Calendar No. 542

103D CONGRESS
2D SESSION

S. 2357

A BILL

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

AUGUST 5, 1984

Read the second time and placed on the calendar

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

Calendar No. 542

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

AUGUST 5, 1984

Read the second time and placed on the calendar

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:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED ACCESS TO STANDARDIZED AND AFFORDABLE HEALTH PLANS

Subtitle A—Rules and Definitions of General Applicability

Part 1—Rules of General Applicability

Sec. 1001. Access to standardized coverage.
Sec. 1002. Standard health plan principles.
Sec. 1003. Protection of consumer choice.

Part 2—Definitions

Sec. 1011. Definitions relating to health plans.
Sec. 1012. Definitions relating to employment and income.
Sec. 1013. Other general definitions.

Subtitle B—Health Plan Standards

Part 1—Establishment and Application of Standards

Sec. 1101. Establishment of National standards.
Sec. 1102. General rules.

Part 2—Insurance Market Reform

Sec. 1111. Guaranteed issue, availability, and renewability.
Sec. 1112. Enrollment.
Sec. 1113. Coverage of dependents.
Sec. 1114. Nondiscrimination based on health status.
Sec. 1115. Benefits.
Sec. 1116. Community rating requirements.
Sec. 1117. Risk adjustment and reinsurance.
Sec. 1118. Financial solvency requirements and consumer protection against provider claims.

Part 3—Delivery System Reform

Sec. 1121. Prohibition of discrimination.
Sec. 1122. Quality assurance standards.
Sec. 1123. Consumer grievance process.
Sec. 1124. Health security cards.
Sec. 1125. Information and marketing standards.
Sec. 1126. Information regarding a patient's right to self-determination in health care services.
Sec. 1127. Contracts with purchasing cooperatives.
Sec. 1128. Health plan arrangements with providers.
Sec. 1129. Utilization management protocols and physician incentive plans.

Part 4—Supplemental Health Benefits Plans

Sec. 1141. Supplemental health benefits plans.

Subtitle C—Benefits and Cost-Sharing

Part 1—Standard Benefits Packages

Sec. 1201. General description of standard benefits packages.
Sec. 1202. Description of categories of items and services.
Sec. 1203. Definitions.

Part 2—National Health Benefits Board

Sec. 1211. Creation of National health benefits board; membership.

Sec. 1212. Qualifications of board members.
Sec. 1213. General duties and responsibilities.
Sec. 1214. Powers.
Sec. 1215. Funding.
Sec. 1216. Applicability of Federal Advisory Committee Act.
Sec. 1217. Congressional consideration of Board proposals.

Subtitle D—Access to Health Plans

PART 1—ACCESS THROUGH EMPLOYERS

Sec. 1301. General employer responsibilities.
Sec. 1302. Auditing of records.
Sec. 1303. Prohibition of certain employer discrimination.
Sec. 1304. Prohibition on self-insuring cost-sharing benefits.
Sec. 1305. Responsibilities in single-payer States.
Sec. 1306. Development of large employer purchasing groups.
Sec. 1307. Rules governing litigation involving retiree health benefits.
Sec. 1308. Enforcement.

PART 2—ACCESS THROUGH HEALTH INSURANCE PURCHASING COOPERATIVES

SUBPART A—GENERAL REQUIREMENTS

Sec. 1321. Organization and operation.
Sec. 1322. Membership.
Sec. 1323. Agreements with standard health plans.
Sec. 1324. Membership and marketing fees.

SUBPART B—COMMUNITY-RATED EMPLOYERS

Sec. 1331. Duties of purchasing cooperatives.

SUBPART C—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Sec. 1341. Requirements applicable to FEHBP.
Sec. 1342. Special rules for FEHBP supplemental plans.
Sec. 1343. Definitions.

PART 3—TREATMENT OF ASSOCIATION PLANS

Sec. 1351. Rules relating to multiple employer welfare arrangements.
Sec. 1352. Association plans.

Subtitle E—Federal Responsibilities

PART 1—SECRETARY OF HEALTH AND HUMAN SERVICES

SUBPART A—GENERAL DUTIES

Sec. 1401. General duties and responsibilities.
Sec. 1402. Annual report.
Sec. 1403. Assistance with family collections.
Sec. 1404. Advisory opinions.
Sec. 1405. Funding.

SUBPART B—RESPONSIBILITIES RELATING TO REVIEW AND APPROVAL OF STATE SYSTEMS

Sec. 1411. Federal review and action on State systems.
Sec. 1412. Failure of participating States to meet conditions for compliance.
Sec. 1413. Reduction in payments for health programs by Secretary of Health and Human Services.
Sec. 1414. Review of Federal determinations.
Sec. 1415. Federal support for State implementation.

SUBPART C—RESPONSIBILITIES IN ABSENCE OF STATE SYSTEMS

Sec. 1421. Application of subpart.
Sec. 1422. Federal assumption of responsibilities in non-participating States.
Sec. 1423. Imposition of surcharge on premiums under federally-operated system.
Sec. 1424. Return to State operation.

SUBPART D—ESTABLISHMENT OF CLASS FACTORS FOR CHARGING PREMIUMS

Sec. 1431. Premium class and age class factors.

SUBPART E—RISK ADJUSTMENT AND REINSURANCE METHODOLOGY FOR PAYMENT OF PLANS

Sec. 1435. Development of a risk adjustment and reinsurance methodology.

SUBPART F—RESPONSIBILITIES FOR FINANCIAL REQUIREMENTS

Sec. 1441. Capital standards for community-rated plans.
Sec. 1442. Standard for guaranty funds.

SUBPART G—OPEN ENROLLMENT

Sec. 1445. Periods of authorized changes in enrollment.
Sec. 1446. Distribution of comparative information.
Sec. 1455. Reports.

PART 2—ESSENTIAL COMMUNITY PROVIDERS

Sec. 1461. Certification.
Sec. 1462. Categories of providers automatically certified.
Sec. 1463. Standards for additional providers.
Sec. 1464. Certification process; review; termination of certifications.
Sec. 1465. Notification of participating States.
Sec. 1466. Health plan requirement.
Sec. 1467. Recommendation on continuation of requirement.
Sec. 1468. Definitions.

PART 3—SPECIFIC RESPONSIBILITIES OF SECRETARY OF LABOR

Sec. 1481. Responsibilities of Secretary of Labor.
Sec. 1482. Federal role with respect to multi-State self-insured health plans.
Sec. 1483. Assistance with employer collections.
Sec. 1484. Penalties for failure of large employer purchasing groups to meet requirements.
Sec. 1485. Applicability of ERISA enforcement mechanisms for enforcement of certain requirements.
Sec. 1486. Workplace wellness program.

PART 4—OFFICE OF RURAL HEALTH POLICY

Sec. 1491. Office of rural health policy.

Subtitle F—Participating State Responsibilities

PART 1—GENERAL RESPONSIBILITIES

Sec. 1501. State plan and certification of standard health plans and supplemental health benefits plans.
Sec. 1502. Community rating areas and health plan service areas.
Sec. 1503. Open enrollment periods.
Sec. 1504. Risk adjustment program.
Sec. 1505. Guaranty funds.
Sec. 1506. Enrollment activities.
Sec. 1507. Rural and medically underserved areas.
Sec. 1508. Public access sites.
Sec. 1509. Requirements relating to possessions of the United States.
Sec. 1510. Right of recovery of certain taxes against providers.

PART 2—TREATMENT OF STATE LAWS

Sec. 1511. Preemption of certain State laws relating to health plans.
Sec. 1512. Override of restrictive State practice laws.

PART 3—STATE FLEXIBILITY

SUBPART A—EXISTING STATE LAWS

Sec. 1521. Continuance of existing Federal law waivers.
Sec. 1522. Hawaii prepaid Health Care Act.
Sec. 1523. Alternative State provider payment systems.
Sec. 1524. Alternative State hospital services payment systems.

SUBPART B—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

Sec. 1531. Single-payer system described.
Sec. 1532. General requirements for single-payer systems.
Sec. 1533. Special rules for States operating statewide single-payer system.
Sec. 1534. Special rules for community rating area-specific single-payer systems.

SUBPART C—EARLY IMPLEMENTATION OF COMPREHENSIVE STATE PROGRAMS

Sec. 1541. Early implementation of comprehensive State programs.

Subtitle G—Miscellaneous Provisions

Sec. 1601. Provision of items or services contrary to religious belief or moral conviction.
Sec. 1602. Antidiscrimination.

TITLE II—NEW BENEFITS

Subtitle A—Coverage of Outpatient Prescription Drugs in Medicare

Sec. 2000. References in subtitle.

PART 1—COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS

Sec. 2001. Coverage of outpatient prescription drugs.
Sec. 2002. Payment rules and related requirements for covered outpatient drugs.
Sec. 2003. Medicare rebates for covered outpatient drugs.
Sec. 2004. Prescription drug payment review commission.
Sec. 2005. Coverage of home infusion drug therapy services.
Sec. 2006. Medicare drug benefit plans.
Sec. 2007. Payment for covered outpatient drug benefit under medicare contracts with HMOs and CMPS.
Sec. 2008. Maintenance of effort.

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.
Sec. 2102. State plans.
Sec. 2103. Individuals with disabilities defined.
Sec. 2104. Home and community-based services covered under State plan.
Sec. 2105. Cost sharing.
Sec. 2106. Quality assurance and safeguards.
Sec. 2107. Advisory groups.
Sec. 2108. Payments to States.
Sec. 2109. Appropriations; allotments to States.
Sec. 2110. Federal evaluations.

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.

Subtitle C—Long-Term Care Insurance Improvement and Accountability

Sec. 2200. Short title.

PART 1—PROMULGATION OF STANDARDS AND MODEL BENEFITS

Sec. 2201. Standards.

PART 2—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

Sec. 2211. Implementation of policy standards.
Sec. 2212. Regulation of sales practices.
Sec. 2213. Additional responsibilities for carriers.
Sec. 2214. Renewability standards for issuance, and basic for cancellation of policies.
Sec. 2215. Benefit standards.
Sec. 2216. Nonforfeiture.
Sec. 2217. Limit of period of contestability and right to return.
Sec. 2218. Civil money penalty.

PART 3—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

Sec. 2221. Long-term care insurance policy defined.
Sec. 2222. Code of conduct with respect to endorsements.

Subtitle D—Life Care

Sec. 2301. Short title.
Sec. 2302. Life care: public insurance program for nursing home care.

Subtitle E—Study and Report

Sec. 2401. Study of issues related to end of life care.

TITLE III—HEALTH PROFESSIONS WORKFORCE

Subtitle A—Workforce Priorities Under Federal Payments

Sec. 3000. Definitions.

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.

subpart b—authorized positions in specialty training

Sec. 3011. Cooperation regarding approved physician training programs.
Sec. 3012. Annual authorization of total number of graduate medical education positions.
Sec. 3013. Annual authorization of number of specialty positions; requirements regarding primary health care.
Sec. 3014. National Council recommendation of number of graduate medical education positions.
Sec. 3015. Allocations among specialities and programs.

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.
Sec. 3032. Application for payments.
Sec. 3033. Availability of funds for payments; annual amount of payments.
Sec. 3034. Payments for dental and podiatric positions.

Chapter 2—Academic Health Centers and Other Eligible Institutions

Sec. 3051. Federal formula payments to academic health centers and other eligible institutions.
Sec. 3052. Request for payments.
Sec. 3053. Availability of funds for payments; annual amount of payments.

subpart d—transitional provisions

Sec. 3055. Transitional payments to institutions.
Sec. 3056. Waiver of foreign country residence requirement with respect to international medical graduates.

PART 2—HEALTH PROFESSIONS SCHOOLS PAYMENTS

SUBPART A—PAYMENTS TO MEDICAL SCHOOLS

Sec. 3061. Federal payments to medical schools.
Sec. 3062. Application for payments.
Sec. 3063. Authorization of appropriations; annual amount of payments.

SUBPART B—PAYMENTS TO NURSING PROGRAMS

Sec. 3071. Federal payments to graduate nurse training programs.
Sec. 3072. National Council on Graduate Nurse Training.

SUBPART C—PAYMENTS TO DENTAL SCHOOLS

Sec. 3073. Dental schools.

SUBPART D—PAYMENTS TO SCHOOLS OF PUBLIC HEALTH

Sec. 3074. Schools of public health.

PART 3—RELATED PROGRAMS

SUBPART A—WORKFORCE DEVELOPMENT

Sec. 3081. Programs of the Secretary of Health and Human Services.
Sec. 3082. Programs of the Secretary of Labor.
Sec. 3083. Requirement for certain programs regarding redeployment of health care workers.

SUBPART B—TRANSITIONAL PROVISIONS FOR WORKFORCE STABILITY

Sec. 3091. Application.
Sec. 3092. Definitions.
Sec. 3093. Obligations of displacing employer and affiliated enterprises in event of displacement.
Sec. 3094. Employment with successors.
Sec. 3095. Collective bargaining obligations during transition period.
Sec. 3096. General provisions.

Subtitle B—Academic Health Centers

Sec. 3131. Discretionary grants regarding access to centers.

Subtitle C—Health Research Initiatives

PART 1—PROGRAMS FOR CERTAIN AGENCIES

Sec. 3201. Biomedical, behavioral and health services research.
Sec. 3202. Health services research.
Sec. 3203. AHCPR guidelines and standards.

PART 2—FUNDING FOR PROGRAM

Sec. 3211. Authorizations of appropriations.

PART 3—MEDICAL TECHNOLOGY IMPACT STUDY

Sec. 3221. Medical technology impact study.

Subtitle D—Core Functions of Public Health Programs; National Initiatives Regarding Preventive Health

PART 1—FUNDING

Sec. 3301. Authorizations of appropriations.

PART 2—CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS

Sec. 3311. Purposes.
Sec. 3312. Grants to States for core functions of public health.
Sec. 3313. Submission of information.
Sec. 3314. Reports.
Sec. 3315. Application for grant.
Sec. 3316. Allocations for certain activities.
Sec. 3317. Definitions.
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.

PART 3—NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION

SUBPART A—GENERAL GRANTS

Sec. 3331. Grants for national prevention initiatives.
Sec. 3332. Priorities.
Sec. 3333. Submission of information.
Sec. 3334. Application for grant.

SUBPART B—DEVELOPMENT OF TELEMEDICINE IN RURAL UNDERSERVED AREAS

Sec. 3341. Grants for development of rural telemedicine.
Sec. 3342. Report and evaluation of telemedicine.
Sec. 3343. Regulations on reimbursement of telemedicine.
Sec. 3344. Authorization of appropriations.
Sec. 3345. Definitions.

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.

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.
Sec. 3422. Certain uses of awards.
Sec. 3423. Application.
Sec. 3424. Purposes and conditions.

SUBPART C—CAPITAL COST OF DEVELOPMENT OF COMMUNITY HEALTH GROUPS AND OTHER PURPOSES

Sec. 3441. Direct loans and grants.

Sec. 3442. Certain requirements.
Sec. 3443. Defaults; right of recovery.
Sec. 3444. Provisions regarding construction or expansion of facilities.
Sec. 3445. Application for assistance.
Sec. 3446. Administration of programs.

SUBPART D—ENABLING AND SUPPLEMENTAL SERVICES

Sec. 3461. Grants and contracts for enabling and supplemental services.
Sec. 3462. Authorizations of appropriations.

PART 2—NATIONAL HEALTH SERVICE CORPS

Sec. 3471. Authorizations of appropriations.
Sec. 3472. Allocation for participation of nurses in scholarship and loan repayment programs.
Sec. 3473. Allocation for participation of psychiatrists, psychologists, and clinical social workers in scholarship and loan repayment programs.

PART 3—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

Sec. 3481. Payments to hospitals.
Sec. 3482. Identification of eligible hospitals.
Sec. 3483. Amount of payments.
Sec. 3484. Base year.

Subtitle F—Mental Health; Substance Abuse

PART 1—AUTHORITIES REGARDING PARTICIPATING STATES

Sec. 3510. Integration of mental health and substance abuse systems.
Sec. 3511. Report on integration of mental health systems.

PART 2—ASSISTANCE FOR STATE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

Sec. 3531. Availability of assistance.
Sec. 3532. Plan requirements.
Sec. 3533. Additional Federal responsibilities.
Sec. 3534. Authorization of appropriations.

Subtitle G—Comprehensive School Health Education; School-Related Health Services

PART 1—HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS FOR SCHOOL HEALTH EDUCATION

Sec. 3601. Purposes.
Sec. 3602. Healthy students-healthy schools grants.
Sec. 3603. Healthy Students-Healthy Schools Interagency Task Force.
Sec. 3604. Duties of the Secretary.

PART 5—SCHOOL-RELATED HEALTH SERVICES

SUBPART A—DEVELOPMENT AND OPERATION

Sec. 3681. Authorization of appropriations.
Sec. 3682. Eligibility for grants.

Sec. 3683. Preferences.
Sec. 3684. Planning and development grants.
Sec. 3685. Grants for operation of school health services.

SUBPART B—CAPITAL COSTS OF DEVELOPING PROJECTS

Sec. 3691. Funding.

Subtitle H—Public Health Service Initiative

Sec. 3695. Public health service initiative.

Subtitle I—Additional Provisions Regarding Public Health

Sec. 3901. Curriculum development and implementation regarding domestic violence and women's health.
Sec. 3902. Community scholarship programs.

Subtitle J—Occupational Safety and Health

Sec. 3903. Occupational injury and illness prevention.

Subtitle K—Full Funding for WIC

Sec. 3905. Full funding for WIC.

Subtitle L—Border Health Improvement

Sec. 3908. Border Health Commission.

TITLE IV—MEDICARE AND MEDICAID

Sec. 4000. References in title.

Subtitle A—Medicare

PART 1—INTEGRATION OF MEDICARE BENEFICIARIES

Sec. 4001. Individual election to remain in certain health plans.
Sec. 4002. Enrollment and termination of enrollment.

PART 2—PROVISIONS RELATING TO PART A

Sec. 4101. Inpatient hospital services update for PPS hospitals.
Sec. 4102. Reduction in payments for capital-related costs for inpatient hospital services.
Sec. 4103. Reductions in disproportionate share payments.
Sec. 4104. Extension of freeze on updates to routine service cost limits for skilled nursing facilities.
Sec. 4105. Medicare-dependent, small rural hospitals.
Sec. 4106. Provisions relating to rural health transition grant program.
Sec. 4107. Payments for sole community hospitals with teaching programs and multihospital campuses.
Sec. 4108. Moratorium on designation of new long-term hospitals.
Sec. 4109. Revised payment methodology for rehabilitation and long-term care hospitals.
Sec. 4110. Termination of indirect medical education payments.
Sec. 4111. Limited service hospital program.
Sec. 4112. Subacute care study.

PART 3—PROVISIONS RELATING TO PART B

Sec. 4201. Updates for physicians' services.
Sec. 4202. Substitution of real GDP to adjust for volume and intensity; repeal of restriction on maximum reduction permitted in default update.
Sec. 4203. Payment for physicians' services relating to inpatient stays in certain hospitals.
Sec. 4204. Changes in underserved area bonus payments.
Sec. 4205. Correction of MVPS upward bias.
Sec. 4206. Demonstration projects for medicare State-based performance standard rate of increase.
Sec. 4207. Elimination of formula-driven overpayments for certain outpatient hospital services.
Sec. 4208. Eye or eye and ear hospitals.
Sec. 4209. Imposition of coinsurance on laboratory services.
Sec. 4210. Application of competitive acquisition process for part B items and services.
Sec. 4211. Application of competitive acquisition procedures for laboratory services.
Sec. 4212. Expanded coverage for physician assistants and nurse practitioners.
Sec. 4213. Elimination of balance billing.
Sec. 4214. Development and implementation of resource-based methodology for practice expenses.
Sec. 4215. Payments for durable medical equipment.
Sec. 4216. General part B premium.

PART 4—PROVISIONS RELATING TO PARTS A AND B

Sec. 4301. Medicare secondary payer changes.
Sec. 4302. Increase in medicare secondary payer coverage for end stage renal disease services to 24 months.
Sec. 4303. Expansion of centers of excellence.
Sec. 4304. Reduction in routine cost limits for home health services.
Sec. 4305. Imposition of 20 percent coinsurance on home health services under medicare.
Sec. 4306. Termination of graduate medical education payments.
Sec. 4307. Medicare select.

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.

PART 2—COORDINATED CARE SERVICES FOR DISABLED MEDICAID ELIGIBLES

Sec. 4605. Coordinated care services for disabled medicaid eligibles.

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.

PART 4—MEDICAID LONG-TERM CARE PROVISIONS

Sec. 4615. Increased resource disregard for individuals receiving certain services.
Sec. 4616. Frail elderly demonstration project waivers.
Sec. 4617. Elimination of requirement of prior institutionalization with respect to habilitation services furnished under a waiver for home or community-based services.
Sec. 4618. Elimination of rule regarding availability of beds in certain institutions.
Sec. 4619. Preadmission screening for mentally retarded individuals.

PART 5—MISCELLANEOUS

Sec. 4621. Medicaid coverage of all certified nurse practitioner and clinical nurse specialist services.
Sec. 4622. Relief from third party liability requirements when cost-effective.

TITLE V—QUALITY AND CONSUMER PROTECTION

Subtitle A—Quality Management and Improvement

Sec. 5001. National quality council.
Sec. 5002. National goals and performance measures of quality.
Sec. 5003. Standards and performance measures for health plans.
Sec. 5004. Plan data analysis and consumer surveys.
Sec. 5005. Evaluation and reporting of quality performance.
Sec. 5006. Development and dissemination of practice guidelines.
Sec. 5007. Research on health care quality.
Sec. 5008. Quality improvement foundations.
Sec. 5009. Consumer information and advocacy.
Sec. 5010. Authorization of appropriations.
Sec. 5011. Role of health plans in quality management.
Sec. 5012. Information on health care providers.
Sec. 5013. Conforming amendments to Public Health Service Act.

Subtitle B—Administrative Simplification

PART 1—PURPOSE AND DEFINITIONS

Sec. 5101. Purpose.
Sec. 5102. Definitions.

PART 2—STANDARDS FOR DATA ELEMENTS AND INFORMATION TRANSACTIONS

Sec. 5111. General requirements on secretary.
Sec. 5112. Standards for data elements of health information.
Sec. 5113. Information transaction standards.
Sec. 5114. Standards relating to written claims submitted by individuals and written explanations of benefits.
Sec. 5115. Timetables for adoption of standards.

PART 3—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

Sec. 5121. Requirements with respect to certain transactions and information.
Sec. 5122. Timetables for compliance with requirements.

PART 4—ACCESSING HEALTH INFORMATION

Sec. 5131. Accessing health information for authorized purposes.
Sec. 5132. Responding to access requests.
Sec. 5133. Length of time information should be accessible.
Sec. 5134. Timetables for adoption of standards and compliance.

PART 5—STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK

Sec. 5141. Standards and certification for health information network services.
Sec. 5142. Ensuring availability of information.

PART 6—PENALTIES

Sec. 5151. General penalty for failure to comply with requirements and standards.

PART 7—MISCELLANEOUS PROVISIONS

Sec. 5161. Imposition of additional requirements.
Sec. 5162. Effect on State law.
Sec. 5164. Health information continuity.
Sec. 5165. Protection of commercial information.
Sec. 5166. Payment for health care services or health plan premiums.
Sec. 5167. Health security cards.
Sec. 5168. Misuse of health security card or personal health identifier.
Sec. 5169. Direct billing for clinical laboratory services.
Sec. 5170. Authorization of appropriations.

PART 8—ASSISTANCE TO THE SECRETARY

Sec. 5171. General requirement on secretary.
Sec. 5172. Health information advisory committee.

PART 9—DEMONSTRATION PROJECTS FOR COMMUNITY-BASED CLINICAL INFORMATION SYSTEMS

Sec. 5181. Grants for demonstration projects.

PART 10—MEDICARE AND MEDICAID COVERAGE DATA BANK

Sec. 5191. Repeal of medicare and medicaid coverage data bank.

Subtitle C—Privacy of Health Information

PART 1—FINDINGS AND DEFINITIONS

Sec. 5201. Findings and purposes.
Sec. 5202. Definitions.

PART 2—AUTHORIZED DISCLOSURES

SUBPART A—GENERAL PROVISIONS

Sec. 5206. General rules regarding disclosure.
Sec. 5207. Authorizations for disclosure of protected health information.
Sec. 5208. Certified health information network services.

SUBPART B—SPECIFIC DISCLOSURES RELATING TO PATIENT

Sec. 5211. Disclosures for treatment and financial and administrative transactions.
Sec. 5212. Next of kin and directory information.
Sec. 5213. Emergency circumstances.

SUBPART C—DISCLOSURE FOR OVERSIGHT, PUBLIC HEALTH, AND RESEARCH PURPOSES

Sec. 5216. Oversight.
Sec. 5217. Public health.
Sec. 5218. Health research.

SUBPART D—DISCLOSURE FOR JUDICIAL, ADMINISTRATIVE, AND LAW ENFORCEMENT PURPOSES

Sec. 5221. Judicial and administrative purposes.
Sec. 5222. Law enforcement.

SUBPART E—DISCLOSURE PURSUANT TO GOVERNMENT SUBPOENA OR WARRANT

Sec. 5226. Government subpoenas and warrants.
Sec. 5227. Access procedures for law enforcement subpoenas and warrants.
Sec. 5228. Challenge procedures for law enforcement warrants and subpoenas.

SUBPART F—DISCLOSURE PURSUANT TO PRIVATE PARTY SUBPOENA

Sec. 5231. Private party subpoenas.
Sec. 5232. Access procedures for private party subpoenas.
Sec. 5233. Challenge procedures for private party subpoenas.

PART 3—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

SUBPART A—ESTABLISHMENT OF SAFEGUARDS

Sec. 5236. Establishment of safeguards.
Sec. 5237. Accounting for disclosures.

SUBPART B—REVIEW OF PROTECTED HEALTH INFORMATION BY SUBJECTS OF THE INFORMATION

Sec. 5241. Inspection of protected health information.
Sec. 5242. Amendment of protected health information.
Sec. 5243. Notice of information practices.

SUBPART C—STANDARDS FOR ELECTRONIC DISCLOSURES

Sec. 5246. Standards for electronic disclosures.

PART 4—SANCTIONS

SUBPART A—NO SANCTIONS FOR PERMISSIBLE ACTIONS

Sec. 5251. No liability for permissible disclosures.
Sec. 5252. No liability for institutional review board determinations.
Sec. 5253. Reliance on certified entity.

SUBPART B—CIVIL SANCTIONS

Sec. 5256. Civil penalty.
Sec. 5257. Civil action.

SUBPART C—CRIMINAL SANCTIONS

Sec. 5261. Wrongful disclosure of protected health information.

PART 5—ADMINISTRATIVE PROVISIONS

Sec. 5266. Relationship to other laws.
Sec. 5267. Rights of incompetents.
Sec. 5268. Exercise of rights.

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.
Sec. 5302. Establishment of Federal outlay program fraud and abuse control account.
Sec. 5303. Use of funds by Inspector General.
Sec. 5304. Rewards for information leading to prosecution and conviction.

PART 2—CIVIL PENALTIES AND RIGHTS OF ACTION

Sec. 5311. Civil monetary penalties.
Sec. 5312. Permitting parties to bring actions on own behalf.
Sec. 5313. Exclusion from program participation.

PART 3—AMENDMENTS TO CRIMINAL LAW

Sec. 5321. Health care fraud.
Sec. 5322. Theft or embezzlement.
Sec. 5323. False Statements.
Sec. 5324. Bribery and graft.
Sec. 5325. Injunctive relief relating to health care offenses.
Sec. 5326. Grand jury disclosure.
Sec. 5327. Forfeitures for violations of fraud statutes.

PART 4—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

Sec. 5331. Amendments to Civil False claims Act.

PART 5—EFFECTIVE DATE

Sec. 5341. Effective date.

Subtitle E—Medical Liability Reform

PART 1—SYSTEM REFORMS

Sec. 5401. Federal tort reform.
Sec. 5402. State-based alternative dispute resolution mechanisms.
Sec. 5403. Requirement of certificate of merit.
Sec. 5404. Limitation on amount of attorney's contingency fees.
Sec. 5405. Periodic payment of awards.
Sec. 5406. Federal study on medical negligence.

PART 2—DEMONSTRATION PROJECT RELATING TO MEDICAL MALPRACTICE LIABILITY

Sec. 5411. Pilot program applying practice guidelines to medical malpractice liability actions.
Sec. 5412. Enterprise liability demonstration project.

Subtitle F—Remedies and Enforcement

PART 1—REVIEW OF BENEFIT DETERMINATIONS FOR ENROLLED INDIVIDUALS

SUBPART A—GENERAL RULES

Sec. 5501. Health plan claims procedure.
Sec. 5502. Review in area complaint review offices of grievances based on acts or practices by health plans.
Sec. 5503. Initial proceedings in complaint review offices.
Sec. 5504. Hearings before hearing officers in complaint review offices.
Sec. 5505. Civil money penalties.

SUBPART B—EARLY RESOLUTION PROGRAMS

Sec. 5511. Establishment of early resolution programs in complaint review offices.
Sec. 5512. Initiation of participation in mediation proceedings.
Sec. 5513. Mediation proceedings.
Sec. 5514. Legal effect of participation in mediation proceedings.
Sec. 5515. Enforcement of settlement agreements.
Sec. 5516. Due process for health care providers.

PART 2—ADDITIONAL REMEDIES AND ENFORCEMENT PROVISIONS

Sec. 5531. Judicial review of Federal action on State systems.
Sec. 5532. Civil enforcement.
Sec. 5533. Priority of certain bankruptcy claims.
Sec. 5534. Private right to enforce State responsibilities.
Sec. 5535. Private right to enforce Federal responsibilities in operating a system in a State.
Sec. 5536. Enforcement of consumer protections.
Sec. 5537. Discrimination claims.
Sec. 5538. Nondiscrimination in federally assisted programs.
Sec. 5539. Civil and administration action by essential community provider.
Sec. 5540. Facial constitutional challenges.
Sec. 5541. Treatment of plans as parties in civil actions.
Sec. 5542. Whistleblower protections.
Sec. 5543. General nonpreemption of rights and remedies.

Subtitle G—Repeal of Exemption

Sec. 5601. Repeal of exemption for health insurance.

TITLE VI—INDIVIDUAL AND EMPLOYER SUBSIDIES

Subtitle A—Individual Premium and Cost-Sharing Assistance

Sec. 6001. Requirement to operate State program.
Sec. 6002. Assistance with standard health plan premiums.
Sec. 6003. Assistance with cost-sharing for standard health plans.

Sec. 6004. Eligibility determinations.
Sec. 6005. End-of-year reconciliation for premium assistance.
Sec. 6006. Enrollment outreach.
Sec. 6007. Payments to States.
Sec. 6008. Definitions and determinations of income.

Subtitle B—Employer Subsidies

Sec. 6101. Purpose.
Sec. 6102. Eligible employers.
Sec. 6103. Employer certification.
Sec. 6104. Amount of subsidy.
Sec. 6105. Definition.

TITLE VII—REVENUE PROVISIONS

Sec. 7000. Amendment of 1986 Code.

Subtitle A—Financing Provisions

Part 1—Increase in Tax on Tobacco Products

Sec. 7101. Increase in excise taxes on tobacco products.
Sec. 7102. Modifications of certain tobacco tax provisions.
Sec. 7103. Imposition of excise tax on manufacture or importation of roll-your-own tobacco.

Part 2—Health Related Assessments

Sec. 7111. Assessments on insured and self-insured health plans.
Sec. 7112. High cost health plan assessment.

Part 3—Recapture of Certain Health Care Subsidies

Sec. 7121. Recapture of certain health care subsidies received by high-income individuals.

Part 4—Other Provisions

Sec. 7131. Increase in tax on certain hollow point and large caliber handgun ammunition.
Sec. 7132. Modification to self-employment tax treatment of certain S corporation shareholders and partners.
Sec. 7133. Extending medicare coverage of, and application of hospital insurance tax to, all State and local government employees.

Subtitle B—Tax Treatment of Employer-Provided Health Care

Part 1—General Provisions

Sec. 7201. Limitation on exclusion for employer-provided health benefits.
Sec. 7202. Health benefits may not be provided under cafeteria plans.
Sec. 7203. Increase in deduction for health insurance costs of self-employed individuals.
Sec. 7204. Limitation on prepayment of medical insurance premiums.

Part 2—Voluntary Employer Health Care Contributions

Sec. 7111. Tax treatment of voluntary employer health care contributions.

Subtitle C—Exempt Health Care Organizations

PART 1—GENERAL PROVISIONS

Sec. 7301. Qualification and disclosure requirements for nonprofit health care organizations.
Sec. 7302. Excise taxes for private inurement by tax-exempt health care organizations.
Sec. 7303. Treatment of health maintenance organizations, parent organizations, and health insurance purchasing cooperatives.
Sec. 7304. Tax treatment of taxable organizations providing health insurance and other prepaid health care services.
Sec. 7305. Repeal of section 833.
Sec. 7306. Tax exemption for high-risk insurance pools.

PART 2—TAX TREATMENT OF SECTION 501(c)(3) BONDS

Sec. 748. Tax treatment of 501(c)(3) bonds similar to governmental bonds.

Subtitle D—Tax Treatment of Long-Term Care Insurance and Services

Sec. 7401. Qualified long-term care services treated as medical care.
Sec. 7402. Treatment of long-term care insurance.
Sec. 7403. Tax treatment of accelerated death benefits under life insurance contracts.
Sec. 7404. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle E—Other Revenue Provisions

PART 1—EMPLOYMENT STATUS PROVISIONS

Sec. 7501. Employment status proposal required from Department of the Treasury.
Sec. 7502. Increase in services reporting penalties.

PART 2—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS

Sec. 7511. Nonrefundable credit for certain primary health services providers.
Sec. 7512. Expensing of medical equipment.

PART 3—MISCELLANEOUS PROVISIONS

Sec. 7521. Post-retirement medical and life insurance reserves.
Sec. 7522. Credit for cost of personal assistance services required by employed individuals.
Sec. 7523. Disclosure of return information for administration of certain programs under the Health Security Act.

Subtitle F—Graduate Medical Education and Academic Health Centers Trust Fund

Sec. 7601. Establishment of Graduate Medical Education and Academic Health Centers Trust Fund.

TITLE VIII—OTHER FEDERAL PROGRAMS

Subtitle A—Indian Health Service

Sec. 8101. Purposes.
Sec. 8102. Definitions.
Sec. 8103. Eligibility and health service coverage of Indians.
Sec. 8104. Supplemental Indian health care benefits.
Sec. 8105. Provision of health services to non-Indians.
Sec. 8106. Essential community providers.
Sec. 8107. Payment by other providers.
Sec. 8108. Contracting authority.
Sec. 8109. Consultation.
Sec. 8110. Transitional studies.
Sec. 8111. Loans and loan guarantees.
Sec. 8112. Simplification of billing.
Sec. 8113. Long-term care demonstrations.
Sec. 8114. Technical assistance.
Sec. 8115. Public health programs.
Sec. 8116. Survey of health services available to Indian veterans.
Sec. 8117. Rule of construction.
Sec. 8118. Authorization of appropriations.
Sec. 8119. Funding methodology.

TITLE IX—WORKERS COMPENSATION MEDICAL SERVICES

Sec. 9000. Application of information requirements.
Sec. 9001. Provision of care in disputed cases.
Sec. 9002. Demonstration projects.
Sec. 9003. Commission on Workers Compensation Medical Services.

TITLE X—PREMIUM FINANCING

Subtitle A—National Health Care Cost and Coverage Commission

Sec. 10001. National Health Care Cost And Coverage Commission.
Sec. 10002. Composition.
Sec. 10003. Duties of Commission.
Sec. 10004. Congressional consideration of Commission recommendations.
Sec. 10005. Operation of the Commission.

Subtitle B—Employer and Individual Premium Requirements and Assistance

Sec. 10101. Application of subtitle.
Sec. 10102. Definitions.

Part 1—Employer Premium Payments

Sec. 10111. Obligation.
Sec. 10112. Community-rated employers.
Sec. 10113. Experience rated employers.

Part 2—Family Payment Responsibilities

subpart a—family share

Sec. 10131. Enrollment and premium payments.
Sec. 10132. Family share of premiums.
Sec. 10133. Amount of premium.
Sec. 10134. Collection shortfall add-on.
Sec. 10135. Family credit.
Sec. 10136. Premium subsidy.

Sec. 10137. No loss of coverage.

SUBPART B—PAYMENT OF FAMILY CREDIT BY CERTAIN FAMILIES

Sec. 10141. Payment of family credit by nonworking and part-time certain families.
Sec. 10142. Limitation of liability based on income.

TITLE XI—ENSURING HEALTH CARE REFORM FINANCING

Sec. 11001. Ensuring health care reform financing.

TITLE I—IMPROVED ACCESS TO STANDARDIZED AND AFFORDABLE HEALTH PLANS

Subtitle A—Rules and Definitions of General Applicability

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-

1 age or the alternative standard benefits package
2 established under subtitle C.
3 (3) CERTIFIED SUPPLEMENTAL HEALTH BENE-
4 FITS PLAN.—
5 (A) IN GENERAL.—The term ''certified
6 supplemental health benefits plan'' means a
7 supplemental health benefits plan which is cer-
8 tified by the appropriate certifying authority as
9 meeting the applicable requirements of part 4
10 of subtitle B.
11 (B) SUPPLEMENTAL HEALTH BENEFITS
12 PLAN.—The term ''supplemental health benefits
13 plan'' means an insured or self-insured health
14 plan which provides health benefits which con-
15 sist of supplemental services or cost-sharing de-
16 scribed in part 4 of subtitle B. Such term does
17 not include a plan which provides for benefit
18 payments, on a periodic basis, for a specified
19 disease or illness or period of hospitalization
20 without regard to the costs incurred or services
21 rendered during the period to which the pay-
22 ments relate.
23 (4) CERTIFIED LONG-TERM CARE INSURANCE
24 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.

1 (c) ADDITIONAL PERIODS OF AUTHORIZED CHANGES
2 IN ENROLLMENT.—
3 (1) IN GENERAL.—Each standard health plan
4 shall provide for changes in enrollment with respect
5 to such other periods and occurrences (including
6 changes in residence, appropriate changes in employ-
7 ment, and the insolvency of carriers or experience-
8 rated employers) for which an individual is author-
9 ized to change enrollment in standard health plans,
10 as the Secretary shall specify.
11 (2) DISENROLLMENT FOR CAUSE.—
12 (A) IN GENERAL.—The Secretary shall es-
13 tablish procedures by which individuals enrolled
14 in a standard health plan may disenroll from
15 such plan for good cause (as defined by Sec-
16 retary) at any time during a year and enroll in
17 another standard health plan. Such procedures
18 shall be implemented by participating States in
19 a manner that ensures continuity of coverage
20 for the standard benefits package or the alter-
21 native standard benefits package for such indi-
22 viduals during the year.
23 (B) ADDITIONAL REMEDIES.—In the case
24 of an individual who changes enrollment from a
25 plan for good cause due to a pattern of under-

service 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

1 broad availability and processing of enrollment
2 forms, including direct enrollment through the mail,
3 and other such processes as the Secretary may des-
4 ignate.

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

14 (g) CHANGE OF ENROLLMENT.—As used in this sec-
15 tion, the term ''change of enrollment'' includes, with re-
16 spect to an individual—

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

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

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

25 (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

1 to be offered a standard premium for individual enroll-
2 ment for the standard benefits package and the alternative
3 standard benefits package established under subtitle C.

4 (c) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
5 ING AREAS.—

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

10 (2) APPLICATION TO ENROLLEES.—

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

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

16 (ii) in the case of enrollment other
17 than individual enrollment, the family ad-
18 justment factor specified under subpara-
19 graph (B); and

20 (iii) the age adjustment factor (speci-
21 fied under subparagraph (C)).

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

1 based on the applicable family enrollment (as
2 compared with such costs for individual enroll-
3 ment).

4 (C) AGE ADJUSTMENT FACTOR.—The Sec-
5 retary, in consultation with the NAIC, shall
6 specify, within 6 months of the date of the en-
7 actment of this Act, uniform age categories and
8 rating increments for age adjustment factors
9 that reflect the relative actuarial costs of ben-
10 efit packages among enrollees. The highest age
11 adjustment factor may not exceed twice the
12 lowest age adjustment factor for individuals 18
13 to 65 years of age. The Secretary shall also
14 provide for the gradual phaseout of age adjust-
15 ment factors by January 1, 2002.

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

23 (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 (1) IN GENERAL.—No standard health plan
2 may discriminate on the basis of the provider's sta-
3 tus as a member of a health care profession for the
4 purposes of selecting among providers of health serv-
5 ices for participation in a provider network, but only
6 if the State authorizes members of that profession to
7 render the services in question and such services are
8 covered in the standard benefits package established
9 under subtitle C.
10 (2) RULE OF CONSTRUCTION.—Nothing in
11 paragraph (1)(B) shall be construed as requiring
12 any standard health plan to:
13 (A) include in a network any individual
14 provider;
15 (B) establish any defined ratio of different
16 categories of health professionals; or
17 (C) establish any specific utilization review
18 or internal quality standards other than that re-
19 quired in other provisions of this Act.
20 **SEC. 1122. QUALITY ASSURANCE STANDARDS.**
21 (a) IN GENERAL.—Each standard health plan shall
22 comply with the plan performance standards in accordance
23 with subtitle A of title V. Each standard health plan shall
24 establish procedures, including ongoing quality improve-
25 ment 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

1 purchasing cooperative through which such plan is offered
2 in accordance with sections 1401(d) and 5009, other ap-
3 plicable information requirements of this Act, and rules
4 promulgated by the Secretary.

5 (b) MARKETING METHODS; ADVERTISING MATE-
6 RIALS.—A standard health plan may utilize direct mar-
7 keting, agency, or other arrangements to distribute health
8 plan information, subject to applicable fair marketing
9 practices laws and standards established by the State or
10 by the Secretary, including standards to prevent selective
11 marketing. All advertising, promotional materials, and
12 other communications with health plan members and the
13 general public must be factually accurate and responsive
14 to the needs of served populations. A standard health plan
15 may not distribute marketing materials to an area smaller
16 than the entire community rating area of the plan.

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

19 (1) may pay a commission or other remunera-
20 tion to an agent or broker in marketing the plan to
21 individuals or groups, but

22 (2) may not vary such remuneration based, di-
23 rectly or indirectly, on the anticipated or actual
24 claims experience associated with the group or indi-
25 viduals 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

1 by the plan are authorized under State law to provide ap-
2 plicable services. Each standard health plan shall—
3 (1) verify the credentials of practitioners and
4 facilities;
5 (2) ensure that all providers meet applicable
6 State licensing and certification standards;
7 (3) ensure that each health care provider par-
8 ticipating in the plan annually discloses information
9 regarding operations, ownership, finances, and work-
10 force necessary to evaluate the providers compliance
11 with this Act;
12 (4) oversee the quality and performance of par-
13 ticipating providers, consistent with section 1122;
14 and
15 (5) investigate and resolve consumer complaints
16 against participating providers.
17 (d) REQUIREMENTS FOR NONNETWORK PLANS.—
18 (1) IN GENERAL.—Each standard health plan
19 shall demonstrate, based on standards established by
20 the Secretary, arrangements with a sufficient num-
21 ber, distribution, and variety of qualified health pro-
22 fessionals that will accept the plan's payment rates
23 in full to ensure that all nonnetwork items and serv-
24 ices covered by the standard benefits package estab-
25 lished 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-

1 tablished under section 1502(d)) with reasonable
2 promptness and in a manner which assure con-
3 tinuity.

4 (2) GATEKEEPER.—With respect to each stand-
5 ard health plan that utilizes a gatekeeper or similar
6 process to approve health care services, such plan
7 shall ensure that such gatekeeper or process does
8 not create an undue burden for enrollees with com-
9 plex or chronic health conditions and shall ensure
10 access to relevant specialists for the continued care
11 of such enrollees when medically indicated. In cases
12 of a patient with a severe, complex, or chronic health
13 condition, such plan shall determine, in conjunction
14 with the enrollee and the enrollee's primary care
15 provider, whether it is medically necessary or appro-
16 priate to use a specialist or a care coordinator from
17 an interdisciplinary team as the gatekeeper or in the
18 health care approval process.

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

24 (4) ELIGIBLE CENTERS OF SPECIALIZED
25 TREATMENT EXPERTISE.—

1 (A) IN GENERAL.—Each standard health
2 plan must demonstrate that adults, children,
3 and individuals with disabilities have access to
4 specialized treatment expertise when medically
5 indicated by meeting evaluation criteria estab-
6 lished by the Secretary. In establishing such
7 criteria, the Secretary may consider a process
8 by which a standard health plan could be
9 deemed to meet such evaluation criteria if such
10 plan demonstrates referrals to designated cen-
11 ters of specialized care when medically nec-
12 essary or appropriate, informs enrollees of the
13 availability of referral care, and ensures compli-
14 ance with section 1123.
15 (B) ELIGIBLE CENTERS.—The Secretary
16 shall establish criteria for designating centers of
17 specialized care and shall designate eligible cen-
18 ters based on such criteria. The criteria shall
19 include requirements for staff credentials and
20 experience, and requirements for measured out-
21 comes in the diagnosis and treatment of pa-
22 tients. The Secretary shall develop additional
23 criteria for outcomes of specialized treatment as
24 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 (1) IN GENERAL.—Each standard health plan
2 shall cover emergency and urgent care services pro-
3 vided to enrollees, without regard to whether or not
4 the provider furnishing such services has a contrac-
5 tual (or other) arrangement with the plan to provide
6 items or services to enrollees of the plan and in the
7 case of emergency services without regard to prior
8 authorization.
9 (2) PAYMENT AMOUNTS.—In the case of emer-
10 gency and urgent care provided to an enrollee out-
11 side of a standard health plan's community rating
12 area, the payment amounts of the plan shall be
13 based on the applicable fee schedule described in
14 subsection (g).
15 (g) APPLICATION OF PLAN FEE SCHEDULE.—
16 (1) IN GENERAL.—Subject to paragraph (2),
17 each standard health plan that provides for payment
18 for services on a fee-for-service basis and has not es-
19 tablished an agreement or contractual arrangement
20 with providers specifying a basis for payment shall
21 make such payment to such providers under a fee
22 schedule established by the plan.
23 (2) RULE OF CONSTRUCTION.—Nothing in the
24 paragraph (1) shall be construed to prevent a stand-
25 ard 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).

1 (2) DIRECT BILLING.—

2 (A) IN GENERAL.—A provider may not
3 charge or collect from an enrollee amounts that
4 are payable by the standard health plan (includ-
5 ing any cost-sharing reduction assistance pay-
6 able by the plan) and shall submit charges to
7 such plan in accordance with any applicable re-
8 quirements of subtitle B of title V (relating to
9 health information systems).

10 (B) PROHIBITION.—An individual or entity
11 that performs clinical laboratory services may
12 not present or cause to be presented, a claim,
13 bill, or demand for payment to any person other
14 than the individual receiving such services, or to
15 the standard health plan of the individual, ex-
16 cept that the Secretary may by regulation es-
17 tablish appropriate exceptions to the require-
18 ment of this subparagraph.

19 (3) PROHIBITION OF BALANCE BILLING OF
20 TAXES.—Any agreement entered into between a
21 standard health plan and a provider shall prohibit
22 the provider from charging patients the amount of
23 any tax recovered from the provider under section
24 4518 of the Internal Revenue Code of 1986.

