO HEALTH CARE SYSTEM PARTICIPANTS.—In this subtitle:

(1) HEALTH INFORMATION TRUSTEE.—The term ''health information trustee'' means—

(A) a health care provider, health plan, health oversight agency, certified health information network service, employer, life insurer, or school or university insofar as it creates, receives, maintains, uses, or transmits protected health information;

(B) any person who obtains protected health information under section 5213, 5217, 5218, 5221, 5222, 5226, or 5231; and

(C) any employee or agent of a person covered under subparagraph (A) or (B).

(2) HEALTH CARE.—The term ''health care''—

(A) means—

(i) a preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

(I) with respect to the physical or mental condition of an individual; or

(II) affecting the structure or function of the human body or any part of the human body; or

(ii) any sale or dispensing of a drug, device, equipment, or other item to an indi-

vidual, or for the use of an individual, pursuant to a prescription; but

(B) does not include any item or service that is not furnished for the purpose of examining, maintaining, or improving the health of an individual.

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession.

(4) HEALTH OVERSIGHT AGENCY.—The term ''health oversight agency'' means a person who—

(A) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers; or

(B)(i) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the effectiveness of, compliance with, or applicability of legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery

of, or payment for, health care or relating to health care fraud or fraudulent claims for payment regarding health; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a Federal or State law governing the assessment, evaluation, determination, or investigation described in clause (i).

(5) HEALTH PLAN.—The term ''health plan'' shall have the meaning given such term under section 5102.

(6) HEALTH RESEARCHER.—The term ''health researcher'' means a person who conducts a biomedical, public health, epidemiological, health services, or health statistics research project or a research project on social and behavioral factors relating to health.

(7) INSTITUTIONAL REVIEW BOARD.—The term ''institutional review board'' means—

(A) a board established in accordance with regulations of the Secretary under section 491(a) of the Public Health Service Act;

(B) a similar board established by the Secretary for the protection of human subjects in research conducted by the Secretary; or

(C) a similar board established under regulations of a Federal Government authority other than the Secretary.

(8) PUBLIC HEALTH AUTHORITY.—The term ''public health authority'' means an authority or instrumentality of the United States, a State, or a political subdivision of a State that is (A) responsible for public health matters; and (B) engaged in such activities as injury reporting, public health surveillance, and public health investigation or intervention.

(c) REFERENCES TO CERTIFIED ENTITIES.—In this subtitle:

(1) CERTIFIED HEALTH INFORMATION NETWORK SERVICE.—The term ''certified health information network service'' means a health information service (as defined under section 5102) that is certified under section 5141.

(2) CERTIFIED HEALTH INFORMATION PROTECTION ORGANIZATION.—The term ''certified health information protection organization'' means a health

information protection organization (as defined in section 5102) that is certified under section 5141.

(d) OTHER TERMS.—In this subtitle:

(1) INDIVIDUAL REPRESENTATIVE.—The term ''individual representative'' means any individual legally empowered to make decisions concerning the provision of health care to an individual (where the individual lacks the legal capacity under State law to make such decisions) or the administrator or executor of the estate of a deceased individual.

(2) LAW ENFORCEMENT INQUIRY.—The term ''law enforcement inquiry'' means an investigation or official proceeding inquiring into whether there is a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(3) PERSON.—The term ''person'' includes an authority of the United States, a State, or a political subdivision of a State.

PART 2—AUTHORIZED DISCLOSURES

Subpart A—General Provisions

SEC. 5206. GENERAL RULES REGARDING DISCLOSURE.

(a) GENERAL RULE.—A health information trustee may disclose protected health information only for a purpose that is authorized under this subtitle.

(b) DISCLOSURE WITHIN A TRUSTEE.—A health information trustee may disclose protected health information to an officer, employee, or agent of the trustee, but only for a purpose that is compatible with and related to the purpose for which the information was collected or received by that trustee.

(c) SCOPE OF DISCLOSURE.—

(1) IN GENERAL.—Every disclosure of protected health information by a health information trustee shall be limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed.

(2) REGULATIONS.—The Secretary, after notice and opportunity for public comment, may issue regulations under paragraph (1), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting disclosure.

(d) NO GENERAL REQUIREMENT TO DISCLOSE.—Nothing in this subtitle that permits a disclosure of health information shall be construed to require such disclosure.

(e) USE AND REDISCLOSURE OF INFORMATION.—The protected health information received under a disclosure permitted by the subtitle may not be used or disclosed unless the use or disclosure is necessary to fulfill the pur-

pose for which the information was obtained and is not otherwise prohibited by law. Protected health information about an individual that is disclosed under this subtitle may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual unless specifically permitted by this subtitle.

(f) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—

(1) IN GENERAL.—Except with respect to protected health information that is disclosed under section 5213 and except as provided in paragraph (2), a health information trustee may not disclose protected health information unless such information is clearly identified as protected health information that is subject to this subtitle.

(2) ROUTINE DISCLOSURES SUBJECT TO WRITTEN AGREEMENT.—A health information trustee who routinely discloses protected health information to a person may satisfy the identification requirement in paragraph (1) through a written agreement between the trustee and the person with respect to the protected health information.

(g) CONSTRUCTION.—Nothing in this subtitle shall be construed to limit the ability of a health information

trustee to charge a reasonable fee for the disclosure or reproduction of health information.

(h) INFORMATION IN WHICH PROVIDERS ARE IDENTIFIED.—The Secretary, after notice and opportunity for public comment, may issue regulations protecting information identifying providers in order to promote the availability of health care services.

SEC. 5207. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) WRITTEN AUTHORIZATIONS.—A health information trustee may disclose protected health information pursuant to an authorization executed by the individual who is the subject of the information, if each of the following requirements is met:

(1) WRITING.—The authorization is in writing, signed by the individual who is the subject of the information, and dated on the date of such signature.

(2) SEPARATE FORM.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

(3) TRUSTEE DESCRIBED.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

(4) RECIPIENT DESCRIBED.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

(5) STATEMENT OF INTENDED DISCLOSURES.—The authorization contains an acknowledgment that the individual who is the subject of the information has read a statement of the disclosures that the person to receive the protected health information intends to make, which statement shall be in writing, on a form that is distinct from the authorization for disclosure, and which statement must be received by the individual authorizing the disclosure on or before such authorization is executed.

(6) INFORMATION DESCRIBED.—The information to be disclosed is described in the authorization.

(7) EXPIRATION DATE SPECIFIED.—The authorization specifies a date or event upon which the authorization expires, which shall not exceed 2 years from the date of the execution of the authorization.

(8) AUTHORIZATION TIMELY RECEIVED.—The authorization is received by the trustee during a period described in subsection (c)(1).