1 (4) RULE OF CONSTRUCTION.—Nothing in this
2 Act shall be construed to—
3 (A) require or force an individual to re-
4 ceive health care solely through the individual's
5 standard health plan; or
6 (B) prohibit any individual from privately
7 contracting with any health care provider and
8 paying for the treatment or service provider by
9 such provider on a cash basis or any other basis
10 as agreed to between the individual and the
11 provider.
12 (i) RELATION TO DETENTION.—A standard health
13 plan is not required to provide any reimbursement to any
14 detention facility for services performed in that facility for
15 detainees in the facility.

16 **SEC. 1129. UTILIZATION MANAGEMENT PROTOCOLS AND**
17 **PHYSICIAN INCENTIVE PLANS.**

18 (a) REQUIRING CONSUMER DISCLOSURE.—Each
19 standard health plan shall disclose upon request to enroll-
20 ees (and prospective enrollees) and to participating pro-
21 viders (and prospective providers), the protocols and fi-
22 nancial incentives used by the plan, including utilization
23 management protocols and physician incentive plans for
24 controlling utilization and costs, while protecting propri-

1 etary business information to the extent specified by the
2 Secretary.

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

7 (1) PERSONNEL.—All review determinations
8 shall be made by health professionals who are li-
9 censed, certified, or otherwise credentialed and who
10 are qualified to review utilization of the treatment
11 being sought.

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

21 (3) NO FINANCIAL INCENTIVE.—Utilization
22 management by each standard health plan may not
23 create financial incentives for reviewers or providers
24 to reduce or limit medically necessary or appropriate
25 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

1 responsible for providing the home health
2 care. Additional periods of care are covered
3 only if such person determines that the re-
4 quirement in clause (i) is satisfied.
5 (9) EXTENDED CARE SERVICES—
6 (A) IN GENERAL.—The extended care serv-
7 ices described in this section are the items and
8 services described in section 1861(h) of the So-
9 cial Security Act, when provided to an inpatient
10 of a skilled nursing facility or a rehabilitation
11 facility.
12 (B) LIMITATIONS.—Extended care services
13 are covered only as an alternative to receiving
14 inpatient hospital services as a result of an ill-
15 ness, injury, disorder, or other health condition.
16 (10) AMBULANCE SERVICES.—
17 (A) IN GENERAL.—The ambulance services
18 described in this paragraph are covered only
19 when indicated by the medical condition of the
20 individual receiving such services. Such services
21 include the following:
22 (i) Ground transportation by ambu-
23 lance.
24 (ii) Air or water transportation by an
25 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 (1) IN GENERAL.—The Board shall promulgate
2 such regulations or establish such guidelines as may
3 be necessary to clarify and refine the items and serv-
4 ices under the categories of health care items and
5 services described in section 1202 in accordance with
6 the requirements of subsections (a)(2) and (b)(2) of
7 section 1201.
8 (2) SCHEDULES FOR ITEMS AND SERVICES.—
9 (A) IN GENERAL.—The Board shall estab-
10 lish and update periodicity schedules for the
11 items and services in the categories of health
12 care items and services described in section
13 1202.
14 (B) SPECIAL RULE WITH RESPECT TO
15 CLINICAL PREVENTIVE SERVICES.—With re-
16 spect to clinical preventive services, the
17 Board—
18 (i) shall specify and define specific
19 items and services as clinical preventive
20 services and shall establish and update a
21 periodicity schedule for such items and
22 services; and
23 (ii) in specifying clinical preventive
24 services and establishing and updating pe-
25 riodicity schedules under clause (i), the

1 Board shall consult with experts in clinical
2 preventive services, including the U.S. Pre-
3 ventive Services Task Force, the Advisory
4 Committee on Immunization Practices, the
5 American College of Obstetricians and
6 Gynecologists, and the American Academy
7 of Pediatrics.

8 (3) MENTAL ILLNESS AND SUBSTANCE ABUSE
9 SERVICES.—

10 (A) PARITY.—

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

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

1 patient, outpatient, residential, and inten-
2 sive non-residential settings.
3 (iii) SPECIAL RULE.—
4 (I) EFFECT ON OTHER BENE-
5 FITS.—If the Board determines that
6 parity of mental illness and substance
7 abuse services with services for other
8 medical conditions cannot be achieved
9 without imposing unduly burdensome
10 cost-sharing requirements on other
11 services, the Board may design mental
12 illness and substance abuse services
13 such that they include the following
14 limits:
15 (aa) Inpatient hospital care
16 may be limited, but in the case of
17 mental illness the limit may not
18 be set at a level below 30 days
19 per year, and in the case of sub-
20 stance abuse services the limit
21 may not be set at a level below
22 the level sufficient to provide de-
23 toxification services.
24 (bb) After the first 5 visits
25 for outpatient adult psycho-

1 therapy, the coinsurance for such
2 services may be set at a level
3 higher than the coinsurance for
4 other services, but no higher than
5 a 50 percent coinsurance level.
6 (cc) Consistent with the
7 process described in section
8 3510, the Board shall ensure
9 that parity for mental illness and
10 substance abuse services with
11 services for other medical condi-
12 tions is established no later than
13 January 1, 2001.
14 (II) LEGISLATIVE PROPOSAL.—If
15 the Board finds that establishing par-
16 ity for mental illness and substance
17 abuse services with services for other
18 medical conditions cannot be achieved
19 by January 1, 2001, without imposing
20 unduly burdensome cost-sharing on all
21 services, the Board shall develop a
22 legislative proposal for an extension of
23 such date. Not later than January 1,
24 2000, the Board shall submit to the
25 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.

1 (b) DETERMINING MEDICAL NECESSITY OR APPRO-
2 PRIATENESS.—
3 (1) IN GENERAL.—The Board shall be author-
4 ized to establish—
5 (A) criteria for determinations of medical
6 necessity or appropriateness;
7 (B) procedures for determinations of med-
8 ical necessity or appropriateness; and
9 (C) regulations or guidelines to be used in
10 determining whether an item or service under
11 the categories of health care items and services
12 described in section 1202 is medically necessary
13 or appropriate.
14 (2) REQUIREMENTS.—The Board shall include
15 the following in establishing criteria, procedures, and
16 regulations under this subsection:
17 (A) SPECIAL RULES WITH RESPECT TO EN-
18 ROLLEES UNDER 22 YEARS OF AGE.—In making
19 any determination with respect to medical ne-
20 cessity or appropriateness with respect to an
21 enrollee under 22 years of age, the Board shall
22 consider whether the item or service is—
23 (i) is appropriate for the age and
24 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-

1 ommend to the Secretary specific areas for
2 which priorities should be given to undertake
3 clinical trials or establish practice guidelines.
4 (3) HEALTH PLAN REQUIREMENTS.—The regu-
5 lations established by the Board under this sub-
6 section shall provide that health plans shall—
7 (A) in making any determination with re-
8 spect to medical necessity or appropriateness,
9 consider the criteria and procedures established
10 by the Board under this subsection;
11 (B) be guided by—
12 (i) the initial determination of medical
13 necessity or appropriateness with respect
14 to an item or service made by an enrollee
15 and the health professional furnishing such
16 item or service; and
17 (ii) available scientific evidence; and
18 (C) if a health plan has developed a treat-
19 ment guideline or utilization protocol, or has
20 made a general coverage determination, the
21 plan shall—
22 (i) provide a copy of, and a written
23 statement of the basis for, the guideline,
24 protocol, or determination at least 60 days
25 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.—

1 (A) IN GENERAL.—The Board shall estab-
2 lish 3 cost-sharing schedules for health plans
3 providing the standard benefits package which
4 permit a variety of delivery system options, in-
5 cluding fee-for-service, preferred provider orga-
6 nizations, point of service, and managed care.
7 Such cost-sharing schedules shall consist of—
8 (i) a low cost-sharing schedule;
9 (ii) a high cost-sharing schedule; and
10 (iii) a combination cost-sharing sched-
11 ule.
12 (B) ACTUARIAL VALUE OF HIGH COST-
13 SHARING SCHEDULE.—A standard benefit pack-
14 age that provides for the cost-sharing schedule
15 established by the Board under this paragraph
16 that has the lowest actuarial value relative to
17 the actuarial values of all other cost-sharing
18 schedules established by the Board under this
19 paragraph, shall have an actuarial value that is
20 equivalent to the actuarial value of the benefits
21 package provided by the Blue Cross/Blue Shield
22 Standard Option under the Federal Employees
23 Health Benefits Program as in effect during
24 1994, adjusted for an average population (as
25 determined by the Board).

1 (3) PLANS PROVIDING ALTERNATIVE STANDARD
2 BENEFITS PACKAGE.—The Board shall establish
3 only one very high deductible cost-sharing schedule
4 for health plans providing the alternative standard
5 benefits package. Such cost-sharing schedule shall
6 provide for a higher deductible than any deductible
7 under a schedule established for health plans pro-
8 viding a standard benefits package.
9 (4) CLINICAL PREVENTIVE SERVICES.—No
10 cost-sharing schedule established by the Board may
11 include cost-sharing for clinical preventive services
12 and prenatal care.
13 (5) COST-SHARING RULES.—Cost-sharing
14 schedules established by the Board may include co-
15 payments, coinsurance, deductibles, and out-of-pock-
16 et limits. The copayments, coinsurance, deductibles
17 and out-of-pocket limits on cost-sharing for a year
18 under the schedules shall be applied based upon ex-
19 penses incurred for covered items and services fur-
20 nished in the year.
21 (6) LIFETIME LIMITS.—No cost-sharing sched-
22 ule established by the Board may include lifetime
23 limits.
24 (d) LEGISLATIVE PROPOSALS ON ACTUARIAL
25 EQUIVALENCE AND HEALTH SERVICE CATEGORIES.—

1 (1) IN GENERAL.—The Board may develop leg-
2 islative proposals for modifications to the actuarial
3 equivalence provisions of section 1201 and the cat-
4 egories of health care items and services under sec-
5 tion 1202.
6 (2) IMPLEMENTING BILL.—The Board shall
7 submit to the Congress an implementing bill which
8 contains such statutory provisions as are necessary
9 or appropriate to implement the legislative proposals
10 developed under paragraph (1).
11 (e) REPORTS.—
12 (1) DENTAL CARE.—The Board shall undertake
13 a study to determine the costs of providing—
14 (A) preventive dental care to all adults;
15 (B) restorative dental care to all adults;
16 and
17 (C) preventive dental care to adults with
18 developmental, cognitive, and other mental dis-
19 abilities.
20 Not later than July 1, 1996, the Board shall pre-
21 pare and submit to the Secretary and the Congress,
22 a report concerning such study.
23 (2) IN VITRO FERTILIZATION.—The Board shall
24 undertake a study to determine the costs of pro-
25 viding coverage for in vitro fertilization in the stand-

ard 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 coop-

1 erative is not a purchasing cooperative
2 described in section 1341, then also
3 through a cooperative so described;
4 and
5 (II) at the option of the em-
6 ployer, to enroll through the employer
7 in one of at least 3 certified commu-
8 nity-rated standard health plans
9 which provide the standard benefits
10 package established under subtitle C,
11 including, if available, a high cost-
12 sharing plan, a combination cost-shar-
13 ing plan, and a low cost-sharing plan
14 as established under such subtitle;
15 and
16 (B) shall provide, upon request, payroll
17 withholding of the employee's premiums.
18 (2) WAIVER OF REQUIREMENT.—The Governor
19 of a participating State (or, the Secretary of Labor,
20 in the case of sponsors of multistate self-insured
21 health plans) may waive the requirement under
22 paragraph (1) for any employer in a rural area of
23 such State which demonstrates an insufficient popu-
24 lation density to support 3 types of certified stand-
25 ard health plans. Such an employer shall at least

1 offer a high cost-sharing plan as established under
2 subtitle C.
3 (3) PROHIBITION ON OFFERING OF ALTER-
4 NATIVE PACKAGE.—No employer may offer an alter-
5 native standard benefits package established under
6 subtitle C.
7 (b) FORWARDING OF INFORMATION.—
8 (1) INFORMATION REGARDING PLANS.—An em-
9 ployer must provide each employee of such em-
10 ployer—
11 (A) with information provided by the State
12 under section 1508 regarding all certified
13 standard health plans offered in the community
14 rating area in which the employer is located,
15 and
16 (B) if the employer knows that an em-
17 ployee resides in another community rating
18 area, information regarding how to obtain infor-
19 mation on certified standard health plans of-
20 fered to residents of such other community rat-
21 ing area.
22 (2) INFORMATION REGARDING EMPLOYEES.—
23 An employer shall forward the name and address
24 (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

1 pending in any court. No security or other under-
2 taking shall be required of any participant or bene-
3 ficiary as a condition for issuance of such relief. An
4 order requiring such maintenance of benefits may be
5 refused or dissolved only upon determination by the
6 court, on the basis of clear and convincing evidence,
7 that the action is clearly without merit.

8 (2) MODIFICATIONS.—Nothing in this section
9 shall preclude a court from modifying the obligation
10 of a plan or plan sponsor to the extent retiree bene-
11 fits are otherwise being paid.

12 (b) BURDEN OF PROOF.—In addition to the relief au-
13 thorized in subsection (a) or otherwise available, if, in any
14 action described in subsection (a), the terms of the em-
15 ployee welfare benefit plan summary plan description or
16 other materials distributed to employees at the time of a
17 participant's retirement or disability are silent or are am-
18 biguous, either on their face or after consideration of ex-
19 trinsic evidence, as to whether retiree health benefits and
20 payments may be terminated or reduced for a participant
21 and his or her beneficiaries after the participant's retire-
22 ment or disability, then the benefits and payments shall
23 not be terminated or reduced for the participant and his
24 or her beneficiaries unless the plan or plan sponsor estab-
25 lishes by a preponderance of the evidence that the sum-

1 mary plan description and other materials about retiree
2 benefits—
3 (1) were distributed to the participant at least
4 90 days in advance of retirement or disability;
5 (2) did not promise retiree health benefits for
6 the lifetime of the participant and his or her spouse;
7 and
8 (3) clearly and specifically disclosed that the
9 plan allowed such termination or reduction as to the
10 participant after the time of his or her retirement or
11 disability.
12 The disclosure described in paragraph (3) must have been
13 made prominently and in language which can be under-
14 stood by the average plan participant.
15 (c) REPRESENTATION.—Notwithstanding any other
16 provision of law, an employee representative of any retired
17 employee or the employee's spouse or dependents may—
18 (1) bring an action described in this section on
19 behalf of such employee, spouse, or dependents; or
20 (2) appear in such an action on behalf of such
21 employee, spouse or dependents.
22 (d) RETIREE HEALTH BENEFITS.—For the purposes
23 of this section, the term ''retiree health benefits'' means
24 health benefits (including coverage) which are provided
25 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 (1) IN GENERAL.—Each cooperative shall be
2 governed by a Board of Directors to be composed of
3 representatives of community-rated employers, com-
4 munity-rated employees, and community-rated indi-
5 viduals as elected by the members of the purchasing
6 cooperative.
7 (2) INITIAL BOARD.—The initial Board of Di-
8 rectors of a purchasing cooperative shall be com-
9 posed of members selected by the sponsoring entity
10 of the cooperative. Subsequent members of the
11 Board of Directors shall be elected as provided for
12 under paragraph (1) after being nominated by a
13 nominating committee appointed by the preceding
14 Board of Directors.
15 (c) ESTABLISHMENT BY STATE OR LOCAL GOVERN-
16 MENT.—A State or local government may establish or
17 sponsor a purchasing cooperative to serve a community
18 rating area. The Secretary shall establish special rules
19 concerning the legal and governing structure of a State
20 or local government purchasing cooperative.
21 (d) MEMBERSHIP.—A purchasing cooperative shall
22 accept all community-rated employers, community-rated
23 employees, and community-rated individuals residing with-
24 in the area served by the cooperative as members if such
25 employers, employees, or individuals request such mem-

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

4 (e) PROHIBITION.—An insurer may not form or un-
5 derwrite a purchasing cooperative but may administer
6 such a cooperative.

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

9 (1) negotiate (regarding premiums and mar-
10 keting fees) with and enter into agreements with
11 standard health plans under section 1323;

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

14 (3) enroll community-rated employees and com-
15 munity-rated individuals in standard health plans;

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

19 (5) provide for coordination with other pur-
20 chasing cooperatives;

21 (6) provide comparative information to the pub-
22 lic and the participating State on standard health
23 plans offered through the purchasing cooperative
24 from information provided by the plans under sec-
25 tion 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.

1 (2) EXCLUSIVE COOPERATIVE.—

2 (A) IN GENERAL.—Nothing in this section
3 shall be construed as requiring a State to cer-
4 tify or establish more than one purchasing co-
5 operative serving a community rating area.

6 (B) SPECIAL RULES.—If a State chooses
7 to certify only one purchasing cooperative in a
8 community rating area, then such cooperative
9 (other than a cooperative established under sec-
10 tion 1341) may not negotiate regarding pre-
11 miums as described in subsection (f)(1) and,
12 notwithstanding section 1323(a)(1), shall enter
13 into an agreement with each standard health
14 plan operating in the area which desires such
15 an agreement.

16 (3) SINGLE ORGANIZATION SERVING MULTIPLE
17 COMMUNITY RATING AREAS.—Nothing in this sec-
18 tion shall be construed as preventing a single not-
19 for-profit corporation from being the purchasing co-
20 operative for more than one community rating area.

21 (4) VOLUNTARY PARTICIPATION.—Nothing in
22 this section shall be construed as requiring any com-
23 munity-rated individual, community-rated employee,
24 or community-rated employer to purchase a stand-
25 ard 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.—

1 (A) IN GENERAL.—Except as provided in
2 subparagraph (B), each purchasing cooperative
3 shall enter into an agreement under paragraph
4 (1) with at least 3 types of standard health
5 plans which provide the standard benefits pack-
6 age established under subtitle C, including, if
7 available, a high cost-sharing plan, a combina-
8 tion cost-sharing plan, and a low cost-sharing
9 plan as established under such subtitle.
10 (B) WAIVER OF REQUIREMENT.—The Gov-
11 ernor of a participating State may waive the re-
12 quirement under subparagraph (A), in a man-
13 ner consistent with section 1301(a)(2)), for any
14 purchasing cooperative in a rural area of such
15 State which demonstrates an insufficient popu-
16 lation density to support 3 types of standard
17 health plans. Such a purchasing cooperative
18 shall at least offer a high cost-sharing plan as
19 established under such subtitle.
20 (3) LIMITATION.—A purchasing cooperative
21 may not enter into an agreement under this section
22 with a standard health plan unless such plan is cer-
23 tified by the State under subtitle E.
24 (4) TERMINATION OF AGREEMENT.—An agree-
25 ment 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

premiums 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.

1 (2) NEGOTIATION.—A purchasing cooperative
2 and a standard health plan shall negotiate the mar-
3 keting fee. Such negotiated fee shall not be binding
4 on such health plan with respect to other purchasing
5 cooperatives through which the plan is offered.
6 (3) LIMITATION.—In no case shall a marketing
7 fee assessed by a standard health plan offered out-
8 side of a purchasing cooperative be lower than the
9 weighted average of the marketing fees negotiated
10 with all purchasing cooperatives for the community
11 rating area involved.
12 (c) DISCLOSURE AND MULTIPLE COOPERATIVES.—
13 (1) DISCLOSURE.—A purchasing cooperative
14 shall, prior to the time of enrollment, publish the
15 membership fee of such cooperative and the mar-
16 keting fees for each standard health plan offered
17 through the cooperative. Such fees shall be cal-
18 culated and identified as separate charges from the
19 premium charged by the standard health plans of-
20 fered by the purchasing cooperative.
21 (2) SUBMISSIONS TO STATE.—
22 (A) IN GENERAL.—Each purchasing coop-
23 erative in a community rating area shall provide
24 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-

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

4 (b) ELECTION OF ENROLLMENT.—

5 (1) IN GENERAL.—An employee of a commu-
6 nity-rated employer may select coverage under any
7 of the standard health plans offered through a pur-
8 chasing cooperative of which the employer is a mem-
9 ber.

10 (2) ENROLLMENT OUTSIDE THE COOPERA-
11 TIVE.—An employee of a community-rated employer
12 may elect to enroll in a plan offered through the
13 purchasing cooperative with which the employer has
14 entered into an agreement or directly with a stand-
15 ard health plan selected by the employer (if such
16 plan is not offered by the cooperative selected by the
17 employer). A community-rated employee not residing
18 in the community rating area served by the pur-
19 chasing cooperative selected by the employer shall
20 enroll in a standard health plan consistent with rules
21 promulgated by the Secretary. The purchasing coop-
22 erative selected by the employer shall be responsible
23 for forwarding premium payments to the appropriate
24 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-

1 rated individuals residing within that area at the
2 community-rated premium established under section
3 1116.

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

12 (3) OFFER OF NATIONAL PLANS.—Each pur-
13 chasing cooperative joined or established under para-
14 graph (1) shall, not later than January 1, 1998,
15 offer to community-rated individuals covered by such
16 cooperative all national FEHBP plans (including
17 employee organization plans) under rules established
18 by the Office of Personnel Management.

19 (b) AGREEMENTS WITH PURCHASING COOPERA-
20 TIVES.—

21 (1) IN GENERAL.—The Office of Personnel
22 Management shall make every effort to enter into an
23 agreement with a purchasing cooperative in each
24 community rating area in the United States to carry
25 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.

1 (d) INFORMATION SYSTEM AND INFORMATION RE-
2 LATED FUNCTIONS.—
3 (1) IN GENERAL.—The Secretary shall—
4 (A) develop and implement standards to
5 establish a national health information system
6 to measure quality as required by title V;
7 (B) provide model format and content re-
8 quirements for summary plan descriptions;
9 (C) provide model format and content re-
10 quirements for comparative plan brochures
11 under section 1125; and
12 (D) provide model format and content re-
13 quirements for comparative purchasing coopera-
14 tive brochures under section 1321.
15 (2) INFORMATION RELATED FUNCTIONS.—
16 (A) DESIGNATION.—The Secretary shall
17 provide for the use of entities in the national
18 health data network to perform information re-
19 lated functions under this section with respect
20 to employers, States, contracting entities, and
21 purchasing cooperatives.
22 (B) FUNCTIONS.—The functions referred
23 to in subparagraph (A) shall include—
24 (i) receipt of information submitted by
25 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

1 guaranty funds and financial reporting and auditing
2 standards under subpart F.
3 (2) FINANCIAL MANAGEMENT STANDARDS.—
4 The Secretary, in consultation with the Secretary of
5 Labor, shall establish, for purposes of section 1118,
6 standards relating to the management of finances,
7 maintenance of records, accounting practices, audit-
8 ing procedures, and financial reporting for States,
9 consumer purchasing cooperatives and health plans.
10 Such standards shall take into account current Fed-
11 eral laws and regulations relating to fiduciary re-
12 sponsibilities and financial management of funds.
13 (3) AUDITING STATE PERFORMANCE.—The
14 Secretary shall perform periodic financial and other
15 audits of States to assure that such States are car-
16 rying out their responsibilities under this Act con-
17 sistent with this Act. Such audits shall include au-
18 dits of State performance in the areas of—
19 (A) assuring enrollment of all community-
20 rated individuals in health plans;
21 (B) management of premium and cost
22 sharing discounts and reductions provided;
23 (C) financial management (including the
24 financial activities of cooperatives and State-
25 designated contracting entities); and

1 (D) assuring enforcement of the anti-
2 discrimination provisions of this Act.
3 (i) STANDARDS FOR HEALTH PLAN GRIEVANCE PRO-
4 CEDURES.—The Secretary shall establish standards for
5 health plan grievance procedures that are used by enroll-
6 ees in pursuing complaints.
7 (j) FIDUCIARY REQUIREMENTS.—The Secretary
8 shall, in consultation with the Secretary of Labor, develop
9 and promulgate fiduciary requirements for the manage-
10 ment of funds by States, plans, cooperatives, and employ-
11 ers.
12 (k) GUARANTY FUNDS.—The Secretary shall estab-
13 lish standards for guaranty funds as provided for in sec-
14 tion 1442.
15 (l) STANDARDS FOR UTILIZATION MANAGEMENT
16 PROGRAMS.—
17 (1) IN GENERAL.—Not later than 12 months
18 after the date of enactment of this Act, the Sec-
19 retary, in consultation with interested parties which
20 may include one or more accrediting organizations,
21 shall promulgate uniform Federal standards for uti-
22 lization management programs, to include the activi-
23 ties described in section 1129.
24 (2) COMPLIANCE.—States shall ensure compli-
25 ance with the Federal standards established under

1 paragraph (1), consistent with their role in certi-
2 fying health plans.
3 (3) REVIEW AND UPDATE.—The Secretary shall
4 periodically review and update utilization manage-
5 ment standards to reflect appropriate policies and
6 practices in health care delivery.
7 (m) COLLECTION ACTIVITIES.—The Secretary may
8 provide (through contract or otherwise) for collection ac-
9 tivities for the collection of amounts owed to States and
10 purchasing cooperatives for health insurance coverage sub-
11 ject to the provisions of this title.
12 **SEC. 1402. ANNUAL REPORT.**
13 (a) IN GENERAL.—The Secretary, in consultation
14 with the National Health Benefits Board and the Health
15 Care Cost and Coverage Commission, shall prepare and
16 submit to the President and the Congress an annual re-
17 port concerning the overall implementation of the new
18 health care system under this Act.
19 (b) MATTERS TO BE INCLUDED.—The Secretary
20 shall include in each annual report under this section the
21 following:
22 (1) Information on Federal and State imple-
23 mentation.
24 (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

1 provided in this Act, the Secretary may not approve
2 a State health care system under this subpart for
3 any year prior to 1996.
4 (b) REVIEW OF COMPLETENESS OF PLANS.—
5 (1) IN GENERAL.—If a State submits a plan
6 under subsection (a)(1), the Secretary shall notify
7 the State, not later than 7 working days after the
8 date of submission, whether or not the plan is com-
9 plete and provides the Secretary with sufficient in-
10 formation to approve or disapprove the document.
11 (2) ADDITIONAL INFORMATION ON INCOMPLETE
12 PLAN.—If the Secretary notifies a State that the
13 State's plan is not complete, the State shall be pro-
14 vided such additional period (not to exceed 45 days)
15 as the Secretary may by regulation establish in
16 which to submit such additional information as the
17 Secretary may require. Not later than 7 working
18 days after the State submits the additional informa-
19 tion, the Secretary shall notify the State respecting
20 the completeness of the plan.
21 (c) ACTION ON COMPLETED DOCUMENTS.—
22 (1) IN GENERAL.—The Secretary shall make a
23 determination (and notify the State) on whether the
24 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 (1) IN GENERAL.—States shall consider alter-
2 native financial instruments and methods for
3 community- and provider-based plans (as defined in
4 paragraph (2)) to meet the capital and solvency
5 standards developed in accordance with this section.
6 Provisions made for such plans shall ensure the fis-
7 cal integrity and financial solvency of such plans.
8 (2) ELIGIBLE PLANS.—Plans eligible for special
9 consideration by States must be offered by public or
10 not-for-profit entities that are owned, or in which a
11 majority share of the plan's investment is held by—
12 (A) health care providers who practice in
13 the plan;
14 (B) individuals who live in the area, or
15 not-for-profit organizations located in the area
16 serviced by the plan;
17 (C) a combination of individuals and orga-
18 nizations described in subparagraphs (A) and
19 (B); or
20 (D) organizations located outside the serv-
21 ice area which provide for control over local op-
22 erations by individuals described in subpara-
23 graphs (A) or (B).
24 (e) DEVELOPMENT OF STANDARDS BY NAIC.—The
25 Secretary may request the National Association of Insur-

1 ance Commissioners to develop model standards for the
2 additional capital requirements described in subsection (c)
3 and to present such standards to the Secretary not later
4 than July 1, 1995. The Secretary may accept such stand-
5 ards as the standards to be applied under subsection (c)
6 or modify the standards in any appropriate manner.

7 **SEC. 1442. STANDARD FOR GUARANTY FUNDS.**

8 (a) IN GENERAL.—In consultation with the States,
9 the Secretary shall establish standards for guaranty funds
10 established by States for community-rated health plans.

11 (b) GUARANTY FUND STANDARDS.—The standards
12 established under subsection (a) for a guaranty fund shall
13 include the following:

14 (1) Each fund must have a method to generate
15 sufficient resources to pay health providers and oth-
16 ers in the case of a failure of a health plan in order
17 to meet obligations with respect to—

18 (A) services rendered by the health plan
19 for the standard benefit package, including any
20 supplemental coverage for cost sharing provided
21 by the health plan, and

22 (B) services rendered prior to health plan
23 insolvency and services to patients after the in-
24 solvency but prior to their enrollment in other
25 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

1 distribution to community-rated individuals enrollment
2 materials and comparative information on health plans
3 and purchasing cooperatives.

4 **PART 2—ESSENTIAL COMMUNITY PROVIDERS**

5 **SEC. 1461. CERTIFICATION.**

6 For purposes of this Act, the Secretary shall certify
7 as an ''essential community provider'' any health care pro-
8 vider or organization that—

9 (1) is within any of the categories of providers
10 and organizations specified in section 1462(a), or

11 (2) meets the standards for certification under
12 section 1463(a).

13 **SEC. 1462. CATEGORIES OF PROVIDERS AUTOMATICALLY**
14 **CERTIFIED.**

15 (a) IN GENERAL.—The categories of providers and
16 organizations, including subrecipients, specified in this
17 subsection are as follows:

18 (1) CATEGORY 1 ENTITIES.—The following enti-
19 ties shall be considered category 1 entities:

20 (A) Covered entities as defined in section
21 340B(a)(4) of the Public Health Service Act
22 (42 U.S.C. 256b(a)(4)), except that subsections
23 (a)(4)(L)(iii) and (a)(7) of such section shall
24 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-

1 ommended changes in the rural health clinics program, to
2 the Congress not later than January 1, 1996.

3 **SEC. 1463. STANDARDS FOR ADDITIONAL PROVIDERS.**

4 (a) STANDARDS.—The Secretary shall publish stand-
5 ards for the certification of additional categories of health
6 care providers and organizations as essential community
7 providers, including the categories described in subsection
8 (b). Such a health care provider or organization shall not
9 be certified unless the Secretary determines, under such
10 standards, that health plans operating in the area served
11 by the applicant would not otherwise be able to assure ade-
12 quate access to items and services included in the standard
13 benefit package if such a provider was not so certified.

14 (b) CATEGORIES TO BE INCLUDED.—The categories
15 described in this subsection are as follows:

16 (1) CERTAIN HEALTH PROFESSIONALS.—A
17 health professional who—

18 (A) for at least 20 hours per week—

19 (i) is located in an area (or areas)
20 designated as a health professional short-
21 age area (under section 332 of the Public
22 Health Service Act) or serves a population
23 (or populations) designated as a medically
24 underserved population (under section 330
25 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 (1) PUBLICATION OF PROCEDURES.—The Sec-
2 retary shall publish, not later than 6 months after
3 the date of the enactment of this Act, the procedures
4 to be used by health care professionals, providers,
5 agencies, and organizations seeking certification
6 under this subpart, including the form and manner
7 in which an application for such certification is to be
8 made.
9 (2) TIMELY DETERMINATION.—The Secretary
10 shall make a determination upon such an application
11 not later than 60 days (or 15 days in the case of
12 a certification for an entity described in section
13 1462) after the date the complete application has
14 been submitted. The determination on an application
15 for certification of an entity described in section
16 1462 shall only involve the verification that the enti-
17 ty is an entity described in such section.
18 (b) REVIEW OF CERTIFICATIONS.—The Secretary
19 shall periodically review whether professionals, providers,
20 agencies, and organizations certified under this subpart
21 continue to meet the requirements for such certification.
22 (c) TERMINATION OR DENIAL OF CERTIFICATION.—
23 (1) PRELIMINARY FINDING.—If the Secretary
24 preliminarily finds that an entity seeking certifi-
25 cation 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

1 requests participation under this section, a
2 health plan shall either—
3 (i) enter into a written provider par-
4 ticipation agreement (described in sub-
5 section (b)) with such providers, or
6 (ii) enter into a written agreement
7 under which the plan shall make payments
8 to such provider in accordance with sub-
9 section (c).
10 (B) EXCEPTION.—A State, as part of the
11 State plan under section 1501(a), may submit
12 to the Secretary for approval a request that the
13 Secretary permit the State to—
14 (i) require health plans operating in
15 certain community rating areas in the
16 State to contract with more than one es-
17 sential community provider of each type
18 referred to in subparagraph (A), based on
19 geographic proximity, cultural and lan-
20 guage needs, capacity to meet the needs of
21 enrollees, or other factors determined rel-
22 evant by the State; and
23 (ii) establish additional types of essen-
24 tial 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.

1 (5) Assignment of enrollees to participating
2 providers.
3 (6) Access by the provider's patients to pro-
4 viders in medical specialties or subspecialties partici-
5 pating in the plan.
6 (c) PAYMENTS FOR PROVIDERS WITHOUT PARTICI-
7 PATION AGREEMENTS.—
8 (1) IN GENERAL.—Payment in accordance with
9 this subsection is payment based, as elected by the
10 electing essential community provider, either—
11 (A) on the fee schedule developed by the
12 State; or
13 (B) on payment methodologies and rates
14 used under the applicable Medicare payment
15 methodology and rates (or the most closely ap-
16 plicable methodology under such program as
17 the Secretary specifies in regulations).
18 (2) SPECIAL RULE FOR FEDERALLY QUALIFIED
19 HEALTH CENTERS.—With respect to each federally
20 qualified health center (as such term is defined in
21 section 1861(aa) of the Social Security Act) that is
22 an essential community provider, a health plan shall
23 make payments based on the reasonable cost rates
24 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.

1 (c) CONSULTATION.—In carrying out activities under
2 this Act with respect to large employer purchasing groups,
3 employer sponsored health plans, and employers, the Sec-
4 retary of Labor shall consult with the Secretary of Health
5 and Human Services.

6 (d) GUARANTY FUNDS.—

7 (1) IN GENERAL.—The Secretary of Labor shall
8 establish standards for guaranty funds to be estab-
9 lished by a State with respect to a self-insured plan
10 operating wholly within the State.

11 (2) MULTISTATE PLANS.—The Secretary of
12 Labor shall establish and administer a guaranty
13 fund with respect to multistate self-insured plans.

14 (e) EMPLOYER-RELATED REQUIREMENTS.—

15 (1) IN GENERAL.—The Secretary of Labor, in
16 consultation with the Secretary, shall be responsible
17 for assuring that employers—

18 (A) make payments of any employer pre-
19 miums (and withhold and make payment of the
20 family share of premiums with respect to quali-
21 fying employees) and provide discounts to em-
22 ployees as required under this Act, including
23 auditing of collection activities with respect to
24 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,

1 a State shall submit to the Secretary a State plan
2 (in a form and manner specified by the Secretary)
3 that describes the State health care system that the
4 State is establishing (or has established).

5 (3) DEADLINE.—If a State is not a partici-
6 pating State with a State health care system in op-
7 eration by January 1, 1997, the provisions of sub-
8 part C of part 1 of subtitle E (relating to respon-
9 sibilities in absence of State systems) shall take ef-
10 fect.

11 (4) SUBMISSION OF INFORMATION SUBSEQUENT
12 TO APPROVAL.—A State approved as a participating
13 State under section 1411 shall submit to the Sec-
14 retary an annual update to the State health care
15 system not later than February 15 of each year fol-
16 lowing the first year for which the State is a partici-
17 pating State. The update shall contain—

18 (A) such information as the Secretary may
19 require to determine that the system shall meet
20 the applicable requirements of this Act for the
21 succeeding year; and

22 (B) such information as the Secretary may
23 require to determine that the State operated
24 the system during the previous year in accord-

ance 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 sub-

1 title B and with the regulations promulgated by
2 the Secretary concerning such standards.
3 (B) DISENROLLMENT DATA.—State review
4 of enrollee disenrollment from each standard
5 health plan to determine whether there is a pat-
6 tern of disenrollment that does not reflect the
7 distribution of such plans' reenrolling member-
8 ship.
9 (C) MONITORING.—State monitoring of
10 the performance of each standard health plan
11 to ensure that such plans continue to meet the
12 criteria for certification.
13 (3) STATE PROGRAMS.—Each participating
14 State shall develop accreditation, certification and
15 enforcement programs in accordance with the guide-
16 lines established by the Secretary under paragraph
17 (1).
18 (4) USE OF PRIVATE ORGANIZATIONS.—
19 (A) IN GENERAL.—A State may utilize pri-
20 vate accreditation organizations to review the
21 compliance by standard health plans with spe-
22 cific standards with which such organizations
23 have demonstrated expertise. A State may use
24 such reviews as the basis for determining plan
25 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

1 Secretary, provide for the division of the State into 1 or
2 more community rating areas.
3 (b) MULTIPLE AREAS.—With respect to a community
4 rating area—
5 (1) no metropolitan statistical area in a State
6 may be incorporated into more than 1 such area in
7 the State;
8 (2) the number of individuals residing within
9 such an area may not be less than 250,000; and
10 (3) no area incorporated in a community rating
11 area may be incorporated into another such area.
12 (c) BOUNDARIES.—
13 (1) IN GENERAL.—In establishing boundaries
14 for community rating areas, a participating State
15 shall comply with the antidiscrimination require-
16 ments of section 1602.
17 (2) COORDINATING MULTIPLE COMMUNITY RAT-
18 ING AREAS.—Nothing in this section shall be con-
19 strued as preventing a participating State from co-
20 ordinating the activities of one or more community
21 rating areas in the State.
22 (3) INTERSTATE COMMUNITY RATING AREAS.—
23 Community rating areas with respect to interstate
24 areas shall be established in accordance with rules
25 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

1 opportunity to change enrollment among the standard
2 health plans offered to such individuals in such area under
3 this Act. The initial annual open enrollment period shall
4 be for a period of 90 days.

5 **SEC. 1504. RISK ADJUSTMENT PROGRAM.**

6 (a) REQUIREMENT FOR IMPLEMENTATION.—In ac-
7 cordance with rules established by the Secretary, each
8 State shall implement a risk adjustment methodology de-
9 veloped by the Secretary under subsection (d).

10 (b) STATE RISK ADJUSTMENT ORGANIZATION.—
11 Each State shall establish a State risk adjustment organi-
12 zation to carry out the adjustments required under the
13 methodology implemented by the State under subsection
14 (a) and make payments in accordance with subsection (c).
15 Such organization shall meet standards established by the
16 Secretary relating to organizational structure, operation,
17 fiduciary responsibilities and financial management.

18 (c) ADJUSTMENTS AND PAYMENTS.—

19 (1) CLASSES OF PURCHASERS.—The Secretary
20 shall specify classes of individual health plan pur-
21 chasers whose expected expenditures are signifi-
22 cantly higher than those of employed individuals cov-
23 ered under community-rated plans.

24 (2) ESTIMATES.—The Secretary shall annually
25 estimate the amount by which the expected expendi-

tures 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 Sec-

1 retary, shall develop a risk adjustment and reinsur-
2 ance methodology for use by States in accordance
3 with this section.
4 (2) METHODOLOGY.—
5 (A) PURPOSES.—The risk adjustment
6 methodology developed under paragraph (1)
7 shall—
8 (i) ensure that assessments imposed
9 on or payments provided to standard
10 health plans reflect the expected relative
11 utilization and expenditures for covered
12 items and services by the enrollees of each
13 plan compared to the average utilization
14 and expenditures for all eligible individ-
15 uals, and
16 (ii) protect standard health plans that
17 enroll a disproportionate share of eligible
18 individuals with respect to whom expected
19 utilization of health care services (included
20 in the benefit package) and expected
21 health care expenditures for such services
22 are greater than the average level of such
23 utilization and expenditures for eligible in-
24 dividuals.

1 (B) FACTORS TO BE CONSIDERED.—The
2 methodology shall take into account the fol-
3 lowing factors:
4 (i) Demographic characteristics.
5 (ii) Health status, including prior use
6 of health services.
7 (iii) Geographic area of residence.
8 (iv) Socio-economic status.
9 (v) The cost sharing of the plan.
10 (vi) Any other factors determined by
11 the Secretary to be material to the pur-
12 poses described in subparagraph (A).
13 (3) SPECIAL CONSIDERATION FOR MENTAL ILL-
14 NESS AND MENTAL RETARDATION.—In developing
15 the methodology under this section, the Secretary
16 shall give consideration to the unique problems of
17 adjusting payments relating to health plans with re-
18 spect to individuals with mental illness and mental
19 retardation.
20 (4) MANDATORY REINSURANCE.—
21 (A) IN GENERAL.—The methodology devel-
22 oped under this section shall include a system
23 of mandatory reinsurance as a component of
24 the risk adjustment methodology.

1 (B) REINSURANCE SYSTEM.—The Sec-
2 retary, in developing the methodology for a
3 mandatory reinsurance system under subpara-
4 graph (A), shall—
5 (i) provide for standard health plans
6 to make payments to state-established re-
7 insurance programs for the purpose of re-
8 insuring all or part of the health care ex-
9 penditures for items and services included
10 in the standard benefit package for classes
11 of high-cost individual health plan pur-
12 chasers (as specified by the Secretary) or
13 specific high-cost treatments or diagnosis;
14 and
15 (ii) specify the manner of creation,
16 structure, and operation of the system in
17 each State, including—
18 (I) the manner (which may be
19 prospective or retrospective) in which
20 standard health plans make payments
21 to the system, and
22 (II) the type and level of reinsur-
23 ance coverage provided by the system.
24 (5) COST-SHARING ADJUSTMENT.—The stand-
25 ards 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

1 separate guaranty fund with respect to self-insured plans
2 operating in the State in accordance with section 1481.

3 **SEC. 1506. ENROLLMENT ACTIVITIES.**

4 (a) PROVIDER-BASED ENROLLMENT MECHA-
5 NISMS.—The Secretary shall promulgate rules regarding
6 the establishment by each participating State, in accord-
7 ance with section 6006, of provider-based enrollment
8 mechanisms for individuals seeking care who are not en-
9 rolled in a standard health plan. Such rules shall include
10 provisions requiring standard health plans to pay pro-
11 viders for care delivered to individuals prior to the individ-
12 ual's enrollment in the plan and be consistent with section
13 1114.

14 (b) COORDINATION OF ENROLLMENT ACTIVITIES.—
15 Each participating State shall coordinate its activities, in-
16 cluding plan enrollment and disenrollment activities, with
17 other States in a manner specified by the Secretary that
18 ensures continuous, nonduplicative coverage of commu-
19 nity-rated and experience-rated individuals in standard
20 health plans and that minimizes administrative procedures
21 and paperwork.

22 **SEC. 1507. RURAL AND MEDICALLY UNDERSERVED AREAS.**

23 (a) IN GENERAL.—If, in accordance with appropriate
24 rules established by the Secretary, a State determines that
25 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-

1 tem for services provided in the State shall apply to all
2 purchasers and payers, including those under employee
3 welfare benefit plans authorized under the Employee Re-
4 tirement Income Security Act of 1974 (29 U.S.C. 1001
5 et seq.), workers' compensation programs under State law,
6 the Federal Employees' Compensation Act under chapter
7 81 of title 5, United States Code, and Federal employee
8 health benefit plans under chapter 89 of title 5, United
9 States Code.

10 **SEC. 1524. ALTERNATIVE STATE HOSPITAL SERVICES PAY-**
11 **MENT SYSTEMS.**

12 (a) IN GENERAL.—No State shall be prevented from
13 enforcing—
14 (1) a State system described in subsection (b),
15 or
16 (2) a State system described in subsection (c),
17 by any provision of the Employee Retirement Income Se-
18 curity Act of 1974 (29 U.S.C. 1001 et seq.) or chapter
19 81 or 89 of title 5, United States Code.

20 (b) REIMBURSEMENT CONTROL SYSTEM.—A State
21 system is described in this subsection if it is a State reim-
22 bursement control system in operation before the date of
23 the enactment of this Act which—
24 (1) applies to substantially all non-Federal
25 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

1 under subtitle C to individuals enrolled in the
2 system, the State shall make payments directly,
3 or through fiscal intermediaries, to such pro-
4 viders and assume (subject to subparagraph
5 (B)) all financial risk associated with making
6 such payments.

7 (B) CAPITATED PAYMENTS PERMITTED.—
8 Nothing in subparagraph (A) shall be construed
9 to prohibit providers furnishing items and serv-
10 ices under the system from receiving payments
11 on a capitated, at-risk basis based on prospec-
12 tively determined rates.

13 (5) PROVISION OF STANDARD BENEFITS PACK-
14 AGE.—

15 (A) IN GENERAL.—The system shall pro-
16 vide for coverage of the standard benefits pack-
17 age established under subtitle C, including the
18 cost-sharing provided under the package (sub-
19 ject to subparagraph (B)), to all individuals en-
20 rolled in the system.

21 (B) IMPOSITION OF REDUCED COST-SHAR-
22 ING.—The system may decrease the cost-shar-
23 ing otherwise provided in the standard benefits
24 package established under subtitle C with re-
25 spect 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-

1 eration and disposition of applications under this
2 subsection. The procedure established by the Secre-
3 taries shall provide that such consideration and dis-
4 position be completed within 90 days, and that if the
5 application is approved, multistate employers be no-
6 tified of such approval.

7 (b) REQUIREMENTS SPECIFIED.—The State program
8 shall be consistent with the reform standards established
9 in this Act and the interim and final (if any) regulations
10 promulgated by the Secretaries, including—

11 (1) a standardized benefits package meeting the
12 requirements established under subtitle C, or in the
13 event such requirements have not been fully promul-
14 gated on the date of the application, the require-
15 ments for a qualified health maintenance organiza-
16 tion (as defined in section 1310(d) of the Public
17 Health Service Act (42 U.S.C. 300e-9(d));

18 (2) insurance reforms and rating requirements
19 as specified under part 2 of subtitle B;

20 (3) standards for health plans as specified
21 under part 3 of subtitle B;

22 (4) the recognition of, and standards for, pur-
23 chasing cooperatives, as specified in part 2 of sub-
24 title 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

1 "(iii) is produced at an establishment li-
2 censed under such section to produce such
3 product.
4 "(C) Insulin certified under section 506 of the
5 Federal Food, Drug, and Cosmetic Act.
6 "(D) Enteral nutrients (but only if provided as
7 a covered home infusion drug).
8 "(3) The term 'covered outpatient drug' does not in-
9 clude any product—
10 "(A) which is administered through infusion in
11 a setting described in paragraph (5)(A)(ii) unless
12 the product is a covered home infusion drug;
13 "(B) when furnished as part of, or as incident
14 to, any other item or service for which payment may
15 be made under this title (other than physicians'
16 services or services which would be physicians' serv-
17 ices if furnished by a physician); or
18 "(C) which is listed under paragraph (2) of sec-
19 tion 1927(d) (other than subparagraph (I) or (J) of
20 such paragraph) as a drug which may be excluded
21 from coverage under a State plan under title XIX
22 and which the Secretary elects to exclude from cov-
23 erage under part B.
24 "(4) For purposes of this subsection, the term 'medi-
25 cally accepted indication', with respect to the use of an

1 outpatient drug, includes any use which has been approved
2 by the Food and Drug Administration for the drug, and
3 includes another use of the drug if—

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

6 ''(B)(i) such use is supported by one or more
7 citations which are included (or approved for inclu-
8 sion) in one or more of the following compendia: the
9 American Hospital Formulary Service-Drug Infor-
10 mation, the American Medical Association Drug
11 Evaluations, the United States Pharmacopoeia-Drug
12 Information, and other authoritative compendia as
13 identified by the Secretary, unless the Secretary has
14 determined that the use is not medically appropriate
15 or the use is identified as not indicated in one or
16 more such compendia, or

17 ''(ii) the carrier involved determines, based
18 upon guidance provided by the Secretary to carriers
19 for determining accepted uses of drugs, that such
20 use is medically accepted based on supportive clinical
21 evidence in peer reviewed medical literature appear-
22 ing in publications which have been identified for
23 purposes of this clause by the Secretary.

1 The Secretary may revise the list of compendia in sub-
2 paragraph (B)(i) designated as appropriate for identifying
3 medically accepted indications for drugs.

4 "(5)(A) For purposes of this subsection, the term
5 'covered home infusion drug' means a covered outpatient
6 drug dispensed to an individual that—

7 "(i) is administered intravenously,
8 subcutaneously, or epidurally, using an access device
9 that is inserted into the body and an infusion device
10 to control the rate of flow of the drug (or through
11 other means of administration determined by the
12 Secretary);

13 "(ii) is administered—

14 "(I) in the individual's home,

15 "(II) in an institution used as the individ-
16 ual's home, but only if the drug is administered
17 during an inpatient day for which payment is
18 not made to the institution under part A for in-
19 patient or extended care services furnished to
20 the individual, or

21 "(III) in a facility other than the individ-
22 ual's home if the administration of the drug at
23 the facility is determined by the Secretary to be
24 cost-effective (in accordance with such criteria
25 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 "(1) DEDUCTIBLE.—

2 "(A) IN GENERAL.—Payment shall be
3 made under paragraph (2) only for expenses in-
4 curred by an individual for a covered outpatient
5 drug during a calendar year after the individual
6 has incurred expenses in the year for such
7 drugs (during a period in which the individual
8 is entitled to benefits under this part) equal to
9 the deductible amount for that year.

10 "(B) DEDUCTIBLE AMOUNT.—

11 "(i) For purposes of subparagraph
12 (A), the deductible amount is—

13 "(I) for 1999, an amount equal
14 to the amount determined under
15 clause (ii)(I);

16 "(II) for 2000, the amount
17 (rounded to the nearest dollar) that
18 the Secretary estimates will ensure
19 that the percentage of individuals cov-
20 ered under this part (other than indi-
21 viduals enrolled with an eligible orga-
22 nization under section 1876, an orga-
23 nization described in section
24 1833(a)(1)(A), or a medicare drug
25 benefit plan under section 1851) dur-

1 ing the year who will incur expenses
2 for covered outpatient drugs equal to
3 or greater than such amount will be
4 the same as the percentage for the
5 previous year;
6 "(III) for 2001, an amount equal
7 to the amount determined under
8 clause (ii)(II); and
9 "(IV) for any succeeding year,
10 the amount (rounded to the nearest
11 dollar) that the Secretary estimates
12 will ensure that the percentage of in-
13 dividuals covered under this part
14 (other than individuals enrolled with
15 an eligible organization under section
16 1876, an organization described in
17 section 1833(a)(1)(A), or a medicare
18 drug benefit plan under section 1851)
19 during the year who will incur ex-
20 penses for covered outpatient drugs
21 equal to or greater than such amount
22 will be the same as the percentage for
23 the previous year.
24 "(ii) For purposes of clause (i), the
25 amount determined under this clause is—

1 "(I) in 1999, an amount deter-
2 mined by the Secretary such that the
3 amount so determined will result in
4 projected incurred spending and ad-
5 ministrative costs (net of projected re-
6 bates under section 1851 and any
7 portion of the part B premium attrib-
8 utable to the covered outpatient drug
9 benefit) for providing payment under
10 this title for covered outpatient drugs
11 that would be equal to a spending tar-
12 get equal to $13,500,000,000; and
13 "(II) in 2001, an amount deter-
14 mined by the Secretary (based on ac-
15 tual experience) that the Secretary es-
16 timates will ensure that the percent-
17 age of individuals covered under this
18 part (other than individuals enrolled
19 with an eligible organization under
20 section 1876, an organization de-
21 scribed in section 1833(a)(1)(A), or a
22 medicare drug benefit plan under sec-
23 tion 1851) during the year who will
24 incur expenses for covered outpatient
25 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 coun-
10 seling individuals to whom covered out-
11 patient drugs are prescribed; and
12 "(iii) identify (and to educate physi-
13 cians, patients, and pharmacists con-
14 cerning)—
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.

1 "(B) PROSPECTIVE REVIEW.—

2 "(i) IN GENERAL.—The program
3 under this paragraph shall provide for on-
4 line prospective review of each covered out-
5 patient drug prescribed for a patient be-
6 fore the prescription is filled or the drug is
7 furnished, including screening for potential
8 drug therapy problems due to therapeutic
9 duplication, drug-to-drug interactions, and
10 incorrect drug dosage or duration of drug
11 treatment.

12 "(ii) DISCUSSION OF APPROPRIATE
13 USE.—In conducting prospective review
14 under this subparagraph, any individual or
15 entity that dispenses a covered outpatient
16 drug shall offer to discuss with the patient
17 to whom the drug is furnished or the pa-
18 tient's caregiver (in person if practicable,
19 or through access to a toll-free telephone
20 service) information regarding the appro-
21 priate use of the drug, potential inter-
22 actions between the drug and other drugs
23 dispensed to the individual, and such other
24 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.

1 "(ii) PRIOR AUTHORIZATION FOR
2 DRUGS ON LIST.—The Secretary shall es-
3 tablish a process under which (subject to
4 clause (iii)) the Secretary may require ad-
5 vance approval for any covered outpatient
6 drug included on the list developed under
7 clause (i).
8 "(iii) RESTRICTIONS ON DENIAL OF
9 APPROVAL.—The Secretary may not deny
10 the approval of a drug under the process
11 established under clause (ii) before its dis-
12 pensing unless the process—
13 "(I) provides responses by tele-
14 phone or other telecommunication de-
15 vice within 24 hours of a request for
16 prior authorization; and
17 "(II) provides for the dispensing
18 of at least a 72-hour supply of a cov-
19 ered outpatient prescription drug in
20 emergency situations (as defined by
21 the Secretary).
22 "(iv) EXPANSION TO OTHER
23 DRUGS.—If the rate of growth of payments
24 under this part for covered outpatient
25 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

1 under the State medicaid program under sec-
2 tion 1927.
3 "(8) BILLING REQUIREMENTS.—
4 "(A) MANDATORY ASSIGNMENT.—(i) Pay-
5 ment under this part for a covered outpatient
6 drug may only be made on an assignment-re-
7 lated basis.
8 "(ii) Except for deductible, coinsurance, or
9 copayment amounts applicable under this part,
10 no person may bill or collect any amount from
11 an individual enrolled under this part or other
12 person for a covered outpatient drug for which
13 payment may be made under this part, and no
14 such individual or person is liable for payment
15 of any amounts billed in violation of this clause.
16 If a person knowingly and willfully bills or col-
17 lects an amount in violation of the previous sen-
18 tence, the Secretary may apply sanctions
19 against such person in accordance with section
20 1842(j)(2). Paragraph (4) of section 1842(j)
21 shall apply in this clause in the same manner
22 as such paragraph applies to such section.
23 "(B) USE OF ELECTRONIC SYSTEM.—The
24 Secretary shall establish, by not later than Jan-
25 uary 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

1 carriers under this section to perform the activities on a
2 regional basis.''.
3 (2) ADDITIONAL FUNCTIONS.—Section
4 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—
5 (A) by striking ''and'' at the end of sub-
6 paragraph (H);
7 (B) by adding ''and'' at the end of sub-
8 paragraph (L);
9 (C) by redesignating subparagraph (L) as
10 subparagraph (I); and
11 (D) by inserting after subparagraph (I) (as
12 so redesignated) the following new subpara-
13 graphs:
14 ''(J) if it makes determinations or payments
15 with respect to covered outpatient drugs, will—
16 ''(i) receive information transmitted under
17 the electronic system established under section
18 1834(d)(8)(B), and
19 ''(ii) respond to requests by pharmacies
20 (and individuals entitled to benefits under this
21 part) as to whether or not such an individual
22 has met the prescription drug deductible estab-
23 lished under section 1834(d)(1)(A) for a year;
24 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-

1 ments of subsection (b), and an agreement to give equal
2 access to discounts in accordance with subsection (e).
3 "(b) TERMS, IMPLEMENTATION, AND ENFORCEMENT
4 OF REBATE AGREEMENT.—
5 "(1) PERIODIC REBATES.—
6 "(A) IN GENERAL.—A rebate agreement
7 under this section shall require the manufac-
8 turer to pay to the Secretary for each calendar
9 quarter, not later than 30 days after the date
10 of receipt of the information described in para-
11 graph (2) for such quarter, a rebate in an
12 amount determined under subsection (c) for all
13 covered outpatient drugs of the manufacturer
14 described in subparagraph (B).
15 "(B) DRUGS INCLUDED IN QUARTERLY
16 REBATE CALCULATION.—Drugs subject to re-
17 bate with respect to a calendar quarter are
18 drugs which are dispensed or provided during
19 such quarter to individuals (other than individ-
20 uals enrolled with an entity with a contract
21 under section 1876 or a medicare drug benefit
22 plan with a contract under section 1851) eligi-
23 ble for benefits under this part, as reported to
24 the Secretary.

1 "(2) INFORMATION FURNISHED TO MANUFAC-
2 TURERS.—
3 "(A) IN GENERAL.—The Secretary shall
4 report to each manufacturer, not later than 60
5 days after the end of each calendar quarter, in-
6 formation on the total number, for each covered
7 outpatient drug, of units of each dosage form,
8 strength, and package size dispensed or pro-
9 vided under the plan during the quarter, on the
10 basis of the data reported to the Secretary de-
11 scribed in paragraph (1)(B).
12 "(B) AUDIT.—The Comptroller General
13 may audit the records of the Secretary to the
14 extent necessary to determine the accuracy of
15 reports by the Secretary pursuant to subpara-
16 graph (A). Adjustments to rebates shall be
17 made to the extent determined necessary by the
18 audit to reflect actual units of drugs dispensed.
19 "(3) PROVISION OF PRICE INFORMATION BY
20 MANUFACTURER.—
21 "(A) QUARTERLY PRICING INFORMA-
22 TION.—Each manufacturer with an agreement
23 in effect under this section shall report to the
24 Secretary, not later than 30 days after the last
25 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—

1 "(A) the total number of units subject to
2 rebate for such quarter, as described in sub-
3 section (b)(1)(B), multiplied by
4 "(B) the amount, if any, by which the av-
5 erage manufacturer retail price for such drugs
6 of the manufacturer exceeds the average manu-
7 facturer retail price for the base quarter, in-
8 creased by the percentage increase in the Con-
9 sumer Price Index for all urban consumers
10 (U.S. average) from the end of such base quar-
11 ter to the month before the beginning of such
12 calendar quarter.
13 "(3) DEPOSIT OF REBATES.—The Secretary
14 shall deposit rebates under this section in the Fed-
15 eral Supplementary Medical Insurance Trust Fund
16 established under section 1841.
17 "(4) APPLICABLE PERCENT.—
18 "(A) NONINNOVATOR MULTIPLE SOURCE
19 DRUG.—
20 "(i) IN GENERAL.—For purposes of
21 this subparagraph, the Secretary may de-
22 velop and implement a sliding scale to de-
23 termine the applicable percent for rebates
24 based on the relationship between the aver-
25 age manufacturer retail price of the non-

1 innovator-multiple source drug furnished
2 over-the-counter and the average manufac-
3 turer retail price of the equivalent inno-
4 vator drug (except as provided in subpara-
5 graph (B)) .
6 "(ii) SLIDING SCALE DESCRIBED.—
7 The sliding scale developed by the Sec-
8 retary under clause (i) shall—
9 "(I) require that the applicable
10 percent be not less than 2 percent and
11 not be greater than 15 percent; and
12 "(II) ensure that the total level
13 of rebates collected under such a slid-
14 ing scale would be equivalent to a flat
15 6 percent rebate on such drugs.
16 "(B) ENTERAL NUTRIENTS AND INSU-
17 LIN.—For purposes of this subparagraph, the
18 applicable percent for enteral nutrients and in-
19 sulin under the sliding scale would be equal to
20 6 percent.
21 "(d) CONFIDENTIALITY OF INFORMATION.—Notwith-
22 standing any other provision of law, information disclosed
23 by a manufacturer under this section is confidential and
24 shall not be disclosed by the Secretary (or a carrier), ex-
25 cept—

1 "(A) as the Secretary determines to be nec-
2 essary to carry out this section,
3 "(B) to permit the Comptroller General to re-
4 view the information provided, and
5 "(C) to permit the Director of the Congres-
6 sional Budget Office to review the information pro-
7 vided.
8 "(e) DEFINITIONS.—For purposes of this section—
9 "(1) AVERAGE MANUFACTURER RETAIL
10 PRICE.—The term 'average manufacturer retail
11 price' means, with respect to a covered outpatient
12 drug of a manufacturer for a calendar quarter, the
13 average price (inclusive of discounts for cash pay-
14 ment, prompt payment, volume purchases, and re-
15 bates (other than rebates under this section), but ex-
16 clusive of nominal prices) paid to the manufacturer
17 for the drug in the United States for drugs distrib-
18 uted to the retail pharmacy class of trade.
19 "(2) AVERAGE MANUFACTURER NON-RETAIL
20 PRICE.—The term 'average manufacturer non-retail
21 price' means, with respect to a covered outpatient
22 drug of a manufacturer for a calendar quarter, the
23 weighted average price (inclusive of discounts for
24 cash payment, prompt payment, volume purchases,
25 and rebates (other than rebates under this section),

1 but exclusive of nominal prices) paid to the manu-
2 facturer for the drug in the United States by hos-
3 pitals and other institutional purchasers that pur-
4 chase drugs for institutional use and not for resale.
5 ''(3) BASE QUARTER.—The term 'base quarter'
6 means, with respect to a covered outpatient drug of
7 a manufacturer, the calendar quarter beginning
8 April 1, 1993, or (if later) the first full calendar
9 quarter during which the drug was marketed in the
10 United States.
11 ''(4) DRUG.—The terms 'innovator multiple
12 source drug', 'noninnovator multiple source drug',
13 and 'single source drug' have the meanings given
14 those terms under section 1927(k)(7), except that
15 the reference in such section to a 'covered outpatient
16 drug' shall be considered a reference to a covered
17 outpatient drug under this part.
18 ''(5) MANUFACTURER.—The term 'manufac-
19 turer' means, with respect to a covered outpatient
20 drug—
21 ''(A) the entity whose National Drug Code
22 number (as issued pursuant to section 510(e) of
23 the Federal Food, Drug, and Cosmetic Act) ap-
24 pears 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:

1 "PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

2 "SEC. 1847. (a)(1) The Director of the Congressional
3 Office of Technology Assessment (in this section referred
4 to as the 'Director' and the 'Office', respectively) shall
5 provide for the appointment of a Prescription Drug Pay-
6 ment Review Commission (in this section referred to as
7 the 'Commission'), to be composed of individuals with ex-
8 pertise in the provision and financing of covered out-
9 patient drugs appointed by the Director (without regard
10 to the provisions of title 5, United States Code, governing
11 appointments in the competitive service).

12 "(2) The Commission shall consist of 11 individuals.
13 Members of the Commission shall first be appointed by
14 no later than January 1, 1996, for a term of 3 years, ex-
15 cept that the Director may provide initially for such short-
16 er terms as will insure that (on a continuing basis) the
17 terms of no more than 4 members expire in any one year.

18 "(3) The membership of the Commission shall in-
19 clude recognized experts in the fields of health care eco-
20 nomics, medicine, pharmacology, pharmacy, and prescrip-
21 tion drug reimbursement, as well as at least one individual
22 who is a medicare beneficiary, one individual representing
23 a research-based pharmaceutical company, and one indi-
24 vidual representing a biotechnology company.

1 "(b)(1) The Commission shall submit to Congress an
2 annual report no later than May 1 of each year, beginning
3 with 1997—
4 "(A) concerning the implementation and
5 the operation of the coverage of covered out-
6 patient drugs under this part, including rec-
7 ommendations to Congress on changes to the
8 program to improve access to prescription
9 drugs, the quality of prescription drug care, and
10 program efficiencies;
11 "(B) reviewing the process of contracting
12 with medicare drug benefits plans under section
13 1851;
14 "(C) concerning the fiscal soundness of the
15 furnishing of covered outpatient drugs under
16 this part;
17 "(D) concerning the appropriateness, fair-
18 ness and effectiveness of the rebate structure
19 under section 1850; and
20 "(E) concerning the advisability of devel-
21 oping a review process to exempt small manu-
22 facturers of single source or innovator multiple
23 source drugs from rebates under section 1850
24 based on the manufacturer's sales and the his-
25 toric pricing of the manufacturer's products.

1 "(c) Section 1845(c)(1) shall apply to the Commis-
2 sion in the same manner as it applies to the Physician
3 Payment Review Commission.
4 "(d) There are authorized to be appropriated such
5 sums as may be necessary to carry out the provisions of
6 this section. Such sums shall be payable from the Federal
7 Supplementary Medical Insurance Trust Fund.".

8 **SEC. 2005. COVERAGE OF HOME INFUSION DRUG THERAPY**
9 **SERVICES.**

10 (a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C.
11 1395k(a)(2)(A)) is amended by inserting "and home infu-
12 sion drug therapy services" before the semicolon.
13 (b) HOME INFUSION DRUG THERAPY SERVICES DE-
14 FINED.—Section 1861 (42 U.S.C. 1395x) is amended—
15 (1) by redesignating the subsection (jj) inserted
16 by section 4156(a)(2) of the Omnibus Budget Rec-
17 onciliation Act of 1990 as subsection (kk); and
18 (2) by inserting after such subsection the fol-
19 lowing new subsection:
20 "Home Infusion Drug Therapy Services
21 "(ll)(1) The term 'home infusion drug therapy serv-
22 ices' means the items and services described in paragraph
23 (2) furnished to an individual who is under the care of
24 a physician—

1 "(A) in a setting described in subsection
2 (t)(5)(A)(ii),
3 "(B) by a qualified home infusion drug therapy
4 provider (as defined in paragraph (3)) or by others
5 under arrangements with them made by that pro-
6 vider, and
7 "(C) under a plan established and periodically
8 reviewed by a physician.
9 "(2) The items and services described in this para-
10 graph are such nursing, pharmacy, and related services
11 (including medical supplies, intravenous fluids, delivery,
12 and equipment) as are necessary to conduct safely and ef-
13 fectively a drug regimen through use of a covered home
14 infusion drug (as defined in subsection (t)(5)), but do not
15 include such covered home infusion drugs.
16 "(3) The term 'qualified home infusion drug therapy
17 provider' means any entity that the Secretary determines
18 meets the following requirements (or, in the case of a
19 home health agency or an entity with respect to which the
20 only items and services described in paragraph (2) fur-
21 nished by the entity are enteral nutrition therapy services,
22 meets any of the following requirements which the Sec-
23 retary considers appropriate):
24 "(A) The entity is capable of providing nursing
25 or pharmacy services and providing or arranging for

1 the other items and services described in paragraph
2 (2) and covered home infusion drugs.
3 ''(B) The entity maintains clinical records on
4 all patients.
5 ''(C) The entity adheres to written protocols
6 and policies with respect to the provision of items
7 and services.
8 ''(D) The entity makes services available (as
9 needed) seven days a week on a 24-hour basis.
10 ''(E) The entity coordinates all services with
11 the patient's physician.
12 ''(F) The entity conducts a quality assessment
13 and assurance program, including drug regimen re-
14 view and coordination of patient care.
15 ''(G) The entity assures that only trained per-
16 sonnel provide covered home infusion drugs (and any
17 other service for which training is required to pro-
18 vide the service safely).
19 ''(H) The entity assumes responsibility for the
20 quality of services provided by others under arrange-
21 ments with the entity.
22 ''(I) In the case of an entity in any State in
23 which State or applicable local law provides for the
24 licensing of entities of this nature, the entity (i) is
25 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

1 furnished by a provider of services to avoid du-
2 plicative payments under this title for the serv-
3 ice costs associated with such services.''.
4 (d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C.
5 1395n(a)(2)) is amended—
6 (1) by striking ''and'' at the end of subpara-
7 graph (E),
8 (2) by striking the period at the end of sub-
9 paragraph (F) and inserting ''; and'', and
10 (3) by inserting after subparagraph (F) the fol-
11 lowing:
12 ''(G) in the case of home infusion drug
13 therapy services, (i) such services are or were
14 required because the individual needed such
15 services for the administration of a covered
16 home infusion drug, (ii) a plan for furnishing
17 such services has been established and is re-
18 viewed periodically by a physician, and (iii)
19 such services are or were furnished while the in-
20 dividual is or was under the care of a physi-
21 cian.''.
22 (e) CERTIFICATION OF HOME INFUSION DRUG
23 THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR
24 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.

1 "(B) SOURCE OF PAYMENT.—The payment
2 to a medicare drug benefit plan under this sec-
3 tion for individuals enrolled under this section
4 with the plan and entitled to benefits under
5 part A and enrolled under part B shall be made
6 from the Federal Supplementary Medical Insur-
7 ance Trust Fund.
8 "(5) DEFINITIONS.—
9 "(A) SERVICE AREA.—The term 'health
10 plan service area' means a health plan service
11 area designated by the State under section
12 1502(d) of the Health Security Act.
13 "(B) CERTIFIED STANDARD HEALTH
14 PLAN.—The term 'certified standard health
15 plan' has the meaning given such term in sec-
16 tion 1011(2) of the Health Security Act.
17 "(b) PAYMENT RULES UNDER CONTRACTS.—
18 "(1) IN GENERAL.—
19 "(A) PAYMENTS.—With respect to any cal-
20 endar year, each medicare drug benefit plan
21 with a contract under this section shall receive
22 a payment under this title with respect to each
23 individual enrolled with the plan for each month
24 such individual is enrolled equal to the applica-
25 ble 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

1 intends to charge for individuals en-
2 rolled under this section with the
3 plan.
4 "(II) PREMIUM FOR SUPPLE-
5 MENTAL PLAN.—A statement of the
6 fixed monthly premium amount that
7 the plan intends to charge for each
8 supplemental plan offering additional
9 cost-sharing benefits.
10 "(ii) NOTICE BEFORE BID SUBMIS-
11 SIONS.—At least 45 days before the date
12 for submitting bids under clause (i) for a
13 year, the Secretary shall provide for notice
14 to medicare drug benefit plans of—
15 "(I) proposed changes to be
16 made in the methodology or benefit
17 coverage assumptions from the meth-
18 odology and assumptions used in the
19 previous calendar year and shall pro-
20 vide such plans an opportunity to
21 comment on such proposed changes;
22 "(II) the applicable monthly per-
23 centage for each month of the cal-
24 endar year as determined by the Sec-
25 retary 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-

1 mium amount submitted under para-
2 graph (2)(C)(i)(I); or
3 ''(II) the applicable monthly per-
4 centage of the amount described in
5 subsection (b)(1)(A).
6 ''(ii) SUPPLEMENTAL PLAN.—
7 ''(I) IN GENERAL.—Each medi-
8 care drug benefit plan with a contract
9 under this section must provide to in-
10 dividuals enrolled with the plan under
11 this section, for the duration of such
12 enrollment during each contract pe-
13 riod, a fixed monthly premium for the
14 supplemental plan described in para-
15 graph (2)(C)(i)(II) equal to the pre-
16 mium amount determined by the plan
17 under such paragraph. An individual
18 that elects to enroll in the supple-
19 mental plan shall be responsible for
20 paying to the plan the fixed monthly
21 premium amount described in the pre-
22 ceding sentence.
23 ''(II) PAYMENT GREATER THAN
24 FIXED MONTHLY PREMIUM.—If, with
25 respect to any individual enrolled in a

1 medicare drug benefit plan with a
2 contract under this section, the
3 amount paid to the plan under sub-
4 section (b)(1)(A) exceeds the applica-
5 ble monthly percentage of the uniform
6 annual premium amount submitted
7 under paragraph (2)(C)(i)(I), the plan
8 shall apply such excess to a premium
9 for any supplemental policy described
10 in paragraph (2)(C)(ii) that the indi-
11 vidual may elect. If the individual
12 does not elect such a policy, the medi-
13 care drug benefit plan shall pay such
14 excess to the Secretary for deposit in
15 the Federal Supplementary Medical
16 Insurance Trust Fund.
17 ''(B) MONTHLY PAYMENTS.—
18 ''(i) IN GENERAL.—The Secretary
19 shall make monthly payments in advance
20 and in accordance with the rate deter-
21 mined under paragraph (1)(A) to each
22 medicare drug benefit plan with a contract
23 under this section for each individual en-
24 rolled 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).

1 "(2) PROVISION OF MEDICALLY NECESSARY
2 CARE.—Each medicare drug benefit plan with a con-
3 tract under this section must—
4 "(A) make the covered outpatient drugs
5 described in paragraph (1)—
6 "(i) available and accessible to en-
7 rolled individuals within the State with
8 reasonable promptness and in a manner
9 which assures continuity, and
10 "(ii) when medically necessary, avail-
11 able and accessible twenty-four hours a
12 day and seven days a week, and
13 "(B) provide for reimbursement with re-
14 spect to drugs which are described in subpara-
15 graph (A) and which are provided to such an
16 individual other than through the plan, if—
17 "(i) the drugs were medically nec-
18 essary and immediately required because of
19 an unforeseen illness, injury, or condition,
20 and
21 "(ii) it was not reasonable given the
22 circumstances to obtain the drugs through
23 the plan.
24 "(3) COST-SHARING.—Each medicare drug ben-
25 efit plan with a contract under this section must

1 provide to individuals enrolled under this section
2 with respect to the drugs described in paragraph
3 (1), cost-sharing requirements that are the same as
4 the cost-sharing requirements for covered outpatient
5 drug under section 1834, except that the deductible
6 for a medicare drug benefit plan shall be reduced by
7 an amount determined by the Secretary such that
8 the cost-sharing of the plan is equal to 95 percent
9 of the actuarial value of the cost sharing require-
10 ments under section 1834.

11 "(4) COST-SHARING FOR SUPPLEMENTAL
12 PLANS.—A supplemental plan may not have cost-
13 sharing that applies differential cost-sharing based
14 on the therapeutic class of drug prescribed or other
15 cost-sharing structures that the Secretary deter-
16 mines would be likely to discourage enrollment by in-
17 dividuals with medical conditions that require exten-
18 sive use of prescription drugs.

19 "(5) ACTUARIAL EQUIVALENCE OF STANDARD
20 PLAN AND SUPPLEMENTAL PLAN.—The premium
21 charged to an individual enrolled under this section
22 for a supplemental policy that eliminates or reduces
23 the cost-sharing requirement imposed on such indi-
24 vidual and the actuarial value of any remaining cost-
25 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

1 drugs and that it will notify each individual of such
2 fact at the time of the individual's enrollment.
3 "(4) NOTICE OF RIGHTS, ETC.—Each medicare
4 drug benefit plan with a contract under this section
5 shall provide each enrollee, at the time of enrollment
6 and not less frequently than annually thereafter, an
7 explanation of the enrollee's rights under this sec-
8 tion, including an explanation of—
9 "(A) the enrollee's rights to benefits from
10 the plan,
11 "(B) the restrictions on payments under
12 this title for covered outpatient drugs furnished
13 other than by or through the plan,
14 "(C) out-of-plan coverage provided by the
15 plan, and
16 "(D) appeal rights of enrollees.
17 "(f) MEMBERSHIP REQUIREMENTS.—
18 "(1) NON-MEDICARE REQUIREMENT.—
19 "(A) IN GENERAL.—Each entity with a
20 contract under this section shall provide at that
21 at least 1/2 of the individuals who are provided
22 with drug coverage by the entity are individuals
23 who are not enrolled in a medicare drug benefit
24 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

1 plan of the United States or a State, under an auto-
2 mobile or liability insurance policy or plan, including
3 a self-insured plan, under no fault insurance, or
4 under a primary plan (as defined in section
5 1862(b)(2)(A)) charge or authorize the provider of
6 such services to charge, in accordance with the
7 charges allowed under such law or policy—
8 "(A) the insurance carrier, employer, or
9 other entity which under such law, plan, or pol-
10 icy is to pay for the provision of such services,
11 or
12 "(B) such enrollee to the extent that the
13 enrollee has been paid under such law, plan, or
14 policy for such services.
15 "(2) PROMPT PAYMENT REQUIREMENT.—
16 "(A) IN GENERAL.—A contract under this
17 section shall require the medicare drug benefit
18 plan to provide prompt payment (consistent
19 with the provisions of section 1842(c)(4)) of
20 claims submitted for covered outpatient drugs
21 furnished to individuals pursuant to such con-
22 tract, if the drugs are not furnished under a
23 contract between the plan and the provider or
24 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—

1 "(I) the quality, appropriateness,
2 and timeliness of drugs provided
3 under the contract, and
4 "(II) the facilities of the organi-
5 zation when there is reasonable evi-
6 dence of some need for such inspec-
7 tion, and
8 "(ii) shall have the right to audit and
9 inspect any books and records of the medi-
10 care drug benefit plan that pertain—
11 "(I) to the ability of the plan to
12 bear the risk of potential financial
13 losses, or
14 "(II) to drugs provided or deter-
15 minations of amounts payable under
16 the contract;
17 "(B) shall require the plan with a contract
18 to provide (and pay for) written notice in ad-
19 vance of the contract's termination, as well as
20 a description of alternatives for obtaining bene-
21 fits under this title, to each individual enrolled
22 under this section with the plan;
23 "(C)(i) shall require the plan to comply
24 with subsections (a) and (c) of section 1318 of
25 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;

1 "(iii) acts to expel or to refuse to re-
2 enroll an individual in violation of the pro-
3 visions of this section;
4 "(iv) engages in any practice that
5 would reasonably be expected to have the
6 effect of denying or discouraging enroll-
7 ment (except as permitted by this section)
8 by eligible individuals with the plan whose
9 medical condition or history indicates a
10 need for substantial future covered out-
11 patient drugs;
12 "(v) misrepresents or falsifies infor-
13 mation that is furnished—
14 "(I) to the Secretary under this
15 section, or
16 "(II) to an individual or to any
17 other entity under this section;
18 "(vi) employs or contracts with any
19 individual or entity that is excluded from
20 participation under this title under section
21 1128 or 1128A for the provision of health
22 care, utilization review, medical social
23 work, or administrative services or employs
24 or contracts with any entity for the provi-
25 sion (directly or indirectly) through such

1 an excluded individual or entity of such
2 services;
3 the Secretary may provide, in addition to any
4 other remedies authorized by law, for any of the
5 remedies described in subparagraph (B).
6 ''(B) REMEDIES.—The remedies described
7 in this subparagraph are—
8 ''(i) civil money penalties of not more
9 than $25,000 for each determination under
10 subparagraph (A) or, with respect to a de-
11 termination under clause (iv) or (v)(I) of
12 such subparagraph, of not more than
13 $100,000 for each such determination,
14 plus, with respect to a determination under
15 subparagraph (A)(ii), double the excess
16 amount charged in violation of such sub-
17 paragraph (and the excess amount charged
18 shall be deducted from the penalty and re-
19 turned to the individual concerned), and
20 plus, with respect to a determination under
21 subparagraph (A)(iv), $15,000 for each in-
22 dividual not enrolled as a result of the
23 practice involved,
24 ''(ii) suspension of enrollment of indi-
25 viduals 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

1 plan provides health care services) and individuals
2 enrolled with the plan under this section.
3 "(2) APPEALS.—An individual enrolled with a
4 medicare drug benefit plan under this section who is
5 dissatisfied by reason of the individual's failure to
6 receive any covered outpatient drug to which the in-
7 dividual believes the individual is entitled and at no
8 greater charge than the individual believes the indi-
9 vidual is required to pay is entitled, if the amount
10 in controversy is $100 or more, to a hearing before
11 the Secretary to the same extent as is provided in
12 section 205(b), and in any such hearing the Sec-
13 retary shall make the plan a party. If the amount
14 in controversy is $1,000 or more, the individual or
15 plan shall, upon notifying the other party, be enti-
16 tled to judicial review of the Secretary's final deci-
17 sion as provided in section 205(g), and both the in-
18 dividual and the plan shall be entitled to be parties
19 to that judicial review.
20 "(3) ADDITIONAL REQUIREMENTS.—Not later
21 then January 1, 1998, the Secretary shall establish
22 standards for additional requirements for medicare
23 drug benefit plans with contracts under this section,
24 that to the extent possible are consistent with the
25 standards relating to eligible organizations that have

1 entered into risk contracts under section 1876, and
2 which provide that a medicare drug benefit plan—
3 "(A) must demonstrate financial solvency;
4 "(B) must demonstrate the ability to pro-
5 vide benefits to all potential enrollees through-
6 out the State served by the plan;
7 "(C) must not engage in marketing or
8 other practices designed to discourage or limit
9 the issuance of a medicare outpatient drug cov-
10 erage plan to any potential enrollee on the basis
11 of health status, claims experience, medical his-
12 tory, or other factors that are generally related
13 to utilization of covered outpatient drugs;
14 "(D) must inform individuals eligible to
15 enroll with the plan about the plan only in ac-
16 cordance with procedures and conditions deter-
17 mined by the Secretary and may not distribute
18 promotional or informational material unless—
19 "(i) at least 45 days before its dis-
20 tribution, the plan has submitted the mate-
21 rial to the Secretary for review,
22 "(ii) the material is made available to
23 all individuals eligible to enroll in the plan
24 in the State served by the plan, and

1 "(iii) the Secretary has not dis-
2 approved the distribution of the material
3 due to a determination that in the Sec-
4 retary's discretion, the material is materi-
5 ally inaccurate or misleading or otherwise
6 makes a material misrepresentation;
7 "(E) must provide convenient access to
8 pharmacies for individuals in each zip code re-
9 gion of the State taking into account the special
10 needs of individuals who are enrolled in part B;
11 "(F) in addition to the access described in
12 subparagraph (E), may provide enrollees with a
13 mail-order pharmacy option;
14 "(G) may establish a formulary system (to
15 be maintained throughout the 1-year contract
16 period) which ensures that—
17 "(i) the formulary shall cover at least
18 one covered outpatient drug in each thera-
19 peutic class of drugs representing a unique
20 mechanism of action (as defined by the
21 Secretary); and
22 "(ii) that any covered outpatient drug
23 excluded by the formulary is subject to a
24 prior authorization process in which the
25 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-

1 nity-based services for individuals with disabilities must
2 meet the following requirements:
3 (1) STATE MAINTENANCE OF EFFORT.—
4 (A) IN GENERAL.—A State plan under this
5 subtitle shall provide that the State will, during
6 any fiscal year that the State is furnishing serv-
7 ices under this subtitle, make expenditures of
8 State funds in an amount equal to the State
9 maintenance of effort amount for the year de-
10 termined under subparagraph (B) for fur-
11 nishing the services described in subparagraph
12 (C) under the State plan under this subtitle
13 and the State plan under title XIX of the Social
14 Security Act.
15 (B) STATE MAINTENANCE OF EFFORT
16 AMOUNT.—
17 (i) IN GENERAL.—The maintenance of
18 effort amount for a State for a fiscal year
19 is an amount equal to—
20 (I) for fiscal year 1998, the base
21 amount for the State (as determined
22 under clause (ii)) updated through the
23 midpoint of fiscal year 1998 by the
24 estimated percentage change in the
25 consumer price index during the pe-

1 riod beginning on October 1, 1994
2 and ending at that midpoint; and
3 (II) for succeeding fiscal years,
4 an amount equal to the amount deter-
5 mined under this clause for the pre-
6 vious fiscal year updated through the
7 midpoint of the year by the estimated
8 percentage change in the consumer
9 price index during the 12-month pe-
10 riod ending at that midpoint, with ap-
11 propriate adjustments to reflect pre-
12 vious underestimations or overesti-
13 mations under this clause in the pro-
14 jected percentage change in the con-
15 sumer price index.
16 (ii) STATE BASE AMOUNT.—The base
17 amount for a State is an amount equal to
18 the total expenditures from State funds
19 made under the State plan under title XIX
20 of the Social Security Act during fiscal
21 year 1994 with respect to medical assist-
22 ance consisting of the services described in
23 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.

1 (C) INITIAL SCREENING.—The plan shall
2 provide a process for the initial screening of an
3 individual who appears to have some reasonable
4 likelihood of being an individual with disabil-
5 ities. Any such process shall require the provi-
6 sion of assistance to individuals who wish to
7 apply but whose disability limits their ability to
8 apply. The initial screening and the determina-
9 tion of disability (as defined under section
10 2103(b)(1)) shall be conducted by a public
11 agency.
12 (D) RESTRICTIONS.—The plan may not
13 limit the eligibility of individuals with disabil-
14 ities based on—
15 (i) income,
16 (ii) age,
17 (iii) residential setting (other than an
18 institutional setting), or
19 (iv) other grounds specified by the
20 Secretary.
21 (E) CONTINUATION OF SERVICES.—The
22 plan must provide assurances that, in the case
23 of an individual receiving medical assistance for
24 home and community-based services under the
25 State medicaid plan under title XIX of the So-

1 cial Security Act as of the date a State's plan
2 is approved under this subtitle, the State will
3 continue to make available (either under this
4 plan, under the State medicaid plan, or other-
5 wise) to such individual an appropriate level of
6 assistance for home and community-based serv-
7 ices, taking into account the level of assistance
8 provided as of such date and the individual's
9 need for home and community-based services.
10 (3) SERVICES.—
11 (A) NEEDS ASSESSMENT.—Not later than
12 the end of the second year of implementation,
13 the plan or its amendments shall include the re-
14 sults of a statewide assessment of the needs of
15 individuals with disabilities in a format required
16 by the Secretary. The needs assessment shall
17 include demographic data concerning the num-
18 ber of individuals within each category of dis-
19 ability described in this subtitle, and the serv-
20 ices available to meet the needs of such individ-
21 uals.
22 (B) SPECIFICATION.—Consistent with sec-
23 tion 2104, the plan shall specify—
24 (i) the services made available under
25 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.

1 (6) PROVIDER REIMBURSEMENT.—

2 (A) PAYMENT METHODS.—The plan shall
3 specify the payment methods to be used to re-
4 imburse providers for services furnished under
5 the plan. Such methods may include retrospec-
6 tive reimbursement on a fee-for-service basis,
7 prepayment on a capitation basis, payment by
8 cash or vouchers to individuals with disabilities,
9 or any combination of these methods. In the
10 case of payment to consumer-directed providers
11 of personal assistance services, including pay-
12 ment through the use of cash or vouchers, the
13 plan shall specify how the plan will assure com-
14 pliance with applicable employment tax and
15 health care coverage provisions.

16 (B) PAYMENT RATES.—The plan shall
17 specify the methods and criteria to be used to
18 set payment rates for—

19 (i) agency administered services fur-
20 nished under the plan; and

21 (ii) consumer-directed personal assist-
22 ance services furnished under the plan, in-
23 cluding cash payments or vouchers to indi-
24 viduals with disabilities, except that such
25 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-

1 dition of its approval effective with that fiscal year. Any
2 significant changes to the State plan shall be submitted
3 to the Secretary in the form of plan amendments and shall
4 be subject to approval by the Secretary.

5 (c) MONITORING.—The Secretary shall annually
6 monitor the compliance of State plans with the require-
7 ments of this subtitle according to specified performance
8 standards. In accordance with section 2108(e), States that
9 fail to comply with such requirements may be subject to
10 a reduction in the Federal matching rates available to the
11 State under section 2108(a) or the withholding of Federal
12 funds for services or administration until such time as
13 compliance is achieved.

14 (d) TECHNICAL ASSISTANCE.—The Secretary shall
15 ensure the availability of ongoing technical assistance to
16 States under this section. Such assistance shall include
17 serving as a clearinghouse for information regarding suc-
18 cessful practices in providing long-term care services.

19 (e) REGULATIONS.—The Secretary shall issue such
20 regulations as may be appropriate to carry out this sub-
21 title on a timely basis.

22 **SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.**

23 (a) IN GENERAL.—For purposes of this subtitle, the
24 term 'individual with disabilities' means any individual

1 within one or more of the following categories of individ-
2 uals:

3 (1) INDIVIDUALS REQUIRING HELP WITH AC-
4 TIVITIES OF DAILY LIVING.—An individual of any
5 age who—

6 (A) requires hands-on or standby assist-
7 ance, supervision, or cueing (as defined in regu-
8 lations) to perform three or more activities of
9 daily living (as defined in subsection (d)), and

10 (B) is expected to require such assistance,
11 supervision, or cueing over a period of at least
12 90 days.

13 (2) INDIVIDUALS WITH SEVERE COGNITIVE OR
14 MENTAL IMPAIRMENT.—An individual of any age—

15 (A) whose score, on a standard mental sta-
16 tus protocol (or protocols) appropriate for
17 measuring the individual's particular condition
18 specified by the Secretary, indicates either se-
19 vere cognitive impairment or severe mental im-
20 pairment, or both;

21 (B) who—

22 (i) requires hands-on or standby as-
23 sistance, supervision, or cueing with one or
24 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-

1 vidual with disabilities only if the following require-
2 ments are met:
3 (A) COMPREHENSIVE ASSESSMENT.—A
4 comprehensive assessment of an individual's
5 need for home and community-based services
6 (regardless of whether all need services are
7 available under the plan) shall be made in ac-
8 cordance with a uniform, comprehensive assess-
9 ment tool that shall be used by a State under
10 this paragraph with the approval of the Sec-
11 retary. The Secretary shall provide guidance to
12 the States with regard to the appropriate quali-
13 fications for individuals who conduct com-
14 prehensive assessments.
15 (B) INDIVIDUALIZED PLAN OF CARE.—An
16 individualized plan of care based on the assess-
17 ment made under subparagraph (A) shall be de-
18 veloped. A plan of care under this subparagraph
19 shall—
20 (i) specify which services included
21 under the individual plan will be provided
22 under the State plan under this subtitle;
23 (ii) identify (to the extent possible)
24 how the individual will be provided any

1 services specified under the plan of care
2 and not provided under the State plan;
3 (iii) specify how the provision of serv-
4 ices to the individual under the plan will be
5 coordinated with the provision of other
6 health care services to the individual; and
7 (iv) be reviewed and updated every 6
8 months (or more frequently if there is a
9 change in the individual's condition).
10 The State shall make reasonable efforts to iden-
11 tify and arrange for services described in clause
12 (ii). Nothing in this subsection shall be con-
13 strued as requiring a State (under the State
14 plan or otherwise) to provide all the services
15 specified in such a plan.
16 (C) INVOLVEMENT OF INDIVIDUALS.—The
17 individualized plan of care under subparagraph
18 (B) for an individual with disabilities shall—
19 (i) be developed by qualified individ-
20 uals (specified under the State plan);
21 (ii) be developed and implemented in
22 close consultation with the individual (or
23 the individual's designated representative);
24 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

1 home and community-based services under
2 this subtitle residing in such area; and
3 (ii) the State plan specifies procedures
4 that the State will implement in order to
5 avoid conflicts of interest.
6 (d) MANDATORY COVERAGE OF PERSONAL ASSIST-
7 ANCE SERVICES.—The State plan shall include, in the
8 array of services made available to each category of indi-
9 viduals with disabilities, both agency-administered and
10 consumer-directed personal assistance services (as defined
11 in subsection (h)).
12 (e) ADDITIONAL SERVICES.—
13 (1) TYPES OF SERVICES.—Subject to subsection
14 (f), services available under a State plan under this
15 subtitle may include any (or all) of the following:
16 (A) Homemaker and chore assistance.
17 (B) Home modifications.
18 (C) Respite services.
19 (D) Assistive devices, as defined in the
20 Technology Related Assistance for Individuals
21 with Disabilities Act.
22 (E) Adult day services.
23 (F) Habilitation and rehabilitation.
24 (G) Supported employment.
25 (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-

1 sistance services or the provider of such serv-
2 ices, services that are provided by an individual
3 who is selected and managed (and, at the op-
4 tion of the service recipient, trained) by the in-
5 dividual receiving the services.

6 (B) STATE RESPONSIBILITIES.—A State
7 plan shall ensure that where services are pro-
8 vided in a consumer-directed manner, the State
9 shall create or contract with an entity, other
10 than the consumer or the individual provider,
11 to—

12 (i) inform both recipients and pro-
13 viders of rights and responsibilities under
14 all applicable Federal labor and tax law;
15 and

16 (ii) assume responsibility for providing
17 effective billing, payments for services, tax
18 withholding, unemployment insurance, and
19 workers' compensation coverage, and act
20 as the employer of the home care provider.

21 (C) RIGHT OF CONSUMERS.—Notwith-
22 standing the State responsibilities described in
23 subparagraph (B), service recipients, and,
24 where appropriate, their designated representa-
25 tive, shall retain the right to independently se-

lect, hire, terminate, and direct (including manage, 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).

1 (2) REQUIRED ANNUAL DEDUCTIBLE.—The
2 State plan shall impose cost sharing in the form of
3 an annual deductible—
4 (A) of $100 for individuals with disabilities
5 with income not less than 150 percent, and less
6 than 175 percent, of such official poverty line
7 (as so applied);
8 (B) of $200 for such individuals with in-
9 come not less than 175 percent, and less than
10 225 percent, of such official poverty line (as so
11 applied);
12 (C) of $300 for such individuals with in-
13 come not less than 225 percent, and less than
14 275 percent, of such official poverty line (as so
15 applied);
16 (D) of $400 for such individuals with in-
17 come not less than 275 percent, and less than
18 325 percent, of such official poverty line (as so
19 applied);
20 (E) of $500 for such individuals with in-
21 come not less than 325 percent, and less than
22 400 percent, of such official poverty line (as so
23 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,

1 (B) setting the minimum standards for
2 agency providers and how such standards will
3 be enforced,
4 (C) setting the minimum competency re-
5 quirements for agency provider employees who
6 provide direct services under this subtitle and
7 how the competency of such employees will be
8 enforced,
9 (D) obtaining meaningful consumer input,
10 including consumer surveys that measure the
11 extent to which participants receive the services
12 described in the plan of care and participant
13 satisfaction with such services,
14 (E) establishing a process to receive, inves-
15 tigate, and resolve allegations of neglect and/or
16 abuse,
17 (F) establishing optional training programs
18 for individuals with disabilities in the use and
19 direction of consumer directed providers of per-
20 sonal assistance services,
21 (G) establishing an appeals procedure for
22 eligibility denials and a grievance procedure for
23 disagreements with the terms of an individual-
24 ized 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 (1) CONFIDENTIALITY.—The State plan shall
2 provide safeguards which restrict the use or disclo-
3 sure of information concerning applicants and bene-
4 ficiaries to purposes directly connected with the ad-
5 ministration of the plan.
6 (2) SAFEGUARDS AGAINST ABUSE.—The State
7 plans shall provide safeguards against physical, emo-
8 tional, or financial abuse or exploitation (specifically
9 including appropriate safeguards in cases where pay-
10 ment for program benefits is made by cash pay-
11 ments or vouchers given directly to individuals with
12 disabilities). All providers of services shall be re-
13 quired to register with the State agency.
14 (3) REGULATIONS.—Not later than January 1,
15 1998, the Secretary shall promulgate regulations
16 with respect to the requirements on States under
17 this subsection.
18 (e) SPECIFIED RIGHTS.—The State plan shall pro-
19 vide that in furnishing home and community-based serv-
20 ices under the plan the following individual rights are pro-
21 tected:
22 (1) The right to be fully informed in advance,
23 orally and in writing, of the care to be provided, to
24 be fully informed in advance of any changes in care
25 to be provided, and (except with respect to an indi-

1 vidual determined incompetent) to participate in
2 planning care or changes in care.
3 (2) The right to—
4 (A) voice grievances with respect to serv-
5 ices that are (or fail to be) furnished without
6 discrimination or reprisal for voicing grievances,
7 (B) be told how to complain to State and
8 local authorities, and
9 (C) prompt resolution of any grievances or
10 complaints.
11 (3) The right to confidentiality of personal and
12 clinical records and the right to have access to such
13 records.
14 (4) The right to privacy and to have one's prop-
15 erty treated with respect.
16 (5) The right to refuse all or part of any care
17 and to be informed of the likely consequences of
18 such refusal.
19 (6) The right to education or training for one-
20 self and for members of one's family or household on
21 the management of care.
22 (7) The right to be free from physical or mental
23 abuse, corporal punishment, and any physical or
24 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-

1 dividuals under this subtitle, that would have
2 been paid for such individuals under the State
3 medicaid plan but for the provision of similar
4 services under the program under this subtitle.
5 At the time a State first submits its plan under
6 this subtitle and before each subsequent fiscal
7 year (through fiscal year 2004), the State also
8 must provide the Secretary with such budgetary
9 information (for each fiscal year through fiscal
10 year 2004), as the Secretary determines to be
11 necessary to carry out this paragraph.