(9) DISCLOSURE TIMELY MADE.—The disclosure occurs during a period described in subsection (c)(2).

(b) AUTHORIZATIONS REQUESTED IN CONNECTION WITH PROVISION OF HEALTH CARE.—

(1) IN GENERAL.—A health information trustee may not request that an individual provide to any other person an authorization described in subsection (a) on a day on which—

(A) the trustee provides health care to the individual requested to provide the authorization; or

(B) in the case of a trustee that is a health facility, the individual is admitted into the facility as a resident or inpatient in order to receive health care.

(2) EXCEPTION.—Paragraph (1) does not apply if a health information trustee requests that an individual provide an authorization described in subsection (a) for the purpose of assisting the individual in obtaining counseling or social services from a person other than the trustee.

(c) TIME LIMITATIONS ON AUTHORIZATIONS.—

(1) RECEIPT BY TRUSTEE.—For purposes of subsection (a)(8), an authorization is timely received if it is received by the trustee during—

(A) the 1-year period beginning on the date on which the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person who provides health counseling or social services to individuals; or

(B) the 30-day period beginning on the date on which the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person other than a person described in subparagraph (A).

(2) DISCLOSURE BY TRUSTEE.—For purposes of subsection (a)(9), a disclosure is timely made if it occurs before the date or event specified in the authorization upon which the authorization expires.

(d) REVOCATION OR AMENDMENT OF AUTHORIZATION.—

(1) IN GENERAL.—An individual may in writing revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except when—

(A) disclosure of protected health information has been authorized to permit validation of expenditures for health care; or

(B) action has been taken in reliance on the authorization.

(2) NOTICE OF REVOCATION.—A health information trustee who discloses protected health information pursuant to an authorization that has been revoked shall not be subject to any liability or penalty under this subtitle if—

(A) the reliance was in good faith;

(B) the trustee had no notice of the revocation; and

(C) the disclosure was otherwise in accordance with the requirements of this subtitle.

(e) DECEASED INDIVIDUAL.—The Secretary shall develop and establish through regulation a procedure for obtaining protected health information relating to a deceased individual when there is no individual representative for such individual.

(f) MODEL AUTHORIZATIONS.—The Secretary, after notice and opportunity for public comment, shall develop and disseminate model written authorizations of the type described in subsection (a) and model statements of in-

tended disclosures of the type described in subsection (a)(5).

(g) COPY.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization.

SEC. 5208. CERTIFIED HEALTH INFORMATION NETWORK SERVICES.

(a) IN GENERAL.—A health information trustee may disclose protected health information to a certified health information network service acting as an agent of the trustee for any purpose permitted by this subtitle. Such a service, acting as an agent of a trustee, may disclose protected health information to another person as permitted under this subtitle to facilitate the completion of the purpose for which such information was disclosed to the service.

(b) CERTIFIED HEALTH INFORMATION PROTECTION ORGANIZATIONS.—A health information trustee may disclose protected health information to a certified health information protection organization for the purpose of creating non-identifiable health information (as defined in section 5102).

Subpart B—Specific Disclosures Relating to Patient

SEC. 5211. DISCLOSURES FOR TREATMENT AND FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) HEALTH CARE TREATMENT.—A health care provider, health plan, employer, or person who receives protected health information under section 5213, may disclose protected health information to a health care provider for the purpose of providing health care to an individual if the individual who is the subject of the information has not previously objected in writing to the disclosure.

(b) DISCLOSURE TO HEALTH PLANS FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health care provider or employer may disclose protected health information to a health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

(c) DISCLOSURE BY HEALTH PLANS FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health plan may disclose protected health information to a health care provider or a health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

SEC. 5212. NEXT OF KIN AND DIRECTORY INFORMATION.

(a) NEXT OF KIN.—A health care provider or person who receives protected health information under section

5213 may disclose protected health information to the next of kin, an individual representative of the individual who is the subject of the information, or an individual with whom that individual has a close personal relationship if—

(1) the individual who is the subject of the information—

(A) has been notified of the individual's right to object and has not objected to the disclosure;

(B) is not competent to be notified about the right to object; or

(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

(2) the information disclosed relates to health care currently being provided to that individual.

(b) DIRECTORY INFORMATION.—A health care provider and a person receiving protected health information under section 5213 may disclose protected health information to any person if—

(1) the information does not reveal specific information about the physical or mental condition of the individual who is the subject of the information or health care provided to that person;

(2) the individual who is the subject of the information—

(A) has been notified of the individual's right to object and has not objected to the disclosure;

(B) is not competent to be notified about the right to object; or

(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

(3) the information consists only of 1 or more of the following items:

(A) The name of the individual who is the subject of the information.

(B) If the individual who is the subject of the information is receiving health care from a health care provider on a premises controlled by the provider—

(i) the location of the individual on the premises; and

(ii) the general health status of the individual, described as critical, poor, fair, stable, or satisfactory or in terms denoting similar conditions.

(d) IDENTIFICATION OF DECEASED INDIVIDUAL.—A health care provider, health plan, employer, or life insurer, may disclose protected health information if necessary to assist in the identification of a deceased individual.

SEC. 5213. EMERGENCY CIRCUMSTANCES.

(a) IN GENERAL.—A health care provider, health plan, employer, or person who receives protected health information under this section may disclose protected health information in emergency circumstances when necessary to protect the health or safety of an individual from imminent harm.

(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be limited to persons who need the information to take action to protect the health or safety of the individual.

Subpart C—Disclosure for Oversight, Public Health, and Research Purposes

SEC. 5216. OVERSIGHT.

(a) IN GENERAL.—A health information trustee may disclose protected health information to a health oversight agency for an oversight function authorized by law.

(b) USE IN ACTION AGAINST INDIVIDUALS.—Notwithstanding section 5206(e), protected health information about an individual that is disclosed under this section may be used in, or disclosed to any person for use

in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information if the action or investigation arises out of and is directly related to receipt of health care or payment for health care or an action involving a fraudulent claim related to health.

SEC. 5217. PUBLIC HEALTH.

A health care provider, health plan, public health authority, employer, or person who receives protected health information under section 5213 may disclose protected health information to a public health authority or other person authorized by law for use in a legally authorized—

(1) disease or injury reporting;

(2) public health surveillance; or

(3) public health investigation or intervention.

SEC. 5218. HEALTH RESEARCH.

(a) IN GENERAL.—A health information trustee may disclose protected health information to a health researcher if an institutional review board determines that the research project engaged in by the health researcher—

(1) requires use of the protected health information for the effectiveness of the project; and

(2) is of sufficient importance to outweigh the intrusion into the privacy of the individual who is

the subject of the information that would result from the disclosure.