12 (B) REPORTS.—Each State with a pro-
13 gram under this subtitle shall submit such re-
14 ports to the Secretary as the Secretary may re-
15 quire in order to monitor compliance with sub-
16 paragraph (A). The Secretary shall specify the
17 format of such reports and establish uniform
18 data reporting elements.

19 (C) ADJUSTMENTS TO APPROPRIATION.—

20 (i) IN GENERAL.—For each fiscal year
21 (beginning with fiscal year 1998 and end-
22 ing with fiscal year 2004) and based on a
23 review of information submitted under sub-
24 paragraph (A), the Secretary shall deter-
25 mine the amount by which the appropria-

1 tion authorized under subsection (a) will
2 increase. The amount of such increase for
3 a fiscal year shall be limited to the reduc-
4 tion in Federal expenditures of medical as-
5 sistance (as determined by Secretary) that
6 would have been made under part A of
7 title XIX for home and community based
8 services for disabled individuals but for the
9 provision of similar services under the pro-
10 gram under this subtitle.
11 (ii) ANNUAL PUBLICATION.—The Sec-
12 retary shall publish before the beginning of
13 such fiscal year, the revised appropriation
14 authorized under this subsection for such
15 fiscal year.
16 (D) CONSTRUCTION.—Nothing in this sub-
17 section shall be construed as requiring States to
18 determine eligibility for medical assistance
19 under the State medicaid plan on behalf of indi-
20 viduals receiving assistance under this subtitle.
21 (b) ALLOTMENTS TO STATES.—
22 (1) IN GENERAL.—The Secretary shall allot the
23 amounts available under the appropriation author-
24 ized for the fiscal year (specified in subsection (a))
25 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

1 long-term care so that services to meet individual needs
2 and preferences can be arranged in home and community-
3 based settings as an alternative to long-term nursing home
4 placement. The Secretary may provide technical assistance
5 to entities seeking to replicate such programs.

6 ''(b) INCENTIVE GRANTS TO ASSIST IN THE DEVEL-
7 OPMENT OF HOSPITAL LINKAGE PROGRAMS.—The Sec-
8 retary shall establish a program under which incentive
9 grants may be awarded to assist private and public agen-
10 cies, including area agencies on aging, and organizations
11 in developing and expanding programs and projects that
12 facilitate the discharge of individuals in hospitals or other
13 acute care facilities who are in need of long-term care serv-
14 ices and placement of such individuals into home and com-
15 munity-based settings.

16 ''(c) ADMINISTRATIVE PROVISIONS.—

17 ''(1) ELIGIBLE ENTITIES.—To be eligible to re-
18 ceive a grant under subsection (b) an entity shall
19 be—

20 ''(A)(i) a State agency as defined in sec-
21 tion 102(43) of the Older Americans Act of
22 1965; or

23 ''(ii) a State agency responsible for admin-
24 istering home and community care programs
25 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

1 homes or other institutional settings and under-
2 taking the planning and management of indi-
3 vidualized care plans to facilitate discharge into
4 such settings;

5 "(C) assurances that nongovernmental
6 case management agencies funded under grants
7 awarded under this section are not direct pro-
8 viders of home and community-based services;

9 "(D) satisfactory assurances that adequate
10 home and community-based long term care
11 services are available, or will be made available,
12 within the community to be served so that indi-
13 viduals being discharged from hospitals or acute
14 care facilities under the proposed program can
15 be served in such home and community-based
16 settings, with flexible, individualized care which
17 reflects individual choice and preference;

18 "(E) a description of the manner in which
19 the program to be administered with amounts
20 received under the grant will be continued after
21 the termination of the grant for which such ap-
22 plication is submitted; and

23 "(F) a description of any waivers or ap-
24 provals necessary to expand the number of indi-
25 viduals served in federally funded home and

1 community-based long term care programs in
2 order to provide satisfactory assurances that
3 adequate home and community-based long term
4 care services are available in the community to
5 be served.
6 ''(3) AWARDING OF GRANTS.—
7 ''(A) PREFERENCES.—In awarding grants
8 under subsection (b), the Secretary shall give
9 preference to entities submitting applications
10 that—
11 ''(i) demonstrate an ability to coordi-
12 nate activities funded using amounts re-
13 ceived under the grant with programs pro-
14 viding individualized home and community-
15 based case management and services to in-
16 dividuals in need of long term care with
17 hospital discharge planning programs; and
18 ''(ii) demonstrate that adequate home
19 and community-based long term care man-
20 agement and services are available, or will
21 be made available to individuals being
22 served under the program funded with
23 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 eval-

uations 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 promul-

gated 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;

1 the date specified in this subsection is the first day
2 of the first calendar quarter beginning after the
3 close of the first legislative session of the State legis-
4 lature that begins on or after January 1, 1995. For
5 purposes of the previous sentence, in the case of a
6 State that has a 2-year legislative session, each year
7 of such session shall be deemed to be a separate reg-
8 ular session of the State legislature.

9 (c) ITEMS INCLUDED IN STANDARDS.—The stand-
10 ards promulgated under subsection (a) shall include—

11 (1) minimum Federal standards for long-term
12 care insurance consistent with the provisions of this
13 subtitle;

14 (2) standards for the enhanced protection of
15 consumers with long-term care insurance; and

16 (3) procedures for the modification of the
17 standards established under paragraph (1) in a
18 manner consistent with future laws to expand exist-
19 ing Federal or State long-term care benefits or es-
20 tablish a comprehensive Federal or State long-term
21 care benefit program.

22 (d) CONSULTATION.—In establishing standards and
23 models of benefits under this section, the Secretary shall,
24 after consultation with representatives of carriers, con-
25 sumer 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.

1 (3) PRIVATE ACTIONS.—An individual may
2 commence a civil action in an appropriate State or
3 United States district court to enforce the provisions
4 of this title and may be awarded appropriate relief
5 and reasonable attorney's fees.
6 (4) CONSUMER ACCESS TO COMPLIANCE INFOR-
7 MATION.—
8 (A) IN GENERAL.—A State regulatory pro-
9 gram shall provide for consumer access to com-
10 plaints filed with the State commissioner or su-
11 perintendent of insurance with respect to long-
12 term care insurance policies.
13 (B) CONFIDENTIALITY.—The access pro-
14 vided under subparagraph (A) shall be limited
15 to the extent required to protect the confiden-
16 tiality of the identity of individual policyholders.
17 (5) PROCESS FOR APPROVAL OF PREMIUMS.—
18 (A) IN GENERAL.—Each State regulatory
19 program shall—
20 (i) provide for a process for approving
21 or disapproving proposed premium in-
22 creases or decreases with respect to long-
23 term care insurance policies; and
24 (ii) establish a policy for receipt and
25 consideration of public comments before

1 approving such a premium increase or de-
2 crease.
3 (B) CONDITIONS FOR APPROVAL.—No pre-
4 mium increase shall be approved (or deemed ap-
5 proved) under subparagraph (A) unless the pro-
6 posed increase is accompanied by an actuarial
7 memorandum which—
8 (i) includes a description of the as-
9 sumptions that justify the increase, includ-
10 ing a financial report on expenditures;
11 (ii) contains such information as may
12 be required under the Standards; and
13 (iii) is made available to the public.
14 (C) APPLICATION.—Except as provided in
15 subparagraph (D), this paragraph shall not
16 apply to a group long-term care insurance pol-
17 icy issued to a group described in section
18 4(E)(1) of the NAIC Long Term Care Insur-
19 ance Model Act (effective January 1991), ex-
20 cept that such group policy shall, pursuant to
21 guidelines developed by the NAIC, provide no-
22 tice to policyholders and certificate holders of
23 any premium change under such group policy.
24 (D) EXCEPTION.—Subparagraph (C) shall
25 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

1 access to actuarial memoranda, including financial
2 information, provided under paragraph (4).
3 (8) DEFAULT.—In the case of a State without
4 a regulatory program approved under subsection (a),
5 the Secretary shall provide for the enforcement ac-
6 tivities described in subsection (c).
7 (c) SECRETARIAL ENFORCEMENT AUTHORITY.—
8 (1) IN GENERAL.—The Secretary shall exercise
9 authority under this section in the case of a State
10 that does not have a regulatory program approved
11 under this section.
12 (2) COMPLAINTS AND INVESTIGATIONS.—The
13 Secretary shall establish procedures—
14 (A) for individuals and entities to file writ-
15 ten, signed complaints respecting alleged viola-
16 tions of the requirements of this subtitle;
17 (B) for responding on a timely basis to
18 such complaints; and
19 (C) for the investigation of—
20 (i) those complaints that have a rea-
21 sonable probability of validity; and
22 (ii) such other alleged violations of the
23 requirements of this subtitle as the Sec-
24 retary 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 (1) IN GENERAL.—Each agent (as defined in
2 section 2233) or association that is selling or offer-
3 ing for sale a long-term care insurance policy has
4 the duty of good faith and fair dealing to the pur-
5 chaser or potential purchaser of such a policy.

6 (2) POLICY REPLACEMENT FORM.—With re-
7 spect to any individual who elects to replace or effect
8 a change in a long-term care insurance policy, the
9 individual that is selling such policy shall ensure
10 that such individual completes a policy replacement
11 form developed by the Secretary, in consultation
12 with the NAIC. A copy of such form shall be pro-
13 vided to such individual and additional copies shall
14 be delivered by the selling individual to the old policy
15 issuer and the new issuer and kept on file for inspec-
16 tion by the State regulatory agency.

17 (3) PROHIBITED PRACTICES.—An agent or as-
18 sociation is considered to have violated paragraph
19 (1) if the agent or association engages in any of the
20 following practices:

21 (A) TWISTING.—Knowingly making any
22 misleading representation (including the inac-
23 curate completion of medical histories) or in-
24 complete or fraudulent comparison of any long-
25 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

1 when considering the purchase of a long-term care insur-
2 ance policy.

3 (c) PROHIBITION OF SALE OR ISSUANCE TO MED-
4 ICAID BENEFICIARIES.—An agent, an association, or a
5 carrier may not knowingly sell or issue a long-term care
6 insurance policy to an individual who is eligible for medical
7 assistance under title XIX of the Social Security Act.

8 (d) PROHIBITION OF SALE OR ISSUANCE OF DUPLI-
9 CATE SERVICE BENEFIT POLICIES.—An agent, associa-
10 tion or its subsidiary, or a carrier may not sell or issue
11 a service-benefit long-term care insurance policy to an in-
12 dividual—

13 (1) knowing that the policy provides for cov-
14 erage that duplicates coverage already provided in
15 another service-benefit long-term care insurance pol-
16 icy held by such individual (unless the policy is in-
17 tended to replace such other policy); or

18 (2) for the benefit of an individual unless the
19 individual (or a representative of the individual) pro-
20 vides a written statement to the effect that the cov-
21 erage—

22 (A) does not duplicate other coverage in ef-
23 fect under a service-benefit long-term care in-
24 surance policy; or

1 (B) will replace another service-benefit
2 long-term care insurance policy.
3 In this subsection, the term ''service-benefit long-term
4 care insurance policy'' means a long-term care insurance
5 policy which provides for benefits based on the type and
6 amount of services furnished.
7 (e) PROHIBITION BASED ON ELIGIBILITY FOR
8 OTHER BENEFITS.—A carrier may not sell or issue a
9 long-term care insurance policy that reduces, limits, or co-
10 ordinates the benefits provided under the policy on the
11 basis that the policyholder has or is eligible for other long-
12 term care insurance coverage or benefits.
13 (f) PROVISION OF OUTLINE OF COVERAGE.—No
14 agent, association or its subsidiary, or carrier may sell or
15 offer for sale a long-term care insurance policy without
16 providing to every individual purchaser or potential pur-
17 chaser (or representative) an outline of coverage that com-
18 plies with the standards established under section
19 2201(a).
20 (g) PENALTIES.—Any agent who sells, offers for sale,
21 or issues a long-term care insurance policy in violation of
22 this section may be imprisoned not more than 5 years,
23 or fined in accordance with title 18, United States Code,
24 and, in addition, is subject to a civil money penalty of not
25 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

1 carrier shall, not later than 30 days after the date of the
2 denial or return, refund directly to the applicant, or in
3 the case of an employer to whomever remits the premium,
4 any premiums paid with respect to such a policy (or cer-
5 tificate). Any such refund shall not be made by delivery
6 by the carrier.

7 (b) MAILING OF POLICY.—If an application for a
8 long-term care insurance policy (or for a certificate under
9 a group long-term care insurance policy) is approved, the
10 carrier shall provide each individual applicant the policy
11 (or certificate) of insurance and outline of coverage not
12 later than 30 days after the date of the approval.

13 (c) INFORMATION ON DENIALS OF CLAIMS.—If a
14 claim under a long-term care insurance policy is denied,
15 the carrier shall, within 15 days of the date of a written
16 request by the policyholder or certificate holder (or rep-
17 resentative)—

18 (1) provide a written explanation of the reasons
19 for the denial;

20 (2) make available all medical and patient
21 records directly relating to such denial; and

22 (3) provide a written explanation of the manner
23 in which to appeal the denial.

24 Except as provided in subsection (e) of section 2215, no
25 claim under such a policy may be denied on the basis of

1 a failure to disclose a condition at the time of issuance
2 of the policy if the application for the policy failed to re-
3 quest information respecting the condition.

4 (d) REPORTING OF INFORMATION.—A carrier that
5 issues one or more long-term care insurance policies shall
6 periodically (not less often than annually) report, in a
7 form and in a manner determined by the Secretary, in
8 consultation with the NAIC, to the Commissioner, super-
9 intendent or director of insurance of each State in which
10 the policy is delivered, and shall make available to the Sec-
11 retary, upon request, information in a form and manner
12 determined by the Secretary, in consultation with the
13 NAIC, concerning—

14 (1) the long-term care insurance policies of the
15 carrier that are in force;

16 (2) the most recent premiums for such policies
17 and the premiums imposed for such policies since
18 their initial issuance;

19 (3) the lapse rate, replacement rate, and rescis-
20 sion rates by policy;

21 (4) the names of that 10 percent of its agents
22 that—

23 (A) have the greatest lapse and replace-
24 ment 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

1 exclusion for preexisting conditions that would have
2 been covered under the group policy being replaced.
3 (c) STANDARDS FOR ISSUANCE.—
4 (1) IN GENERAL.—
5 (A) GUARANTEE.—An agent, association
6 or carrier that sells or issues long-term care in-
7 surance policies shall guarantee that such poli-
8 cies shall be sold or issued to an individual, or
9 eligible individual in the case of a group plan,
10 if such individual meets the minimum medical
11 underwriting requirements of such policy.
12 (B) PREMIUM FOR CONVERTED POLICY.—
13 If a group policy from which conversion is made
14 is a replacement for a previous group policy,
15 the premium for the converted policy shall be
16 calculated on the basis of the insured's age at
17 the inception of coverage under the group policy
18 from which conversion is made. Where the
19 group policy from which conversion is made re-
20 placed previous group coverage, the premium
21 for the converted policy shall be calculated on
22 the basis of the insured's age at inception of
23 coverage under the group policy replaced.
24 (2) UPGRADE FOR CURRENT POLICIES.—The
25 Secretary, in consultation with the NAIC, shall es-

1 tablish standards, including those providing guid-
2 ance on medical underwriting and age rating, with
3 respect to the access of individuals to policies offer-
4 ing upgraded benefits.

5 (3) RATE STABILIZATION.—The Secretary, in
6 consultation with the NAIC, shall establish stand-
7 ards for premium rate stabilization.

8 (d) EFFECT OF INCAPACITATION.—

9 (1) IN GENERAL.—

10 (A) PROHIBITION.—Except as provided in
11 paragraph (2), a long-term care insurance pol-
12 icy in effect as of the effective date of the
13 standards established under section 2201(a)
14 may not be canceled for nonpayment if the pol-
15 icy holder is determined by a long-term care
16 provider, physician, or other health care pro-
17 vider (independent of the issuer of the policy),
18 to be cognitively or mentally incapacitated so as
19 to not make payments in a timely manner.

20 (B) REINSTATEMENT.—A long-term care
21 policy shall include a provision that provides for
22 the reinstatement of such coverage, in the event
23 of lapse, if the insurer is provided with proof of
24 cognitive or mental incapacitation. Such rein-
25 statement 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-

1 spect to definitions and terminology used for long-
2 term care services and providers; and
3 (2) use a uniform format for presenting the
4 outline of coverage under such a policy;
5 as prescribed under guidelines issued by the Secretary, in
6 consultation with the NAIC, and periodically updated.
7 (b) DISCLOSURE.—
8 (1) OUTLINE OF COVERAGE.—
9 (A) REQUIREMENT.—Each carrier that
10 sells or offers for sale a long-term care insur-
11 ance policy shall provide an outline of coverage
12 to each individual policyholder under such pol-
13 icy that meets the applicable standards estab-
14 lished pursuant to section 2201(a), complies
15 with the requirements of subparagraph (B), and
16 is in a uniform format as prescribed in guide-
17 lines issued by the Secretary, in consultation
18 with the NAIC, and periodically updated.
19 (B) CONTENTS.—The outline of coverage
20 for each long-term care policy shall substan-
21 tially and accurately reflect the contents of the
22 policy or the master policy and shall include at
23 least the following:
24 (i) A description of the benefits and
25 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—

1 (I) national average costs for
2 nursing facility and home health care
3 and information (in graph form) on
4 the relationship of the value of the
5 benefits provided under the policy to
6 such national average costs and State
7 average costs; and
8 (II) other public and private
9 long-term care insurance products and
10 long-term care programs where made
11 available by the Federal Government
12 or by a State government.
13 (viii) A statement of the percentage
14 limit on annual premium increases that is
15 provided under the policy pursuant to this
16 section.
17 (2) CERTIFICATES.—A certificate issued pursu-
18 ant to a group long-term care insurance policy shall
19 include—
20 (A) a description of the principal benefits
21 and coverage provided in the policy;
22 (B) a statement of the principal exclusions,
23 reductions, and limitations contained in the pol-
24 icy; 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 (1) IN GENERAL.—A long-term care insurance
2 policy may not condition or limit eligibility—
3 (A) for benefits for a type of services to
4 the need for or receipt of any other services;
5 (B) for any benefit on the medical neces-
6 sity for such benefit;
7 (C) for benefits furnished by licensed or
8 certified providers in compliance with conditions
9 which are in addition to those required for li-
10 censure or certification under State law, or if
11 no State licensure or certification laws exists,
12 developed by the Secretary, in consultation with
13 the NAIC; or
14 (D) for residential care (if covered under
15 the policy) only—
16 (i) to care provided in facilities which
17 provide a higher level of care; or
18 (ii) to care provided in facilities which
19 provide for 24-hour or other nursing care
20 not required in order to be licensed by the
21 State.
22 (2) HOME HEALTH CARE OR COMMUNITY-
23 BASED SERVICES.—If a long-term care insurance
24 policy provides benefits for the payment of specified

1 home health care or community-based services, the
2 policy—
3 (A) may not limit such benefits to services
4 provided by registered nurses or licensed prac-
5 tical nurses;
6 (B) may not require benefits for such serv-
7 ices to be provided by a nurse or therapist that
8 can be provided by a home health aide or a
9 home care worker who is licensed or certified
10 under State licensure or certification laws, or if
11 no such laws exist, who is in compliance with
12 qualifications developed by the Secretary, in
13 consultation with the NAIC;
14 (C) may not limit such benefits to services
15 provided by agencies or providers certified
16 under title XVIII of the Social Security Act;
17 and
18 (D) shall provide, at a minimum—
19 (i) benefits for personal care services
20 (including home health aide and home care
21 worker services as defined by the Sec-
22 retary, in consultation with the NAIC),
23 home health services, adult day care, and
24 respite care in an individual's home or in
25 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-

1 cluding each group policyholder, the option to pur-
2 chase a long-term care insurance policy that pro-
3 vides for increases in benefit levels, with benefit
4 maximums or reasonable durations that are mean-
5 ingful, to account for reasonably anticipated in-
6 creases in the costs of long-term care services cov-
7 ered by the policy. A carrier may not offer to a pol-
8 icyholder an inflation protection feature that is less
9 favorable to the policyholder than one of the fol-
10 lowing:

11 (A) With respect to policies that provide
12 for automatic periodic increases in benefits, the
13 policy provides for an annual increase in bene-
14 fits in a manner so that such increases are
15 computed annually at a rate of not less than 5
16 percent.

17 (B) With respect to policies that provide
18 for periodic opportunities to elect an increase in
19 benefits, the policy guarantees that the insured
20 individual will have the right to periodically in-
21 crease the benefit levels under the policy with-
22 out providing evidence of insurability or health
23 status so long as the option for the previous pe-
24 riod was not declined. The amount of any such

1 additional benefit may not be less than the dif-
2 ference between—
3 (i) the existing policy benefit; and
4 (ii) such existing benefit compounded
5 annually at a rate of at least 5 percent for
6 the period beginning on the date on which
7 the existing benefit is purchased and ex-
8 tending until the year in which the offer of
9 increase is made.
10 (C) With respect to service benefit policies,
11 the policy covers a specified percentage of the
12 actual or reasonable charges and does not in-
13 clude a maximum specified indemnity amount
14 or limit.
15 (2) EXCEPTION.—The requirements of para-
16 graph (1) shall not apply to life insurance policies or
17 riders containing accelerated long-term care benefits.
18 (3) REQUIRED INFORMATION.—Carriers shall
19 include the following information in or together with
20 the outline of coverage provided under this subtitle:
21 (A) A comparison (shown as a graph) of
22 the benefit levels of a policy that increases ben-
23 efits over the policy period with a policy that
24 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-

1 curred, indemnity prepaid or other basis, for one or more
2 necessary diagnostic, preventive, therapeutic, rehabilita-
3 tive, maintenance or personal care services, provided in a
4 setting other than an acute care unit of a hospital. Such
5 term includes—

6 (1) group and individual annuities and life in-
7 surance policies, riders or certificates that provide
8 directly, or that supplement long-term care insur-
9 ance; and

10 (2) a policy, rider or certificates that provides
11 for payment of benefits based on cognitive impair-
12 ment or the loss of functional capacity.

13 (b) ISSUANCE.—Long-term care insurance policies
14 may be issued by—

15 (1) carriers;

16 (2) fraternal benefit societies;

17 (3) nonprofit health, hospital, and medical serv-
18 ice corporations;

19 (4) prepaid health plans;

20 (5) health maintenance organizations; or

21 (6) any similar organization to the extent they
22 are otherwise authorized to issue life or health insur-
23 ance.

24 (c) POLICIES EXCLUDED.—The term ''long-term care
25 insurance policy'' shall not include any insurance policy,

1 rider or certificate that is offered primarily to provide
2 basic Medicare supplement coverage, basic hospital ex-
3 pense coverage, basic medical-surgical expense coverage,
4 hospital confinement indemnity coverage, major medical
5 expense coverage, disability income or related asset-protec-
6 tion coverage, accident only coverage, specified disease or
7 specified accident coverage, or limited benefit health cov-
8 erage. With respect to life insurance, such term shall not
9 include life insurance policies, riders or certificates—

10 (1) that accelerate the death benefit specifically
11 for one or more of the qualifying events of terminal
12 illness, medical conditions requiring extraordinary
13 medical intervention, or permanent institutional con-
14 finement,

15 (2) that provide the option of a lump-sum pay-
16 ment for those benefits, or

17 (3) with respect to which neither the benefits
18 nor the eligibility for the benefits is conditioned
19 upon the receipt of long-term care.

20 (d) APPLICATIONS.—Notwithstanding any other pro-
21 vision of this subtitle, this subtitle shall apply to any prod-
22 uct advertised, marketed or offered as a long-term insur-
23 ance 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

1 (c)) that are provided to the individual by a nursing
2 facility while the individual is an inpatient of the fa-
3 cility.
4 ''(2) NONFORFEITURE.—The Secretary shall
5 establish standards to ensure the nonforfeiture of
6 benefits for which premiums have been paid.
7 ''(b) TYPES.—Coverage may be provided under this
8 title for—
9 ''(1) nursing care provided by or under the su-
10 pervision of a registered professional nurse;
11 ''(2) physical, occupational, or speech therapy
12 furnished by a facility or by others under arrange-
13 ments with a facility;
14 ''(3) medical social work services;
15 ''(4) drug, biological, supply, appliance, and
16 equipment for use in the facility, that is ordinarily
17 furnished by the facility for the care and treatment
18 of an inpatient;
19 ''(5) such other services necessary to the func-
20 tioning of a patient, including personal care and as-
21 sistance with activities of daily living, as are gen-
22 erally provided by a nursing home facility; and
23 ''(6) with respect to the initial 6 months of cov-
24 ered residence in a nursing facility, such room and

1 board costs as are not covered by beneficiary copay-
2 ment.
3 "(c) COVERAGE AMOUNT.—
4 "(1) IN GENERAL.—The amount of coverage
5 provided with respect to an eligible individual for the
6 services described in subsection (b) shall, based on
7 an election made by the individual, not exceed
8 $30,000, $60,000, or $90,000 over the lifetime of
9 the eligible individual. Such amounts shall be ad-
10 justed by the Secretary to reflect increases in the
11 Consumer Price Index.
12 "(2) ASSET PROTECTION.—An eligible indi-
13 vidual shall be entitled to the asset protection pro-
14 vided under section 2708.
15 "(d) PAYMENT.—Amounts provided under this title
16 with respect to an eligible individual for the services de-
17 scribed in subsection (b) shall be paid from the general
18 fund of the Treasury of the United States.
19 "(e) RESIDENTIAL CARE FACILITIES.—The Sec-
20 retary shall consider the feasibility of making payments
21 under this title for services delivered in residential care
22 facilities. Not later than 2 years after the date of enact-
23 ment of this Act, the Secretary shall report its findings
24 to the Congress with respect to the feasibility of making
25 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

1 "(IV) has achieved a score, on a
2 standard mental status protocol (or proto-
3 cols) appropriate for measuring the indi-
4 vidual's particular condition specified by
5 the Secretary, that indicates either severe
6 cognitive impairment or severe mental im-
7 pairment, or both; and
8 "(ii) to require such assistance, super-
9 vision, or cueing over a period of at least
10 90 days; and
11 "(2)(A) the individual has filed an application
12 for such benefits, and is in need of, benefits covered
13 under this title; or
14 "(B) the legal guardian of the individual has
15 filed an application on behalf of an individual who
16 is in need of benefits covered under this title; or
17 "(C) the representative of an individual who is
18 cognitively impaired and who is in need of benefits
19 covered under this title has filed an application on
20 behalf of the individual.
21 "(b) CURRENT INDIVIDUALS.—An individual who is
22 in a hospital or nursing home on the date of the enroll-
23 ment of the individual in the program established under
24 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

1 period beginning on the date such individuals pur-
2 chase insurance under this title.
3 "(3) EXTENSION BEYOND INITIAL YEAR.—If an
4 individual is confined to a nursing home or hospital
5 during a period that extends beyond the first year
6 after the effective date of this title, an individual
7 shall be eligible to enroll in the program established
8 by this title during the 60-day period beginning after
9 the individual's spell of illness.
10 "(4) SUBSEQUENT YEARS.—During years sub-
11 sequent to the 1-year period referred to in para-
12 graph (2), an individual shall be eligible to purchase
13 insurance under this title within 6 months of the
14 35th, 45th, 55th or 65th birthday of the individual.
15 "(5) ACTIVATION OF BENEFITS.—To receive
16 coverage under the insurance program established by
17 this title, an individual shall have purchased such
18 coverage not later than 1 month prior to admission
19 to a nursing facility, unless the reason for the need
20 of services is a result of an accident or stroke subse-
21 quent to the date that such individual enrolled for
22 coverage under this title.
23 "(d) PUBLIC EDUCATION.—In the 12 months pre-
24 ceding the initial enrollment period, the Secretary shall,
25 either directly or through grants and contracts, conduct

1 a public service and education campaign designed to in-
2 form potentially eligible individuals as to the nature of the
3 benefits and the limited enrollment period. In conducting
4 such campaigns the Secretary shall make information
5 available to individuals through the open enrollment proc-
6 ess for obtaining health care benefits under this Act.

7 **"SEC. 2704. PREMIUM RATES.**

8 "(a) IN GENERAL.—The Secretary shall determine
9 one premium rate for individuals electing to purchase cov-
10 erage under this title at age 35 (or between the ages of
11 35 and 44 during the initial enrollment period), a separate
12 rate for those individuals who elect coverage at age 45
13 (or between the ages of 45 and 54 during the initial enroll-
14 ment period), a separate rate for those individuals who
15 elect such coverage at age 55 (or between that ages of
16 55 and 64 during the initial enrollment period), and a sep-
17 arate rate for those individuals who elect such coverage
18 at age 65 (or at age 65 and over during the initial enroll-
19 ment period). During the initial enrollment period, the
20 Secretary shall establish actuarily fair, age-rated pre-
21 miums for persons age 65 and over.

22 "(b) REVISION.—The Secretary shall revise premium
23 rates annually to increase such rates to reflect the amount
24 of the increase in the cost of living adjustment with re-
25 spect to benefits under title II of the Social Security Act.

1 "(c) RATES.—In developing premium rates under the
2 program established under this title, the Secretary shall
3 establish rates that are expected to cover 100 percent of
4 the reimbursement amount provided under this title for
5 nursing home stays for those individuals enrolled in the
6 program.

7 "(d) WAIVER.—An individual electing to purchase
8 coverage under this title shall not be required to pay pre-
9 miums during any period in which such individual is re-
10 ceiving benefits under this title.

11 "(e) PAYMENT.—Premiums shall be paid under this
12 section into the general fund of the Treasury of the United
13 States.

14 **"SEC. 2705. QUALIFIED SERVICE PROVIDERS.**

15 "(a) IN GENERAL.—To be considered as a covered
16 nursing home service under this title, such service must
17 have been provided by a qualified service provider.

18 "(b) TYPES.—A provider shall be considered a quali-
19 fied service provider under this title if the provider is a
20 nursing facility that is certified by the State and meets
21 the requirements of this title and any other standards es-
22 tablished by the Secretary by regulation for the safe and
23 efficient provision of services covered under this title.

1 **"SEC. 2706. REIMBURSEMENT.**

2 "(a) AMOUNT.—Monthly reimbursement for nursing
3 facility services under this title shall equal 65 percent (or
4 during the initial 6 months of coverage, 80 percent) of
5 the amount the Secretary determines to be reasonable and
6 appropriate to cover the cost of care provided under this
7 title.

8 "(b) PROSPECTIVE PAYMENT.—To the extent fea-
9 sible, the Secretary shall establish a prospective payment
10 mechanism for payment for nursing home services under
11 this title that takes into account the expected resource uti-
12 lization of individual patients based on their degree of dis-
13 ability, the methodology recommended for reimbursement
14 of skilled nursing facilities under title XVIII of the Social
15 Security Act, and other factors determining service re-
16 quirements.

17 "(c) ROOM AND BOARD PAYMENT.—An individual
18 receiving benefits under this program shall be responsible
19 for the payment of an amount for room and board that
20 is equal to—

21 "(1) with respect to the initial 6 months of resi-
22 dence in a nursing facility, 20 percent of the average
23 per diem rate paid by the Secretary to nursing facili-
24 ties receiving reimbursement under this title; and

25 "(2) with respect to subsequent periods of resi-
26 dence, 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

1 based on the results of a preliminary telephone interview
2 or written questionnaire (completed by the applicant, by
3 the caregiver of the applicant, or by the legal guardian
4 or representative of the applicant) that shall be validated
5 through the use of a screening tool administered in person
6 to each applicant determined eligible through initial tele-
7 phone or written questionnaire interviews not later than
8 15 days from the date on which such individual initially
9 applied for services under this title.

10 ''(c) QUESTIONNAIRES AND SCREENING TOOLS.—

11 ''(1) IN GENERAL.—The Secretary shall estab-
12 lish a telephone or written questionnaire and a
13 screening tool to be used by the Screening Agency
14 to determine the eligibility of an individual for serv-
15 ices under this title consistent with requirements of
16 this title and the standards established by the Sec-
17 retary by regulation.

18 ''(2) QUESTIONNAIRES.—The questionnaire
19 shall include questions about the functional impair-
20 ment and mental status of an individual and other
21 criteria that the Secretary shall prescribe by regula-
22 tion.

23 ''(3) SCREENING TOOLS.—The screening tool
24 should measure functional impairment caused by
25 physical or cognitive conditions as well as informa-

1 tion concerning cognition disability, behavioral prob-
2 lems (such as wandering or abusive and aggressive
3 behavior), and any other criteria that the Secretary
4 shall prescribe by regulation. The screening tool
5 shall be administered in person.

6 ''(d) NOTIFICATION.—Not later than 15 days after
7 the date on which an individual initially applied for serv-
8 ices under this title (by telephone or written question-
9 naire), the Screening Agency shall notify such individual
10 that such individual is not eligible for benefits, or that
11 such individuals must schedule an in-person screening to
12 determine final eligibility for benefits under this title. The
13 Screening Agency shall notify such individual of its final
14 decision not later than 2 working days after the in-person
15 screening.

16 ''(e) IN-PERSON SCREENING.—An individual (or the
17 legal guardian or representative of such individual) whose
18 application for benefits under this title is denied on the
19 basis of information provided through a telephone or writ-
20 ten questionnaire, shall be notified of such individual's
21 right to an in-person screening by a nurse or appropriate
22 health care professionals.

23 ''(f) APPEALS.—The Secretary shall establish a
24 mechanism for hearings and appeals in cases in which in-

1 dividuals contest the eligibility findings of the Screening
2 Agency.

3 "(g) PAYMENT.—

4 "(1) PAYMENT FOR SCREENING.—The Screen-
5 ing Agency may require payment from individuals
6 only in accordance with standards established by the
7 Secretary.

8 "(2) NO PAYMENT FOR POOREST.—The Screen-
9 ing Agency may not require payment for individuals
10 with incomes of less than 150 percent of the official
11 poverty line.

12 **"SEC. 2708. ASSET PROTECTION.**

13 "Notwithstanding any other provision of law, the as-
14 sets an eligible individual may retain and be determined
15 eligible for nursing facility benefits, including payments of
16 room and board under this title, under State Medicaid
17 programs (in accordance with section 1902(a)(10)) shall
18 be increased by the amount of coverage ($30,000,
19 $60,000, or $90,000) elected under section 2702.

20 **"SEC. 2709. RELATION TO PRIVATE INSURANCE.**

21 "(a) IN GENERAL.—Except as provided in subsection
22 (b), an insurer may not offer a long-term care insurance
23 policy to an individual who has purchased coverage under
24 this title if the coverage under such policy duplicates the
25 coverage provided under this title.

1 "(b) DEVELOPMENT OF STANDARD PACKAGES.—The
2 Secretary shall develop standard long-term care insurance
3 benefits packages that insurers may offer to insured indi-
4 viduals under this title. Such packages shall provide cov-
5 erage for benefits that compliment, but do not duplicate,
6 those covered under this title.

7 **"SEC. 2710. DEFINITIONS.**

8 "As used in this title:

9 "(1) NURSING FACILITY.—The term 'nursing
10 facility' means—

11 "(A) a skilled nursing facility (as defined
12 in section 1819(a) of the Social Security Act);
13 or

14 "(B) a facility that is a nursing facility (as
15 defined in section 1919(a) of such Act) which
16 meets the requirements of section
17 1819(b)(4)(C) of such Act (relating to nursing
18 care).

19 "(2) SPELL OF ILLNESS.—The term 'spell of
20 illness' means a period of consecutive days beginning
21 with the first day on which an individual is fur-
22 nished services as an inpatient in a hospital or nurs-
23 ing facility and ending with the close of the first 6
24 consecutive months thereafter during which the indi-
25 vidual is no longer an inpatient of a nursing facility,

1 or 90 days after the individual is no longer an inpa-
2 tient in a hospital.

3 **"SEC. 2711. REPORTS.**

4 "(a) IN GENERAL.—Prior to the promulgation of reg-
5 ulations implementing this title, the Secretary shall report
6 to Congress on—

7 "(1) the actuarially-sound premium rates to be
8 used in the implementation of this Act, including
9 whether the premiums will cover 100 percent of the
10 benefits paid out, and whether Federal funds will be
11 required to support the payment of benefits;

12 "(2) an assessment of the impact of such pre-
13 mium rates on the affordability of coverage under
14 this Act;

15 "(3) a projected enrollment of individuals by
16 age category; and

17 "(4) an estimate of current and projected en-
18 rollment of individuals, by age category in coverage
19 under private long-term care insurance.

20 "(b) LIFE CARE REPORT.—Not later than 2 years
21 after the promulgation of regulations implementing this
22 title, the Secretary shall report to Congress on the fol-
23 lowing aspects of the Life Care Act:

24 "(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

1 agreement with a qualified applicant for payments under
2 section 3031 and section 3051 for a calendar year is that
3 the qualified applicant will ensure that the number of indi-
4 viduals enrolled in the program in the subsequent aca-
5 demic year is in accordance with this subpart.

6 (b) DEFINITIONS.—

7 (1) APPROVED PROGRAM.—For purposes of this
8 subtitle:

9 (A) The term ''approved physician training
10 program'', with respect to the medical specialty
11 involved, means a residency or other post-
12 graduate program that trains physicians and
13 meets the following conditions:

14 (i) Participation in the program may
15 be counted toward certification in the med-
16 ical specialty as determined under the ap-
17 plicable standards of the American Board
18 of Medical Specialties or the Council on
19 Postdoctoral Training of the American Os-
20 teopathic Association.

21 (ii) The program is accredited by the
22 Accreditation Council on Graduate Medical
23 Education, or approved by the Council on
24 Postdoctoral Training of the American Os-
25 teopathic 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-

1 demic years 1998–1999, 1999–2000, and 2000–
2 2001.
3 (2) VOLUNTARY COMPLIANCE.—A medical spe-
4 cialty shall not be subject to the mandatory alloca-
5 tion system described in section 3015 if—
6 (A) by June 1, 1997, each eligible ap-
7 proved physician training program has sub-
8 mitted to the National Council a proposal for
9 first year positions in approved physician train-
10 ing programs in that particular medical spe-
11 cialty for the academic years 1998–99, 1999–
12 2000, and 2000–2001 and the total proposed
13 number of all such positions for the specialty
14 does not exceed the number of positions estab-
15 lished for such specialty under paragraph (1)
16 for each such academic year; and
17 (B) in subsequent academic years, the
18 total proposed number of first year positions in
19 approved physician training programs in that
20 particular medical specialty does not exceed the
21 number of individuals nationwide who are au-
22 thorized to be enrolled in approved medical
23 training programs for such medical specialty for
24 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 consid-

1 ering the factors described in paragraph (2) annu-
2 ally recommend to the Secretary a change in—
3 (A) the aggregate number of all training
4 participants entering the first year of graduate
5 medical education training in approved physi-
6 cian training programs nationwide determined
7 under section 3012(4); and
8 (B) in accordance with subsection (b), the
9 distribution of positions among medical special-
10 ties determined under section 3013(a) and
11 3013(b)(1)(D).
12 (2) FACTORS FOR CONSIDERATION.—In devel-
13 oping a recommendation under paragraph (1), the
14 Secretary shall consider the impact on rural, inner
15 city, and public hospitals of reducing numbers of in-
16 dividuals authorized to enter approved physician
17 training programs and the appropriate supply of
18 physicians in the aggregate and in particular med-
19 ical specialties.
20 (b) LIMITATIONS ON RECOMMENDED PERCENT FOR
21 PRIMARY CARE FOR ACADEMIC YEAR 2001–2002.—For
22 the academic year 2001–2002, the number that the Na-
23 tional Council may recommend under subsection (a)(1)(B)
24 may not be more than 5 percentage points less or 5 per-

1 centage points more than the number described in section
2 3013(b)(1)(D).

3 (c) CONSIDERATION AND IMPLEMENTATION BY THE
4 SECRETARY.—The Secretary shall in the Secretary's dis-
5 cretion implement the recommendations by the National
6 Council under subsection (a) in accordance with sections
7 3012 and 3013(b)(1). The Secretary may not modify such
8 recommendations.

9 **SEC. 3015. ALLOCATIONS AMONG SPECIALITIES AND PRO-**
10 **GRAMS.**

11 (a) IN GENERAL.—Subject to the provisions of sec-
12 tions 3012 and 3013, for each academic year, the National
13 Council shall for each medical specialty make allocations
14 among eligible programs of the annual number of specialty
15 positions that the Council has designated for such year.
16 The preceding sentence is subject to subsection (b)(3).

17 (b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

18 (1) IN GENERAL.—For each medical specialty,
19 the National Council shall make the annual alloca-
20 tions under subsection (a) for periods of 3 academic
21 years.

22 (2) ADVANCE NOTICE TO PROGRAMS.—With re-
23 spect to the first academic year of an allocation pe-
24 riod established by the National Council, the Na-
25 tional 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.

1 (B) STUDY.—Not later than January 1,
2 1998, the Secretary shall complete a study to
3 determine the effect that applying weighting
4 factors in calculating the number of full-time-
5 equivalent training participants would have on
6 supporting national workforce goals.
7 (4) INTERNATIONAL MEDICAL GRADUATES RE-
8 QUIRED TO PASS FMGEMS EXAMINATION.—Such
9 rules shall provide that, in the case of an individual
10 who is an international medical graduate, the indi-
11 vidual shall not be counted as a training participant
12 unless—
13 (A) the individual has passed the
14 FMGEMS examination or the U.S. Medical Li-
15 censing Examination, or
16 (B) the individual has previously received
17 certification from, or has previously passed the
18 examination of, the Educational Commission for
19 Foreign Medical Graduates.
20 (5) COUNTING TIME SPENT IN OUTPATIENT
21 SETTINGS.—Such rules shall provide that only time
22 spent in activities relating to patient care shall be
23 counted and that all the time so spent by a training
24 participant under an approved physician training
25 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.

1 (5) INITIAL TRAINING PERIOD.—The term ''ini-
2 tial training period'' means the period of time re-
3 quired for board eligibility, except that—
4 (A) except as provided in subparagraph
5 (B), in no case shall the initial period of partici-
6 pation exceed an aggregate period of formal
7 training of more than 5 years for any indi-
8 vidual, and
9 (B) a period, of not more than 2 years,
10 during which an individual is in a—
11 (i) residency or fellowship program in
12 geriatric medicine, preventive medicine, or
13 adolescent medicine, or
14 (ii) a fellowship program in family
15 medicine, general internal medicine or gen-
16 eral pediatrics, which provides training for
17 a faculty position in family medicine, gen-
18 eral internal medicine or general pediat-
19 rics,
20 shall be treated as part of the initial training
21 participation period, but shall not be counted
22 against any limitation on the initial training pe-
23 riod.
24 The initial training period shall be determined, with
25 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-

1 cation, in its Directory of Residency Training
2 Programs or the equivalent directory regarding
3 postdoctoral training for osteopathic physician
4 training programs—
5 (i) increases the minimum number of
6 years of formal training necessary to sat-
7 isfy the requirements for a specialty, above
8 the period specified in its 1985–1986 Di-
9 rectory, the Secretary may increase the pe-
10 riod of time required for board eligibility
11 for that specialty, but not to exceed the pe-
12 riod of time required for board eligibility
13 specified in that later Directory, or
14 (ii) decreases the minimum number of
15 years of formal training necessary to sat-
16 isfy the requirements for a specialty, below
17 the period specified in its 1985–1986 Di-
18 rectory, the Secretary may decrease the pe-
19 riod of time required for board eligibility
20 for that specialty, but not below the period
21 of time required for board eligibility speci-
22 fied 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-

1 ment to provide funding for such payments in the
2 amounts, and for the years specified in this subpart.
3 (b) PAYMENTS TO MEDICAL SCHOOLS.—The purpose
4 specified in this subsection is to assist an eligible medical
5 school with the direct costs of academic programs includ-
6 ing the education of medical students (especially in pri-
7 mary health care and ambulatory training), graduate stu-
8 dents in biomedical sciences, and otherwise unfunded fac-
9 ulty research. Payments under this section shall supple-
10 ment and not supplant existing resources for this purpose.
11 A funding agreement for such payments is that the med-
12 ical school involved will expend the payments received pur-
13 suant to section 3063(b) as follows:
14 (1) 50 percent shall be expended for primary
15 health care education (including prevention), and
16 peer reviewed primary care research in departments
17 and divisions of primary care, including family medi-
18 cine departments, and divisions of general internal
19 medicine, geriatric medicine, and general pediatrics,
20 or in medical schools in which primary care activities
21 are primarily performed by other organizational
22 units of the medical school, such other units. The
23 medical school will distribute such amounts among
24 the departments, divisions, or other units of primary
25 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-

1 ducted by the faculty at the eligible medical school
2 (including health services research) compared to all
3 such research conducted by the faculty at all eligible
4 medical schools nationwide; and
5 (3) the product of ¼ of the amount available
6 for the academic year pursuant to subsection (a)
7 and the proportion of the eligible medical school's
8 number of graduates in primary care specialties
9 from the class graduating 6 years prior to such aca-
10 demic year who complete eligible programs in pri-
11 mary health care and do not subsequently enter a
12 nonprimary health care training program compared
13 to such number of graduates of all eligible medical
14 schools nationwide in such year.
15 The Secretary shall establish a method for measuring fac-
16 ulty research contributions.
17 (c) STUDIES.—
18 (1) FUNDING LEVEL AND ALLOCATION METH-
19 OD.—Not later than January 1, 1998, the Secretary
20 shall arrange for an independent study and report to
21 be completed, by the Institute of Medicine or other
22 similar entity, concerning the amount of and alloca-
23 tion method for medical school funding, and the im-
24 pact of the payments under this part on national
25 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 application 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 regional 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 conditions 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

1 services entity, and other experts in health care
2 financing, delivery, and professions training.
3 (2) EX OFFICIO MEMBERS; OTHER FEDERAL
4 OFFICERS OR EMPLOYEES.—The membership of the
5 National Council on Graduate Nurse Training shall
6 include individuals designated by the Secretary, the
7 Secretary of Veterans Affairs, and the Secretary of
8 the Department of Defense to serve as members of
9 the Council from among Federal officers or employ-
10 ees who are appointed by the President, by the Sec-
11 retary, the Secretary of Veterans Affairs, the Sec-
12 retary of Defense, or other Federal officers who are
13 appointed by the President with the advice and con-
14 sent of the Senate.
15 (d) CHAIR.—The Secretary shall, from among mem-
16 bers of the National Council on Graduate Nurse Training
17 appointed under subsection (c)(1), designate an individual
18 to serve as the Chair of the Council.

19 **Subpart C—Payments to Dental Schools**

20 **SEC. 3073. DENTAL SCHOOLS.**

21 (a) FEDERAL PAYMENTS TO DENTAL SCHOOLS.—
22 (1) ENTITLEMENT.—Each eligible school of
23 dentistry that in accordance with paragraph (2) sub-
24 mits to the Secretary an application for calendar
25 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 compli-

ance 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 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 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 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.—

1 For purposes of subsection (a), the programs described
2 in this section include a program to support projects to
3 increase the number of racial and ethnic underrepresented
4 minority and disadvantaged persons in medicine, osteop-
5 athy, dentistry, advanced practice nursing, public health,
6 psychology, and other health professions, including
7 projects to provide continuing financial assistance for such
8 persons entering health professions training programs; for
9 financial assistance for facility renovation or construction;
10 to increase support for recruitment and retention of such
11 persons in the health professions; to maintain efforts to
12 foster interest in health careers among such persons at
13 the preprofessional level; and to increase the number of
14 racial and ethnic minority health professions faculty at
15 programs that have a significant number of underrep-
16 resented racial and ethnic minorities.

17 (d) EXPANDING RURAL HEALTH CAREER OPPORTU-
18 NITIES AND RETENTION EFFORTS.—

19 (1) IN GENERAL.—For purposes of subsection
20 (a), the programs described in this section include
21 programs to support projects to increase the number
22 of individuals living in rural, underserved commu-
23 nities who enter the fields of medicine, osteopathy,
24 dentistry, advanced practice nursing, public health,
25 psychology, and other health professions, and to en-

1 courage the retention of such health care profes-
2 sionals in rural, underserved communities.
3 (2) RURAL HEALTH CAREER TRAINING.—
4 Projects to increase the number of individuals re-
5 cruited from rural, underserved areas include
6 projects—
7 (A) to provide continuing financial assist-
8 ance for such persons entering health profes-
9 sions education and training programs;
10 (B) to increase efforts to foster interest in
11 health careers among such persons at the
12 preprofessional level;
13 (C) to foster the development of training
14 curricula appropriate to rural health care set-
15 tings; and
16 (D) to increase support for recruitment of
17 such persons in the health professions.
18 (3) RETENTION OF RURAL HEALTH CARE PRO-
19 VIDERS.—Projects to encourage the retention of in-
20 dividuals providing health care in rural, underserved
21 areas include projects—
22 (A) to establish State and regional locum
23 tenans programs in rural health care settings so
24 that substitute health care providers are avail-

able 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, particu-

larly 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 pro-

1 vide directly, or facilitate the provision of,
2 labor exchange services to displaced health
3 care industry workers, including assess-
4 ment, counseling, testing, job-search assist-
5 ance, job referral and placement, and re-
6 ferral to training and educational pro-
7 grams, where appropriate.
8 (IV) The Secretary of Labor shall de-
9 velop performance goals for the effective
10 performance of such job banks with respect
11 to the number and quality of jobs listed,
12 the degree of participation by employers in
13 the affected community, and success in
14 placement of job bank users in jobs listed,
15 taking into account specific geographic,
16 economic and labor market characteristics
17 of the community served.
18 (D) A program to provide for joint labor-
19 management decision-making in the health care
20 sector on workplace matters related to the re-
21 structuring of the health care delivery system
22 provided for in this Act.
23 (E) A program to collect data regarding
24 the adequacy of the supply of health care work-
25 ers by occupation and sector of the health in-

1 dustry in light of existing and projected demand
2 for such workers.
3 (F)(i) A program to encourage the adop-
4 tion and utilization of high performance, high
5 quality health care delivery systems, including
6 employee participation committees and em-
7 ployee team systems that will contribute to
8 more effective health care by increasing the role
9 and the area of independent decisionmaking of
10 health care workers.
11 (ii) For purposes of this subparagraph, the
12 term ''employee participation committees''
13 means committees of workers independently se-
14 lected by and from a facility's nonmanagerial
15 workforce, or selected by unions where collective
16 bargaining agreements are in effect, and which
17 operate independently without employer inter-
18 ference and consult with management on issues
19 of efficiency, productivity, and quality of care,
20 except that an employee participation com-
21 mittee established under and operating in con-
22 formity with this subparagraph shall not be
23 considered a labor organization within the
24 meaning of section 2(5) of the National Labor
25 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 dissemination 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 dis-

placed 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 per-

formed 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 bar-

gaining 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 devoted 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 re-

search which holds the promise of prevention of intentional and unintentional injury and cure and prevention 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

1 devices, biotechnology and other health care innova-
2 tions. Over 90 percent of the most prescribed drugs
3 in the United States were discovered by the re-
4 search-based pharmaceutical industry.

5 (10) United States industry is the preeminent
6 world leader in the research, development and deliv-
7 ery of innovative therapies that improve the quality
8 of care for people throughout the world.

9 (11) Global health care budgets may constrict
10 private sector investment in research and develop-
11 ment. Further, they may be inconsistent with the
12 goal of developing promising new cost effective treat-
13 ment therapies.

14 (b) AVAILABILITY OF FUNDS.—

15 (1) IN GENERAL.—With respect to each cal-
16 endar year, the Secretary shall pay, from funds in
17 the Treasury not otherwise appropriated, for activi-
18 ties under this section, an amount equal to 0.25 per-
19 cent in 1996 and subsequent years, of all private
20 premiums required to be paid in accordance with the
21 Act.

22 (2) DEFINITION.—For purposes of this sub-
23 section, the term ''private health premiums'' means
24 all premium related payments made by employers,
25 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

1 centers, as the case may be, pursuant to allocation plans
2 developed by the various advisory councils to such direc-
3 tors, after consultation with such directors.''.

4 **SEC. 3202. HEALTH SERVICES RESEARCH.**

5 (a) IN GENERAL.—The Secretary shall distribute the
6 remainder of the amounts made available under section
7 3201 in a fiscal year (not to exceed 20 percent of the total
8 of amounts available in a fiscal year under such section),
9 to the Agency for Health Care Policy and Research for
10 policy-initiated and investigator-initiated research.

11 (b) RESEARCH ON HEALTH CARE REFORM.—Section
12 902 of the Public Health Service Act (42 U.S.C. 299a),
13 as amended by section 2(b) of Public Law 102–410 (106
14 Stat. 2094), is amended by adding at the end the following
15 subsection:

16 ''(f) RESEARCH ON HEALTH CARE REFORM.—

17 ''(1) IN GENERAL.—In carrying out section
18 901(b), the Administrator shall conduct and support
19 research on the reform of the health care system of
20 the United States, as directed by the Secretary.

21 ''(2) PRIORITIES.—In carrying out paragraph
22 (1), the Administrator shall give priority to the fol-
23 lowing:

24 ''(A) Conducting and supporting research
25 on the appropriateness and effectiveness of al-

1 ternative clinical strategies (including commu-
2 nity-based programs and preventive services),
3 the quality and outcomes of care, and adminis-
4 trative simplification.

5 "(B) Conducting and supporting research
6 on the appropriateness and effectiveness of al-
7 ternative community-based and clinical strate-
8 gies including integrating preventive services
9 into primary care, the effectiveness of preven-
10 tive counseling and health education, and the
11 efficacy and cost-effectiveness of clinical preven-
12 tive services.

13 "(C) Conducting and supporting research
14 on consumer choice and information resources;
15 on the role of shared decision making in en-
16 hancing patient and provider therapeutic op-
17 tions; the effects of health care reform on
18 health delivery systems; methods for risk ad-
19 justment; factors influencing access to health
20 care for vulnerable populations, including chil-
21 dren, persons with low-income, persons with
22 disabilities, or individuals with chronic or com-
23 plex health conditions, and primary care.

24 "(D) The development of clinical practice
25 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-

1 istrator to Congress (in accordance with subsection
2 (c)) concerning the results of the study and may
3 provide any recommendations determined to be nec-
4 essary to ensure the availability, access, and appro-
5 priate use of medical technologies to improve the
6 quality of health care in the United States.

7 (2) PURPOSE.—The purpose of the study under
8 paragraph (1) is to assess the impact of old, new,
9 and emerging medical technologies on health care
10 costs, social costs, and patient outcomes, and to
11 identify the factors, including government and pri-
12 vate payor reimbursement policies, that impede or
13 encourage innovation that improves patient out-
14 comes. Congress intends that the study complement
15 the technology assessment, outcomes research, and
16 guideline development activities authorized under
17 title IX of the Public Health Service Act by pro-
18 viding a comprehensive context for understanding
19 the economic and social factors related to the devel-
20 opment and use of medical technologies.

21 (3) DEFINITIONS.—As used in this section:

22 (A) ECONOMIC BENEFITS.—The term
23 ''economic benefits'' may include, based on
24 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

1 the biotechnology, pharmaceutical, and medical
2 device industries, and such other industries that
3 invent, develop, or market medical technologies.
4 (E) PATIENT OUTCOMES.—The term 'pa-
5 tient outcomes' may include—
6 (i) changes in clinical outcomes, in-
7 cluding stabilization of patients with pro-
8 gressive disease or health conditions, re-
9 sulting from the use of safe and effective
10 medical technology in prevention, diag-
11 nosis, or treatment;
12 (ii) changes in mortality, morbidity,
13 and health service use, including stabiliza-
14 tion of patients with progressive diseases;
15 (iii) changes in quality of life, includ-
16 ing ability to perform activities of daily liv-
17 ing, ability to return to work, relief from
18 discomfort or pain, alleviation of fatigue,
19 and improved mental functioning and well-
20 being; and
21 (iv) other outcomes that are deter-
22 mined by the Advisory Committee to be
23 relevant to assessing the impact of medical
24 technology.
25 (b) ADVISORY COMMITTEE.—

1 (1) IN GENERAL.—The Administrator shall es-
2 tablish an Advisory Committee to assist the Agency
3 for Health Care Policy and Research in preparing
4 the reports required under subsection (c). Except as
5 provided in paragraph (3), no member of the Advi-
6 sory Committee shall be an employee of the Federal
7 Government.

8 (2) MEMBERSHIP.—The Advisory Committee
9 shall be balanced in its representation of interested
10 parties and shall be composed of at least two indi-
11 viduals appointed by the President of the Institute
12 of Medicine and two individuals from each of the fol-
13 lowing categories to be appointed by the Adminis-
14 trator:

15 (A) Experts in medical technology assess-
16 ment.

17 (B) Experts in objective measures of im-
18 proved patient outcomes, such as clinical out-
19 comes, mortality, morbidity, and health service
20 use.

21 (C) Experts in subjective measures of im-
22 proved patient outcomes, such as quality of life.

23 (D) Experts in quantifying the economic
24 costs of disease to the health care system, in-
25 cluding public and private payers.

1 (E) Experts in quantifying the economic
2 impact of the medical technology industry.
3 (F) Experts in health statistics and epide-
4 miology.
5 (G) Physicians and other health care pro-
6 viders.
7 (H) Officers or employees of health plans
8 and other health care payers.
9 (I) Experts in the ethical implications of
10 health care.
11 (J) Experts in private sector financial mar-
12 ket investment in the medical technology indus-
13 try.
14 (K) Consumers and members of patient
15 advocacy groups.
16 (L) Health professional organizations.
17 (M) Officers or employees of biotechnology
18 companies.
19 (N) Officers or employees of medical device
20 companies.
21 (O) Officers or employees of pharma-
22 ceutical companies.
23 (3) EX OFFICIO.—The following individuals or
24 their designees shall serve as ex officio members of
25 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,

1 community-based providers, local health depart-
2 ments, State health departments, purchasing co-
3 operatives, and other sectors of State and local gov-
4 ernment that affect health, including education,
5 labor, transportation, welfare, criminal justice, envi-
6 ronment, agriculture, and housing.

7 (6) To conduct research on the effectiveness
8 and cost-effectiveness of public health programs.

9 **SEC. 3312. GRANTS TO STATES FOR CORE FUNCTIONS OF**
10 **PUBLIC HEALTH.**

11 (a) IN GENERAL.—The Secretary shall make grants
12 to States that submit applications as prescribed in section
13 3313 in an amount which bears the same ratio to the
14 available amounts for that fiscal year as the amounts pro-
15 vided by the Secretary under the provisions of law listed
16 in section 1902(2) of the Public Health Service Act to the
17 State for fiscal year 1981 bear to the total amount appro-
18 priated for such provisions of law for fiscal year 1981.

19 (b) CORE FUNCTIONS OF PUBLIC HEALTH PRO-
20 GRAMS.—For purposes of subsection (a), the functions de-
21 scribed in this subsection are, subject to subsection (c),
22 as follows:

23 (1)(A) Data collection, activities related to pop-
24 ulation health (including the population of individ-
25 uals 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 emphasis 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.

1 (11) Other relevant programs as determined ap-
2 propriate by the Secretary.
3 (c) ALLOCATION OF FUNDS.—In awarding grants to
4 States and local governments under a single application
5 under this section, the Secretary shall delineate to each
6 grantee the amounts to be dedicated to each of the pro-
7 grams described in subsection (b) and ensure that funding
8 allotments for each of such programs are consistent with
9 the requirements of Federal law.
10 (d) UNIFORM CORE FUNCTIONS OF PUBLIC HEALTH
11 REPORTING SYSTEM.—
12 (1) DEVELOPMENT.—The Secretary, acting
13 through the Director of the Office of Disease Pre-
14 vention and Health Promotion and the Director of
15 the Centers for Disease Control and Prevention, in
16 consultation with other relevant Federal and State
17 health agencies with data collection responsibilities,
18 shall develop and implement a Uniform Core Public
19 Health Functions Reporting System to collect pro-
20 gram and fiscal data concerning the programs de-
21 scribed in subsection (b).
22 (2) REQUIREMENTS.—The system developed
23 under paragraph (1) shall—
24 (A) use outcomes consistent with the goals
25 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.

1 (3) PROCESS FOR ESTABLISHING PRIORITIES.—
2 (A) PREFERENCE.—In establishing prior-
3 ities for grants under this part, preference shall
4 be given to projects that—
5 (i) reduce the prevalence of chronic
6 diseases including cardiovascular disease,
7 stroke, diabetes, and cancer;
8 (ii) prevent violence against women by
9 training providers and other health care
10 professionals to identify victims of domes-
11 tic violence, to provide appropriate exam-
12 ination and treatment, and to refer the vic-
13 tims for appropriate social and legal serv-
14 ices; and
15 (iii) establish community health advi-
16 sor programs described in subparagraph
17 (B).
18 (B) COMMUNITY HEALTH ADVISOR PRO-
19 GRAMS.—For purposes of subparagraph
20 (A)(iii), the term ''community health advisor
21 program'' means a program that performs the
22 following functions:
23 (i) Provides outreach services to in-
24 form the community of the availability of
25 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.

1 (E) Private practice health professionals,
2 including rural health clinics.
3 (F) Other publicly funded health or social
4 services agencies.
5 (b) APPLICATION.—To be eligible to receive a grant
6 under this section an entity shall prepare and submit to
7 the Secretary an application at such time, in such manner
8 and containing such information as the Secretary may re-
9 quire, including a description of the use to which the entity
10 will apply any amounts received under the grant.
11 (c) PREFERENCE.—The Secretary shall, in awarding
12 grants under this section, give preference to applicants
13 that—
14 (1) are health care providers in rural health
15 care networks or providers that propose to form
16 such networks, and the majority of the providers in
17 such a network are located in a medically under-
18 served or health professional shortage areas;
19 (2) can demonstrate broad geographic coverage
20 in the rural areas of the State, or States in which
21 the applicant is located;
22 (3) propose to use Federal funds to develop
23 plans for, or to establish, telemedicine systems that
24 will link rural hospitals and rural health care pro-
25 viders 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

1 transmission, or reconverts the received data signals
2 into user information, and is normally found on the
3 terminal of a circuit and on the premises of the end
4 user.

5 (3) FIBER OPTIC CABLE.—The term ''fiber
6 optic cable'' means a bundle of optical transmission
7 elements or waveguides usually consisting of a fiber
8 core and fiber cladding that can guide a lightwave
9 and that are incorporated into an assembly of mate-
10 rials that provide tensile strength and external pro-
11 tection.

12 (4) INTERACTIVE VIDEO EQUIPMENT.—The
13 term ''interactive video equipment'' means equip-
14 ment used to produce and prepare for transmission
15 audio and visual signals from at least two distant lo-
16 cations in order that individuals at such locations
17 can verbally and visually communicate with each
18 other, and such equipment includes monitors, other
19 display devices, cameras or other recording devices,
20 audio pick-up devices, and other related equipment.

21 (5) RURAL HEALTH CARE NETWORK.—The
22 term ''rural health care network'' means a group of
23 rural hospitals or other rural care health care pro-
24 viders (including clinics, physicians and non-physi-
25 cians 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

1 that are available for the purpose described in such sub-
2 section.

3 (c) ELIGIBLE ENTITIES.—For purposes of this part,
4 the term ''eligible entities'' means—

5 (1) covered entities as defined in section
6 340B(a)(4) of the Public Health Service Act (42
7 U.S.C. 256b(a)(4)), except that subsection
8 (a)(4)(L)(iii) and (a)(7) of such section shall not
9 apply;

10 (2) school health service sites under title III of
11 this Act;

12 (3) nonprofit hospitals meeting the criteria for
13 public hospitals which are eligible entities under sec-
14 tion 340B of the Public Health Service Act, except
15 that subsection (a)(4)(L)(iii) of such section shall
16 not apply, and children's hospitals meeting com-
17 parable criteria as determined appropriate by the
18 Secretary;

19 (4) public and private, nonprofit community
20 mental health centers and substance abuse treat-
21 ment providers receiving funds from the Substance
22 Abuse and Mental Health Services Administration;

23 (5) runaway homeless youth centers or transi-
24 tional living programs for homeless youth for the
25 provision of health services under the Runaway

1 Homeless Youth Act of 1974 (42 U.S.C. 5701 et
2 seq.);
3 (6) rural referral centers under section
4 1886(d)(5)(C) of the Social Security Act, except
5 that such eligibility is restricted to the receipt of
6 grants under section 3441; and
7 (7) public or nonprofit entities in nonmetropoli-
8 tan areas (as defined by the Department of Com-
9 merce) in a consortium of community-based pro-
10 viders that includes at least three of the following:
11 (A) community or migrant health centers;
12 (B) local health departments;
13 (C) community mental health centers;
14 (D) nonprofit hospitals;
15 (E) private practice health professionals,
16 including rural health clinics; or
17 (F) other publicly funded health or social
18 services agencies;
19 except that such eligibility is restricted to the receipt
20 of grants or contracts under section 3421(a).
21 (d) PRIORITY.—In making awards from amounts ap-
22 propriated under subsection (a)(1)(B) and section 3462,
23 the Secretary shall give the highest priority to providing
24 adequate assistance to federally qualified health centers
25 in order to ensure the provision of comprehensive primary

1 health care services, other covered services and benefits,
2 and enabling services to medically underserved populations
3 that were served by such centers prior to the date of enact-
4 ment of this Act, except that such federally qualified
5 health centers must continue to meet the requirements for
6 designation under section 1861(aa)(4) of the Social Secu-
7 rity Act.

8 (e) EQUITABLE DISTRIBUTION.—The Secretary
9 shall, in awarding grants, entering into contracts, and
10 making loans under this part, assure an equitable distribu-
11 tion of funds between rural and urban areas.

12 **Subpart B—Development of Community Health**
13 **Groups and Health Care Sites and Services**

14 **SEC. 3421. GRANTS AND CONTRACTS FOR DEVELOPMENT**
15 **OF PLANS AND NETWORKS AND THE EXPAN-**
16 **SION AND DEVELOPMENT OF HEALTH CARE**
17 **SITES AND SERVICES.**

18 (a) AUTHORITY.—

19 (1) IN GENERAL.—The Secretary may make
20 grants to and enter into contracts with eligible enti-
21 ties described in section 3411(c) for—

22 (A) the development of community health
23 groups whose principal purpose is to provide
24 the comprehensive benefit package under title I
25 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-

1 and provider-based health plans under section 1651(d),
2 are participants in the community health group, except in
3 areas such as rural areas, where providers are severely
4 limited in number.

5 (d) LIMITATION ON AWARDS.—The Secretary may
6 not make awards under subsection (a)(1) for more than
7 5 years to the same community health group.

8 (e) DEFINITIONS.—For purposes of this subpart:

9 (1) The term ''community health group''
10 means—

11 (A) a community health network that—

12 (i) is a public or nonprofit private
13 consortium of health care providers that
14 principally provides some of the items and
15 services of the standard benefit package to
16 medically underserved populations, and
17 residents of health professional shortage
18 areas;

19 (ii) has an agreement with one or
20 more health plans; and

21 (iii) has a written agreement gov-
22 erning the participation of health care pro-
23 viders in the consortium to which each par-
24 ticipating provider is a party; or

25 (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

1 (3) rural primary care hospitals under section
2 1820(i)(2) of such Act;
3 for the capital costs of developing community health
4 groups (as defined in section 3421(e)) and expanding ex-
5 isting health delivery sites or developing new health deliv-
6 ery sites.
7 (b) USE OF ASSISTANCE.—
8 (1) IN GENERAL.—The capital costs for which
9 grants and loans made pursuant to subsection (a)
10 may be expended are, subject to paragraphs (2) and
11 (3), the following:
12 (A) The acquisition, modernization, expan-
13 sion or construction of facilities, or the conver-
14 sion of unneeded hospital facilities to facilities
15 that will assure or enhance the provision and
16 accessibility of health care and enabling services
17 to medically underserved populations.
18 (B) The purchase of major equipment, in-
19 cluding equipment necessary for the support of
20 external and internal information systems.
21 (C) The establishment of reserves required
22 for furnishing services on a prepaid or capitated
23 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

1 hospitals described in section 3482. The preceding sen-
2 tence—
3 (1) is an entitlement in the Secretary on behalf
4 of such eligible hospitals (but is not an entitlement
5 in the State in which any such hospital is located or
6 in any individual receiving services from any such
7 hospital); and
8 (2) constitutes budget authority in advance of
9 appropriations Acts and represents the obligation of
10 the Federal Government to provide funding for such
11 payments in the amounts, and for the fiscal years,
12 specified in subsection (b).
13 (b) APPROPRIATIONS.—
14 (1) IN GENERAL.—For purposes of subsection
15 (a)(2), the amounts and fiscal years specified in this
16 subsection are (in the aggregate for all eligible hos-
17 pitals) $1,300,000,000 for the fiscal year in which
18 the general effective date occurs and for each subse-
19 quent fiscal year.
20 (2) SPECIAL RULE FOR YEARS BEFORE GEN-
21 ERAL EFFECTIVE DATE.—
22 (A) IN GENERAL.—For each of the fiscal
23 years 1996 and 1997, the amount specified in
24 this subsection for purposes of subsection (a)(2)
25 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.

1 (b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE
2 FOR UNCOVERED SERVICES.—
3 (1) ALLOCATION FROM TOTAL AMOUNT; DETER-
4 MINATION OF STATE-SPECIFIC PORTION OF ALLOCA-
5 TION.—Of the total amount available for payments
6 under this section in a year, 33.33 percent shall be
7 allocated to hospitals for assistance in furnishing
8 hospital services that are not covered services under
9 title I (in accordance with regulations of the Sec-
10 retary) or in furnishing hospital services to individ-
11 uals, including those residing in Southwestern bor-
12 der States, who are not eligible individuals under
13 title I, in accordance with this subsection. The
14 amount available for payments to eligible hospitals
15 in a State shall be equal to an amount determined
16 in accordance with a methodology specified by the
17 Secretary that shall take into consideration the vol-
18 ume of such services provided by hospital in the
19 State as compared to the volume of such services
20 provided by all eligible hospitals.
21 (2) DETERMINATION OF HOSPITAL PAYMENT
22 AMOUNT.—The amount of payment to an eligible
23 hospital in a State from the amount available for
24 payments to eligible hospitals in the State under
25 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

1 October 1, 1998, submit to the Secretary a report con-
2 taining the information described in subsection (b) on (in-
3 cluding a plan for) the measures to be implemented by
4 the State to achieve the integration of the mental illness
5 and substance abuse services of the State and its political
6 subdivisions with the mental illness and substance abuse
7 services that are included in the comprehensive benefit
8 package under title I. The plan required in the preceding
9 sentence shall meet the conditions described in section
10 3083(b). In addition, each State shall submit to the Sec-
11 retary a report containing the information described in
12 subsection (c) for each year in which the State participates
13 under title I up to and including the year 2001 or the
14 date on which an unlimited benefit for mental illness and
15 substance abuse services is provided, whichever occurs
16 later.

17 (b) REQUIRED CONTENTS OF INTEGRATION RE-
18 PORT.—With respect to the provision of items and services
19 relating to mental illness and substance abuse, the report
20 of a State under subsection (a) shall, at a minimum, con-
21 tain the following information:

22 (1) Information on the number of individuals
23 served by or through mental illness and substance
24 abuse programs administered by State and local

1 agencies and the proportion who are eligible persons
2 under title I.
3 (2) Information on the extent to which each
4 health provider furnishing mental illness and sub-
5 stance abuse services under a State program partici-
6 pates or will participate in one or more regional or
7 corporate alliance health plans, and, in the case of
8 providers that do not so participate, the reasons for
9 the lack of participation.
10 (3) With respect to the two years preceding the
11 year in which the State becomes a participating
12 State under title I—
13 (A) the amount of funds expended by the
14 State and its political subdivisions for each of
15 such years for items and services that are in-
16 cluded in the comprehensive benefit package
17 under such title;
18 (B) the amount of funds expended for
19 medically necessary and appropriate items and
20 services not included in such benefit package,
21 including medical care, other health care, and
22 supportive services related to the provision of
23 health care.
24 (4) An estimate of the amount that the State
25 will expend to furnish items and services not in-

1 cluded in such package once the expansion of cov-
2 erage for mental illness and substance abuse services
3 is implemented in the year 2001.

4 (5) A description of how the State will assure
5 that all individuals served by mental illness and sub-
6 stance abuse programs funded by the State will be
7 enrolled in a health plan and how mental illness and
8 substance abuse services not covered under the ben-
9 efit package will continue to be furnished to such en-
10 rollees.

11 (6) A description of the conditions under which
12 the integration of mental illness and substance abuse
13 providers into regional and corporate alliances can
14 be achieved, and an identification of changes in par-
15 ticipation and certification requirements that are
16 needed to achieve the integration of such programs
17 and providers into health plans.

18 (7) If the integration of mental illness and sub-
19 stance abuse programs operated by the State into
20 one or more health plans is not medically appro-
21 priate or feasible for one or more groups of individ-
22 uals treated under State programs, a description of
23 the reasons that integration is not feasible or appro-
24 priate and a plan for assuring the coordination for
25 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.

1 (3) The amount of funds expended on medically
2 necessary and appropriate items and services not
3 covered or reimbursed in the comprehensive benefit
4 package by source of revenue.
5 (4) The amount of funds expended by the State
6 on substance abuse and mental illness services for
7 individuals who are not eligible to receive the com-
8 prehensive benefit package pursuant to this Act, and
9 the source of revenue for such services.
10 (d) GENERAL PROVISIONS.—Reports under sub-
11 sections (b) and (c) shall be provided at the time and in
12 the manner prescribed by the Secretary. The Secretary
13 shall also determine what, if any, reports shall be sub-
14 mitted in years following the implementation of an unlim-
15 ited benefit for mental illness and substance abuse serv-
16 ices.
17 (e) REPORTING REQUIREMENT.—Each State shall
18 report annually to the Secretary on the incidence and
19 prevalence of mental illness and substance abuse disorders
20 in the prison population, changes in such incidence and
21 prevalence in the prison population, and potential causa-
22 tive factors with respect to such changes, including an es-
23 timate of the extent to which the denial of treatment, or
24 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

1 complied with section 1504 as it affects mental
2 health and substance abuse services;
3 (3) describe payment, utilization review, and
4 other mechanisms that the State will use to encour-
5 age appropriate service delivery and management of
6 costs;
7 (4) describe uniform patient placement criteria
8 that the State will use to ensure placement in appro-
9 priate substance abuse treatment programs;
10 (5) describe the processes the State will use to
11 ensure that individuals will continue to have access
12 to treatment through referrals from nonhealth public
13 entities, such the juvenile or criminal justice sys-
14 tems, or social service systems;
15 (6) specify the methods the State will use to en-
16 sure that individuals receiving services under the
17 program have access to all medically necessary and
18 appropriate mental health and substance abuse serv-
19 ices;
20 (7) define terms that will be used by the State
21 in determining the eligibility of individuals for serv-
22 ices under the program;
23 (8) describe how health plans will use services
24 under the comprehensive managed mental health

1 and substance abuse programs established under
2 this part;
3 (9) describe the role of local government in fi-
4 nancing and managing the integrated mental illness
5 and substance abuse treatment system;
6 (10) describe the sources of funding, including
7 Medicaid and the block grants authorized by title
8 XIX of the Public Health Service Act, that will be
9 used by the State, other than the grant received
10 under this part, to operate the program, and provide
11 the status of any request for a Medicaid waiver
12 made by the State to the Secretary;
13 (11) describe how the State provided for broad-
14 based public input in the development of the plan,
15 and the mechanism that will be used for ongoing
16 public comment on and review of amendments to the
17 plan; and
18 (12) describe grievance procedures that will be
19 available for individuals dissatisfied with their health
20 plan's participation in the comprehensive managed
21 mental health and substance abuse program, and
22 mechanisms that will be available to review the per-
23 formance of health plans and fee-for-service arrange-
24 ments 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 educational 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 im-

provement 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

1 waiver has been inadequate to justify a continuation
2 of the waiver or if it is no longer necessary to
3 achieve its original purpose.
4 (e) DEFINITIONS.—As used in this section:
5 (1) COMPREHENSIVE SCHOOL HEALTH EDU-
6 CATION.—The term ''comprehensive school health
7 education'' means a planned, sequential program of
8 health education that addresses the physical, emo-
9 tional and social dimensions of student health in
10 kindergarten through grade 12. Such program
11 shall—
12 (A) be designed to assist students in devel-
13 oping the knowledge and behavioral skills need-
14 ed to make positive health choices and maintain
15 and improve their health, prevent disease and
16 injuries, and reduce risk behaviors which ad-
17 versely impact health;
18 (B) be comprehensive and include a variety
19 of components addressing personal health, com-
20 munity and environmental health, injury pre-
21 vention and safety, nutritional health, the ef-
22 fects of substance use and abuse, consumer
23 health regarding the benefits and appropriate
24 use of medical services including immunizations
25 and other clinical preventive services, and other

1 components deemed appropriate by the local
2 educational agencies;
3 (C) be designed to be linguistically and cul-
4 turally competent and responsive to the needs
5 of the students served; and
6 (D) address locally relevant priorities as
7 determined by parents, students, teachers, and
8 school administrators and health officials.
9 (2) ELIGIBLE STATE.—The term ''eligible
10 State'' means a State with a memorandum of under-
11 standing or a written cooperative agreement entered
12 into by the agencies responsible for health and edu-
13 cation concerning the planning and implementation
14 of comprehensive school health education programs.
15 Among these States a priority shall be given to
16 qualified States as defined in section 3682(c).
17 (3) STATE EDUCATIONAL AGENCY.—The term
18 ''State educational agency'' means the officer or
19 agency primarily responsible for the State super-
20 vision of public elementary and secondary schools.
21 (4) LOCAL EDUCATIONAL AGENCY.—The term
22 ''local educational agency'' means a public board of
23 education or other public authority legally con-
24 stituted within a State for either administrative con-
25 trol 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 Adminis-

1 tration, the Office of School Health Education within the
2 Department of Education, and other Federal agencies and
3 departments which have responsibility for components of
4 school health and education.

5 (b) CO-CHAIRPERSONS.—The Assistant Secretary for
6 Health and the Assistant Secretary for Elementary and
7 Secondary Education shall serve as co-chairpersons of the
8 task force established under subsection (a).

9 (c) FUNCTIONS AND ACTIVITIES.—The task force es-
10 tablished under subsection (a) shall—

11 (1) review and coordinate all Federal efforts in
12 school health education and health services;

13 (2) provide scientific and technical advice con-
14 cerning the development and implementation of
15 model comprehensive school health education pro-
16 grams and curricula;

17 (3) develop model student learning objectives
18 and assessment instruments that shall be made
19 available to all States;

20 (4) develop a uniform grant application form (a
21 form that serves as the principal document con-
22 taining the core information concerning a particular
23 entity) and procedures that may be used with re-
24 spect to all school health education-related programs
25 (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 Representatives 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 sec-

tion 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 citywide 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

1 (8) for applicants in rural areas, the assurances
2 required under paragraph (4) shall be fulfilled to the
3 maximum extent possible.
4 (e) STATE LAWS.—Notwithstanding any other provi-
5 sion in this part, no school based health clinic may provide
6 services, to any minor, when to do so is a violation of State
7 laws or regulations pertaining to informed consent for
8 medical services to minors.
9 (f) LIMITATION ON ADMINISTRATIVE FUNDS.—In
10 the case of a State applying on behalf of local educational
11 partnerships, the applicant may retain not more than 5
12 percent of grants awarded under this subpart for adminis-
13 trative costs.
14 (g) DURATION OF GRANT.—A grant under this sec-
15 tion shall be for a period determined appropriate by the
16 Secretary.
17 (h) AMOUNT OF GRANT.—The annual amount of a
18 grant awarded under this section shall not be more than
19 $200,000 per school-based or school-linked health service
20 site.
21 (i) FEDERAL SHARE.—
22 (1) IN GENERAL.—Subject to paragraph (3), a
23 grant for services awarded under this section may
24 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, dentistry, 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 employers, 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—

1 "(I) $444,000,000 for fiscal year 1996;
2 "(II) $696,000,000 for fiscal year 1997;
3 "(III) $775,000,000 for fiscal year 1998;
4 "(IV) $924,000,000 for fiscal year 1999; and
5 "(V) $1,077,000,000 for fiscal year 2000.
6 "(ii) The Secretary of Agriculture shall be entitled
7 to receive the funds and shall accept the funds.
8 "(C) In lieu of obligating the funds made available
9 under subparagraph (B) to carry out this subsection, if
10 the amount appropriated (in addition to the amount ap-
11 propriated under subparagraph (B)(i)) to carry out this
12 subsection for—
13 "(i) fiscal year 1996 is less than
14 $3,470,000,000, the amount referred to in subpara-
15 graph (B)(i)(I) shall be obligated by the Secretary,
16 during the period beginning December 31, 1995,
17 and ending June 30, 1996, to increase the special
18 assistance factor prescribed under section 11(a) of
19 the National School Lunch Act (42 U.S.C.
20 1759a(a)) for free lunches served under the school
21 lunch program (as established under section 4 of
22 such Act (42 U.S.C. 1753));
23 "(ii) fiscal year 1997 is less than
24 $3,470,000,000, the amount referred to in subpara-
25 graph (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 coordinated 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 dis-

ease 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 residing 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 amend-

ment 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.

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

1 standard health plan under subtitle B of title I of the
2 Health Security Act shall provide each individual who
3 meets the requirements of paragraph (2) with the oppor-
4 tunity to elect (by submitting an application at such time
5 and in such manner as specified by the Secretary) to con-
6 tinue enrollment in such plan (for the same benefits as
7 other individuals enrolled in the plan) and to have pay-
8 ments made by the Secretary to the plan on the individ-
9 ual's behalf in accordance with paragraph (3). The pre-
10 mium imposed with respect to such an individual by the
11 plan shall be in an amount (determined in accordance with
12 rules of the Secretary and notwithstanding other provi-
13 sions of such Act) which reflects the difference between
14 the premium otherwise established (adjusted by a factor
15 to reflect the actuarial difference between medicare bene-
16 ficiaries and other plan enrollees) and the amount payable
17 under paragraph (3).

18 "(2) An individual meets the requirements of this
19 paragraph if the individual is—

20 "(A) enrolled in the health plan of an eligible
21 organization in a month in which the individual is
22 either not entitled to benefits under part A, or is an
23 employee (as defined in the Health Security Act) or
24 the spouse or dependent of an employee,

1 "(B) entitled to benefits under part A and en-
2 rolled under part B in the succeeding month,
3 "(C) a community-rated individual under the
4 Health Security Act in that succeeding month, and
5 "(D) not an experience-rated employee (as de-
6 fined in the Health Security Act) or the spouse or
7 dependent of an experience-rated employee in that
8 succeeding month.
9 "(3) The Secretary shall make a payment to an eligi-
10 ble organization on behalf of each individual enrolled with
11 the organization for whom an election is in effect under
12 this subsection in an amount determined by the rate speci-
13 fied by subsection (a)(1)(C) (notwithstanding the second
14 sentence of paragraph (1)). Such payment shall be made
15 from the Federal Hospital Insurance Trust Fund and the
16 Federal Supplementary Medical Insurance Trust Fund as
17 provided under subsection (a)(5) (other than as provided
18 under subparagraph (B) of that paragraph).
19 "(4) The period for which payment may be made
20 under paragraph (3)—
21 "(A) begins with the first month for which the
22 individual meets the requirements of paragraph (2)
23 (or a later month, in the case of a late application,
24 as may be specified by the Secretary); and
25 "(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

1 Act) and shall reduce by 10.41 percent the
2 unadjusted hospital-specific rate (as described in 42
3 CFR 412.328(e)(1), as in effect on the date of the
4 enactment of the Health Security Act).''.
5 (2) REDUCTION IN UPDATE.—Section
6 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—
7 (A) in subparagraph (B)(i)—
8 (i) by striking ''and (II)'' and insert-
9 ing ''(II)'', and
10 (ii) by striking the semicolon at the
11 end and inserting the following: '', and
12 (III) an annual update factor established
13 for the prospective payment rates applica-
14 ble to discharges in a fiscal year which
15 (subject to reduction under subparagraph
16 (C)) will be based upon such factor as the
17 Secretary determines appropriate to take
18 into account amounts necessary for the ef-
19 ficient and effective delivery of medically
20 appropriate and necessary care of high
21 quality;'';
22 (B) by redesignating subparagraph (C) as
23 subparagraph (D); and
24 (C) by inserting after subparagraph (B)
25 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

1 Secretary shall take into account the impact of new
2 technologies, survival rates, and changes in the prac-
3 tice of rehabilitation medicine.''.

4 (2) TARGET AMOUNT CALCULATION FOR REHA-
5 BILITATION HOSPITALS AND DISTINCT PART
6 UNITS.—

7 (A) IN GENERAL.—Section 1886(b)(3) (42
8 U.S.C. 1395ww(b)(3)) is amended—

9 (i) in subparagraph (A), by striking
10 ''(D), and (E)'' and inserting ''(D), (E),
11 and (F)'';

12 (ii) in subparagraph (B)(ii), by strik-
13 ing ''and (E)'' and inserting ''(E), and
14 (F)''; and

15 (iii) by adding at the end the fol-
16 lowing new subparagraph:

17 ''(F)(i) Subject to clause (ii), for cost re-
18 porting periods beginning on or after October 1,
19 1994, in the case of a hospital described in sub-
20 section (d)(1)(B)(ii) or a rehabilitation unit de-
21 scribed in such subparagraph, the term 'target
22 amount' means—

23 ''(I) with respect to the first 12-
24 month cost reporting period in which this

1 subparagraph is applied to the hospital or
2 unit—
3 ''(aa) the allowable operating
4 costs of inpatient hospital services (as
5 defined in subsection (a)(4)) recog-
6 nized under this title for the hospital
7 or unit for the 12-month cost report-
8 ing period (in this subparagraph re-
9 ferred to as the 'base cost reporting
10 period') preceding the first cost re-
11 porting period for which this subpara-
12 graph was in effect with respect to
13 such hospital, increased (in a com-
14 pounded manner), by
15 ''(bb) the applicable percentage
16 increases applied to such hospital or
17 unit under this paragraph for cost re-
18 porting periods after the base cost re-
19 porting period and up to and includ-
20 ing such first 12-month cost reporting
21 period, or
22 ''(II) with respect to a later cost re-
23 porting period, the target amount for the
24 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

1 developed under subparagraph (A) to the Con-
2 gress.
3 (b) ASSIGNMENT OF NEW BASE YEAR FOR CER-
4 TIFIED LONG-STAY HOSPITALS THAT ALSO SERVE A SIG-
5 NIFICANT PROPORTION OF LOW-INCOME PATIENTS.—
6 (1) REBASING FOR LONG-TERM HOSPITALS.—
7 (A) IN GENERAL.—Section 1886(b)(3) (42
8 U.S.C. 1395ww(b)(3)), as amended by sub-
9 section (a), is further amended—
10 (i) in subparagraph (A), by striking
11 ''(E), and (F)'' and inserting ''(E), (F),
12 and (G)'';
13 (ii) in subparagraph (B)(ii), by strik-
14 ing ''(E), and (F)'' and inserting ''(E),
15 (F), and (G)''; and
16 (iii) by inserting after subparagraph
17 (F) the following new subparagraph:
18 ''(G)(i) For cost reporting periods begin-
19 ning on or after October 1, 1994, in the case
20 of a hospital described in subsection
21 (d)(1)(B)(iv) that—
22 ''(I) has not received the additional
23 payment amount described in paragraph
24 (1)(A) for at least the preceding 2 consecu-
25 tive 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 facilities 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;

1 "(ii) at the time such facility applies
2 to the State for designation as a rural pri-
3 mary care hospital, is a hospital (or, in the
4 case of a facility that closed during the 12-
5 month period that ends on the date the fa-
6 cility applies for such designation, at the
7 time the facility closed), with a participa-
8 tion agreement in effect under section
9 1866(a);
10 "(iii) has in effect an agreement to
11 participate with other hospitals and facili-
12 ties in a rural health network;
13 "(iv) provides 24-hour emergency
14 services to ill or injured persons prior to
15 admission to the facility or prior to their
16 transportation to a full-service hospital;
17 "(v) provides not more than 15 inpa-
18 tient beds (meeting such conditions as the
19 Secretary may establish) for providing
20 acute inpatient care;
21 "(vi) provides inpatient care for a pe-
22 riod not to exceed an average length of 96
23 hours (unless a longer period is required
24 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 facility 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);

"(2) is designated as a rural primary care hospital or medical assistance facility by the State in which it is located; and

"(3) meets such other criteria as the Secretary may require.

"(g) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a rural primary care hospital or medical assistance facility solely because, at the time the facility applies to the State for designation as a rural primary care hospital or medical assistance facility, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital

1 facilities are used for the furnishing of extended care serv-
2 ices, except that the number of beds used for the fur-
3 nishing of such services may not exceed the total number
4 of licensed inpatient beds at the time the facility applies
5 to the State for such designation (minus the number of
6 inpatient beds used for providing inpatient care in a rural
7 primary care facility pursuant to subsection (d)(2)(A)(vi)).
8 The Secretary may establish additional conditions of par-
9 ticipation for rural primary care hospitals with a substan-
10 tial number of such beds. For purposes of the first sen-
11 tence, the number of beds of the facility used for the fur-
12 nishing of extended care services shall not include any
13 beds of a unit of the facility that is licensed as a distinct-
14 part skilled nursing facility at the time the facility applies
15 to the State for designation as a rural primary care hos-
16 pital or medical assistance facility.

17 "(h) GRANTS.—

18 "(1) LIMITED SERVICE HOSPITAL PROGRAM.—
19 The Secretary may award grants to States that have
20 submitted applications in accordance with subsection
21 (c) for—

22 "(A) engaging in activities relating to plan-
23 ning and implementing a rural health care plan;

24 "(B) in the case of a rural primary care
25 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 program 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

1 DRG basis instead of using the 96-hour average length
2 of stay criteria described in subsection (d)(2)(A)(vii).
3 "(j) WAIVER OF CONFLICTING PART A PROVI-
4 SIONS.—The Secretary is authorized to waive such provi-
5 sions of this part and part C as are necessary to conduct
6 the program established under this section.
7 "(k) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated from the Federal Hos-
9 pital Insurance Trust Fund—
10 "(1) for making grants under subsection (h)(1)
11 to States that have established a rural primary care
12 hospital program in the State under subsection
13 (d)(1)(A), $15,000,000 for each of fiscal years 1993
14 through 1995; and
15 "(2) for making grants to all States under sub-
16 section (h), $25,000,000 in each of the fiscal years
17 1996 through 1999.".
18 (b) PART A AMENDMENTS RELATING TO RURAL PRI-
19 MARY CARE HOSPITALS AND MEDICAL ASSISTANCE FA-
20 CILITIES.—
21 (1) DEFINITIONS.—Section 1861 (42 U.S.C.
22 1395x) is amended by adding at the end the fol-
23 lowing new subsection:

1 ''MEDICAL ASSISTANCE FACILITY; MEDICAL ASSISTANCE
2 FACILITY SERVICES
3 ''(oo)(1) The term 'medical assistance facility' means
4 a facility certified by the Secretary as a medical assistance
5 facility under section 1820(f).
6 ''(2) The term 'medical assistance facility services'
7 means items and services, furnished to an inpatient for
8 a medical assistance facility by such facility, that would
9 be inpatient hospital services if furnished to an inpatient
10 of a hospital by a hospital.''.
11 (2) COVERAGE AND PAYMENT.—(A)(i) Section
12 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by
13 striking ''inpatient hospital services'' the first place
14 it appears and inserting '', inpatient hospital serv-
15 ices and inpatient medical assistance facility serv-
16 ices''; and
17 (ii) by striking ''inpatient hospital services'' the
18 second place it appears and inserting ''such serv-
19 ices''.
20 (B) Section 1814 (42 U.S.C. 1395f) is amend-
21 ed—
22 (i) in subsection (b), by striking ''inpatient
23 rural primary care hospital services,'' and in-
24 serting ''inpatient rural primary care hospital
25 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 inserting ''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

1 care hospital services, or inpatient medical assist-
2 ance facility services''; and
3 (B) by striking ''and inpatient rural primary
4 care hospital services''.
5 (2) Sections 1813(a) and 1813(b)(3)(A) (42 U.S.C.
6 1395e(a), 1395e(b)(3)(A)) are each amended by striking
7 ''inpatient hospital services'' each place it appears and in-
8 serting ''inpatient hospital services, inpatient rural pri-
9 mary care hospital services, or inpatient medical assist-
10 ance facility services,''.
11 (3) Section 1813(b)(3)(B) (42 U.S.C.
12 1395e(b)(3)(B)) is amended by striking ''inpatient hos-
13 pital services'' and inserting ''inpatient hospital services,
14 inpatient rural primary care hospital services, inpatient
15 medical assistance facility services,''.
16 (4) Section 1861(a) (42 U.S.C. 1395x(a)) is amend-
17 ed—
18 (A) in paragraph (1), by striking ''inpatient
19 hospital services'' and inserting ''inpatient hospital
20 services, inpatient rural primary care hospital serv-
21 ices, inpatient medical assistance facility services,'';
22 and
23 (B) in paragraph (2), by striking ''hospital''
24 and inserting ''hospital, rural primary care hospital,
25 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 reduced 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 (1) LIMITATIONS DESCRIBED.—Part B of title
2 XVIII (42 U.S.C. 1831 et seq.) is amended by in-
3 serting after section 1848 the following new section:
4 "LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES
5 RELATING TO INPATIENT STAYS IN CERTAIN HOSPITALS
6 "SEC. 1849. (a) DEFINITIONS.—In this section, the
7 following definitions apply:
8 "(1) HOSPITAL.—The term 'hospital' means a
9 subsection (d) hospital as defined in section
10 1886(d)(1)(B).
11 "(2) MEDICAL STAFF.—An individual fur-
12 nishing a physician's service is considered to be on
13 the medical staff of a hospital—
14 "(A) if (in accordance with requirements
15 for hospitals established by the Joint Commis-
16 sion on Accreditation of Health Organiza-
17 tions)—
18 "(i) the individual is subject to by-
19 laws, rules, and regulations established by
20 the hospital to provide a framework for the
21 self-governance of medical staff activities;
22 "(ii) subject to such bylaws, rules, and
23 regulations, the individual has clinical
24 privileges granted by the hospital's gov-
25 erning 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 individual 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).