(b) RESEARCH REQUIRING DIRECT CONTACT.—A health information trustee may disclose protected health information to a health researcher for a research project that includes direct contact with an individual who is the subject of protected health information if an institutional review board determines that—

(1) the research project meets the requirements of paragraphs (1) and (2) of subsection (a);

(2) direct contact is necessary to accomplish the research purpose; and

(3) the direct contact will be made in a manner that minimizes the risk of harm, embarrassment, or other adverse consequences to the individual.

(c) USE OF HEALTH INFORMATION NETWORK.—

(1) IN GENERAL.—A health information trustee may disclose protected health information to a health researcher using the health information network (as defined in section 5102) only if an institutional review board certified by the Secretary under paragraph (2) determines that the research project engaged in by the health researcher meets the requirements of this section.

(2) CERTIFICATION OF INSTITUTIONAL REVIEW BOARDS.—

(A) REGULATIONS.—The Secretary, after notice and opportunity for public comment, shall issue regulations establishing certification requirements for institutional review boards under this subtitle. Such regulations shall be based on regulations issued under section 491(a) of the Public Health Service Act and shall ensure that institutional review boards certified under this paragraph have the qualifications to access and protect the confidentiality of research subjects.

(B) CERTIFICATION.—The Secretary shall certify an institutional review board that meets the certification requirements established by the Secretary under subparagraph (A).

(d) OBLIGATIONS OF RECIPIENT.—A person who receives protected health information pursuant to subsection (a)—

(1) shall remove or destroy, at the earliest opportunity consistent with the purposes of the project, information that would enable an individual to be identified, unless—

(A) an institutional review board has determined that there is a health or research justification for retention of such identifiers; and

(B) there is an adequate plan to protect the identifiers from disclosure that is inconsistent with this section; and

(2) shall use protected health information solely for purposes of the health research project for which disclosure was authorized under this section.

Subpart D—Disclosure For Judicial, Administrative, and Law Enforcement Purposes

SEC. 5221. JUDICIAL AND ADMINISTRATIVE PURPOSES.

A health care provider, health plan, health oversight agency, or employer may disclose protected health information—

(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which the individual who is the subject of the information is a party and in which the individual has placed the individual's physical or mental condition in issue;

(2) to a court, and to others ordered by a court, if the protected health information is developed in

response to a court-ordered physical or mental examination; or

(3) pursuant to a law requiring the reporting of specific medical information to law enforcement authorities.

SEC. 5222. LAW ENFORCEMENT.

(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 5213 may disclose protected health information to a law enforcement agency (other than a health oversight agency governed by section 5216) if the information is requested for use—

(1) in an investigation or prosecution of a health information trustee;

(2) in the identification of a victim or witness in a law enforcement inquiry; or

(3) in connection with the investigation of criminal activity committed against the trustee or on premises controlled by the trustee.

(b) CERTIFICATION.—When a law enforcement agency (other than a health oversight agency) requests that a health information trustee disclose protected health information under this section, the law enforcement agency shall provide the trustee with a written certification that—

(1) specifies the information requested;

(2) states that the information is needed for a lawful purpose under this section; and

(3) is signed by a supervisory official of a rank designated by the head of the agency.

(c) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—Notwithstanding section 5206(e), protected health information about an individual that is disclosed to a law enforcement agency under this section may be used in, or disclosed for, an administrative, civil, or criminal action or investigation against the individual if the action or investigation arises out of and is directly related to the action or investigation for which the information was obtained.

Subpart E—Disclosure Pursuant to Government Subpoena or Warrant

SEC. 5226. GOVERNMENT SUBPOENAS AND WARRANTS.

(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 5213 may disclose protected health information under this section if the disclosure is pursuant to—

(1) a subpoena issued under the authority of a grand jury, and the trustee is provided a written certification by the grand jury seeking the information

that the grand jury has complied with the applicable access provisions of section 5227;

(2) an administrative subpoena or a judicial subpoena or warrant, and the trustee is provided a written certification by the person seeking the information that the person has complied with the applicable access provisions of section 5227; or

(3) an administrative subpoena or a judicial subpoena or warrant, and the disclosure otherwise meets the conditions of section 5216, 5217, 5221, or 5222.

(b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

(1) ACTIONS OR INVESTIGATIONS.—Notwithstanding section 5206(c), protected health information about an individual that is received under subsection (a) may be disclosed for, or used in, any administrative, civil, or criminal action or investigation against the individual if the action or investigation arises out of and is directly related to the inquiry for which the information was obtained.

(2) SPECIAL RULE.—Protected health information about an individual that is received under subsection (a)(3) may not be disclosed by the recipient unless the recipient complies with the conditions and restrictions on disclosure with which the recipient

would have been required to comply if the disclosure had been made under section 5216, 5217, 5221, or 5222.

SEC. 5227. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS AND WARRANTS.

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about an individual under paragraph (1) or (2) of section 5226(a) for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

(b) WARRANTS.—A government authority that obtains protected health information about an individual under circumstances described in subsection (a) and pursuant to a warrant shall, not later than 30 days after the date the warrant was executed, serve the individual with, or mail to the last known address of the individual, a notice that protected health information about the individual was so obtained, together with a notice of the individual's right to challenge the warrant in accordance with section 5228.

(c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected health information about an individual under cir-

cumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served on the individual on or before the date of return of the subpoena, together with a notice of the individual's right to challenge the subpoena in accordance with section 5228, and—

(1) 15 days have passed since the date of service on the individual and within that time period the individual has not initiated a challenge in accordance with section 5228; or

(2) disclosure is ordered by a court after challenge under section 5228.

(d) APPLICATION FOR DELAY.—

(1) IN GENERAL.—A government authority may apply ex parte and under seal to an appropriate court to delay (for an initial period of not longer than 90 days) serving a notice or copy of a subpoena required under subsection (b) or (c) with respect to a law enforcement inquiry. The government authority may apply to the court for extensions of the delay.

(2) REASONS FOR DELAY.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

(3) EX PARTE ORDER.—The court shall enter an ex parte order delaying or extending the delay of notice, an order prohibiting the disclosure of the request for, or disclosure of, the protected health information, and an order requiring the disclosure of the protected health information if the court finds that—

(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry;

(C) the government authority's need for the information outweighs the privacy interest of the individual who is the subject of the information; and

(D) there is reasonable ground to believe that receipt of notice by the individual will result in—

(i) endangering the life or physical safety of any individual;

(ii) flight from prosecution;

(iii) destruction of or tampering with evidence or the information being sought; or

(iv) intimidation of potential witnesses.

SEC. 5228. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT WARRANTS AND SUBPOENAS.

(a) MOTION TO QUASH.—Within 15 days after the date of service of a notice of execution or a copy of a subpoena of a government authority seeking protected health information about an individual under paragraph (1) or (2) of section 5226(a), the individual may file a motion to quash—

(1) in the case of a State judicial warrant or subpoena, in the court which issued the warrant or subpoena;

(2) in the case of a warrant or subpoena issued under the authority of a State that is not a State judicial warrant or subpoena, in a court of competent jurisdiction; or

(3) in the case of any other warrant or subpoena issued under the authority of a Federal court or the United States, in the United States district court for the district in which the individual resides or in which the warrant or subpoena was issued.

(b) COPY.—A copy of the motion shall be served by the individual upon the government authority by registered or certified mail.

(c) PROCEEDINGS.—The government authority may file with the court such papers, including affidavits and other sworn documents, as sustain the validity of the warrant or subpoena. The individual may file with the court reply papers in response to the government authority's filing. The court, upon the request of the individual or the government authority or both, may proceed in camera. The court may conduct such proceedings as it deems appropriate to rule on the motion, but shall endeavor to expedite its determination.

(d) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds there is probable cause to believe the protected health information is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds the individual's privacy interest outweighs the government authority's need for the information. The individual shall have the burden of demonstrating that the individual's privacy interest outweighs the need by the government authority for the information.

(e) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In reaching its determination, the court shall consider—

(1) the particular purpose for which the information was collected;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

(5) any other factor deemed relevant by the court.

(f) ATTORNEY'S FEES.—In the case of a motion brought under subsection (a) in which the individual has substantially prevailed, the court may assess against the government authority a reasonable attorney's fee and other litigation costs (including expert's fees) reasonably incurred.

(g) NO INTERLOCUTORY APPEAL.—A ruling denying a motion to quash under this section shall not be deemed to be a final order, and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a

ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protected health information disclosed.

Subpart F—Disclosure Pursuant to Private Party Subpoena

SEC. 5231. PRIVATE PARTY SUBPOENAS.

A health care provider, health plan, employer, or person who receives protected health information under section 5213 may disclose protected health information under this section if the disclosure is pursuant to a subpoena issued on behalf of a private party who has complied with the access provisions of section 5232.

SEC. 5232. ACCESS PROCEDURES FOR PRIVATE PARTY SUBPOENAS.

A private party may not obtain protected health information about an individual pursuant to a subpoena unless a copy of the subpoena together with a notice of the individual's right to challenge the subpoena in accordance with section 5233 has been served upon the individual on or before the date of return of the subpoena, and—

(1) 15 days have passed since the date of service on the individual, and within that time period the

individual has not initiated a challenge in accordance with section 5233; or

(2) disclosure is ordered by a court under section 5233.

SEC. 5233. CHALLENGE PROCEDURES FOR PRIVATE PARTY SUBPOENAS.

(a) MOTION TO QUASH SUBPOENA.—Within 15 days after service of a copy of the subpoena seeking protected health information under section 5231, the individual who is the subject of the protected health information may file in any court of competent jurisdiction a motion to quash the subpoena and serve a copy of the motion on the person seeking the information.

(b) STANDARD FOR DECISION.—The court shall grant a motion under subsection (a) unless the respondent demonstrates that—

(1) there is reasonable ground to believe the information is relevant to a lawsuit or other judicial or administrative proceeding; and

(2) the need of the respondent for the information outweighs the privacy interest of the individual.

(c) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (b) whether the need of the respondent for the information

outweighs the privacy interest of the individual, the court shall consider—

(1) the particular purpose for which the information was collected;

(2) the degree to which disclosure of the information would embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the information to the lawsuit or proceeding; and

(5) any other relevant factor.

(d) ATTORNEY'S FEES.—In the case of a motion brought under subsection (a) in which the individual has substantially prevailed, the court may assess against the respondent a reasonable attorney's fee and other litigation costs and expenses (including expert's fees) reasonably incurred.

PART 3—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

Subpart A—Establishment of Safeguards

SEC. 5236. ESTABLISHMENT OF SAFEGUARDS.

(a) IN GENERAL.—A health information trustee shall establish and maintain appropriate administrative, technical, and physical safeguards—

(1) to ensure the integrity and confidentiality of protected health information created or received by the trustee; and

(2) to protect against any anticipated threats or hazards to the security or integrity of such information.

(b) REGULATIONS.—The Secretary shall promulgate regulations regarding security measures for protected health information.

SEC. 5237. ACCOUNTING FOR DISCLOSURES.

(a) IN GENERAL.—

(1) REQUIREMENT TO CREATE OR MAINTAIN RECORD.—A health information trustee shall create and maintain, with respect to any protected health information disclosed in exceptional circumstances (as described in paragraph (2)), a record of—

(A) the date and purpose of the disclosure;

(B) the name of the person to whom or to which the disclosure was made;

(C) the address of the person to whom or to which the disclosure was made or the location to which the disclosure was made; and

(D) the information disclosed, if the recording of the information disclosed is practicable, taking into account the technical capa-

bilities of the system used to maintain the record and the costs of such maintenance.

(2) EXCEPTIONAL CIRCUMSTANCES DESCRIBED.—For purposes of paragraph (1) protected health information is disclosed in exceptional circumstances if the disclosure—

(A) is not a routine part of doing business, as determined in accordance with guidelines promulgated by the Secretary; or

(B) is permitted under sections 5213 and 5217.

(b) DISCLOSURE RECORD PART OF INFORMATION.—A record created and maintained under paragraph (a) shall be maintained as part of the protected health information to which the record pertains.

Subpart B—Review of Protected Health Information By Subjects of the Information

SEC. 5241. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Except as provided in subsection (c), a health care provider or health plan—

(1) shall permit an individual who is the subject of protected health information to inspect any such information that the provider or plan maintains;

(2) shall permit the individual to have a copy of the information;

(3) shall permit a person who has been designated in writing by the individual who is the subject of the information to inspect, or to have a copy of, the information on behalf of the individual or to accompany the individual during the inspection; and

(4) may offer to explain or interpret information that is inspected or copied under this subsection.

(b) ADDITIONAL REQUESTS.—Except as provided in subsection (c), a health plan or health care provider shall, upon written request of an individual—

(1) determine the identity of previous providers to the individual; and

(2) obtain protected health information regarding the individual.