1 "(c) DETERMINATION OF ALLOWABLE AVERAGE PER
2 ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC
3 PER ADMISSION RELATIVE VALUES.—
4 "(1) ALLOWABLE AVERAGE PER ADMISSION
5 RELATIVE VALUE.—
6 "(A) URBAN HOSPITALS.—In the case of a
7 hospital located in an urban area, the allowable
8 average per admission relative value established
9 under this subsection for a year is equal to 125
10 percent (or 120 percent for years after 1999) of
11 the median of 1996 hospital-specific per admis-
12 sion relative values determined under paragraph
13 (2) for all hospital medical staffs.
14 "(B) RURAL HOSPITALS.—In the case of a
15 hospital located in a rural area, the allowable
16 average per admission relative value established
17 under this subsection for 1998 and each suc-
18 ceeding year, is equal to 140 percent of the me-
19 dian of the 1996 hospital-specific per admission
20 relative values determined under paragraph (2)
21 for all hospital medical staffs.
22 "(2) HOSPITAL-SPECIFIC PER ADMISSION REL-
23 ATIVE VALUE.—
24 "(A) IN GENERAL.—The hospital-specific
25 per admission relative value projected for a hos-

pital (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 determine 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

1 (G) of section 1886(d)(5). The adjustment for
2 teaching status or disproportionate share shall
3 not be less than zero.

4 "(d) AMOUNT OF REDUCTION.—The amount of pay-
5 ment otherwise made under this part for a physician's
6 service that is subject to a reduction under subsection (b)
7 during a year shall be reduced by 15 percent, in the case
8 of a service furnished by a member of the medical staff
9 of the hospital for which the Secretary determines under
10 subsection (b)(1) that the hospital medical staff's pro-
11 jected relative value per admission exceeds the allowable
12 average per admission relative value.

13 "(e) RECONCILIATION OF REDUCTIONS BASED ON
14 HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION
15 WITH ACTUAL RELATIVE VALUES.—

16 "(1) DETERMINATION OF ACTUAL AVERAGE
17 PER ADMISSION RELATIVE VALUE.—Not later than
18 October 1 of each year (beginning with 1999), the
19 Secretary shall determine the actual average per ad-
20 mission relative value (as determined pursuant to
21 section 1848(c)(2)) for the physicians' services fur-
22 nished by members of a hospital's medical staff to
23 inpatients of the hospital during the previous year,
24 on the basis of claims for payment for such services
25 that are submitted to the Secretary not later than

1 90 days after the last day of such previous year. The
2 actual average per admission relative value shall be
3 adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hos-
4 pital medical staff (as determined by the Secretary
5 under subsection (c)(2)(C)).
6
7 "(2) RECONCILIATION WITH REDUCTIONS
8 TAKEN.—
9 "(A) REIMBURSEMENT.—In the case of a
10 hospital for which the payment amounts for
11 physicians' services furnished by members of
12 the hospital's medical staff to inpatients of the
13 hospital were reduced under this section for a
14 year—
15 "(i) if the actual average per admis-
16 sion relative value for such hospital's med-
17 ical staff during the year (as determined
18 by the Secretary under paragraph (1)) did
19 not exceed the allowable average per ad-
20 mission relative value applicable to the hos-
21 pital's medical staff under subsection
22 (c)(1) for the year, the Secretary shall re-
23 imburse the fiduciary agent for the medical
24 staff by the amount by which payments for
25 such services were reduced for the year

1 under subsection (d), including interest at
2 an appropriate rate determined by the Sec-
3 retary; and
4 ''(ii) if the actual average per admis-
5 sion relative value for such hospital's med-
6 ical staff during the year (as determined
7 by the Secretary under paragraph (1)) ex-
8 ceeded the allowable average per admission
9 relative value applicable to the hospital's
10 medical staff under subsection (c)(1) for
11 the year, the Secretary shall reimburse the
12 fiduciary agent for the medical staff, as a
13 percent of the total amount of payment
14 otherwise determined under this part for
15 physicians' services furnished during the
16 year to inpatients of the hospital by the
17 hospital's medical staff (prior to the reduc-
18 tion under subsection (d)), the difference
19 between 15 percentage points and the ac-
20 tual number of percentage points that the
21 medical staff exceeded the allowable aver-
22 age per admission relative value, including
23 interest at any appropriate rate determined
24 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 member 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 serv-

ices, 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 increase 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 indi-

1 vidual in an urban area by such practitioner when such
2 practitioner refers such individual to an urban area for
3 the furnishing of services'' after ''as defined by the Sec-
4 retary''.

5 (d) CONFORMING AMENDMENTS.—

6 (1) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4))
7 is amended by striking ''subsection (s)(2)(K)(i)'' and
8 inserting ''subsection (s)(2)(K)''.

9 (2) Section 1862(a)(14) (42 U.S.C.
10 1395y(a)(14)), as amended by section4108(b)(4)(K),
11 is amended by striking ''section 1861(s)(2)(K)(i)''
12 and inserting ''section 1861(s)(2)(K)''.

13 (3) Section 1866(a)(1)(H) (42 U.S.C.
14 1395cc(a)(1)(H)), as amended by section
15 4108(b)(4)(L)(ii), is further amended by striking
16 ''section 1861(s)(2)(K)(i)'' and inserting ''section
17 1861(s)(2)(K)''.

18 (e) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to services furnished on or after
20 January 1, 1997.

21 **SEC. 4213. ELIMINATION OF BALANCE BILLING.**

22 Effective January 1, 1996, notwithstanding any pro-
23 vision of title XVIII of the Social Security Act (42 U.S.C.
24 1395 et seq.), a nonparticipating physician, or nonparticipating
25 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 fur-

1 nished to individuals entitled to benefits under such
2 title:
3 (A) Facility, professional, and related serv-
4 ices relating to cataract surgery.
5 (B) Coronary artery bypass surgery and
6 related services.
7 (C) Such other services as the Secretary
8 and the center may agree to cover under the
9 contract.
10 (b) REBATE OF PORTION OF SAVINGS.—In the case
11 of any services provided under a contract conducted under
12 subsection (a), the Secretary shall make a payment to
13 each individual to whom such services are furnished (at
14 such time and in such manner as the Secretary may pro-
15 vide) in an amount equal to 10 percent of the amount by
16 which—
17 (1) the amount of payment that would have
18 been made by the Secretary under title XVIII of the
19 Social Security Act to the center for such services if
20 the services had not been provided under the con-
21 tract, exceeds
22 (2) the amount of payment made by the Sec-
23 retary under such title to the center for such serv-
24 ices.

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

1 group of basic benefits described in subsection
2 (p)(2)(B), and
3 ''(III) an enrollee's liability under such pol-
4 icy for physician's services covered under part
5 B of this title is limited to the nominal copay-
6 ments described in subclause (II),
7 the policy shall nevertheless be treated as meeting
8 those requirements if the policy meets the require-
9 ments of subparagraph (B).
10 ''(B) A policy meets the requirements of this sub-
11 paragraph if—
12 ''(i) full benefits are provided for items and
13 services furnished through a network of entities
14 which have entered into contracts or agreements
15 with the issuer of the policy,
16 ''(ii) full benefits are provided for items and
17 services furnished by other entities if the services are
18 medically necessary and immediately required be-
19 cause of an unforeseen illness, injury, or condition
20 and it is not reasonable given the circumstances to
21 obtain the services through the network,
22 ''(iii) the network offers sufficient access,
23 ''(iv) the issuer of the policy has arrangements
24 for an ongoing quality assurance program for items
25 and services furnished through the network,

1 "(v)(I) the issuer of the policy provides to each
2 enrollee at the time of enrollment an explanation
3 of—
4 "(aa) the restrictions on payment under
5 the policy for services furnished other than by
6 or through the network,
7 "(bb) out of area coverage under the pol-
8 icy,
9 "(cc) the policy's coverage of emergency
10 services and urgently needed care, and
11 "(dd) the availability of a policy through
12 the entity that meets the 1991 Model NAIC
13 Regulation or 1991 Federal Regulation without
14 regard to this subsection and the premium
15 charged for such policy, and
16 "(II) each enrollee prior to enrollment acknowl-
17 edges receipt of the explanation provided under sub-
18 clause (I), and
19 "(vi) the issuer of the policy makes available to
20 individuals, in addition to the policy described in this
21 subsection, any policy (otherwise offered by the
22 issuer to individuals in the State) that meets the
23 1991 Model NAIC Regulation or 1991 Federal Reg-
24 ulation and other requirements of this section with-
25 out regard to this subsection.

1 ''(C)(i) A policy described in this subparagraph—
2 ''(I) is offered by an eligible organization (as
3 defined in section 1876(b)),
4 ''(II) is not a policy or plan providing benefits
5 pursuant to a contract under section 1876 or an ap-
6 proved demonstration project described in section
7 603(c) of the Social Security Amendments of 1983,
8 section 2355 of the Deficit Reduction Act of 1984,
9 or section 9412(b) of the Omnibus Budget Reconcili-
10 ation Act of 1986, and
11 ''(III) provides benefits which, when combined
12 with benefits which are available under this title, are
13 substantially similar to benefits under policies of-
14 fered to individuals who are not entitled to benefits
15 under this title.
16 ''(ii) In making a determination under subclause (III)
17 of clause (i) as to whether certain benefits are substan-
18 tially similar, there shall not be taken into account, except
19 in the case of preventive services, benefits provided under
20 policies offered to individuals who are not entitled to bene-
21 fits under this title which are in addition to the benefits
22 covered by this title and which are benefits an entity must
23 provide in order to meet the definition of an eligible orga-
24 nization under section 1876(b)(1).''.

1 (b) RENEWABILITY OF MEDICARE SELECT POLI-
2 CIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is
3 amended—
4 (1) by striking ''(1) Each'' and inserting
5 ''(1)(A) Except as provided in subparagraph (B),
6 each'';
7 (2) by redesignating subparagraphs (A) and
8 (B) as clauses (i) and (ii), respectively; and
9 (3) by adding at the end the following new sub-
10 paragraph:
11 ''(B)(i) In the case of a policy that meets the
12 requirements of subsection (t), an issuer may cancel
13 or nonrenew such policy with respect to an indi-
14 vidual who leaves the service area of such policy; ex-
15 cept that, if such individual moves to a geographic
16 area where such issuer, or where an affiliate of such
17 issuer, is issuing medicare supplemental policies,
18 such individual must be permitted to enroll in any
19 medicare supplemental policy offered by such issuer
20 or affiliate that provides benefits comparable to or
21 less than the benefits provided in the policy being
22 canceled or nonrenewed. An individual whose cov-
23 erage is canceled or nonrenewed under this subpara-
24 graph shall, as part of the notice of termination or
25 nonrenewal, be notified of the right to enroll in other

1 medicare supplemental policies offered by the issuer
2 or its affiliates.
3 "(ii) For purposes of this subparagraph, the
4 term 'affiliate' shall have the meaning given such
5 term by the 1991 NAIC Model Regulation.".
6 (c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C.
7 1395ss(t)(2)) is amended—
8 (1) by striking "(2)" and inserting "(2)(A)";
9 (2) by redesignating subparagraphs (A), (B),
10 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-
11 spectively;
12 (3) in clause (iv), as redesignated—
13 (A) by striking "paragraph (1)(E)(i)" and
14 inserting "paragraph (1)(B)(v)(I); and
15 (B) by striking "paragraph (1)(E)(ii)" and
16 inserting "paragraph (1)(B)(v)(II)";
17 (4) by striking "the previous sentence" and in-
18 serting "this subparagraph"; and
19 (5) by adding at the end the following new sub-
20 paragraph:
21 "(B) If the Secretary determines that an issuer of
22 a policy approved under paragraph (1) has made a mis-
23 representation to the Secretary or has provided the Sec-
24 retary with false information regarding such policy, the
25 issuer is subject to a civil money penalty in an amount

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;

1 "(2) affecting the amount, duration, and scope
2 of any medical assistance consisting of payment for
3 the items and services described in paragraph (1); or
4 "(3) prohibiting payment of medical assistance
5 for items and services covered under the standard
6 benefits package to the extent that the items and
7 services under this part exceed the items and serv-
8 ices covered under such package with respect to
9 amount, duration, and scope.
10 "(c) EXCEPTIONS.—Subsection (a) shall not affect
11 the provision of medical assistance consisting of payment
12 for items and services in the standard benefits package—
13 "(1) which are provided to—
14 "(A) an individual eligible for medical as-
15 sistance under the State plan who is not a pre-
16 mium subsidy eligible individual (as defined in
17 6002(a)(2) of the Health Security Act);
18 "(B) an individual with respect to whom
19 supplemental security income benefits are being
20 paid under title XVI; and
21 "(C) an individual who is eligible for bene-
22 fits under part A of title XVIII; or
23 "(2) which consist of emergency services to cer-
24 tain aliens under section 1903(v)(2).
25 "(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 package 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

1 assistance under any plan of the State approved
2 under part A or part E of title IV.
3 "(4) NON-CASH ELIGIBLES PAYMENT
4 AMOUNT.—
5 "(A) IN GENERAL.—The non-cash eligibles
6 payment amount for a State for a year is an
7 amount equal to the State's base payment
8 amount (determined under subparagraph (B))
9 for the applicable year updated by the percent-
10 age change in the health expenditures index (as
11 described in paragraph (5)(A)) and the State
12 population index (as described in paragraph
13 (5)(C)) during the period beginning on October
14 1, 1994, and ending on December 31 of the
15 year preceding the applicable year (as deter-
16 mined by the Secretary).
17 "(B) STATE BASE PAYMENT AMOUNT.—
18 "(i) IN GENERAL.—The base payment
19 amount for a State for an applicable year
20 shall be an amount, as determined by the
21 Secretary, equal to the total expenditures
22 from State funds made under the State
23 plan during fiscal year 1994 with respect
24 to medical assistance consisting of items
25 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

1 plan for medical assistance during the fis-
2 cal year.
3 "(ii) REDUCTION IN LIMIT.—For fis-
4 cal years ending in a calendar year during
5 which the percentage of individuals covered
6 by insurance, as determined by the Na-
7 tional Health Care Cost and Coverage
8 Commission established under section
9 10001 of the Health Security Act—
10 "(I) equals or exceeds 85 percent
11 but is less than 88 percent, '10 per-
12 cent' shall be substituted for '12 per-
13 cent' in clause (i);
14 "(II) equals or exceeds 88 per-
15 cent but is less than 90 percent, '8
16 percent' shall be substituted for '12
17 percent' in clause (i);
18 "(III) equals or exceeds 90 per-
19 cent but is less than 92 percent, '6
20 percent' shall be substituted for '12
21 percent' in clause (i); and
22 "(IV) equals or exceeds 92 per-
23 cent, '4 percent' shall be substituted
24 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 estab-

lished 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 consisting 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 establish 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 encom-

pass 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 appointed 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 car-

rying 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, gov-

erning 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

1 duties under this section. The Council may establish advi-
2 sory committees.

3 (n) ACCESS TO INFORMATION.—The Council may se-
4 cure directly from any department or agency of the United
5 States information necessary to enable it to carry out its
6 functions, to the extent such information is otherwise
7 available to a department or agency of the United States.
8 Upon request of the chair, the head of that department
9 or agency shall furnish that information to the Council.

10 (o) DELEGATION OF AUTHORITY.—Except as other-
11 wise provided, the Council may delegate any function to
12 such officers and employees as the Council may designate
13 and may authorize such successive redelegations of such
14 functions with the Council as the Council deems to be nec-
15 essary or appropriate. No delegation of functions by the
16 Council shall relieve the Council of responsibility for the
17 administration of such functions.

18 (p) RULEMAKING.—The Council is authorized to es-
19 tablish such rules as may be necessary to carry out this
20 section.

21 (q) HEALTH CARE PROVIDER.—For purposes of this
22 subtitle, the term ''health care provider'' means an indi-
23 vidual who, or entity that, provides an item or service to
24 an individual that is covered under the health plan (as

1 defined in section 1111) in which the individual is en-
2 rolled.

3 **SEC. 5002. NATIONAL GOALS AND PERFORMANCE MEAS-**
4 **URES OF QUALITY.**

5 (a) IN GENERAL.—The National Quality Council
6 shall develop a set of national quality goals and perform-
7 ance measures of quality for both the general population
8 and for population subgroups defined by demographic
9 characteristics and health status. The goals and measures
10 shall incorporate goals identified by the Secretary of
11 Health and Human Services for meeting public health ob-
12 jectives utilizing, but not limited to, goals delineated in
13 Healthy People 2000.

14 (b) SUBJECT OF MEASURES.—National measures of
15 quality performance shall be developed under subsection
16 (a) in a manner that provides statistical and other infor-
17 mation on at least the following subjects:

18 (1) Outcomes of health care services and proce-
19 dures.

20 (2) Population health status.

21 (3) Health promotion.

22 (4) Prevention of diseases, disorders, disabil-
23 ities, injuries, and other health conditions.

24 (5) Access to care and appropriateness of care.

25 (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 national 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 assistance 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 coordi-

1 nation with relevant data from health plans and other
2 sources, be designed to assess the impact of this Act both
3 for the general population of the United States and for
4 populations vulnerable to discrimination or to receiving in-
5 adequate care due to health status, demographic charac-
6 teristics, or geographic location.

7 (b) SURVEY ADMINISTRATION AND DATA ANAL-
8 YSIS.—The National Quality Council shall approve a
9 standard design for the consumer surveys and sampling
10 of relevant plan data described in subsection (a) which
11 shall be administered by the Administrator of the Agency
12 for Health Care Policy and Research or such other appro-
13 priate entity as the Council shall designate on a plan-by-
14 plan and State-by-State basis. Sufficient consumer survey
15 and plan data shall be collected and verified to provide
16 for reliable and valid analysis. A State may add survey
17 questions on quality measures of local interest to surveys
18 conducted in the State. The plan-level survey shall include
19 a subset of consumer survey questions related to consumer
20 satisfaction, perceived health status, access, and such
21 other survey items designated by the Council.

22 (c) SAMPLING STRATEGIES.—The National Quality
23 Council shall approve sampling strategies under sub-
24 section (a) that ensure that appropriate survey samples
25 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 improvement 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

1 paragraph (2) for the State or region in which the
2 foundation is located. The foundation shall establish
3 a program of activities incorporating such duties and
4 shall be able to demonstrate the involvement of a
5 broad cross-section of the providers and health care
6 institutions throughout the State or region. A foun-
7 dation may apply for and conduct research described
8 in section 5007.

9 (2) DUTIES DESCRIBED.—The duties described
10 in this paragraph include the following:

11 (A) Collaboration with and technical assist-
12 ance to providers and health plans in ongoing
13 efforts to improve the quality of health care
14 provided to individuals in the State.

15 (B) Population-based monitoring of prac-
16 tice patterns and patient outcomes,on an other
17 than a case-by-case basis.

18 (C) Developing programs in lifetime learn-
19 ing for health professionals to improve the qual-
20 ity of health care by ensuring that health pro-
21 fessionals remain informed about new knowl-
22 edge, acquire new skills, and adopt new roles as
23 technology and societal demands change.

24 (D) Disseminating information about suc-
25 cessful quality improvement programs, practice

1 guidelines, and research findings, including in-
2 formation on innovative staffing of health pro-
3 fessionals.

4 (E) Assist in developing innovative patient
5 education systems that enhance patient involve-
6 ment in decisions relating to their health care,
7 including an emphasis on shared decision-
8 making between patients and health care pro-
9 viders.

10 (F) Issuing a report to the public regard-
11 ing the foundation's activities for the previous
12 year including areas of success during the pre-
13 vious year and areas for opportunities in im-
14 proving health outcomes for the community,
15 and the adoption of guidelines.

16 (G) Providing notice to the State or appro-
17 priate entity if the foundation determines, after
18 reasonable opportunities for improvement, that
19 the quality of a provider or plan remains so in-
20 adequate that the patients or enrollees of such
21 a provider or plan are subject to potential harm
22 in utilizing the services of such provider or serv-
23 ices under such plan.

24 (d) RESTRICTIONS ON DISCLOSURE.—The restric-
25 tions 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.

1 (2) REQUIREMENTS FOR NATIONAL CENTER.—
2 The National Center of Consumer Information and
3 Advocacy shall be a national non-profit organization
4 with public education and health policy expertise and
5 shall have sufficient staff to carry out its duties and
6 a demonstrated ability to represent and work with a
7 broad spectrum of consumers, including vulnerable
8 and underserved populations.
9 (3) STATE-BASED CENTERS.—The Consumer
10 Information and Advocacy Center in each State shall
11 disseminate State reports on quality performance (as
12 defined in section 5005(4)) and health plan con-
13 sumer report cards (as defined in section 5005(2))
14 in order to facilitate consumer choice of health
15 plans, perform public outreach and provide edu-
16 cation and assistance regarding consumer rights and
17 responsibilities under this Act, and assist consumers
18 in dealing with problems that arise with consumer
19 purchasing cooperatives, large group purchasers,
20 health plans, insurance agencies, and health care
21 providers operating in such State.
22 (b) CONTRACTS.—
23 (1) SOLICITATION.—The Secretary shall solicit
24 contracts from private non-profit organizations
25 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 Advocacy 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

1 throughout the State, and a State-wide toll-free hot-
2 line to carry out the advocacy duties of this section.
3 Through direct contact and the hotline, the Center
4 shall provide the following services in the State, in-
5 cluding appropriate assistance to individuals with
6 limited English language ability—
7 (A) outreach and education relating to con-
8 sumer rights and responsibilities under this Act,
9 including such rights and services available
10 through the Center;
11 (B) assistance with enrollment in health
12 plans, or obtaining services or reimbursement
13 from health plans;
14 (C) assistance with filing an application for
15 premium or cost sharing subsidies;
16 (D) information to enrollees about existing
17 grievance procedures and coordination with
18 other entities to assist in identifying, inves-
19 tigating, and resolving enrollee grievances under
20 this Act (including grievances before State med-
21 ical boards);
22 (E) referrals to appropriate local providers
23 of legal assistance and to appropriate State and
24 Federal agencies which may be of assistance to
25 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. Each Center shall have the capability to accept electronic quality data from plans as required under subtitle B.

(e) EVALUATION AND REPORT.—The Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract. The Center shall report to the Secretary and the State annually on the nature and patterns of consumer complaints received in the Center and its local offices during each year and any policy, regulatory, and legislative recommendations for needed improvements together with a record of the activities of the Center.

(f) CONFLICTS OF INTEREST.—The Secretary shall ensure that no individual involved in the designation of a State Center, the Center itself, or of any delegate thereof is subject to a conflict of interest, including affiliation with (through ownership or common control) a health care fa-

1 cility, managed care organization, health insurance com-
2 pany or association of health care facilities or providers.
3 No grantee under this section may have a direct involve-
4 ment with the licensing, certification, or accreditation of
5 a health care facility, a health care plan, or a provider
6 of health care services .

7 (g) LEGAL COUNSEL.—The Secretary shall ensure
8 that adequate legal counsel is available, and is able, with-
9 out conflict of interest, to assist the Center, and the local
10 offices thereof in the performance of their official duties.

11 (h) COORDINATION.—The Center shall coordinate its
12 activities with all appropriate entities including Quality
13 Improvement Foundations (established under section
14 5008) and the State agencies designated to carry out cli-
15 ent advocacy activities pursuant to section 2106.

16 (i) CONSTRUCTION.—Nothing in this section shall re-
17 place grievance procedures established or otherwise re-
18 quired under this Act.

19 **SEC. 5010. AUTHORIZATION OF APPROPRIATIONS.**

20 (a) NATIONAL QUALITY COUNCIL.—For the purpose
21 of carrying out this subtitle with respect to the establish-
22 ment and activities of the National Quality Council, there
23 are authorized to be appropriated $4,000,000 for each of
24 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 performance, 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 indi-

1 vidual, or the past, present, or future payment
2 for the provision of health care to an individual.
3 (5) HEALTH INFORMATION NETWORK.—The
4 term ''health information network'' means the health
5 information system that is formed through the appli-
6 cation of the requirements and standards established
7 under this subtitle.
8 (6) HEALTH INFORMATION PROTECTION ORGA-
9 NIZATION.—The term ''health information protection
10 organization'' means a private entity or an entity op-
11 erated by a State that accesses standard data ele-
12 ments of health information through the health in-
13 formation network, processes such information into
14 non-identifiable health information, and may store
15 such information.
16 (7) HEALTH INFORMATION NETWORK SERV-
17 ICE.—The term ''health information network serv-
18 ice''—
19 (A) means a private entity or an entity op-
20 erated by a State that enters into contracts
21 to—
22 (i) process or facilitate the processing
23 of nonstandard data elements of health in-
24 formation 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

1 health information uniform and compatible for electronic
2 transmission through the health information network:
3 (1) the health information that is appropriate
4 for transmission in connection with transactions de-
5 scribed in subsections (a), (b), and (d) of section
6 5121;
7 (2) the quality information required to be sub-
8 mitted by a health plan under title I and subtitle A
9 of this title; and
10 (3) patient medical record information.
11 (b) ADDITIONS.—The Secretary may make additions
12 to the sets of data elements adopted under subsection (a)
13 as the Secretary determines appropriate in a manner that
14 minimizes the disruption and cost of compliance with such
15 additions.
16 (c) CERTAIN DATA ELEMENTS.—
17 (1) UNIQUE HEALTH IDENTIFIERS.—The Sec-
18 retary shall establish a system to provide for a
19 standard unique health identifier for each individual,
20 employer, health plan, and health care provider for
21 use in the health care system. The personal health
22 identifier for an individual shall be an encrypted
23 form of the social security account number assigned
24 to the individual by the Secretary under section
25 205(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

1 provide that a claim for reimbursement for medical serv-
2 ices furnished is tested by an algorithm specified by the
3 Secretary against all records of enrollment and eligibility
4 for the individual who received such services to determine
5 any primary and secondary obligors for payment.

6 (c) ELECTRONIC SIGNATURE.—The Secretary, in co-
7 ordination with the Secretary of Commerce, shall promul-
8 gate regulations specifying procedures for the electronic
9 transmission and authentication of signatures, compliance
10 with which will be deemed to satisfy State and Federal
11 statutory requirements for written signatures with respect
12 to information transactions required by this Act and writ-
13 ten signatures on medical records and prescriptions.

14 **SEC. 5114. STANDARDS RELATING TO WRITTEN CLAIMS**
15 **SUBMITTED BY INDIVIDUALS AND WRITTEN**
16 **EXPLANATIONS OF BENEFITS.**

17 The Secretary shall adopt standard methods and for-
18 mats which—

19 (1) may be used by an individual to submit a
20 written claim when the individual's health care pro-
21 vider does not submit the claim; and

22 (2) shall be used by health plans to submit a
23 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 attach-

1 ments which shall be adopted not later than 24 months
2 after the date of the enactment of this subtitle).

3 (c) STANDARDS FOR WRITTEN CLAIMS AND EXPLA-
4 NATIONS OF BENEFITS.—The Secretary shall adopt
5 standard methods and formats described in section 5114
6 not later than 9 months after the date of the enactment
7 of this subtitle.

8 (d) MODIFICATIONS TO STANDARDS.—

9 (1) IN GENERAL.—Except as provided in para-
10 graph (2), the Secretary shall review the standards
11 adopted under this subtitle and shall adopt modified
12 standards as determined appropriate, but no more
13 frequently than once every 6 months. Any modifica-
14 tion to standards shall be completed in a manner
15 which minimizes the disruption and cost of compli-
16 ance.

17 (2) SPECIAL RULES.—

18 (A) MODIFICATIONS DURING FIRST 12-
19 MONTH PERIOD.—Except with respect to addi-
20 tions and modifications to code sets under sub-
21 paragraph (B), the Secretary shall not adopt
22 any modifications to standards adopted under
23 this subtitle during the 12-month period begin-
24 ning on the date such standards are adopted
25 unless the Secretary determines that a modi-

1 fication is necessary in order to permit compli-
2 ance with requirements relating to the stand-
3 ards.
4 (B) ADDITIONS AND MODIFICATIONS TO
5 CODE SETS.—
6 (i) IN GENERAL.—The Secretary shall
7 ensure that procedures exist for the rou-
8 tine maintenance, testing, enhancement,
9 and expansion of code sets to accommodate
10 changes in biomedical science and health
11 care delivery.
12 (ii) ADDITIONAL RULES.—If a code
13 set is modified under this subsection, the
14 modified code set shall include instructions
15 on how data elements that were encoded
16 prior to the modification are to be con-
17 verted or translated so as to preserve the
18 value of the data elements. Any modifica-
19 tion to a code set under this subsection
20 shall be implemented in a manner that
21 minimizes the disruption and cost of com-
22 plying with such modification.
23 (e) EVALUATION OF STANDARDS.—The Secretary
24 may establish a process to measure or verify the consist-
25 ency of standards adopted or modified under this subtitle.

1 Such process may include demonstration projects and
2 analysis of the cost of implementing such standards and
3 modifications.

4 **PART 3—REQUIREMENTS WITH RESPECT TO**
5 **CERTAIN TRANSACTIONS AND INFORMATION**

6 **SEC. 5121. REQUIREMENTS WITH RESPECT TO CERTAIN**
7 **TRANSACTIONS AND INFORMATION.**

8 (a) REQUIREMENTS ON PLANS AND PROVIDERS RE-
9 LATING TO FINANCIAL AND ADMINISTRATIVE TRANS-
10 ACTIONS.—If a health care provider or a health plan con-
11 ducts any of the following transactions, such transactions
12 shall be standard transactions and the information trans-
13 mitted or received in connection with such transaction
14 shall be in the form of standard data elements:

15 (1) Claims (including coordination of benefits).
16 (2) Claims attachments.
17 (3) Responses to research inquiries by a health
18 researcher.
19 (4) Other transactions determined appropriate
20 by the Secretary consistent with the goal of reducing
21 administrative costs.

22 (b) REQUIREMENT ONLY ON PLANS RELATING TO
23 FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a
24 person desires to conduct any of the following transactions
25 with a health plan as a standard transaction, the health

1 plan shall conduct such standard transaction and the in-
2 formation transmitted or received in connection with such
3 transaction shall be in the form of standard data elements:
4 (1) Enrollment and disenrollment.
5 (2) Eligibility.
6 (3) Payment and remittance advice.
7 (4) Premium payments.
8 (5) First report of injury.
9 (6) Claims status.
10 (7) Referral certification and authorization.
11 (8) Other transactions determined appropriate
12 by the Secretary consistent with the goal of reducing
13 administrative costs.
14 (c) REQUIREMENT ON PLANS RELATING TO QUALITY
15 INFORMATION.—Any quality information required to be
16 submitted by a health plan under title I or subtitle A of
17 this title shall be in the form of standard data elements
18 and the transmission of such data shall be in the form
19 of a standard transaction.
20 (d) REQUIREMENT ONLY ON PURCHASING COOPERA-
21 TIVES.—If a person desires to conduct any of the following
22 transactions with a purchasing cooperative (as defined in
23 section 1013(12)) as a standard transaction, the coopera-
24 tive shall conduct such standard transaction and the infor-

1 mation transmitted or received in connection with such
2 transaction shall be in the form of standard data elements:
3 (1) Enrollment and disenrollment.
4 (2) Premium payments.
5 (e) REQUIREMENT WITH RESPECT TO DISCLOSURE
6 OF INFORMATION.—
7 (1) IN GENERAL.—A health plan or health care
8 provider shall make the standard data elements
9 transmitted or received by such plan or provider in
10 connection with the transactions described in sub-
11 sections (a), (b), and (c) or acquired under section
12 5164(a) available for disclosure as authorized by this
13 subtitle.
14 (2) SPECIAL RULE.—In the case of a health
15 care provider that does not file claims, such provider
16 shall be responsible for making standard data ele-
17 ments for encounter information available for disclo-
18 sure as authorized by this subtitle.
19 (f) SATISFACTION OF REQUIREMENTS.—A health
20 care provider, health plan, or consumer purchasing cooper-
21 ative may satisfy the requirement imposed on such pro-
22 vider, plan, or cooperative under subsection (a), (b), (c),
23 (d), or (e) by—
24 (1) directly transmitting standard data ele-
25 ments;

(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 agen-

1 cy that is necessary to comply with a requirement
2 under this Act, such plan or provider shall make
3 such information available to such organization for
4 a charge that does not exceed the reasonable cost of
5 transmitting the information. If requested, a health
6 information protection organization that receives in-
7 formation under the preceding sentence must make
8 such information available to any other such organi-
9 zation that is certified under section 5141 for a
10 charge that does not exceed the reasonable cost of
11 transmitting the information.

12 (c) FUNCTIONAL SEPARATION.—The standards
13 adopted by the Secretary under subsection (a) shall ensure
14 that any health information disclosed under such sub-
15 section shall not, after such disclosure, be used or released
16 for an administrative, regulatory, or law enforcement pur-
17 pose unless such disclosure was made for such purpose.

18 (d) PUBLIC USE FUNCTIONS.—Nothing in this sub-
19 title shall be construed to limit the authority of a Federal
20 or State agency to make non-identifiable health informa-
21 tion available for public use functions.

22 **SEC. 5132. RESPONDING TO ACCESS REQUESTS.**

23 (a) IN GENERAL.—The Secretary may adopt, and
24 modify as appropriate, standards under which a health
25 care provider or health plan shall respond to requests for

1 access to health information consistent with this subtitle
2 and subtitle C.

3 (b) STANDARDS DESCRIBED.—The standards under
4 subsection (a) shall provide—

5 (1) for a standard format under which a pro-
6 vider or plan will respond to each request either by
7 satisfying the request or responding with an expla-
8 nation of the specific restriction which results in a
9 failure to satisfy the request; and

10 (2) that any restrictions will not prevent a plan
11 or provider from responding to a request in a timely
12 manner taking into account the age and amount of
13 the information being requested.

14 (c) CONSTRUCTION.—Nothing in this section shall be
15 construed as permitting a health care provider or health
16 plan to refuse to disclose any health information that is
17 required to be disclosed by law.

18 **SEC. 5133. LENGTH OF TIME INFORMATION SHOULD BE AC-**
19 **CESSIBLE.**

20 The Secretary shall adopt standards with respect to
21 the length of time any standard data elements for a type
22 of health information should be accessible through the
23 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 proc-

1 essing information in a manner that prevents access
2 to such information by such larger organization.
3 (b) CERTIFICATION BY THE SECRETARY.—
4 (1) ESTABLISHMENT.—Not later than 12
5 months after the date of the enactment of this sub-
6 title, the Secretary shall establish a certification pro-
7 cedure for health information network services which
8 ensures that certified services are qualified to meet
9 the requirements of this subtitle and the standards
10 established by the Secretary under this section. Such
11 certification procedure shall be implemented in a
12 manner that minimizes the costs and delays of oper-
13 ations for such services.
14 (2) APPLICATION.—Each entity desiring to be
15 certified as a health information network service
16 shall apply to the Secretary for certification in a
17 form and manner determined appropriate by the
18 Secretary.
19 (3) AUDITS AND REPORTS.—The procedure es-
20 tablished under paragraph (1) shall provide for au-
21 dits by the Secretary and reports by an entity cer-
22 tified under this section as the Secretary determines
23 appropriate in order to monitor such entity's compli-
24 ance 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 sta-

tus 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 include 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

1 receive technical assistance from appropriate Federal
2 agencies.
3 (c) MEMBERSHIP.—
4 (1) IN GENERAL.—The committee shall consist
5 of 15 members to be appointed by the President not
6 later than 60 days after the date of the enactment
7 of this subtitle. The President shall designate 1
8 member as the Chair.
9 (2) EXPERTISE.—The membership of the com-
10 mittee shall consist of individuals who are of recog-
11 nized standing and distinction and who possess the
12 demonstrated capacity to discharge the duties im-
13 posed on the committee.
14 (3) TERMS.—Each member of the committee
15 shall be appointed for a term of 5 years, except that
16 the members first appointed shall serve staggered
17 terms such that the terms of no more than 3 mem-
18 bers expire at one time.
19 (4) VACANCIES.—
20 (A) IN GENERAL.—A vacancy on the com-
21 mittee shall be filled in the manner in which the
22 original appointment was made and shall be
23 subject to any conditions which applied with re-
24 spect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

(d) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the committee have been appointed, the committee shall hold its first meeting.

(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as

1 the committee considers advisable to carry out the pur-
2 poses of this section.

3 (f) OTHER ADMINISTRATIVE PROVISIONS.—Subpara-
4 graphs (C), (D), and (H) of section 1886(e)(6) of the So-
5 cial Security Act shall apply to the committee in the same
6 manner as they apply to the Prospective Payment Assess-
7 ment Commission.

8 (g) REPORTS.—

9 (1) IN GENERAL.—The committee shall annu-
10 ally prepare and submit to Congress and the Sec-
11 retary a report including at least an analysis of—

12 (A) the status of the health information
13 network established under this subtitle, includ-
14 ing whether the network is fulfilling the pur-
15 pose described in section 5101;

16 (B) the savings and costs of the network;

17 (C) the activities of health information net-
18 work services certified under section 5141,
19 health care providers, health plans, and other
20 entities using the network to exchange health
21 information;

22 (D) the extent to which entities described
23 in subparagraph (C) are meeting the standards
24 adopted under this subtitle and working to-

gether 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 clinical 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 net-

works 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 substantially 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 individual, or for the use of an individual, pursuant to a prescription; but

(B) does not include any item or service that is not furnished for the purpose of 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

1 health care in the ordinary course of business or
2 practice of a profession.
3 (4) HEALTH OVERSIGHT AGENCY.—The term
4 ''health oversight agency'' means a person who—
5 (A) performs or oversees the performance
6 of an assessment, evaluation, determination, or
7 investigation relating to the licensing, accredita-
8 tion, or certification of health care
9 providers; or
10 (B)(i) performs or oversees the perform-
11 ance of an assessment, evaluation, determina-
12 tion, or investigation relating to the effective-
13 ness of, compliance with, or applicability of
14 legal, fiscal, medical, or scientific standards or
15 aspects of performance related to the delivery
16 of, or payment for, health care or relating to
17 health care fraud or fraudulent claims for pay-
18 ment regarding health; and
19 (ii) is a public agency, acting on behalf of
20 a public agency, acting pursuant to a require-
21 ment of a public agency, or carrying out activi-
22 ties under a Federal or State law governing the
23 assessment, evaluation, determination, or inves-
24 tigation 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.

1 (2) REGULATIONS.—The Secretary, after notice
2 and opportunity for public comment, may issue reg-
3 ulations under paragraph (1), which shall take into
4 account the technical capabilities of the record sys-
5 tems used to maintain protected health information
6 and the costs of limiting disclosure.
7 (d) NO GENERAL REQUIREMENT TO DISCLOSE.—
8 Nothing in this subtitle that permits a disclosure of health
9 information shall be construed to require such disclosure.
10 (e) USE AND REDISCLOSURE OF INFORMATION.—
11 The protected health information received under a disclo-
12 sure permitted by the subtitle may not be used or disclosed
13 unless the use or disclosure is necessary to fulfill the pur-
14 pose for which the information was obtained and is not
15 otherwise prohibited by law. Protected health information
16 about an individual that is disclosed under this subtitle
17 may not be used in, or disclosed to any person for use
18 in, any administrative, civil, or criminal action or inves-
19 tigation directed against the individual unless specifically
20 permitted by this subtitle.
21 (f) IDENTIFICATION OF DISCLOSED INFORMATION AS
22 PROTECTED INFORMATION.—
23 (1) IN GENERAL.—Except with respect to pro-
24 tected health information that is disclosed under sec-
25 tion 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

1 who is the subject of the information, if each of the fol-
2 lowing requirements is met:

3 (1) WRITING.—The authorization is in writing,
4 signed by the individual who is the subject of the in-
5 formation, and dated on the date of such signature.

6 (2) SEPARATE FORM.—The authorization is not
7 on a form used to authorize or facilitate the provi-
8 sion of, or payment for, health care.

9 (3) TRUSTEE DESCRIBED.—The trustee is spe-
10 cifically named or generically described in the au-
11 thorization as authorized to disclose such informa-
12 tion.

13 (4) RECIPIENT DESCRIBED.—The person to
14 whom the information is to be disclosed is specifi-
15 cally named or generically described in the author-
16 ization as a person to whom such information may
17 be disclosed.

18 (5) STATEMENT OF INTENDED DISCLOSURES.—
19 The authorization contains an acknowledgment that
20 the individual who is the subject of the information
21 has read a statement of the disclosures that the per-
22 son to receive the protected health information in-
23 tends to make, which statement shall be in writing,
24 on a form that is distinct from the authorization for
25 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 facil-

ity 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).

1 (2) DISCLOSURE BY TRUSTEE.—For purposes
2 of subsection (a)(9), a disclosure is timely made if
3 it occurs before the date or event specified in the au-
4 thorization upon which the authorization expires.
5 (d) REVOCATION OR AMENDMENT OF AUTHORIZA-
6 TION.—
7 (1) IN GENERAL.—An individual may in writing
8 revoke or amend an authorization described in sub-
9 section (a), in whole or in part, at any time, except
10 when—
11 (A) disclosure of protected health informa-
12 tion has been authorized to permit validation of
13 expenditures for health care; or
14 (B) action has been taken in reliance on
15 the authorization.
16 (2) NOTICE OF REVOCATION.—A health infor-
17 mation trustee who discloses protected health infor-
18 mation pursuant to an authorization that has been
19 revoked shall not be subject to any liability or pen-
20 alty under this subtitle if—
21 (A) the reliance was in good faith;
22 (B) the trustee had no notice of the rev-
23 ocation; and
24 (C) the disclosure was otherwise in accord-
25 ance 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 intended 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.

1 (b) DIRECTORY INFORMATION.—A health care pro-
2 vider and a person receiving protected health information
3 under section 5213 may disclose protected health informa-
4 tion to any person if—
5 (1) the information does not reveal specific in-
6 formation about the physical or mental condition of
7 the individual who is the subject of the information
8 or health care provided to that person;
9 (2) the individual who is the subject of the in-
10 formation—
11 (A) has been notified of the individual's
12 right to object and has not objected to the dis-
13 closure;
14 (B) is not competent to be notified about
15 the right to object; or
16 (C) exigent circumstances exist such that
17 it would not be practicable to notify the indi-
18 vidual of the right to object; and
19 (3) the information consists only of 1 or more
20 of the following items:
21 (A) The name of the individual who is the
22 subject of the information.
23 (B) If the individual who is the subject of
24 the information is receiving health care from a

1 health care provider on a premises controlled by
2 the provider—
3 (i) the location of the individual on
4 the premises; and
5 (ii) the general health status of the in-
6 dividual, described as critical, poor, fair,
7 stable, or satisfactory or in terms denoting
8 similar conditions.
9 (d) IDENTIFICATION OF DECEASED INDIVIDUAL.—A
10 health care provider, health plan, employer, or life insurer,
11 may disclose protected health information if necessary to
12 assist in the identification of a deceased individual.

13 **SEC. 5213. EMERGENCY CIRCUMSTANCES.**

14 (a) IN GENERAL.—A health care provider, health
15 plan, employer, or person who receives protected health
16 information under this section may disclose protected
17 health information in emergency circumstances when nec-
18 essary to protect the health or safety of an individual from
19 imminent harm.
20 (b) SCOPE OF DISCLOSURE.—The disclosure of pro-
21 tected health information under this section shall be lim-
22 ited to persons who need the information to take action
23 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 (1) IN GENERAL.—A health information trustee
2 may disclose protected health information to a
3 health researcher using the health information net-
4 work (as defined in section 5102) only if an institu-
5 tional review board certified by the Secretary under
6 paragraph (2) determines that the research project
7 engaged in by the health researcher meets the re-
8 quirements of this section.
9 (2) CERTIFICATION OF INSTITUTIONAL REVIEW
10 BOARDS.—
11 (A) REGULATIONS.—The Secretary, after
12 notice and opportunity for public comment,
13 shall issue regulations establishing certification
14 requirements for institutional review boards
15 under this subtitle. Such regulations shall be
16 based on regulations issued under section
17 491(a) of the Public Health Service Act and
18 shall ensure that institutional review boards
19 certified under this paragraph have the quali-
20 fications to access and protect the confiden-
21 tiality of research subjects.
22 (B) CERTIFICATION.—The Secretary shall
23 certify an institutional review board that meets
24 the certification requirements established by the
25 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 sub-

section (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 pur-

suant 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 circumstances 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 capabilities 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.

1 (c) EXCEPTIONS.—A health care provider or health
2 plan is not required by this section to permit inspection
3 or copying of protected health information if any of the
4 following conditions apply:

5 (1) MENTAL HEALTH TREATMENT NOTES.—
6 The information consists of psychiatric, psycho-
7 logical, or mental health treatment notes, and the
8 provider or plan determines, based on reasonable
9 medical judgment, that inspection or copying of the
10 notes would cause sufficient harm to the individual
11 who is the subject of the notes so as to outweigh the
12 desirability of permitting access, and the provider or
13 plan has not disclosed the notes to any person not
14 directly engaged in treating the individual, except
15 with the authorization of the individual or under
16 compulsion of law.

17 (2) INFORMATION ABOUT OTHERS.—The infor-
18 mation relates to an individual other than the indi-
19 vidual seeking to inspect or have a copy of the infor-
20 mation and the provider or plan determines, based
21 on reasonable medical judgment, that inspection or
22 copying of the information would cause sufficient
23 harm to 1 or both of the individuals so as to out-
24 weigh 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 confidentiality 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

1 copying of protected health information under this sub-
2 section. The health care provider or health plan may re-
3 quire a cost reimbursement for such inspection and copy-
4 ing.

5 (f) STATEMENT OF REASONS FOR DENIAL.—If a
6 health care provider or health plan denies a request for
7 inspection or copying under this section, the provider or
8 plan shall provide the individual who made the request (or
9 the individual's designated representative) with a written
10 statement of the reasons for the denial.

11 (g) DEADLINE.—A health care provider or health
12 plan shall comply with or deny a request for inspection
13 or copying of protected health information under this sec-
14 tion within the 30-day period beginning on the date on
15 which the provider or plan receives the request.