(c) EXCEPTIONS.—A health care provider or health plan is not required by this section to permit inspection or copying of protected health information if any of the following conditions apply:

(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes, and the provider or plan determines, based on reasonable

medical judgment, that inspection or copying of the notes would cause sufficient harm to the individual who is the subject of the notes so as to outweigh the desirability of permitting access, and the provider or plan has not disclosed the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

(2) INFORMATION ABOUT OTHERS.—The information relates to an individual other than the individual seeking to inspect or have a copy of the information and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the information would cause sufficient harm to 1 or both of the individuals so as to outweigh the desirability of permitting access.

(3) ENDANGERMENT TO LIFE OR SAFETY.—The provider or plan determines that disclosure of the information could reasonably be expected to endanger the life or physical safety of any individual.

(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of a person (other than a health care provider) who provided information under a promise of con-

fidentiality to a health care provider concerning the individual who is the subject of the information.

(5) ADMINISTRATIVE PURPOSES.—The information—

(A) is used by the provider or plan solely for administrative purposes and not in the provision of health care to the individual who is the subject of the information; and

(B) has not been disclosed by the provider or plan to any other person.

(d) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health care provider or health plan shall permit inspection and copying under subsection (a) of any reasonably segregable portion of a record after deletion of any portion that is exempt under subsection (c).

(e) CONDITIONS.—A health care provider or health plan may require a written request for the inspection and copying of protected health information under this subsection. The health care provider or health plan may require a cost reimbursement for such inspection and copying.

(f) STATEMENT OF REASONS FOR DENIAL.—If a health care provider or health plan denies a request for inspection or copying under this section, the provider or plan shall provide the individual who made the request (or

the individual's designated representative) with a written statement of the reasons for the denial.

(g) DEADLINE.—A health care provider or health plan shall comply with or deny a request for inspection or copying of protected health information under this section within the 30-day period beginning on the date on which the provider or plan receives the request.

SEC. 5242. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A health care provider or health plan shall, within the 45-day period beginning on the date on which the provider or plan receives from an individual a written request that the provider or plan correct or amend the information—

(1) make the correction or amendment requested;

(2) inform the individual of the correction or amendment that has been made; and

(3) inform any person who is identified by the individual, who is not an officer, employee or agent of the provider or plan, and to whom the uncorrected or unamended portion of the information was previously disclosed, of the correction or amendment that has been made.

(b) REFUSAL TO CORRECT.—If the provider or plan refuses to make the corrections, the provider or plan shall inform the individual of—

(1) the reasons for the refusal of the provider or plan to make the correction or amendment;

(2) any procedures for further review of the refusal; and

(3) the individual's right to file with the provider or plan a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the provider or plan.

(c) BASES FOR REQUEST TO CORRECT OR AMEND.—An individual may request correction or amendment of protected health information about the individual under paragraph (a) if the information is not timely, accurate, relevant to the system of records, or complete.

(d) STATEMENT OF DISAGREEMENT.—After an individual has filed a statement of disagreement under paragraph (b)(3), the provider or plan, in any subsequent disclosure of the disputed portion of the information—

(1) shall include a copy of the individual's statement; and

(2) may include a concise statement of the reasons of the provider or plan for not making the requested correction or amendment.

(e) RULE OF CONSTRUCTION.—This section shall not be construed to require a health care provider or health plan to conduct a formal, informal, or other hearing or proceeding concerning a request for a correction or amendment to protected health information the provider or plan maintains.

(f) CORRECTION.—For purposes of paragraph (a), a correction is deemed to have been made to protected health information when information that is not timely, accurate, relevant to the system of records, or complete is clearly marked as incorrect or when supplementary correct information is made part of the information.

SEC. 5243. NOTICE OF INFORMATION PRACTICES.

(a) PREPARATION OF WRITTEN NOTICE.—A health care provider or health plan shall prepare a written notice of information practices describing the following:

(1) PERSONAL RIGHTS OF AN INDIVIDUAL.—The rights under this subpart of an individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclo-

sures of protected health information and for revoking such authorizations.

(2) PROCEDURES OF PROVIDER OR PLAN.—The procedures established by the provider or plan for the exercise of the rights of individuals about whom protected health information is maintained.

(3) AUTHORIZED DISCLOSURES.—The disclosures of protected health information that are authorized.

(b) DISSEMINATION OF NOTICE.—A health care provider or health plan—

(1) shall, upon request, provide any individual with a copy of the notice of information practices described in subsection (a); and

(2) shall make reasonable efforts to inform individuals in a clear and conspicuous manner of the existence and availability of the notice.

(c) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, shall develop and disseminate a model notice of information practices for use by health care providers and health plans under this section.

Subpart C—Standards for Electronic Disclosures

SEC. 5246. STANDARDS FOR ELECTRONIC DISCLOSURES.

The Secretary shall promulgate standards for disclosing protected health information in accordance with this

subtitle in electronic form. Such standards shall include standards relating to the creation, transmission, receipt, and maintenance, of any written document required or authorized under this subtitle.

PART 4—SANCTIONS

Subpart A—No Sanctions for Permissible Actions

SEC. 5251. NO LIABILITY FOR PERMISSIBLE DISCLOSURES.

A health information trustee who makes a disclosure of protected health information about an individual that is permitted by this subtitle shall not be liable to the individual for the disclosure under common law.

SEC. 5252. NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.

If the members of an institutional review board make a determination in good faith that—

(1) a health research project is of sufficient importance to outweigh the intrusion into the privacy of an individual; and

(2) the effectiveness of the project requires use of protected health information,

the members, the board, and the parent institution of the board shall not be liable to the individual as a result of the determination.

SEC. 5253. RELIANCE ON CERTIFIED ENTITY.

If a health information trustee contracts with a certified health information network service to make a disclosure of any protected health information on behalf of such trustee in accordance with this subtitle and such service makes a disclosure of such information that is in violation of this subtitle, the trustee shall not be liable to the individual who is the subject of the information for such unlawful disclosure.

Subpart B—Civil Sanctions

SEC. 5256. CIVIL PENALTY.

(a) VIOLATION.—Any health information trustee who the Secretary determines has substantially failed to comply with this subtitle shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $10,000 for each such violation.

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A of the Social Security Act, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

SEC. 5257. CIVIL ACTION.

(a) IN GENERAL.—An individual who is aggrieved by conduct in violation of this subtitle may bring a civil action to recover—

(1) the greater of actual damages or liquidated damages of $5,000;

(2) punitive damages;

(3) a reasonable attorney's fee and expenses of litigation;

(4) costs of litigation; and

(5) such preliminary and equitable relief as the court determines to be appropriate.

(b) LIMITATION.—No action may be commenced under this section more than 3 years after the date on which the violation was or should reasonably have been discovered.

Subpart C—Criminal Sanctions

SEC. 5261. WRONGFUL DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) OFFENSE.—A person who knowingly—

(1) obtains protected health information relating to an individual in violation of this subtitle; or

(2) discloses protected health information to another person in violation of this subtitle,

shall be punished as provided in subsection (b).

(b) PENALTIES.—A person described in subsection (a) shall—

(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

(3) if the offense is committed with intent to sell, transfer, or use protected health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

PART 5—ADMINISTRATIVE PROVISIONS

SEC. 5266. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as provided in subsections (b), (c), and (d), this subtitle preempts State law.

(b) LAWS RELATING TO PUBLIC OR MENTAL HEALTH.—Nothing in this subtitle shall be construed to preempt or operate to the exclusion of any State law relating to public health or mental health that prevents or regulates disclosure of protected health information otherwise allowed under this subtitle.

(c) PRIVILEGES.—Nothing in this subtitle is intended to preempt or modify State common or statutory law to the extent such law concerns a privilege of a witness or

person in a court of the State. This subtitle does not supersede or modify Federal common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the United States. Authorizations pursuant to section 5207 shall not be construed as a waiver of any such privilege.

(d) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This subtitle shall not be construed to preempt, supersede, or modify the operation of—

(1) any law that provides for the reporting of vital statistics such as birth or death information;

(2) any law requiring the reporting of abuse or neglect information about any individual;

(3) subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases); or

(4) any Federal law or regulation governing confidentiality of alcohol and drug patient records.

SEC. 5267. RIGHTS OF INCOMPETENTS.

(a) EFFECT OF DECLARATION OF INCOMPETENCE.—Except as provided in section 5268, if an individual has been declared to be incompetent by a court of competent jurisdiction, the rights of the individual under this subtitle

shall be exercised and discharged in the best interests of the individual through the individual's representative.

(b) NO COURT DECLARATION.—Except as provided in section 5268, if a health care provider determines that an individual, who has not been declared to be incompetent by a court of competent jurisdiction, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure may be exercised and discharged in the best interest of the individual by the individual's representative.

SEC. 5268. EXERCISE OF RIGHTS.

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual; or

(2) who, acting alone, has the legal right, as determined by State law, to apply for and obtain a type of medical examination, care, or treatment and who has sought such examination, care, or treatment, the individual shall exercise all rights of an individual under this subtitle with respect to protected health information relating to such examination, care, or treatment.

(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

(1) under 14 years of age, all the individual's rights under this subtitle shall be exercised through the parent or legal guardian of the individual; or

(2) 14, 15, 16, or 17 years of age, the rights of inspection and amendment, and the right to authorize disclosure of protected health information of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.

Subtitle D—Expanded Efforts To Combat Health Care Fraud and Abuse Affecting Federal Outlay Programs

PART 1—IMPROVED ENFORCEMENT

SEC. 5301. HEALTH CARE FRAUD AND ABUSE AFFECTING FEDERAL OUTLAY PROGRAMS.

(a) IN GENERAL.—Not later than January 1, 1995, the Secretary and the Attorney General of the United States shall establish a joint program—

(1) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse affecting Federal outlay programs,

(2) to conduct investigations (including consumer complaint investigations), audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) to facilitate the enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH PURCHASING COOPERATIVES AND CERTIFIED HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of purchasing cooperatives and certified standard health plans.

(d) AUTHORITIES OF ATTORNEY GENERAL AND SECRETARY.—In carrying out duties under subsection (a), the Attorney General and the Secretary shall—

(1) conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the program established under such subsection;

(2) have access (including on-line access as requested and available) to all records available to purchasing cooperatives and certified standard health plans relating to the activities described in paragraph (1) (subject to restrictions based on the confidentiality of certain information under subtitles B and C of this title); and

(3) issue advisory opinions, fraud alerts, and other appropriate educational material to assist in compliance with the provisions of this subtitle.

(e) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or the Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part 2.

(f) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out duties and responsibilities under the program established under subsection (a), the

Inspector General is authorized to exercise all powers granted under the Inspector General Act of 1978 to the same manner and extent as provided in that Act.

(g) DEFINITIONS.—In this subtitle:

(1) CERTIFIED STANDARD HEALTH PLANS; PURCHASING COOPERATIVES.—The terms ''certified standard health plan'' and ''purchasing cooperative'' have the meanings given such terms by sections 1011(2) and 1013(16), respectively.

(2) FEDERAL OUTLAY PROGRAMS.—The term ''Federal outlay programs'' means—

(A) any program under title XVIII of the Social Security Act,

(B) any State health care program (as defined in section 1128(h) of the Social Security Act),

(C) any program under the Public Health Service Act, and

(D) any program under this Act, including any State program approved under title I which certifies standard health plans, supplemental health benefits plans, and long-term care policies.

(3) INSPECTOR GENERAL.—The term ''Inspector General'' means the Inspector General of the Department of Health and Human Services.

SEC. 5302. ESTABLISHMENT OF FEDERAL OUTLAY PROGRAM FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is hereby established an account to be known as the ''Federal Outlay Program Fraud and Abuse Control Account'' (in this section referred to as the ''Anti-Fraud Account''). The Anti-Fraud Account shall consist of—

(A) such gifts and bequests as may be made as provided in paragraph (2);

(B) such amounts as may be deposited in the Anti-Fraud Account as provided in section 5311(d)(2) and title IX of the Social Security Act; and

(C) such amounts as are transferred to the Anti-Fraud Account under paragraph (3).

(2) AUTHORIZATION TO ACCEPT GIFTS.—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for

the benefit of the Anti-Fraud Account or any activity financed through the Anti-Fraud Account.

(3) TRANSFER OF AMOUNTS.—

(A) IN GENERAL.—Subject to the limitation in subparagraph (B), the Secretary of the Treasury shall transfer to the Anti-Fraud Account an amount equal to the sum of the following:

(i) Criminal fines imposed in cases involving a Federal health care offense (as defined in subsection (d)).

(ii) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(iii) Administrative penalties and assessments imposed under section 5311 (except as otherwise provided by law).

(iv) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(B) LIMITATION.—The Secretary of the Treasury shall not transfer more than the

$75,000,000, plus 50 percent of the excess (if any) of the amount described in subparagraph (A) for any fiscal year (beginning in fiscal year 1995).

(b) USE OF FUNDS.—

(1) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and the Attorney General of the United States in carrying out the Federal Outlay Program Fraud and Abuse Control Program established under section 5301 (including the administration of the Program), and may be used to cover costs incurred in operating the Program, including costs of—

(A) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(B) investigations;

(C) financial and performance audits of health care programs and operations;

(D) inspections and other evaluations;

(E) rewards paid under section 5304; and

(F) provider and consumer education (including the provision of advisory opinions) re-

garding compliance with the provisions of this subtitle.