16 **SEC. 5242. AMENDMENT OF PROTECTED HEALTH INFORMA-**
17 **TION.**

18 (a) IN GENERAL.—A health care provider or health
19 plan shall, within the 45-day period beginning on the date
20 on which the provider or plan receives from an individual
21 a written request that the provider or plan correct or
22 amend the information—

23 (1) make the correction or amendment re-
24 quested;

(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 disclosures 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 dissemi-

nate 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

1 made unconditionally to the Anti-Fraud Account, for
2 the benefit of the Anti-Fraud Account or any activ-
3 ity financed through the Anti-Fraud Account.
4 (3) TRANSFER OF AMOUNTS.—
5 (A) IN GENERAL.—Subject to the limita-
6 tion in subparagraph (B), the Secretary of the
7 Treasury shall transfer to the Anti-Fraud Ac-
8 count an amount equal to the sum of the fol-
9 lowing:
10 (i) Criminal fines imposed in cases in-
11 volving a Federal health care offense (as
12 defined in subsection (d)).
13 (ii) Penalties and damages imposed
14 under the False Claims Act (31 U.S.C.
15 3729 et seq.), in cases involving claims re-
16 lated to the provision of health care items
17 and services (other than funds awarded to
18 a relator or for restitution).
19 (iii) Administrative penalties and as-
20 sessments imposed under section 5311 (ex-
21 cept as otherwise provided by law).
22 (iv) Amounts resulting from the for-
23 feiture of property by reason of a Federal
24 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) regarding 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 relat-

ing 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).

1 (2) TREATMENT OF AMOUNTS RECOVERED.—
2 Any amounts recovered under the preceding sen-
3 tence shall be paid to the Secretary and such por-
4 tions of the amounts recovered as is determined to
5 have been improperly paid from a certified standard
6 health plan or certified long-term care policy for the
7 delivery of or payment for health care items or serv-
8 ices shall be repaid to such plan or policy (and en-
9 rollees of such plan or policy as appropriate) and the
10 remainder of the amounts recovered shall be depos-
11 ited in the Federal Outlays Program Fraud and
12 Abuse Control Account established under section
13 5302.
14 (b) PENALTIES.—
15 (1) GENERAL RULE.—In the case of a person
16 who the Secretary determines has committed an ac-
17 tion described in subsection (a), the person shall be
18 subject to the civil monetary penalty (together with
19 any additional assessment) to which the person
20 would be subject to under section 1128A of the So-
21 cial Security Act if the action was taken with respect
22 to title V, XVIII, XIX, or XX of such Act.
23 (2) PENALTIES DESCRIBED.—Section 1128A(a)
24 of the Social Security Act (42 U.S.C. 1320a-7a(a))
25 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, dur-

ing 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;

1 "(9) employs or contracts with any individual
2 or entity who is excluded from participating in a
3 program under title XVIII or a Federal outlay pro-
4 gram in accordance with this section, section 1128,
5 or section 1156, for the provision of any services (in-
6 cluding but not limited to health care, utilization re-
7 view, medical social work, or administrative), or em-
8 ploys or contracts with any entity for the direct or
9 indirect provision of such services, through such an
10 excluded individual or entity; or
11 "(10) submits false or fraudulent statements,
12 data or information, or claims to the Secretary, the
13 Secretary of Labor,any other Federal agency, a
14 State health care agency, a purchasing cooperative
15 (under subtitle ____ of title ____ of the Health Se-
16 curity Act), or any other Federal, State or local
17 agency charged with implementation or oversight of
18 a certified health plan under this Act or a public
19 program that the person knows or should know is
20 fraudulent;".
21 (2) REMUNERATION DEFINED.—Section
22 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is
23 amended by adding at the end the following new
24 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 respect 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 Sec-

retary'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

1 or entity from participating in any applicable health
2 plan if the individual or entity—
3 (A) is excluded from participation in a
4 public program under, or is otherwise described
5 in, section 1128(a) of the Social Security Act
6 (relating to individuals and entities convicted of
7 health care-related crimes or patient abuse);
8 (B) has been convicted after the date of
9 the enactment of this section, under Federal or
10 State law, in connection with the delivery of a
11 health care item or service of a criminal offense
12 consisting of a felony relating to fraud, theft,
13 embezzlement, breach of fiduciary responsi-
14 bility, or other financial misconduct; or
15 (C) has been convicted after such date,
16 under Federal or State law, of a criminal of-
17 fense consisting of a felony relating to the un-
18 lawful manufacture, distribution, prescription,
19 or dispensing of a controlled substance.
20 (2) WAIVER PERMITTED.—
21 (A) IN GENERAL.—When, in the opinion of the
22 Secretary, mandatory exclusion under paragraph (1)
23 of an individual or entity would significantly harm
24 the public health or pose a significant risk to the
25 public health, the Secretary may waive such exclu-

1 sion and shall apply such other appropriate penalties
2 as authorized under this subtitle.
3 (B) APPLICATION FOR WAIVER OF EXCLU-
4 SION.—
5 (i) IN GENERAL.—An individual or entity
6 subject to mandatory exclusion under this sub-
7 section may apply to the Secretary, in a manner
8 specified by the Secretary in regulations, for
9 waiver of the exclusion.
10 (ii) SECRETARIAL RESPONSE.—The Sec-
11 retary may waive the exclusion for the reasons
12 described in subparagraph (A).
13 (b) PERMISSIVE EXCLUSION.—The Secretary may
14 exclude and individual or entity from participating in any
15 applicable health plan if the individual or entity—
16 (1) is excluded from participation in a public
17 program under, or is otherwise described in, section
18 1128(b) of the Social Security Act (other than para-
19 graphs (3), (6)(A), (6)(C), (6)(D), (10), or (13) of
20 such section);
21 (2) has been convicted after the date of the en-
22 actment of this section, under Federal or State law,
23 in connection with the delivery of a health care item
24 or service of a criminal offense consisting of a mis-
25 demeanor 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 exclusion under subsection (a), the minimum period of exclusion shall be not less than 2 years.

(C) MINIMUM PERIOD FOR CERTAIN PERMISSIVE EXCLUSIONS.—

(i) FRAUD, OBSTRUCTION OF INVESTIGATION, AND CONTROLLED SUBSTANCE CONVICTION.—In the case of an exclusion of an individual excluded from participation in a public program under, or is otherwise described in, paragraph (1) or (2) of section 1128(b) of the Social Security Act or paragraph (1), (2), or (3) of subsection (b) of this section, the period of exclusion shall be a minimum of 1 year, unless the Secretary determines that a longer period is necessary because of aggravating circumstances.

(ii) SUSPENSIONS.—In the case of an exclusion of an individual or entity excluded from participation in a public program under, or is otherwise described in,

paragraph (4), (5)(A), or (5)(B) of section 1128(b) of the Social Security Act, the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(iii) UNNECESSARY SERVICES.—In the case of an exclusion of an individual or entity described in paragraph (6)(B) of section 1128(b) of the Social Security Act, the period of the exclusion shall be not less than 1 year.

(d) NOTICE TO ENTITIES ADMINISTERING PUBLIC PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR HEALTH CARE ITEMS OR SERVICES.—

(1) IN GENERAL.—The Secretary shall exercise the authority under this section in a manner that results in an individual's or entity's exclusion from all certified standard health plans under such program for the delivery of or payment for health care items or services.

(2) NOTIFICATION.—The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of the fact and circumstances of each exclusion (together with the period thereof) effected against an individual or entity under this section or under section 5311(b)(3).

(e) NOTICE TO STATE LICENSING AGENCIES.—The provisions of section 1128(e) of the Social Security Act shall apply to this section in the same manner as such provisions apply to sections 1128 and 1128A of such Act.

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—

(1) IN GENERAL.—Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b) of the Social Security Act, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g) of such Act, except that such action shall be brought in the Court of Appeals of the United States for the judicial circuit in which the individual or entity resides, or has a principal

place of business, or, if the individual or entity does not reside or have a principal place of business within any such judicial circuit, in the United States Court of Appeals for the District of Columbia Circuit.

(2) ADMINISTRATIVE HEARING.—Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination based on paragraphs (6)(B), (7), (8), (9), (11), (12), (14), or (15) of section 1128(b) of the Social Security Act, shall be entitled to a hearing by an administrative law judge (as provided under section 205(b) of the Social Security Act) on the determination before any exclusion based upon the determination takes effect. If a hearing is requested, the exclusion shall be effective upon the issuance of an order by the administrative law judge upholding the determination of the Secretary to exclude.

(g) CONVICTED DEFINED.—In this section, the term ''convicted'' has the meaning given such term in section 1128(i) of the Social Security Act.

(h) REQUEST FOR EXCLUSION.—

(1) IN GENERAL.—The sponsor of any standard health plan, the board of any purchasing cooperative, and the Secretary of Labor in the case of a multistate self-insured health plan may request that the Secretary of Health and Human Services exclude an individual or entity with respect to actions under a certified health plan in accordance with this section.

(2) RESPONSE BY SECRETARY.—

(A) IN GENERAL.—An individual or entity excluded (or directed to be excluded) from participation under this section or section 5411(b)(3) may apply to the Secretary, in a manner specified by the Secretary in regulations and at the end of the minimum period of exclusion (or, in the case of an individual or entity described in section 1128(b)(12) of the Social Security Act, the period of exclusion) provided under this section or section 5411(b)(3) and at such other times as the Secretary may provide, for termination of the exclusion.

(B) SECRETARIAL RESPONSE.—The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date

of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(i) there is no basis under this section or section 5411(b)(3) for a continuation of the exclusion, and

(ii) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(C) NOTIFICATION OF TERMINATION.—The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of each termination of exclusion made under this paragraph.

(i) EFFECT OF EXCLUSION.—Notwithstanding any other provision of this Act, no payment may be made under a certified standard health plan for the delivery of or payment for any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(1) by an individual or entity during the period when such individual or entity is excluded pursuant

to this section from participation in a certified standard health plan; or

(2) at the medical direction or on the prescription of a physician during the period when the physician is excluded pursuant to this section from participation in a certified health plan and the person furnishing the item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 5321. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any purchasing cooperative, certified standard health plan, certified long-term care insurance policy, or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the

money or property owned by, or under the custody or control of, any purchasing cooperative, certified standard health plan, certified long-term care insurance policy, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title) such person shall be imprisoned for any term of years.

''(b) As used in this section the terms 'purchasing cooperative', 'certified standard health plan', and 'certified long-term care insurance policy' have the meanings given those terms in sections 1013(16), 1011(2), and 1011(4) of the Health Security Act, respectively.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

SEC. 5322. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"§ 668. Theft or embezzlement in connection with health care

''(a) Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a purchasing cooperative, certified standard health plan, certified long-term care insurance policy, or of any fund connected with such a cooperative, plan, or policy, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) As used in this section, the terms 'purchasing cooperative', 'certified standard health plan', and 'certified long-term care insurance policy' have the meanings given those terms in sections 1013(16), 1011(2), and 1011(4) of the Health Security Act, respectively.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''668. Theft or embezzlement in connection with health care.''.

SEC. 5323. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"§ 1033. False statements relating to health care matters

''(a) Whoever, in any matter involving a purchasing cooperative, certified standard health plan, or certified long-term care insurance policy, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section, the terms 'purchasing cooperative', 'certified standard health plan', and 'certified long-term care insurance policy' have the meanings given those terms in sections 1013(16), 1011(2), and 1011(4) of the Health Security Act, respectively.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''1033. False statements relating to health care matters.''.

SEC. 5324. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 226. Bribery and graft in connection with health care

''(a) Whoever—

''(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to any other person, with intent—

''(A) to influence any of the health care official's actions, decisions, or duties relating to a purchasing cooperative, certified standard health plan, or certified long-term care insurance policy;

''(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a purchasing cooperative, certified standard health plan, or certified long-term care insurance policy; or

''(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

''(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or

1 for any other person or entity, the giving of which
2 violates paragraph (1) of this subsection;
3 shall be fined under this title or imprisoned not more than
4 15 years, or both.
5 ''(b) Whoever, otherwise than as provided by law for
6 the proper discharge of any duty, directly or indirectly
7 gives, offers, or promises anything of value to a health
8 care official, for or because of any of the health care offi-
9 cial's actions, decisions, or duties relating to a purchasing
10 cooperative, certified standard health plan, or certified
11 long-term care insurance policy, shall be fined under this
12 title or imprisoned not more than two years, or both.
13 ''(c) As used in this section—
14 ''(1) the term 'health care official' means—
15 ''(A) an administrator, officer, trustee, fi-
16 duciary, custodian, counsel, agent, or employee
17 of any purchasing cooperative, certified stand-
18 ard health plan, or certified long-term care in-
19 surance policy;
20 ''(B) an officer, counsel, agent, or em-
21 ployee, of an organization that provides services
22 under contract to any purchasing cooperative,
23 certified standard health plan, or certified long-
24 term care insurance policy;

"(C) an official or employee of a State agency having regulatory authority over any purchasing cooperative, certified standard health plan, or certified long-term care insurance policy;

"(D) an officer, counsel, agent, or employee of a health care sponsor;

"(2) the term 'health care sponsor' means any individual or entity serving as the sponsor of a certified health plan for purposes of the Health Security Act, and includes the joint board of trustees or other similar body used by two or more employers to administer a certified standard health plan for purposes of such Act; and

"(3) the terms 'purchasing cooperative', 'certified standard health plan', and 'certified long-term care insurance policy' have the meanings given those terms in sections 1013(16), 1011(2), and 1011(4) of the Health Security Act, respectively.".

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"226. Bribery and graft in connection with health care.".

SEC. 5325. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 5302(d) of the Health Security Act);''.

SEC. 5326. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

''(c) A person who is privy to grand jury information concerning a health law violation—

''(1) received in the course of duty as an attorney for the Government; or

''(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 5302(d) of the Health Security Act).''.

SEC. 5327. FORFEITURES FOR VIOLATIONS OF FRAUD STATUTES.

Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

''(6) The court, in imposing sentence on a person convicted of a Federal health care offense (as defined in section 5302(d) of the Health Security Act), shall order such person to forfeit to the United States any property, real or personal, constituting or traceable to the gross proceeds obtained, directly or indirectly, as a result of the commission of the offense.''.

PART 4—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

SEC. 5331. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

Section 3729 of title 31, United States Code, is amended—

(1) in subsection (a)(7), by inserting ''or to a certified standard health plan or certified long-term care insurance policy'' after ''property to the Government'';

(2) in the matter following subsection (a)(7), by inserting ''or certified standard health plan or certified long-term care insurance policy'' before ''sustains because of the act of that person,'';

(3) at the end of the first sentence of subsection (a), by inserting ''or certified standard health plan or certified long-term care insurance policy'' before ''sustains because of the act of the person.'';

(4) in subsection (c)—

(A) by inserting ''the term'' after ''section,''; and

(B) by adding at the end the following: ''The term also includes any request or demand, whether under contract of otherwise, for money or property which is made or presented to a certified standard health plan or certified long-term care insurance policy.''; and

(5) by adding at the end the following:

''(f) CERTIFIED STANDARD HEALTH PLAN AND CERTIFIED LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the terms 'purchasing cooperative', 'certified standard health plan', and 'certified long-term care insurance policy' have the mean-

ings given those terms in sections 1013(16), 1011(2), and 1011(4) of the Health Security Act, respectively.''.

PART 5—EFFECTIVE DATE

SEC. 5341. EFFECTIVE DATE.

Except as otherwise provided in this subtitle, the provisions of, and amendments made by, this subtitle shall be effective on and after January 1, 1996.

Subtitle E—Medical Liability Reform

PART 1—SYSTEM REFORMS

SEC. 5401. FEDERAL TORT REFORM.

(a) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in section 5402, this subtitle shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this subtitle shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(2) PREEMPTION.—The provisions of this subtitle shall preempt any State law to the extent that such law is inconsistent with the limitations contained in such provisions.

(3) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this subtitle shall be construed to—

(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(B) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(4) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability ac-

tions on the basis of section 1331 or 1337 of title 28, United States Code.

(b) DEFINITIONS.—In this subtitle, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the

1 laws or regulations of the State to be licensed or cer-
2 tified by the State to engage in the delivery of such
3 services in the State.

4 (5) INJURY.—The term ''injury'' means any ill-
5 ness, disease, or other harm that is the subject of
6 a medical malpractice liability action or a medical
7 malpractice claim.

8 (6) MEDICAL MALPRACTICE LIABILITY AC-
9 TION.—The term ''medical malpractice liability ac-
10 tion'' means a cause of action brought in a State or
11 Federal court against a health care provider or
12 health care professional by which the plaintiff brings
13 a medical malpractice claim.

14 (7) MEDICAL MALPRACTICE CLAIM.—The term
15 ''medical malpractice claim'' means a claim brought
16 against a health care provider or health care profes-
17 sional in which a claimant alleges that injury was
18 caused by the provision of (or the failure to provide)
19 health care services, except that such term does not
20 include—

21 (A) any claim based on an allegation of an
22 intentional tort;

23 (B) any claim based on an allegation that
24 a product is defective that is brought against

any individual or entity that is not a health care professional or health care provider; or

(C) any claim brought pursuant to subtitle F.

SEC. 5402. STATE-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) APPLICATION TO MALPRACTICE CLAIMS UNDER PLANS.—Prior to or immediately following the commencement of any medical malpractice action, the parties shall participate in the alternative dispute resolution system administered by the State under subsection (b). Such participation shall be in lieu of any other provision of Federal or State law or any contractual agreement made by or on behalf of the parties prior to the commencement of the medical malpractice action.

(b) ADOPTION OF MECHANISM BY STATE.—Each State shall—

(1) maintain or adopt at least one of the alternative dispute resolution methods satisfying the requirements specified under subsection (c) and (d) for the resolution of medical malpractice claims arising from the provision of (or failure to provide) health care services to individuals enrolled in a standard health plan; and

(2) clearly disclose to enrollees (and potential enrollees) the availability and procedures for consumer grievances, including a description of the alternative dispute resolution method or methods adopted under this subsection.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The Attorney General, in consultation with the Secretary, shall, by regulation, develop alternative dispute resolution methods for the use by States in resolving medical malpractice claims under subsection (a). Such methods shall include at least the following:

(A) ARBITRATION.—The use of arbitration, a nonjury adversarial dispute resolution process which may, subject to subsection (d), result in a final decision as to facts, law, liability or damages.

(B) CLAIMANT-REQUESTED BINDING ARBITRATION.—For claims involving a sum of money that falls below a threshold amount set by the Secretary, the use of arbitration not subject to subsection (d). Such binding arbitration shall be at the sole discretion of the claimant.

(C) MEDIATION.—The use of mediation, a settlement process coordinated by a neutral third party without the ultimate rendering of a formal opinion as to factual or legal findings.

(D) EARLY NEUTRAL EVALUATION.—The use of early neutral evaluation, in which the parties make a presentation to a neutral attorney or other neutral evaluator for an assessment of the merits, to encourage settlement. If the parties do not settle as a result of assessment and proceed to trial, the neutral evaluator's opinion shall be kept confidential.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under paragraph (1), the Attorney General shall assure that the methods promote the resolution of medical malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) provides for timely resolution of claims;

(C) provides for the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution for individuals enrolled in plans.

(3) WAIVER AUTHORITY.—Upon application of a State, the Attorney General, in consultation with the Secretary, may grant the State the authority to fulfill the requirement of subsection (b) by adopting a mechanism other than a mechanism established by the Attorney General pursuant to this subsection, except that such mechanism must meet the standards set forth in paragraph (2).

(d) FURTHER REDRESS.—Except with respect to the claimant-requested binding arbitration method set forth in subsection (c)(1)(B), and notwithstanding any other provision of a law or contractual agreement, a plan enrollee dissatisfied with the determination reached as a result of an alternative dispute resolution method applied under this section may, after the final resolution of the enrollee's claim under the method, initiate or resume a cause of action to seek damages or other redress with respect to the claim to the extent otherwise permitted under State law. The results of any alternative dispute resolution procedure are inadmissible at any subsequent trial, as are all statements, offers, and other communications made during such procedures, unless otherwise admissible under State law.

SEC. 5403. REQUIREMENT OF CERTIFICATE OF MERIT.

(a) REQUIRING SUBMISSION WITH COMPLAINT.—Except as provided in subsection (c) and subject to the penalties of subsection (e), no medical malpractice liability action may be brought by any individual unless, at the time the individual commences such action, the individual or the individual's attorney submits an affidavit declaring that—

(1) the individual (or the individual's attorney) has consulted and reviewed the facts of the claim with a qualified specialist (as defined in subsection (d));

(2) the individual or the individual's attorney has obtained a written report by a qualified specialist that clearly identifies the individual and that includes the specialist's determination that, based upon a review of the available medical record and other relevant material, a reasonable medical interpretation of the facts supports a finding that the claim against the defendant is meritorious and based on good cause; and

(3) on the basis of the qualified specialist's review and consultation, the individual (or the individual's attorney) has concluded that the claim is meritorious and based on good cause.

(b) IDENTITY OF SPECIALIST.—Only upon a showing of good cause may a court order that the identity of the specialist used for purposes of subsection (a) be revealed. In such an event, such identity shall be reviewed by the court on an in camera basis only.

(c) EXTENSION IN CERTAIN INSTANCES.—

(1) IN GENERAL.—Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a medical malpractice liability action without submitting an affidavit described in such subsection if—

(A) despite good faith efforts, the individual is unable to obtain the written report before the expiration of the applicable statute of limitations;

(B) despite good faith efforts, at the time the individual commences the action, the individual has been unable to obtain medical records or other information necessary, pursuant to any applicable law, to prepare the written report requested; or

(C) the court of competent jurisdiction determines that the affidavit requirement shall be extended upon a showing of good cause.

(2) DEADLINE FOR SUBMISSION WHERE EXTENSION APPLIES.—In the case of an individual who brings an action to which paragraph (1) applies, the action shall be dismissed unless the individual submits the affidavit described in subsection (a) not later than—

(A) in the case of an action to which subparagraph (A) of paragraph (1) applies, 90 days after commencing the action; or

(B) in the case of an action to which subparagraph (B) of paragraph (1) applies, 90 days after obtaining the information described in such subparagraph or when good cause for an extension no longer exists.

(d) QUALIFIED SPECIALIST DEFINED.—

(1) IN GENERAL.—As used in subsection (a), the term ''qualified specialist'' means, with respect to a medical malpractice liability action, a health care professional who is reasonably believed by the individual bringing the action (or the individual's attorney) to have expertise in the same or substantially similar area of practice to that involved in the action.

(2) EVIDENCE OF EXPERTISE.—For purposes of paragraph (1), evidence of required expertise may include evidence that the individual—

(A) practices (or has practiced) or teaches (or has taught) in the same or substantially similar area of health care or medicine to that involved in the action; or

(B) is otherwise qualified by experience or demonstrated competence in the relevant practice area.

(e) SANCTIONS FOR SUBMITTING FALSE AFFIDAVIT.—Upon the motion of any party or on its own initiative, the court in a medical malpractice liability action may impose a sanction on a party, the party's attorney, or both, for—

(1) any knowingly false statement made in an affidavit described in subsection (a);

(2) making any false representations in order to obtain a qualified specialist's report; or

(3) failing to have the qualified specialist's written report in his or her custody and control;

and may require that the sanctioned party reimburse the other party to the action for costs and reasonable attorney's fees.

SEC. 5404. LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

(a) IN GENERAL.—An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with such action (including the resolution of the claim that is the subject of the action under any alternative dispute resolution system) in excess of—

(1) 33⅓ percent of the first $150,000 of the total amount recovered by judgment or settlement in such action; plus

(2) 25 percent of any amount recovered above the amount described in paragraph (1);

unless otherwise determined under State law. Such amount shall be computed after deductions are made for all the expenses associated with the claim other than those attributable to the normal operating expenses of the attorney.

(b) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) may, in the discretion of the court, be based on the cost of the annuity or trust established to make the payments. In any case in which an an-

nuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 5405. PERIODIC PAYMENT OF AWARDS.

(a) IN GENERAL.—A party to a medical malpractice liability action may petition the court to instruct the trier of fact to award any future damages on an appropriate periodic basis. If the court, in its discretion, so instructs the trier of fact, and damages are awarded on a periodic basis, the court may require the defendant to purchase an annuity or other security instrument (typically based on future damages discounted to present value) adequate to assure payments of future damages.

(b) FAILURE OR INABILITY TO PAY.—With respect to an award of damages described in subsection (a), if a defendant fails to make payments in a timely fashion, or if the defendant becomes or is at risk of becoming insolvent, upon such a showing the claimant may petition the court for an order requiring that remaining balance be dis-

1 counted to present value and paid to the claimant in a
2 lump-sum.

3 (c) MODIFICATION OF PAYMENT SCHEDULE.—The
4 court shall retain authority to modify the payment sched-
5 ule based on changed circumstances.

6 (d) FUTURE DAMAGES DEFINED.—As used in this
7 section, the term ''future damages'' means any economic
8 or noneconomic loss other than that incurred or accrued
9 as of the time of judgment.

10 **SEC. 5406. FEDERAL STUDY ON MEDICAL NEGLIGENCE.**

11 (a) STUDY.—To improve the level of empirical data
12 on the incidence and effect of medical negligence in the
13 United States, the Secretary of Health and Human Serv-
14 ices shall commission and oversee a nationwide inter-
15 disciplinary study to evaluate—

16 (1) the incidence of injuries resulting from med-
17 ical treatment, including a determination of the per-
18 centage of such injuries that resulted from the neg-
19 ligence of a physician, other health care provider or
20 health care institution;

21 (2) the costs of medical expenses and lost wages
22 to the victims of medical negligence and their fami-
23 lies, and their compensation for such losses under
24 the current malpractice system;

(3) methods to reduce the incidence and costs of medical negligence; and

(4) methods to promote the efficient and fair resolution of legal claims stemming from the incidence of medical negligence.

(b) ACCESS TO RECORDS.—For the purposes of the study conducted under subsection (a), the Secretary of Health and Human Services shall have the powers necessary to access hospital patients' records while maintaining patient confidentiality.

(c) REPORT TO CONGRESS.—Not later than 3 years after the commission of the study under subsection (a), the study shall be completed and the Secretary of Health and Human Services shall prepare and submit to Congress a report describing the findings of the study.

PART 2—DEMONSTRATION PROJECT RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 5411. PILOT PROGRAM APPLYING PRACTICE GUIDELINES TO MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) ESTABLISHMENT.—Not later than 1 year after the Secretary of Health and Human Services determines that appropriate practice guidelines are available and were developed with the input of health care providers, legal professionals and consumer representatives, the Secretary

shall establish pilot programs under which the Secretary shall provide funds (in such amounts as the Secretary determines appropriate) to one or more eligible States to determine the effect of applying practice guidelines in the resolution of medical malpractice liability actions.

(b) ELIGIBILITY OF STATE.—To be eligible to participate in a pilot program under subsection (a), a State 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—

(1) assurances that, under the law of the State, in the resolution of any medical malpractice liability action, compliance or noncompliance with an appropriate practice guideline shall be admissible by either party at trial as presumptive evidence-of nonliability or liability for medical negligence; and

(2) such other information and assurances as the Secretary may require.

(c) REPORTS TO CONGRESS.—Not later than 3 months after the last day of each year for which a pilot program established under subsection (a) is in effect, the Secretary of Health and Human Services shall prepare and submit to Congress a report describing the operation of the program during the year for which the report is submitted. Such report shall contain such recommenda-

1 tions as the Secretary considers appropriate, include rec-
2 ommendations relating to revisions to the laws governing
3 medical practice liability.

4 **SEC. 5412. ENTERPRISE LIABILITY DEMONSTRATION**
5 **PROJECT.**

6 (a) ESTABLISHMENT.—The Secretary of Health and
7 Human Services shall establish a demonstration project
8 under which the Secretary shall provide funds (in such
9 amount as the Secretary considers appropriate) to one or
10 more eligible States to demonstrate whether substituting
11 liability for medical malpractice on the part of the health
12 plan in which a physician participates for the personal li-
13 ability of the physician will result in improvements in the
14 quality of care provided under the plan, reductions in de-
15 fensive medical practices, and better risk management.

16 (b) ELIGIBILITY OF STATE.—A State is eligible to
17 participate in the demonstration project established under
18 subsection (a) if the State submits an application to the
19 Secretary (at such time and in such form as the Secretary
20 may require) containing such information and assurances
21 as the Secretary may require, including assurances that
22 the State—

23 (1) has entered into an agreement with a health
24 plan (other than a fee-for-service plan) operating in
25 the State under which the plan assumes legal liabil-

ity with respect to any medical malpractice claim arising from the provision of (or failure to provide) services under the plan by any physician participating in the plan;

(2) has provided that, under the law of the State, a physician participating in a plan that has entered into an agreement with the State under paragraph (1) may not be liable in damages or otherwise for such a claim and the plan may not require such physician to indemnify the plan for any such liability; and

(3) will provide the Secretary with such reports on the operation of the project as the Secretary may require.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out demonstration projects under this section.

Subtitle F—Remedies and Enforcement

PART 1—REVIEW OF BENEFIT DETERMINATIONS FOR ENROLLED INDIVIDUALS

Subpart A—General Rules

SEC. 5501. HEALTH PLAN CLAIMS PROCEDURE.

(a) DEFINITIONS.—For purposes of this section—

(1) CLAIM.—The term ''claim'' means a claim for payment or provision of benefits under a health plan, a request for preauthorization of items or services which is submitted to a health plan prior to receipt of the items or services, or the denial, reduction or termination of any service or request for a referral or reimbursement.

(2) INDIVIDUAL CLAIMANT.—The term ''individual claimant'' with respect to a claim means any individual who submits the claim to a health plan in connection with the individual's enrollment under the plan, or on whose behalf the claim is submitted to the plan by a provider.

(3) PROVIDER CLAIMANT.—The term ''provider claimant'' with respect to a claim means any provider who submits the claim to a health plan with respect to items or services provided to an individual enrolled under the plan.

(b) GENERAL RULES GOVERNING TREATMENT OF CLAIMS.—

(1) ADEQUATE NOTICE OF DISPOSITION OF CLAIM.—In any case in which a claim is submitted in complete form to a health plan, the plan shall provide to the individual claimant and any provider claimant with respect to the claim a written notice

of the plan's approval or denial of the claim within 15 days after the date of the submission of the claim. The notice to the individual claimant shall be written in language calculated to be understood by the typical individual enrolled under the plan and in a form which takes into account accessibility to the information by individuals whose primary language is not English. In the case of a denial of the claim, the notice shall be provided within 5 days after the date of the determination to deny the claim, and shall set forth the specific reasons for the denial. Such notice shall include an explanation of the specific reasons and facts underlying the decision to reduce or fail to provide services or pay the claim. The notice of a denial shall clearly explain the right to appeal the denial under paragraph (2) and a description of the process for appealing such decision sufficient to allow the claimant to initiate an appeal and submit evidence to the decision maker in support of the position of the claimant. Failure by any plan to comply with the requirements of this paragraph with respect to any claim submitted to the plan shall be treated as approval by the plan of the claim.

(2) PLAN'S DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.—The plan shall review its denial of the claim if an individual claimant or provider claimant with respect to the claim submits to the plan a written request for reconsideration of the claim after receipt of written notice from the plan of the denial. The plan shall allow any such claimant not less than 60 days, after receipt of written notice from the plan of the denial, to submit the claimant's request for reconsideration of the claim.

(3) TIME LIMIT FOR REVIEW.—The plan shall complete any review required under paragraph (2), and shall provide the individual claimant and any provider claimant with respect to the claim written notice of the plan's decision on the claim after reconsideration pursuant to the review, within 30 days after the date of the receipt of the request for reconsideration.

(4) DE NOVO REVIEWS.—Any review required under paragraph (2)—

(A) shall be de novo,

(B) shall be conducted by an individual who did not make the initial decision denying the claim and who is authorized to approve the claim, and

(C) shall include review by a qualified physician in the same speciality as the treating physician if the resolution of any issues involved requires medical expertise.

(c) TREATMENT OF URGENT REQUESTS TO PLANS FOR PREAUTHORIZATION.—

(1) IN GENERAL.—This subsection applies in the case of any claim submitted by an individual claimant or a provider claimant consisting of a request for preauthorization of items or services which is accompanied by an attestation that—

(A) failure to immediately provide the items or services could reasonably be expected to result in—

(i) placing the health of the individual claimant (or, with respect to an individual claimant who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part,

or

(B) immediate provision of the items or services is necessary because the individual claimant has made or is at serious risk of making an attempt to harm such individual claimant or another individual.

(2) SHORTENED TIME LIMIT FOR CONSIDERATION OF REQUESTS FOR PREAUTHORIZATION.—Notwithstanding subsection (b)(1), a health plan shall approve or deny any claim described in paragraph (1) within 12 hours after submission of the claim to the plan. Failure by the plan to comply with the requirements of this paragraph with respect to the claim shall be treated as approval by the plan of the claim.

(3) EXPEDITED EXHAUSTION OF PLAN REMEDIES.—Any claim described in paragraph (1) which is denied by the plan shall be treated as a claim with respect to which all remedies under the plan provided pursuant to this section are exhausted, irrespective of any review provided under subsection (b)(2).

(4) DENIAL OF PREVIOUSLY AUTHORIZED CLAIMS NOT PERMITTED.—In any case in which a health plan approves a claim described in paragraph (1)—

(A) the plan may not subsequently deny payment or provision of benefits pursuant to the claim, unless the plan makes a showing of an intentional misrepresentation of a material fact by the individual claimant, and

(B) in the case of a violation of subparagraph (A) in connection with the claim, all remedies under the plan provided pursuant to this section with respect to the claim shall be treated as exhausted.

(d) TIME LIMIT FOR DETERMINATION OF INCOMPLETENESS OF CLAIM.—For purposes of this section—

(1) any claim submitted by an individual claimant and accepted by a provider serving under contract with a health plan and any claim described in subsection (b)(1) shall be treated with respect to the individual claimant as submitted in complete form, and

(2) any other claim for benefits under the plan shall be treated as filed in complete form as of 10 days after the date of the submission of the claim, unless the plan provides to the individual claimant and any provider claimant, within such period, a written notice of any required matter remaining to be filed in order to complete the claim.

1 Any filing by the individual claimant or the provider claim-
2 ant of additional matter requested by the plan pursuant
3 to paragraph (2) shall be treated for purposes of this sec-
4 tion as an initial filing of the claim.

5 (e) ADDITIONAL NOTICE AND DISCLOSURE RE-
6 QUIREMENTS FOR HEALTH PLANS.—In the case of a de-
7 nial of a claim for benefits under a health plan, the plan
8 shall include, together with the specific reasons provided
9 to the individual claimant and any provider claimant
10 under subsection (b)(1)—

11 (1) if the denial is based in whole or in part on
12 a determination that the claim is for an item or
13 service which is not covered by the comprehensive
14 benefit package or exceeds payment rates under the
15 applicable fee schedule, the factual basis for the de-
16 termination,

17 (2) if the denial is based in whole or in part on
18 exclusion of coverage with respect to services be-
19 cause the services are determined to comprise an ex-
20 perimental treatment or investigatory procedure, the
21 medical basis for the determination and a descrip-
22 tion of the process used in making the determina-
23 tion, and

24 (3) if the denial is based in whole or in part on
25 a determination that the treatment is not medically

1 necessary or appropriate or is inconsistent with the
2 plan's practice guidelines, the medical basis for the
3 determination, the guidelines used in making the de-
4 termination, and a description of the process used in
5 making the determination.

6 (f) WAIVER OF RIGHTS PROHIBITED.—A health plan
7 may not require any party to waive any right under the
8 plan or this Act as a condition for approval of any claim
9 under the plan, except to the extent otherwise specified
10 in a formal settlement agreement.

11 **SEC. 5502. REVIEW IN AREA COMPLAINT REVIEW OFFICES**
12 **OF GRIEVANCES BASED ON ACTS OR PRAC-**
13 **TICES BY HEALTH PLANS.**

14 (a) COMPLAINT REVIEW OFFICES.—

15 (1) IN GENERAL.—In accordance with rules
16 which shall be prescribed by the Secretary of Labor,
17 each State shall establish and maintain a complaint
18 review office for each community rating area estab-
19 lished by such State. According to designations
20 which shall be made by each State under regulations
21 of the Secretary of Labor, the complaint review of-
22 fice for a community rating area established by such
23 State shall also serve as the complaint review office
24 for large group sponsors operating in the State with
25 respect to individuals who are enrolled under health

1 plans maintained by such sponsors and who reside
2 within the area of the community rating area.
3 (2) HEALTH SYSTEMS NOT ESTABLISHED BY
4 STATES.—In the case of any health care system es-
5 tablished in any State by the Secretary of Health
6 and Human Services, the Secretary of Health and
7 Human Services shall assume all duties and obliga-
8 tions of such State under this part in accordance
9 with the applicable regulations of the Secretary of
10 Labor under this part.
11 (b) FILINGS OF COMPLAINTS BY AGGRIEVED PER-
12 SONS.—In the case of any person who is aggrieved by—
13 (1) any act or practice engaged in by any
14 health plan which consists of or results in denial of
15 payment or provision of benefits under the plan or
16 delay in the payment or provision of benefits, or
17 (2) any act or practice engaged in by any other
18 plan maintained in a community rating area or by
19 a large group sponsor which consists of or results in
20 denial of payment or provision of benefits under a
21 supplemental benefit policy or a cost sharing policy
22 or delay in the payment or provision of the benefits,
23 if the claimant alleges that the denial or delay consists
24 of a failure to comply with the terms of the plan (including
25 the provision of benefits in full when due in accordance

with the terms of the plan), or with the applicable requirements of this Act, such person may file a complaint with the appropriate complaint review office.

(c) EXHAUSTION OF PLAN REMEDIES.—Any complaint including a claim to which section 5501 applies may not be filed until the complainant has exhausted all remedies provided under the plan with respect to the claim in accordance with such section.

(d) FORM OF COMPLAINT.—The complaint shall be in writing under oath or affirmation, shall set forth the complaint in a manner calculated to give notice of the nature of the complaint, and shall contain such information as may be prescribed in regulations of the Secretary of Labor.

(e) NOTICE OF FILING.—The complaint review office shall serve by certified mail a notice of the complaint (including the date, place, and circumstances of the alleged violation) on the person or persons alleged in the complaint to have committed the violation within 10 days after the filing of the complaint.

(f) TIME LIMITATION.—Complaints may not be brought under this section with respect to any violation later than one year after the date on which the complaining party knows or should have reasonably known

that a violation has occurred. This subsection shall not prevent the subsequent amending of a complaint.

SEC. 5503. INITIAL PROCEEDINGS IN COMPLAINT REVIEW OFFICES.

(a) ELECTIONS.—Whenever a complaint is brought to the complaint review office under section 5502(b), the complaint review office shall provide the complainant with an opportunity, in such form and manner as shall be prescribed in regulations of the Secretary of Labor, to elect one of the following:

(1) To forego further proceedings in the complaint review office and rely on remedies available in a court of competent jurisdiction.

(2) To submit the complaint as a dispute under the Early Resolution Program established under subpart B and thereby suspend further review proceedings under this section pending termination of proceedings under the Program.

(3) In any case in which an election under paragraph (1) or (2) is not made, or an election under paragraph (2) was made but resolution of all matters in the complaint was not obtained upon termination of proceedings pursuant to the election by settlement agreement or otherwise, to proceed with the complaint to a hearing in the complaint review

office under section 5504 regarding the unresolved matters.

(b) DUTY OF COMPLAINT REVIEW OFFICE.—The complaint review office shall provide (in a linguistically appropriate manner) an explanation to complainants bringing complaints to the office concerning the legal and other ramifications of each option available under this section.

(c) EFFECT OF PARTICIPATION IN EARLY RESOLUTION PROGRAM.—Any matter in a complaint brought to the complaint review office which is included in a dispute which is timely submitted to the Early Resolution Program established under subpart B shall not be assigned to a hearing under section 5504 unless the proceedings under the Program with respect to the dispute are terminated without settlement or resolution of the dispute with respect to such matter. Upon termination of any proceedings regarding a dispute submitted to the Program, the applicability of this section to any matter in a complaint which was included in the dispute shall not be affected by participation in the proceedings, except to the extent otherwise required under the terms of any settlement agreement or other formal resolution obtained in the proceedings.

SEC. 5504. HEARINGS BEFORE HEARING OFFICERS IN COMPLAINT REVIEW OFFICES.

(a) HEARING PROCESS.—

(1) ASSIGNMENT OF COMPLAINTS TO HEARING OFFICERS AND NOTICE TO PARTIES.—

(A) IN GENERAL.—In the case of an election under section 5503(a)(3)—

(i) the complaint review office shall assign the complaint, and each motion in connection with the complaint, to a hearing officer employed by the State in the office; and

(ii) the hearing officer shall have the power to issue and cause to be served upon the plan named in the complaint a copy of the complaint and a notice of hearing before the hearing officer at a place fixed in the notice, not less than 5 days after the serving of the complaint.

(B) QUALIFICATIONS FOR HEARING OFFICERS.—No individual may serve in a complaint review office as a hearing officer unless the individual meets standards which shall be prescribed by the Secretary of Labor. Such standards shall include experience, training, ability to communicate with the enrollee, affiliations, dili-

gence, absence of actual or potential conflicts of interest, and other qualifications deemed relevant by the Secretary of Labor. At no time shall a hearing officer have any official, financial, or personal conflict of interest with respect to issues in controversy before the hearing officer.

(2) AMENDMENT OF COMPLAINTS.—Any such complaint may be amended by the hearing officer conducting the hearing, upon the motion of the complainant, in the hearing officer's discretion at any time prior to the issuance of an order based thereon.

(3) ANSWERS.—The party against whom the complaint is filed shall have the right to file an answer to the original or amended complaint and to appear in person or otherwise and give testimony at the place and time fixed in the complaint.

(b) ADDITIONAL PARTIES.—In the discretion of the hearing officer conducting the hearing, any other person may be allowed to intervene in the proceeding and to present testimony.

(c) HEARINGS.—

(1) DE NOVO HEARING.—Each hearing officer shall hear complaints and motions de novo.

(2) TESTIMONY.—The testimony taken by the hearing officer shall be reduced to writing. Thereafter, the hearing officer, in his or her discretion, upon notice may provide for the taking of further testimony or hear argument.

(3) AUTHORITY OF HEARING OFFICERS.—The hearing officer may 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 paragraph and upon application of the hearing officer, an appropriate district court of the United States may issue an order requiring compliance with the subpoena and any failure to obey the order may be punished by the court as a contempt thereof. The hearing officer may also seek enforcement of the subpoena in a State court of competent jurisdiction.

(4) EXPEDITED HEARINGS.—Notwithstanding section 5503 and the preceding provisions of this section, upon receipt of a complaint containing a claim described in section 5501(c)(1), the complaint review office shall promptly provide the complainant with the opportunity to make an election under section 5503(a)(3) and assignment to a hearing on the

complaint before a hearing officer. The complaint review office shall ensure that such a hearing commences not later than 24 hours after receipt of the complaint by the complaint hearing office and not later than 3 days after the receipt of a complaint, the Complaint Review Office shall provide a decision.

(d) DECISION OF HEARING OFFICER.—

(1) IN GENERAL.—Not later than 120 days after the date on which a complaint is assigned under this section, the hearing officer shall decide if the preponderance of the evidence justifies the denial of services and whether to decide in favor of the complainant with respect to each alleged act or practice. Each such decision—

(A) shall include the hearing officer's findings of fact, and

(B) shall constitute the hearing officer's final disposition of the proceedings.

(2) DECISIONS FINDING IN FAVOR OF COMPLAINANT.—If the hearing officer's decision includes a determination that any party named in the complaint has engaged in or is engaged in an act or practice described in section 5502(b), the hearing officer shall issue and cause to be served on such party an order which requires such party—

(A) to cease and desist from such act or practice,

(B) to provide the benefits due under the terms of the plan and to otherwise comply with the terms of the plan and the applicable requirements of this Act,

(C) to pay to the complainant prejudgment interest on the actual costs incurred in obtaining the items and services at issue in the complaint,

(D) to pay to the prevailing complainant a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the hearing on the charges on which the complainant prevails, and

(E) to provide other appropriate relief.

(3) DECISIONS NOT IN FAVOR OF COMPLAINANT.—If the hearing officer's decision includes a determination that the party named in the complaint has not engaged in or is not engaged in an act or practice referred to in section 5502(b), the hearing officer—

(A) shall include in the decision a dismissal of the charge in the complaint relating to the act or practice, and

(B) upon a finding that such charge is frivolous, shall issue and cause to be served on the complainant an order which requires the complainant to pay to such party a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the proceedings on such charge.

(4) SUBMISSION AND SERVICE OF DECISIONS.—The hearing officer shall submit each decision to the complaint review office at the conclusion of the proceedings and the office shall cause a copy of the decision to be served on the parties to the proceedings.

(e) FINAL DECISION.—The decision of the hearing officer shall be final and binding upon all parties.

(f) COURT ENFORCEMENT OF ORDERS.—

(1) IN GENERAL.—The complainant may petition any court of competent jurisdiction for enforcement of the order. In any such proceeding, the order of the hearing officer shall not be subject to review.

(2) AWARDING OF COSTS.—In any action for court enforcement under this subsection, a prevailing complainant shall be entitled to a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to such action.

SEC. 5505. CIVIL MONEY PENALTIES.

(a) DENIAL OR DELAY IN PAYMENT OR PROVISION OF BENEFITS.—

(1) IN GENERAL.—The Secretary of Labor may assess a civil penalty against any health plan, or against any other plan in connection with benefits provided thereunder under a supplemental benefit policy or a cost sharing policy, for unreasonable denial or delay in the payment or provision of benefits thereunder, in an amount not to exceed—

(A) $25,000 per violation, or $75,000 per violation in the case of a finding of bad faith on the part of the plan, and

(B) in the case of a finding of a pattern or practice of such violations engaged in by the plan, $1,000,000 in addition to the total amount of penalties assessed under subparagraph (A) with respect to such violations.

For purposes of subparagraph (A), each violation with respect to any single individual shall be treated as a separate violation.

(2) CIVIL ACTION TO ENFORCE CIVIL PENALTY.—The Secretary of Labor may commence a civil action in any court of competent jurisdiction to enforce a civil penalty assessed under paragraph (1).

(3) SUPPLEMENTAL PLANS.—Nothing in this section shall be construed to limit the rights and remedies available under State law with respect to supplemental benefit plans.

(b) CIVIL PENALTIES FOR CERTAIN OTHER ACTIONS.—The Secretary of Labor may assess a civil penalty described in section 5505(b)(1) against any experience-rated health plan, or against any other plan sponsored by a large employer group purchaser in connection with benefits provided thereunder under a cost sharing policy, for any action described in section 5505(a). The Secretary of Labor may initiate proceedings to impose such penalty in the same manner as the Secretary of Health and Human Services may initiate proceedings under section 5505 with respect to actions described in section 5505(a).

Subpart B—Early Resolution Programs

SEC. 5511. ESTABLISHMENT OF EARLY RESOLUTION PROGRAMS IN COMPLAINT REVIEW OFFICES.

(a) ESTABLISHMENT OF PROGRAMS.—Each State shall establish and maintain an Early Resolution Program in each complaint review office in such State. The Program shall include—

(1) the establishment and maintenance of forums for mediation of disputes in accordance with this subpart, and

(2) the establishment and maintenance of such forums for other forms of alternative dispute resolution (including binding arbitration) as may be prescribed in regulations of the Secretary of Labor.