Twenty percent of the amounts available in the Anti-Fraud Account for any fiscal year shall be used for costs described in subparagraph (F).

(2) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(c) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(d) FEDERAL HEALTH CARE OFFENSE DEFINED.—For purposes of subsection (a)(3)(A)(i), the term ''Federal health care offense'' means a violation of, or a criminal conspiracy to violate—

(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;

(2) section 1128B of the Social Security Act;

(3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud;

(4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; or

(5) sections 301, 303(a)(2), or 303 (b) or (e) of the Federal Food Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.

SEC. 5303. USE OF FUNDS BY INSPECTOR GENERAL.

(a) REIMBURSEMENTS FOR INVESTIGATIONS.—

(1) IN GENERAL.—The Inspector General is authorized to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payer, or otherwise.

(2) CREDITING.—Funds received by the Inspector General as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of their deposit.

(3) EXCEPTION FOR FORFEITURES.—This subsection does not apply to investigative costs paid to the Inspector General from the Department of Justice Asset Forfeiture Fund, which monies shall be

deposited and expended in accordance with subsection (b).

(b) HHS OFFICE OF INSPECTOR GENERAL ASSET FORFEITURE PROCEEDS FUND.—

(1) IN GENERAL.—There is hereby established the ''HHS Office of Inspector General Asset Forfeiture Proceeds Fund'', to be administered by the Inspector General, which shall be available to the Inspector General without fiscal year limitation for expenses relating to the investigation of matters within the jurisdiction of the Inspector General.

(2) DEPOSITS.—There shall be deposited in the Fund all proceeds from forfeitures that have been transferred to the Inspector General from the Department of Justice Asset Forfeiture Fund under section 524 of title 28, United States Code.

SEC. 5304. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

(a) IN GENERAL.—In special circumstances, the Secretary and the Attorney General of the United States may jointly make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution of a Federal health care offense (as defined in section 5302(d)).

(b) INELIGIBLE PERSONS.—A person is not eligible for a payment under subsection (a) if—

(1) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

(2) the person knowingly participated in the offense;

(3) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

(A) in a criminal, civil, or administrative proceeding;

(B) in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation; or

(C) by the news media, unless the person is the original source of the information; or

(4) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

(c) DEFINITION.—For the purposes of subsection (b)(3)(C), the term ''original source'' means a person who

has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the government prior to disclosure by the news media.

(d) NO JUDICIAL REVIEW.—Neither the failure of the Secretary and the Attorney General to authorize a payment under subsection (a) nor the amount authorized shall be subject to judicial review.

PART 2—CIVIL PENALTIES AND RIGHTS OF ACTION

SEC. 5311. CIVIL MONETARY PENALTIES.

(a) ACTIONS SUBJECT TO PENALTY.—

(1) IN GENERAL.—Any person who is determined by the Secretary to have committed any action with respect to a certified standard health plan or certified long-term care plan or long-term care services provided under this Act that would subject the person to a penalty under paragraphs (1) through (11) of section 1128A of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act, shall be subject to a penalty in accordance with subsection (b).

(2) TREATMENT OF AMOUNTS RECOVERED.—Any amounts recovered under the preceding sentence shall be paid to the Secretary and such por-

tions of the amounts recovered as is determined to have been improperly paid from a certified standard health plan or certified long-term care policy for the delivery of or payment for health care items or services shall be repaid to such plan or policy (and enrollees of such plan or policy as appropriate) and the remainder of the amounts recovered shall be deposited in the Federal Outlays Program Fraud and Abuse Control Account established under section 5302.

(b) PENALTIES.—

(1) GENERAL RULE.—In the case of a person who the Secretary determines has committed an action described in subsection (a), the person shall be subject to the civil monetary penalty (together with any additional assessment) to which the person would be subject to under section 1128A of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act.

(2) PENALTIES DESCRIBED.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking ''$2,000'' and inserting ''$10,000''; and

(B) by striking ''twice the amount claimed'' and inserting ''3 times the amount claimed''.

(3) INTEREST ON PENALTIES.—Section 1128A(f) of such Act (42 U.S.C. 1320a-7a(f)) is amended by adding after the first sentence the following: ''Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where such penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of such penalties and assessments owed to cover the costs of collection.''.

(c) ADDITIONAL OFFENSES.—

(1) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''or'' at the end of paragraphs (1) and (2);

(B) by striking the comma at the end of paragraph (2) and inserting a semicolon; and

(C) by inserting after paragraph (3) the following new paragraphs:

''(4) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a Federal outlay program (as defined in section 5301(g)(1) of the Health Security Act) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a Federal outlay program;

''(5) in the case of a person who is not an organization, agency, or other entity, who is excluded from participating in a program under title XVIII or a Federal outlay program in accordance with this section, section 1128, or section 1156 and who, during the period of exclusion, retains either a direct or

indirect ownership or control interest of 5 percent or more in, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII;

''(6) engages in a practice that circumvents a payment methodology intended to reimburse for two or more discreet medical items or services at a single or fixed amount, including but not limited to, multiple admissions or readmission to hospitals and other institutions reimbursed on a diagnosis reimbursement grouping basis;

''(7) engages in a practice which has the effect of limiting (as compared to other plan enrollees) the appropriate utilization of health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

''(8) fails to comply with a quality assurance program or a utilization review activity;

''(9) employs or contracts with any individual or entity who is excluded from participating in a

program under title XVIII or a Federal outlay program in accordance with this section, section 1128, or section 1156, for the provision of any services (including but not limited to health care, utilization review, medical social work, or administrative), or employs or contracts with any entity for the direct or indirect provision of such services, through such an excluded individual or entity; or

''(10) submits false or fraudulent statements, data or information, or claims to the Secretary, the Secretary of Labor,any other Federal agency, a State health care agency, a purchasing cooperative (under subtitle ____ of title ____ of the Health Security Act), or any other Federal, State or local agency charged with implementation or oversight of a certified health plan under this Act or a public program that the person knows or should know is fraudulent;''.

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for

free or for other than fair market value, except that such term does not include the waiver of coinsurance or deductible amounts by a person or entity, if—

''(A) the waiver is not offered as part of any advertisement or solicitation;

''(B) the person does not routinely waive coinsurance or deductible amounts; and

''(C) the person—

''(i) waives the coinsurance and deductible amounts after determining in good faith that the individual is indigent;

''(ii) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(iii) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary.''.

(3) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) of such Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(A) in subparagraph (A), by striking ''claimed,'' and inserting the following: ''claimed, including any person who presents or causes to be presented a claim for an item or

service which includes a procedure or diagnosis code that the person knows or should know will result in a greater payment to the person than the code applicable to the item or service actually provided or actual patient medical condition,'';

(B) in subparagraph (C), by striking ''or'' at the end;

(C) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(D) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or''.

(c) PROCEDURES FOR IMPOSITION OF PENALTIES.—

(1) APPLICABILITY OF PROCEDURES UNDER SOCIAL SECURITY ACT.—Except as otherwise provided in paragraph (2), the provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil monetary penalty, assessment, or exclusion under this section in the same manner as such provisions apply with re-

spect to the imposition of a penalty, assessment, or exclusion under section 1128A of such Act.

(4) AUTHORITY OF SECRETARY OF LABOR TO IMPOSE PENALTIES, ASSESSMENTS, AND EXCLUSIONS.—

(A) IN GENERAL.—The Secretary of Labor may initiate an action to impose a civil monetary penalty, assessment, or exclusion under this section with respect to actions relating to a certified multistate self-insured health plan if authorized by the Attorney General of the United States and the Secretary pursuant to regulations promulgated by the Secretary in consultation with the Attorney General.

(B) REGULATIONS DESCRIBED.—Under the regulations promulgated under subparagraph (A), the Attorney General and the Secretary shall review an action proposed by the Secretary of Labor, and not later than 60 days after receiving notice of the proposed action from the Secretary of Labor, shall—

(i) approve the proposed action to be taken by the Secretary of Labor;

(ii) disapprove the proposed action; or

(iii) assume responsibility for initiating a criminal, civil, or administrative action based on the information provided in the notice.

(C) ACTION DEEMED APPROVED.—If the Attorney General and the Secretary fail to respond to a proposed action by the Secretary of Labor within the period described in paragraph (2), the Attorney General and the Secretary shall be deemed to have approved the proposed action to be taken by the Secretary of Labor.

(e) NOTIFICATION OF LICENSING AUTHORITIES.—Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) of the Social Security Act) that such a penalty, assessment, or exclusion has become final and the reasons therefore.

SEC. 5312. PERMITTING PARTIES TO BRING ACTIONS ON OWN BEHALF.

(a) IN GENERAL.—Subject to subsections (b) and (c), a certified standard health plan (as defined in section 1011(2)) or an experience-rated employer (as defined in section 1011(5)(E)) that suffers harm or monetary loss

exceeding the sum or value of $10,000 (excluding interest) as a result of any activity of an individual or entity which makes the individual or entity subject to a civil monetary penalty under section 5311 may, in a civil action against the individual or entity in the United States District Court, obtain treble damages and costs including attorneys' fees against the individual or entity and such equitable relief as is appropriate.

(b) REQUIREMENTS FOR BRINGING ACTION.—A person may bring a civil action under this section only if—

(1) the person provides the Secretary with written notice of—

(A) the person's intent to bring an action under this section,

(B) the identities of the individuals or entities the person intends to name as defendants to the action, and

(C) all information the person possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under section 5311 against the defendants, and

(2) one of the following conditions is met:

(A) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (1), the Secretary does not notify the person that the Secretary intends to initiate an investigation to determine whether to impose a civil monetary penalty under section 5311 against the defendants.

(B) The Secretary notifies the person during the 60-day period described in subparagraph (A) that the Secretary intends to initiate an investigation to determine whether to impose a civil monetary penalty under such section against the defendants, and the Secretary subsequently notifies the person that the Secretary no longer intends to initiate an investigation or proceeding to impose a civil monetary penalty against the defendants.

(C) After the expiration of the 1-year period that begins on the date written notice is provided to the Secretary, the Secretary has not initiated a proceeding to impose a civil monetary penalty against the defendants.

(c) TREATMENT OF EXCESS AWARDS.—If a person is awarded any amounts in an action brought under this section that are in excess of the damages suffered by the

person as a result of the defendant's activities, 20 percent of such amounts shall be withheld from the person for payment into the Federal Outlays Program Fraud and Abuse Control Account established under section 5302.

(d) STATUTE OF LIMITATIONS.—No action may be brought under this section more than 6 years after the date of the activity with respect to which the action is brought.

(e) NO LIMITATION ON OTHER ACTIONS.—Nothing in this section shall limit the right of any person to pursue any other right of action or remedy available under the law.

(f) PENDANT JURISDICTION.—Nothing in this section shall be construed, by reason of a claim arising under this section, to confer on the Courts of the United States jurisdiction over any State law claim.

SEC. 5313. EXCLUSION FROM PROGRAM PARTICIPATION.

(a) MANDATORY EXCLUSION.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall exclude an individual or entity from participating in any applicable health plan if the individual or entity—

(A) is excluded from participation in a public program under, or is otherwise described in, section 1128(a) of the Social Security Act

(relating to individuals and entities convicted of health care-related crimes or patient abuse);

(B) has been convicted after the date of the enactment of this section, under Federal or State law, in connection with the delivery of a health care item or service of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

(C) has been convicted after such date, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(2) WAIVER PERMITTED.—

(A) IN GENERAL.—When, in the opinion of the Secretary, mandatory exclusion under paragraph (1) of an individual or entity would significantly harm the public health or pose a significant risk to the public health, the Secretary may waive such exclusion and shall apply such other appropriate penalties as authorized under this subtitle.

(B) APPLICATION FOR WAIVER OF EXCLUSION.—

(i) IN GENERAL.—An individual or entity subject to mandatory exclusion under this subsection may apply to the Secretary, in a manner specified by the Secretary in regulations, for waiver of the exclusion.

(ii) SECRETARIAL RESPONSE.—The Secretary may waive the exclusion for the reasons described in subparagraph (A).

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude and individual or entity from participating in any applicable health plan if the individual or entity—

(1) is excluded from participation in a public program under, or is otherwise described in, section 1128(b) of the Social Security Act (other than paragraphs (3), (6)(A), (6)(C), (6)(D), (10), or (13) of such section);

(2) has been convicted after the date of the enactment of this section, under Federal or State law, in connection with the delivery of a health care item or service of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

(3) has been convicted after the date of the enactment of this section, under Federal or State law,

of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(c) PERIOD OF EXCLUSION.—

(1) NOTICE OF EXCLUSION.—An exclusion under this section shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2) EFFECTIVE DATE OF EXCLUSION.—Such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(3) PERIOD OF EXCLUSION.—

(A) IN GENERAL.—The Secretary shall specify, in the notice of exclusion under paragraph (1), the minimum period (or, in the case of an exclusion of an individual excluded from participation in a public program under, or is otherwise described in, section 1128(b)(12) of the Social Security Act, the period) of the exclusion.

(B) MINIMUM PERIOD FOR MANDATORY EXCLUSIONS.—In the case of a mandatory ex-

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