Each State shall ensure that the standards applied in Early Resolution Programs administered in such State which apply to any form of alternative dispute resolution described in paragraph (2) and which relate to time requirements, qualifications of facilitators, arbitrators, or other mediators, and confidentiality are at least equivalent to the standards which apply to mediation proceedings under this subpart.

(b) DUTIES OF COMPLAINT REVIEW OFFICES.—Each complaint review office in a State—

(1) shall administer its Early Resolution Program in accordance with regulations of the Secretary of Labor,

(2) shall, pursuant to subsection (a)(1)—

(A) recruit and train individuals to serve as facilitators for mediation proceedings under the Early Resolution Program from attorneys who have the requisite expertise for such service, which shall be specified in regulations of the Secretary of Labor,

(B) provide meeting sites, maintain records, and provide facilitators with administrative support staff, and

(C) establish and maintain attorney referral panels,

(3) shall ensure that, upon the filing of a complaint with the office, the complainant is adequately apprised of the complainant's options for review under this part, and

(4) shall monitor and evaluate the Program on an ongoing basis.

SEC. 5512. INITIATION OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) ELIGIBILITY OF CASES FOR SUBMISSION TO EARLY RESOLUTION PROGRAM.—A dispute may be submitted to the Early Resolution Program only if the following requirements are met with respect to the dispute:

(1) NATURE OF DISPUTE.—The dispute consists of—

(A) an assertion by an individual enrolled under a health plan of one or more claims against the health plan for payment or provision of benefits, or against any other health plan with respect to benefits provided under a supplemental benefit policy or a cost sharing

policy, based on alleged coverage under the plan; and

(B) a denial by the plan of the claims, or a denial of appropriate reimbursement based on the claims, by the plan.

(2) NATURE OF DISPUTED CLAIM.—Each claim consists of—

(A) a claim for payment or provision of benefits under the plan; or

(B) a request for information or documents the disclosure of which is required under this Act (including claims of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

(b) FILING OF ELECTION.—A complainant with a dispute which is eligible for submission to the Early Resolution Program may make the election under section 5503(a)(2) to submit the dispute to mediation proceedings under the Program not later than 15 days after the date the complaint is filed with the complaint review office under section 5502(b).

(c) AGREEMENT TO PARTICIPATE.—

(1) ELECTION BY CLAIMANT.—A complainant may elect participation in the mediation proceedings only by entering into a written participation agree-

1 ment (including an agreement to comply with the
2 rules of the Program and consent for the complaint
3 review office to contact the health plan regarding the
4 agreement), and by releasing plan records to the
5 Program for the exclusive use of the facilitator as-
6 signed to the dispute.

7 (2) PARTICIPATION BY PLANS OR HEALTH BEN-
8 EFITS CONTRACTORS.—Each party whose participa-
9 tion in the mediation proceedings has been elected
10 by a claimant pursuant to paragraph (1) shall par-
11 ticipate in, and cooperate fully with, the proceedings.
12 The claims review office shall provide such party
13 with a copy of the participation agreement described
14 in paragraph (1), together with a written description
15 of the Program. Such party shall submit the copy of
16 the agreement, together with its authorized signa-
17 ture signifying receipt of notice of the agreement, to
18 the claims review office, and shall include in the sub-
19 mission to the claims review office a copy of the
20 written record of the plan claims procedure com-
21 pleted pursuant to section 5501 with respect to the
22 dispute and all relevant plan documents. The rel-
23 evant documents shall include all documents under
24 which the plan is or was administered or operated,
25 including copies of any insurance contracts under

which benefits are or were provided and any fee or reimbursement schedules for health care providers.

SEC. 5513. MEDIATION PROCEEDINGS.

(a) ROLE OF FACILITATOR.—In the course of mediation proceedings under the Early Resolution Program, the facilitator assigned to the dispute shall prepare the parties for a conference regarding the dispute and serve as a neutral mediator at such conference, with the goal of achieving settlement of the dispute.

(b) PREPARATIONS FOR CONFERENCE.—In advance of convening the conference, after identifying the necessary parties and confirming that the case is eligible for the Program, the facilitator shall analyze the record of the claims procedure conducted pursuant to section 5501 and any position papers submitted by the parties to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents.

(c) CONFERENCE.—Upon convening the conference, the facilitator shall assist the parties in identifying undisputed issues and exploring settlement. If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement. If no settlement is reached, the facilitator shall present the facilitator's evaluation, including an assessment of the parties' positions,

the likely outcome of further administrative action or litigation, and suggestions for narrowing the issues in dispute.

(d) TIME LIMIT.—The facilitator shall ensure that mediation proceedings with respect to any dispute under the Early Resolution Program shall be completed within 120 days after the election to participate. The parties may agree to one extension of the proceedings by not more than 30 days if the proceedings are suspended to obtain an agency ruling or to reconvene the conference in a subsequent session.

(e) INAPPLICABILITY OF FORMAL RULES.—Formal rules of evidence shall not apply to mediation proceedings under the Early Resolution Program. All statements made and evidence presented in the proceedings shall be admissible in the proceedings. The facilitator shall be the sole judge of the proper weight to be afforded to each submission. The parties to mediation proceedings under the Program shall not be required to make statements or present evidence under oath.

(f) REPRESENTATION.—Parties may participate pro se or be represented by attorneys throughout the proceedings of the Early Resolution Program.

(g) CONFIDENTIALITY.—

(1) IN GENERAL.—Under regulations of the Secretary of Labor, rules similar to the rules under section 574 of title 5, United States Code (relating to confidentiality in dispute resolution proceedings) shall apply to the mediation proceedings under the Early Resolution Program.

(2) CIVIL REMEDIES.—The Secretary of Labor may assess a civil penalty against any person who discloses information in violation of the regulations prescribed pursuant to paragraph (1) in the amount of three times the amount of the claim involved. The Secretary of Labor may bring a civil action to enforce such civil penalty in any court of competent jurisdiction.

SEC. 5514. LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) PROCESS NONBINDING.—Findings and conclusions made in the mediation proceedings of the Early Resolution Program shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the Program.

(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a case is settled through participation in mediation proceedings under the Program, the facilitator shall

assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties, which shall be enforceable under section 5515.

(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under subpart A, or any other right under this Act or the plan, with respect to any person who is not a party to the settlement agreement.

SEC. 5515. ENFORCEMENT OF SETTLEMENT AGREEMENTS.

(a) ENFORCEMENT.—Any party to a settlement agreement entered pursuant to mediation proceedings under this subpart may petition any court of competent jurisdiction for the enforcement of the agreement, by filing in the court a written petition praying that the agreement be enforced. In such a proceeding, the order of the hearing officer shall not be subject to review.

(b) COURT REVIEW.—It shall be the duty of the court to advance on the docket and to expedite to the greatest possible extent the disposition of any petition filed under this section, with due deference to the role of settlement agreements under this part in achieving prompt resolution of disputes involving health plans.

(c) AWARDING OF ATTORNEY'S FEES AND OTHER COSTS AND EXPENSES.—In any action by an individual enrolled under a health plan for court enforcement under this section, a prevailing plaintiff shall be entitled to reasonable costs and expenses (including a reasonable attorney's fee and reasonable expert witness fees) on the charges on which the plaintiff prevails.

SEC. 5516. DUE PROCESS FOR HEALTH CARE PROVIDERS.

(a) PUBLICLY AVAILABLE STANDARDS AND PROCESS.—Each health plan shall establish and utilize—

(1) publicly available standards for contracting with health care providers; and

(2) a publicly available process for dismissing such providers or failing to renew contracts with such providers.

(b) NOTICE REQUIREMENT.—

(1) IN GENERAL.—The process established by a health plan under subsection (a) shall include reasonable notification to a health care provider of a decision to dismiss such provider or not to renew a contract with such provider before such decision takes effect.

(2) EXCEPTION.—The notice required under paragraph (1) shall not apply if failure to dismiss a

provider or renewing a provider's contract would adversely affect the health or safety of a patient.

(3) CONTENTS OF NOTICE.—Each notice to a health care provider under paragraph (1) shall contain the reasons for the dismissal or failure to renew. Such reasons shall be consistent with the standards established under subsection (a).

(c) REVIEW.—The process established by a health plan under subsection (a) shall include an opportunity for review of the health plan's action by a health care provider who is dismissed by a health plan or with respect to whom a health plan fails to renew a contract. Such review shall be conducted by—

(1) the provider's peers who have contracts with, or are employed by, the health plan; and

(2) if there is mutual consent of the provider and the health plan, one or more enrollees in the health plan.

A health care provider may have an attorney present in connection with any review under this subsection if the provider notifies the health plan that an attorney will be present in advance of the review proceeding.

(d) EFFECT ON OTHER LAWS.—The provisions of this section shall not supersede any other provision of Federal or State law.

PART 2—ADDITIONAL REMEDIES AND ENFORCEMENT PROVISIONS

SEC. 5531. JUDICIAL REVIEW OF FEDERAL ACTION ON STATE SYSTEMS.

(a) IN GENERAL.—Any State that is aggrieved by a determination by the Secretary under subpart B of part 1 of subtitle E of title I shall be entitled to judicial review of such determination in accordance with this section.

(b) JUDICIAL REVIEW.—

(1) JURISDICTION.—The courts of appeals of the United States (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction to review a determination described in subsection (a), to affirm the determination, or to set it aside, in whole or in part. A judgment of a court of appeals in such an action shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(2) PETITION FOR REVIEW.—A State that desires judicial review of a determination described in subsection (a) shall, within 30 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which the State is located a petition for review of such determination. A copy of the petition shall be transmitted

by the clerk of the court to the Secretary, and the Secretary shall file in the court the record of the proceedings on which the determination or action was based, as provided in section 2112 of title 28, United States Code.

(3) SCOPE OF REVIEW.—The findings of fact of the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may make new or modified findings of fact and may modify its previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

SEC. 5532. CIVIL ENFORCEMENT.

Unless otherwise provided in this Act, the district courts of the United States shall have jurisdiction of civil actions brought by—

(1) the Secretary of Labor to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this Act; and

(2) the Secretary of Health and Human Services to enforce any final order of such Secretary or

to collect any civil monetary penalty assessed by such Secretary under this Act.

SEC. 5533. PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.

Section 507(a)(8) of title 11, United States Code, is amended to read as follows:

"(8) Eighth, allowed unsecured claims—

"(A) based upon any commitment by the debtor to the Federal Deposit Insurance Corporation, the Resolution Trust Corporation, the Director of the Office of Thrift Supervision, the Comptroller of the Currency, or the Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution; or

"(B) for payments under title X of the Health Security Act owed to a State.".

SEC. 5534. PRIVATE RIGHT TO ENFORCE STATE RESPONSIBILITIES.

The failure of a participating State to carry out a responsibility applicable to participating States under this Act constitutes a deprivation of rights secured by this Act for the purposes of section 1977 of the Revised Statutes of the United States (42 U.S.C. 1983). In an action brought under such section, the court shall exercise juris-

diction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 5535. PRIVATE RIGHT TO ENFORCE FEDERAL RESPONSIBILITIES IN OPERATING A SYSTEM IN A STATE.

(a) IN GENERAL.—The failure of the Secretary of Health and Human Services to carry out a responsibility under subpart C of part 1 of subtitle E of title I, confers an enforceable right of action on any person who is aggrieved by such failure. Such a person may commence a civil action against the Secretary in an appropriate State court or district court of the United States.

(b) EXHAUSTION OF REMEDIES.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

(c) RELIEF.—In an action under subsection (a), if the court finds that a failure described in such subsection has occurred, the aggrieved person may recover compensatory damages and the court may award any other appropriate relief.

(d) ATTORNEY'S FEES.—In an action under subsection (a), the court, in its discretion, may allow the pre-

vailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

SEC. 5536. ENFORCEMENT OF CONSUMER PROTECTIONS.

(a) COVERED VIOLATIONS.—The provisions of this section shall apply with respect to a health plan that fails to fulfill a duty imposed on the plan under section 1122 and subtitle A of this title.

(b) ADMINISTRATIVE ENFORCEMENT AND CIVIL PENALTIES.—The penalties described in section 1867(d)(1) of the Social Security Act and the procedures described in section 1128A of such Act (other than the first two sentences of subsection (a) and subsection (b)) shall apply to health plans described in subsection (a). In addition to such penalties, an amount not to exceed $1,000,000 may be assessed in the case of a finding of a pattern or practice of such violations. The Secretary shall establish procedures whereby, when a consumer has disenrolled from a health plan violating the duties described in subsection (a), successor health plans may recover from the original health plan for health care costs attributable to such violations.

(c) CORRECTION OF SUBSTANTIAL VIOLATIONS.—Upon an administrative or judicial finding of a substantial

violation of the duties described in subsection (a), the State or court may—

(1) inform all current enrollees of the plan of the violation and that they may disenroll immediately from that plan and enroll with another community-rated health plan; and

(2) notify the health plan that it shall immediately cease enrollment activities until it has obtained certifications from the appropriate certifying entity or court that the violation has been corrected.

Such actions shall not be taken without providing the health plan with a reasonable opportunity to correct such violations, except where providing such an opportunity would risk health or safety.

SEC. 5537. DISCRIMINATION CLAIMS.

(a) CIVIL ACTION BY AGGRIEVED PERSON.—

(1) IN GENERAL.—Any person who is aggrieved by a violation of section 1602 may commence a civil action against the party or parties committing such violation in an appropriate State court or district court of the United States.

(2) STANDARDS.—The standards used to determine whether a violation has occurred in a complaint alleging discrimination on the basis of age or disability under section 1602 shall be the standards ap-

1 plied under the Age Discrimination Act of 1975 (42
2 U.S.C. 6101 et seq.) and the Americans with Dis-
3 abilities Act of 1990 (42 U.S.C. 12101 et seq.).
4 (3) RELIEF.—In any action under paragraph
5 (1), if the court finds a violation of section 1602, the
6 court may award such equitable and injunctive relief
7 as it deems appropriate, and may award to the ag-
8 grieved person any sums lost as a result of the viola-
9 tion. If the court finds that the party or parties
10 committing a violation engaged in intentional dis-
11 crimination in violation of section 1602, the ag-
12 grieved person may recover compensatory damages.
13 If the court finds that the party or parties commit-
14 ting such violation did so with malice or reckless in-
15 difference to the federally protected rights of the ag-
16 grieved person, the aggrieved person may recover
17 punitive damages under this section against a de-
18 fendant other than a government, government agen-
19 cy or political subdivision.
20 (4) ATTORNEYS' FEES.—In any action under
21 paragraph (1), the court, in its discretion, may allow
22 the prevailing party, other than the United States,
23 a reasonable attorney's fee (including expert fees
24 and other litigation expenses) as part of the costs,

and the United States shall be liable for costs the same as a private person.

(b) ACTION BY SECRETARY.—Whenever the Secretary of Health and Human Services finds that a party has failed to comply with section 1602 or with an applicable regulation issued under such section, the Secretary shall notify the party. If within a reasonable period of time the party fails or refuses to comply, the Secretary may—

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

(2) terminate or limit the participation of such party in the programs authorized by this Act;

(3) withhold Federal financial assistance to the party; or

(4) take such other action as may be provided by law.

(c) ACTION BY ATTORNEY GENERAL.—When a matter is referred to the Attorney General under subsection (b)(1), the Attorney General may bring a civil action in a district court of the United States for such relief as may be appropriate, including injunctive relief. In a civil action under this section, the court—

(1) may grant any equitable relief that the court considers to be appropriate;

(2) may award such other relief as the court considers to be appropriate, including in cases of intentional discrimination compensatory and punitive damages; and

(3) may, to vindicate the public interest when requested by the Attorney General, assess a civil money penalty against the party in an amount—

(A) not exceeding $50,000 for a first violation; and

(B) not exceeding $100,000 for any subsequent violation.

SEC. 5538. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

Federal payments under this Act shall be treated as Federal financial assistance for purposes of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 303 of the Age Discrimination Act of 1975 (42 U.S.C. 6102), and section 601 of the Civil Rights Act of 1964 (42 U.S.C. 2000d).

SEC. 5539. CIVIL AND ADMINISTRATION ACTION BY ESSENTIAL COMMUNITY PROVIDER.

(a) IN GENERAL.—An electing essential community provider (as defined in section 1466(d)) who is aggrieved by the failure of a health plan to fulfill a duty imposed on the plan by section 1466 may commence a civil action

1 against the plan in an appropriate State court or district
2 court of the United States.

3 (b) RELIEF.—In an action under subsection (a), if
4 the court finds that the health plan has failed to fulfill
5 a duty imposed on the plan by section 1466, the electing
6 essential community provider may recover compensatory
7 damages and the court may order any other appropriate
8 relief.

9 (c) ATTORNEY'S FEES.—In any action under sub-
10 section (a), the court, in its discretion, may allow the pre-
11 vailing party, other than the United States, a reasonable
12 attorney's fee (including expert fees) as part of the costs,
13 and the United States shall be liable for costs the same
14 as a private person.

15 (d) STATE COMPLAINT SYSTEM REQUIRED.—Prior
16 to commencing an action under subsection (a), the ag-
17 grieved essential community provider may first elect to
18 utilize the administrative process provided under this sub-
19 section as follows:

20 (1) The Secretary shall prescribe regulations
21 governing administrative grievance actions by essen-
22 tial community providers that shall be consistent
23 with the requirements of section 5504 and that shall
24 provide for the consolidation of complaints (at the
25 election of the essential community providers) in

cases involving multiple complaints against a single health plan.

(2) A State shall make available to each electing essential community provider that is aggrieved by an action of a health plan under section 1466, the opportunity to file a complaint in the complaint review office established under section 5502. In the case of essential community providers located in a cooperative established in any State by the Secretary, the Secretary shall assume all of the duties and obligations of such State under this section.

SEC. 5540. FACIAL CONSTITUTIONAL CHALLENGES.

(a) JURISDICTION.—The United States District Court for the District of Columbia shall have original and exclusive jurisdiction of any civil action brought to invalidate this Act or a provision of this Act on the ground of its being repugnant to the Constitution of the United States on its face and for every purpose. In any action described in this subsection, the district court may not grant any temporary order or preliminary injunction restraining the enforcement, operation, or execution of this Act or any provision of this Act.

(b) CONVENING OF THREE-JUDGE COURT.—An action described in subsection (a) shall be heard and deter-

mined by a district court of three judges in accordance with section 2284 of title 28, United States Code.

(c) CONSOLIDATION.—When actions described in subsection (a) involving a common question of law or fact are pending before a district court, the court shall order all the actions consolidated.

(d) DIRECT APPEAL TO SUPREME COURT.—In any action described in subsection (a), an appeal may be taken directly to the Supreme Court of the United States from any final judgment, decree, or order in which the district court—

(1) holds this Act or any provision of this Act invalid; and

(2) makes a determination that its holding will materially undermine the application of the Act as whole.

(e) CONSTRUCTION.—This section does not limit—

(1) the right of any person—

(A) to a litigation concerning the Act or any portion of the Act; or

(B) to petition the Supreme Court for review of any holding of a district court by writ of certiorari at any time before the rendition of judgment in a court of appeals; or

(2) the authority of the Supreme Court to grant a writ of certiorari for the review described in paragraph (1)(B).

SEC. 5541. TREATMENT OF PLANS AS PARTIES IN CIVIL ACTIONS.

(a) IN GENERAL.—A health plan may sue or be sued under this Act as an entity. Service of summons, subpoena, or other legal process of a court or hearing officer upon a trustee or an administrator of any such plan in his or her capacity as such shall constitute service upon the plan. In a case where a plan has not designated in applicable plan documents an individual as agent for the service of legal process, service upon the Secretary of Health and Human Services (in the case of a community-rated health plan) or the Secretary of Labor (in the case of an experienced-rated health plan) shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(b) OTHER PARTIES.—Any money judgment under this Act against a plan referred to in subsection (a) shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability

against such person is established in his individual capacity under this Act.

SEC. 5542. WHISTLEBLOWER PROTECTIONS.

(a) IN GENERAL.—A health plan may not discharge, discriminate or otherwise take adverse action against any employee with respect to compensation, terms, conditions or privileges of employment because the employee (or any person acting pursuant to the request of the employee) provided information to any Federal, State or private supervisory agency or entity regarding a possible violation of any provision of this Act or any regulation issued under this Act.

(b) CIVIL ACTION.—An employee or former employee who believes that such employee has been discharged, discriminated or otherwise subject to adverse action in violation of subsection (a) may file a civil action in the appropriate United States district court within 2 years of the date of such discharge, discrimination or adverse action.

(c) DETERMINATION OF COURT.—If a court in an action under subsection (b) determines that a violation of subsection (a) has occurred, the court may order the health care entity or plan that committed the violation—

(1) to reinstate the employee to his or her former position;

(2) to pay compensatory damages to the employee;

(3) to pay reasonable costs and attorneys fees incurred by the employee in bringing such action; and

(4) to take such other appropriate actions to remedy any past discrimination.

SEC. 5543. GENERAL NONPREEMPTION OF RIGHTS AND REMEDIES.

Nothing in this subtitle shall be construed to deny, impair, or otherwise adversely affect a right or remedy available under law to any person, except to the extent the right or remedy is inconsistent with this title.

Subtitle G—Repeal of Exemption

SEC. 5601. REPEAL OF EXEMPTION FOR HEALTH INSURANCE.

(a) IN GENERAL.—Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson Act, is amended by adding at the end the following:

"(c) Notwithstanding that the business of insurance is regulated by State law, nothing in this Act shall limit the applicability of the following Acts to the business of insurance to the extent that such business relates to the provision of health benefits:

"(1) The Sherman Act (15 U.S.C. 1 et seq.).

"(2) The Clayton Act (15 U.S.C. 12 et seq.).

"(3) Federal Trade Commission Act (15 U.S.C. 41 et seq.).

"(4) The Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 21a et seq.), known as the Robinson-Patman Antidiscrimination Act.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the first day of the sixth month beginning after the date of the enactment of this Act.

TITLE VI—INDIVIDUAL AND EMPLOYER SUBSIDIES

Subtitle A—Individual Premium and Cost-Sharing Assistance

SEC. 6001. REQUIREMENT TO OPERATE STATE PROGRAM.

(a) IN GENERAL.—A participating State shall have in effect a program for furnishing premium assistance and cost-sharing assistance in accordance with this subtitle for calendar years beginning after 1996.

(b) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this subtitle.

SEC. 6002. ASSISTANCE WITH STANDARD HEALTH PLAN PREMIUMS.

(a) ELIGIBILITY.—

(1) IN GENERAL.—An eligible individual (as defined in section 6008(4)) who has been determined by a State under section 6004 to be a premium subsidy eligible individual (as defined in paragraph (2)) shall be eligible for premium assistance in the amount determined under subsection (b).

(2) PREMIUM SUBSIDY ELIGIBLE INDIVIDUAL.—For purposes of this subtitle, the term ''premium subsidy eligible individual'' means any of the following individuals:

(A) INDIVIDUALS WITH INCOMES BELOW A CERTAIN INCOME THRESHOLD.—An eligible individual who has a family income determined under section 6008(3) which does not exceed 200 percent of the poverty line (as defined in section 6008(5)).

(B) CHILDREN.—An eligible individual who—

(i) is a child (as defined in section 6008(2));

(ii) has a family income determined under section 6008(3) which does not exceed 240 percent of the poverty line; and

(iii) has not been enrolled in a health plan during the 6-month period ending on

the date the individual submits an application to the State for premium assistance under this subtitle.

(C) PREGNANT WOMEN.—An eligible individual who—

(i) is a pregnant woman (as defined in section 6008(6));

(ii) has a family income determined under section 6008(3) which does not exceed 240 percent of the poverty line; and

(iii) is not enrolled in a health plan on the date the individual submits an application to the State for premium assistance under this subtitle.

(3) SPECIAL RULE WITH RESPECT TO CHILDREN AND PREGNANT WOMEN.—An eligible individual may not be a premium subsidy eligible individual described in subparagraphs (B) or (C) of paragraph (2) if an employer contribution of at least 80 percent of the premium under a standard health plan that is available to the individual through the employer is made or offered to be made on behalf of the individual.

(b) AMOUNT OF ASSISTANCE.—

(1) IN GENERAL.—

1 (A) FORMULA.—The amount of premium
2 assistance for a month for a premium subsidy
3 eligible individual is—
4 (i) the least of —
5 (I) the subsidy percentage speci-
6 fied in paragraph (2) multiplied by
7 1/12th of the annual premium paid for
8 coverage under a standard health plan
9 in which the individual is enrolled;
10 (II) the subsidy percentage speci-
11 fied in paragraph (2) multiplied by
12 1/12th of the weighted average annual
13 premium rate (as defined in subpara-
14 graph (B)) for all community-rated
15 standard health plans offered in the
16 community rating area in which the
17 individual resides; or
18 (III) the subsidy percentage spec-
19 ified in paragraph (2) multiplied by
20 1/12th of the annual reference pre-
21 mium for the community rating area
22 in which the individual resides (as de-
23 fined in subparagraph (C)); minus
24 (ii) the amount of any employer con-
25 tribution made or offered to be made on

behalf of the individual for coverage under the standard health plan that is available to the individual through an employer.

(B) WEIGHTED AVERAGE ANNUAL PREMIUM RATE.—For purposes of this paragraph, the term ''weighted average annual premium rate'' means the average premium for the community-rated standard health plans offered in the community rating area in which the individual resides, weighted to reflect the total enrollment of community-rated eligible individuals among such plans.

(C) REFERENCE PREMIUM.—For purposes of this paragraph, the term ''reference premium'' means the reference premium established under section 4512 of the Internal Revenue Code of 1986.

(D) SPECIAL RULES FOR DETERMINING AMOUNT OF EMPLOYER CONTRIBUTIONS.—For purposes of determining the amount of an employer contribution under subparagraph (A), the following rules shall apply:

(i) FAMILY CONTRIBUTIONS.—If an employer makes a contribution on behalf of a family (rather than any particular indi-

vidual) such contribution shall be allocated ratably among the individuals in the family.

(ii) GREATEST EMPLOYER CONTRIBUTION AVAILABLE.—The employer contribution with respect to any individual is the largest employer contribution offered to be made on behalf of the individual by the individual's employer or any employer of any member of the individual's family.

(2) SUBSIDY PERCENTAGE.—For purposes of paragraph (1)(A), the term ''subsidy percentage'' means the following:

(A) INDIVIDUALS WITH INCOMES BELOW CERTAIN INCOME THRESHOLD.—

(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), for a premium subsidy eligible individual described in subsection (a)(2)(A), 100 percent reduced (but not below zero) by .80 percentage points for each 1 percentage point (or portion thereof) by which such individual's family income exceeds 100 percent of the poverty line.

(ii) AFDC RECIPIENTS.—For a premium subsidy eligible individual described in subsection (a)(2)(A) who is a member of a family receiving aid to families with dependent children under part A or E of title IV of the Social Security Act, the subsidy percentage shall be 100 percent.

(iii) NON-CASH MEDICAID ELIGIBLES.—

(I) IN GENERAL.—For a premium subsidy eligible individual described in subsection (a)(2)(A) who is a non-cash medicaid eligible described in subclause (II), the subsidy percentage shall be 100 percent during the 6-month period beginning on January 1, 1997.

(II) NON-CASH MEDICAID ELIGIBLE.—The non-cash medicaid eligibles described in this subclause are individuals receiving medical assistance under the State plan under title XIX of the Social Security Act as of December 31, 1996, who are not individuals—

(aa) who are members of a family receiving aid to families with dependent children under part A or E of title IV of the Social Security Act;

(bb) with respect to whom supplemental security income benefits are being paid under title XVI of such Act; or

(cc) eligible for benefits under part A of title XVIII of such Act.

(B) CHILDREN AND PREGNANT WOMEN.—For a premium subsidy eligible individual described in subparagraph (B) or (C) of subsection (a)(2), 100 percent reduced (but not below zero) by 1.82 percentage points for each 1 percentage point (or portion thereof) by which such individuals family income exceeds 185 percent of the poverty line.

(c) PAYMENTS.—

(1) IN GENERAL.—The amount of the premium assistance available to a premium subsidy eligible individual under subsection (b) shall be paid by the State in which the individual resides directly to the

standard health plan in which the individual is enrolled. Payments under the preceding sentence shall commence in the first month during which the individual is enrolled in a certified standard health plan and determined under section 6004 to be a premium subsidy eligible individual.

(2) SPECIAL RULE WITH RESPECT TO FAMILIES WITH MULTIPLE CHILDREN.—If a family includes more than 1 child described in subsection (a)(2)(B), no premium assistance may be paid to a plan under paragraph (1) on behalf of any such child unless such assistance is paid on behalf of all such children.

(3) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium assistance paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

SEC. 6003. ASSISTANCE WITH COST-SHARING FOR STANDARD HEALTH PLANS.

(a) NON-AFDC LOW-INCOME INDIVIDUALS.—

(1) INDIVIDUALS WORKING FOR COMMUNITY-RATED EMPLOYERS.—

(A) IN GENERAL.—If a non-AFDC low-income individual described in subparagraph (B)

is enrolled in a community-rated standard health plan providing a high cost-sharing schedule, such individual shall be eligible for cost-sharing assistance consisting of a reduction in the cost-sharing under such plan to the level of a plan providing a low cost-sharing schedule.

(B) INDIVIDUAL DESCRIBED.—A non-AFDC low-income individual described in this subparagraph is an individual who is employed by a community-rated employer and who is unable to enroll in a standard health plan—

(i) with a premium at or below the weighted average premium rate for all community-rated standard health plans offered through the purchasing cooperative offered by the individual's employer, and

(ii) providing a low or combination cost-sharing schedule.

(2) INDIVIDUALS WORKING FOR EXPERIENCE-RATED EMPLOYERS.—

(A) IN GENERAL.—If a non-AFDC low-income individual described in subparagraph (B) is enrolled in an experience-rated standard health plan providing a high cost-sharing schedule, such individual shall be eligible for cost-

sharing assistance consisting of a reduction in the cost-sharing under such plan to the level of a plan providing a low cost-sharing schedule.

(B) INDIVIDUAL DESCRIBED.—A non-AFDC low-income individual described in this subparagraph is an individual who is employed by an experience-rated employer and who is unable to enroll in a standard health plan offered by such employer providing a low or combination cost-sharing schedule.

(3) NON-WORKING INDIVIDUALS.—

(A) IN GENERAL.—If a non-AFDC low-income individual described in subparagraph (B) is enrolled in a community-rated standard plan providing a high cost-sharing schedule, such individual shall be eligible for cost-sharing assistance consisting of a reduction in the cost-sharing under such plan to the level of a plan providing a low cost-sharing schedule.

(B) INDIVIDUAL DESCRIBED.—A non-AFDC low-income individual described in this subparagraph is an individual who is not employed and who is unable to enroll in a standard health plan—

(i) with a premium at or below the weighted average premium rate for all community-rated standard health plans offered in the community rating area in which the individual resides, and

(ii) providing a low or combination cost-sharing schedule.

(4) NON-AFDC LOW-INCOME INDIVIDUAL.—For purposes of this subsection, the term ''non-AFDC low-income individual'' means an eligible individual who—

(A) has a family income determined under section 6008(3) which does not exceed 150 percent of the poverty line; and

(B) is not a member of a family receiving aid to families with dependent children under part A or E of title IV of the Social Security Act.

(b) AFDC RECIPIENTS.—

(1) LOW OR COMBINATION COST-SHARING PLAN.—An AFDC recipient enrolled in a community-rated standard plan—

(A) with a premium at or below the weighted average premium rate for all community rated-standard health plans offered in the

1 community rating area in which the individual
2 resides, and
3 (B) providing a low or combination cost-
4 sharing schedule,
5 shall be eligible for cost-sharing assistance consisting
6 of a reduction in the amount of copayment applied
7 with respect to an item or service in an amount
8 equal to 20 percent of the copayment amount other-
9 wise applicable under the plan, rounded to the near-
10 est dollar.
11 (2) HIGH COST-SHARING PLAN.—If an AFDC
12 recipient is unable to enroll in a health plan de-
13 scribed in paragraph (1) and such individual is en-
14 rolled in a community-rated standard plan providing
15 a high cost-sharing schedule, such individual shall be
16 eligible for cost-sharing assistance consisting of a re-
17 duction in the cost-sharing under such plan to the
18 level of a plan providing a low cost-sharing schedule.
19 (3) AFDC RECIPIENT.—For purposes of this
20 subsection, the term ''AFDC recipient'' means an el-
21 igible individual who is a member of a family receiv-
22 ing aid to families with dependent children under
23 part A or E of title IV of the Social Security Act.
24 (c) NOTIFICATION OF HEALTH PLANS.—If a State
25 determines that an individual is eligible for cost-sharing

assistance under this section, the State shall notify the standard health plan in which such individual is enrolled of such determination in a timely manner.

SEC. 6004. ELIGIBILITY DETERMINATIONS.

(a) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State programs under this subtitle with respect to determining eligibility for premium and cost-sharing assistance.

(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

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

(2) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under subsection (c).

(3) DISTRIBUTION OF APPLICATIONS.—A State program shall make applications accessible at locations where individuals are most likely to obtain the applications.

(4) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall require individuals to submit revised applications to reflect changes in

estimated family incomes, including changes in employment status of family members, during the year. The State shall revise the amount of any premium assistance based on such a revised application.

(5) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this subtitle. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

(c) ADMINISTRATION OF STATE PROGRAMS.—

(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this subtitle which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary.

(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

(A) be simple in form and understandable to the average individual;

(B) require the provision of information necessary to make a determination as to wheth-

er an individual is eligible for assistance, including a declaration of estimated income by the individual based, at the election of the individual—

(i) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made; or

(ii) on estimated income for the entire year for which the application is submitted; and

(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

(d) EFFECTIVENESS OF ELIGIBILITY.—A determination by a State that an individual is a premium subsidy eligible individual or an individual eligible for cost-sharing assistance shall be effective for the calendar year for which such determination is made unless a revised application submitted under subsection (b)(4) indicates that an individual is no longer eligible for assistance.

(e) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

(1) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of infor-

mation in an application for assistance under this subtitle shall be liable to the Federal Government for the amount any assistance received by individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and, shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any assistance received by individual on the basis of a misrepresentation.

(2) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount required under paragraph (1) and submit such amount to the Secretary in a timely manner.

SEC. 6005. END-OF-YEAR RECONCILIATION FOR PREMIUM ASSISTANCE.

(a) IN GENERAL.—

(1) REQUIREMENT TO FILE STATEMENT.—An individual who received premium assistance under this subtitle from a State for any month in a calendar year shall file with the State an income reconciliation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the

State may specify in accordance with regulations promulgated by the Secretary.

(2) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under paragraph (1) at the end of the year to an individual who received premium assistance under this subtitle from such State in any month during the year.

(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—

(1) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to an individual, the State shall compute the amount of premium assistance that should have been provided under this subtitle with respect to the individual for the year involved.

(2) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was greater than the amount computed under paragraph (1), the individual is liable to the State to pay an amount equal to the amount of the excess payment. Any amount collected by a State under this paragraph shall be submitted to the Secretary in a timely manner.

(3) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was less than the amount computed under paragraph (1), the State shall pay to the individual an amount equal to the amount of the deficit.

(4) STATE OPTION.—A State may, in accordance with regulations promulgated by the Secretary, establish a procedure under which any overpayments or underpayments of premium assistance determined under paragraphs (2) and (3) with respect to an individual for a year may be collected or paid, as appropriate, through adjustments to the premium assistance furnished to such individual in the succeeding year.

(c) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this subtitle, including return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

(d) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement under this section in a year who fails to file such a statement, the entire amount of the premium assistance provided in such year shall be considered an excess amount under subsection (b)(2) and such individual shall not be eligible for

premium assistance under this subtitle until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

(e) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under subsection (a) is subject to the same penalties as are provided under section 6004(e) for a misrepresentation of material fact described in such section.

SEC. 6006. ENROLLMENT OUTREACH.

(a) IN GENERAL.—The Secretary shall promulgate regulations under which each State operating a program for premium assistance under this subtitle shall have in effect an enrollment outreach system under which individuals may be determined eligible for such assistance by health care providers who furnish services to such individuals.

(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

(1) HEALTH CARE PROVIDERS.—Each State shall permit only the classes or categories of health care providers determined appropriate by the Sec-

1 retary (referred to in this subsection as ''eligible
2 health care providers'') to participate in an enroll-
3 ment outreach system established by the State.

4 (2) APPLICATION FOR ASSISTANCE.—Each
5 State shall develop and make available to eligible
6 health care providers in the State an enrollment
7 package for distribution to potentially eligible indi-
8 viduals which includes a simple form for individuals
9 who receive services from such providers to apply for
10 premium assistance. Such form shall—

11 (A) permit an individual completing the
12 form to make a declaration that the individual
13 is eligible for a full subsidy under section 6002;
14 and

15 (B) permit an individual to enroll in a
16 community-rated standard health plan offered
17 in the community rating area in which the indi-
18 vidual resides.

19 (3) SUBMISSION OF COMPLETED APPLICA-
20 TION.—An individual who receives an enrollment ap-
21 plication form from an eligible health care provider
22 may complete the form and submit it to the individ-
23 ual's provider or the State agency operating the pro-
24 gram for premium assistance under this subtitle. If
25 a health care provider receives an application under

this section the provider shall submit the application to the State agency administering the premium assistance program under this subtitle within a period of time determined appropriate by the Secretary in regulations.

(4) SELECTION OF HEALTH PLAN.—An individual may select a community-rated standard health plan with which to enroll on the date the individual submits an application form under this section or the individual may make such selection at a later date determined appropriate by the Secretary in regulations. If an individual fails to select a health plan with which to enroll by the date determined appropriate by the Secretary, the State agency shall select such a plan for the individual.

(5) EFFECTIVE DATE OF ENROLLMENT.—An individual who is enrolled in a community-rated standard health plan in accordance with the enrollment eligibility system established under this section shall be an enrollee of the plan as of the date the individual submits an application to the State agency or a health care provider.

(6) PERIOD OF ELIGIBILITY.—An individual who submits an application to a health care provider under an enrollment outreach system under this sec-

tion shall be eligible for premium assistance under this subtitle for the period beginning on the date such application is submitted and ending 60 days after such date.

(7) NO STATE RESPONSIBILITY FOR ADMINISTRATIVE ERRORS.—Section 6002(c)(3) shall not apply to any eligibility determinations made under this section.

(8) NO RECONCILIATION REQUIRED.—The reconciliation provisions of section 6005 shall not apply to any premium assistance paid on behalf of an individual during a period of eligibility for such assistance under this section.

(9) REQUIREMENT ON STATES.—During a period of eligibility for premium assistance under this section, an individual shall be given an opportunity by a State to apply for continuing eligibility for premium assistance under this subtitle.

SEC. 6007. PAYMENTS TO STATES.

(a) IN GENERAL.—

(1) PAYMENTS FROM THE SECRETARY.—A State operating a program for furnishing premium assistance under this subtitle shall be entitled to receive payments from the Secretary in an amount equal to the premium assistance paid on behalf of

individuals eligible for such assistance under this subtitle. Such payments shall be made at such time and in such form as provided in regulations promulgated by the Secretary.

(2) STATE ENTITLEMENT.—This subsection constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to States operating programs under this subtitle in accordance with this section.

(b) STATE ASSESSMENTS FOR ADMINISTRATION COSTS.—A State operating a program for furnishing premium and cost-sharing assistance under this subtitle may impose a premium assessment on the insured health plans offered in the State in an amount not to exceed one percent of the amount of the premium. Amounts collected pursuant to this subsection may only be used to cover the administrative costs of the State in operating such program.

(c) AUDITS.—The Secretary shall conduct regular audits of the activities under the State programs conducted under this subtitle.

SEC. 6008. DEFINITIONS AND DETERMINATIONS OF INCOME.

For purposes of this subtitle:

(1) STANDARD HEALTH PLAN.—The term ''standard health plan'' means a health plan (as defined in section 1011(2)(B)) providing the standard benefits package as described in section 1201(a).

(2) CHILD.—The term ''child'' means an individual who is under 19 years of age.

(3) DETERMINATIONS OF INCOME.—

(A) FAMILY INCOME.—The term ''family income'' means, with respect to an individual who—

(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and children who are dependents of the individual; or

(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the other individual's spouse, and children who are dependents of the other individual.

(B) DEPENDENT.—The term ''dependent'' shall have the meaning given such term under

section 152 of the Internal Revenue Code of 1986.

(C) SPECIAL RULE FOR FOSTER CHILDREN.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency shall not be considered a dependent of another individual.

(D) MODIFIED ADJUSTED GROSS INCOME.—The term ''modified adjusted gross income'' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

(ii) increased by—

(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax, and

(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not in-

cluded in gross income under section 86 of such Code.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

(E) SPECIAL RULE FOR INDIVIDUALS TEMPORARILY UNEMPLOYED.—

(i) IN GENERAL.—For purposes of determining eligibility for premium assistance under this subtitle for an individual who becomes unemployed, such individual's spouse, and children who are dependents of such individual, the family income for such individuals determined under subparagraph (A) shall be reduced—

(I) for each month before and after the period of unemployment, by an amount equal to the lesser of the gross wages of the individual for the month or 1/12th of the amount equal to 75 percent of the poverty line for an individual; and

(II) for each month after the date the individual becomes unemployed, by an amount equal to any

unemployment compensation under an unemployment compensation law of a State or of the United States received by or on behalf of the unemployed individual.

(ii) LIMITATION.—Clause (i) shall no longer apply to an individual on the earlier of—

(I) the date on which the period of unemployment ends; or

(II) the end of the 6-month period beginning on the first day of the first month during which the individual receives premium assistance under this subtitle that would not be available to such individual if the provisions of clause (i) did not apply.

(iii) SPECIAL RULE.—Clause (i) shall not apply if an employer contribution of at least 80 percent of the premium under a standard health plan is available to the unemployed individual through an employer of a member of the individual's family.

(4) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term ''eligible individual'' means an individual who is residing in the United States and who is—

(i) a citizen or national of the United States; or

(ii) an alien permanently residing in the United States under color of law (as defined in subparagraph (C)).

(B) EXCLUSION.—The term ''eligible individual'' shall not include an individual who is an inmate of a public institution (except as a patient of a medical institution).

(C) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term ''alien permanently residing in the United States under color of law'' means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

(i) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(ii) An alien who is granted asylum under section 208 of such Act.

(iii) An alien whose deportation is withheld under section 243(h) of such Act.

(iv) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(v) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

(vi) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(5) POVERTY LINE.—The term ''poverty line'' 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.

(6) PREGNANT WOMAN.—

(A) IN GENERAL.—The term ''pregnant woman'' includes a woman deemed to be a pregnant woman under subparagraph (B).

(B) PERIOD AFTER TERMINATION OF PREGNANCY.—For purposes of this subtitle, a woman shall be deemed to be a pregnant woman during the period beginning on the date of the termination of the pregnancy and ending on the first day of the first month that begins more than 90 days after such date.

Subtitle B—Employer Subsidies

SEC. 6101. PURPOSE.

It is the purpose of this subtitle to provide subsidies to eligible employers to assist such employers in providing, or expanding the provision of, health care coverage for the employees of such employers.

SEC. 6102. ELIGIBLE EMPLOYERS.

(a) IN GENERAL.—To be eligible for a subsidy under this subtitle an employer shall—

(1) comply with the requirements of part 1 of subtitle D of title I;

(2) contribute to the cost of health care coverage for all employees of the same class (limited to full- or part-time) employed by the employer;

(3) contribute not less than 50 percent of the cost of health care coverage for each class of family enrollment for each employee so covered; and

(4) prepare and submit to the Secretary of Labor an application, at such time, in such manner and containing such information as the Secretary may require.

(b) APPLICATION OF REQUIREMENTS.—

(1) IN GENERAL.—The requirements of paragraphs (2) and (3) of subsection (a) shall only apply with respect to the employees described in paragraph (2).

(2) COVERAGE OF EMPLOYEES.—The employees described in this paragraph are those employees—

(A) for which the employer is contributing to the costs of health care coverage; and

(B) for which the employer did not make such a contribution prior to the date of enactment of this Act.

(c) SOLE PROPRIETORSHIPS.—A sole proprietorship with not less than 3 full-time employees (including the sole proprietor) shall be eligible for a subsidy under this subtitle if such proprietorship reports the payment of wages (as defined in the Internal Revenue Code of 1986), in the year prior to the year for which the subsidy is applied for,

in an amount required under regulations promulgated by the Secretary of Labor.

(d) INELIGIBILITY.—

(1) SELF-EMPLOYED.—A self-employed individual (as such term is defined in section 1011(c)) shall not be eligible for a subsidy under this subtitle.

(2) EMPLOYEE LEASING FIRMS.—An employer that is an employee leasing firm shall not be eligible for a subsidy under this subtitle. The Secretary of Labor shall promulgate regulations defining the term ''employee leasing firm''.

(3) STATE OR LOCAL GOVERNMENTS.—An employer that is a State or local government shall not be eligible for a subsidy under this section.

SEC. 6103. EMPLOYER CERTIFICATION.

(a) REQUIREMENT.—An employer that submits an application under section 6102(a)(4) shall certify that such employer, prior to the date of enactment of this Act, did not contribute to the costs of health care coverage for the employees for which the employer is applying for the subsidy.

(b) CONTRIBUTION LIMIT.—For purposes of subsection (a), an employer shall be treated as having contributed to the health care coverage of an employee if the

amount of such contribution is $500 or more (as annualized).

(c) UNION SICKNESS FUNDS.—For purposes of this subtitle, employers that contribute to union sickness funds on behalf of their employees shall be deemed to have contributed to the costs of health care coverage for the employees of such employer.

(d) REGULATIONS.—For purposes of this section, the Secretary of Labor shall promulgate regulations to enable an employer to determine whether and to what extent an employer contributed to the costs of an employee's health care coverage prior to the date of enactment of this Act. An employer shall utilize such regulations in submitting a certification under this section.

SEC. 6104. AMOUNT OF SUBSIDY.

(a) IN GENERAL.—With respect to an employee for which a subsidy application submitted by an employer has been approved by the Secretary of Labor under this subtitle, the employer shall receive a subsidy (to be paid over a 5-year period) in an amount that equals—

(1) with respect to the first 3 years after the date of enactment of this Act—

(A)(i) in the case of a community-rated employer, 50 percent of the lesser of—

(I) the weighted average premium rate (as defined in section 6002(b)(1)(C)) for the purchasing cooperative through which the employer has contributed to the employee's health care coverage (for the year involved);

(II) the community-rate of the standard health plan under which the employee received coverage (for the year involved); or

(III) the weighted average premium rate of the community rating area in which the employee resides; or

(ii) in the case of an experience-rated employer, 50 percent of the lesser of—

(I) the weighted average premium rate of the community rating area in which the employee resides; or

(II) the premium rate for the experience-rated plan under which the employee received coverage (for the year involved);

less

(B) 12 percent of the wages of the employee (for the year involved);

(2) with respect to the fourth year after the date of enactment of this Act—

(A) 37.5 percent of the lesser of the amounts referred to in subparagraph (A) of paragraph (1) (for the type of employer and the year involved); less

(B) 12 percent of the wages of the employee (for the year involved); and

(3) with respect to the fifth year after the date of enactment of this Act—

(A) 25 percent of the lesser of the amounts referred to in subparagraph (A) of paragraph (1) (for the type of employer and the year involved); less

(B) 12 percent of the wages of the employee (for the year involved).

(b) LIMITATIONS.—

(1) AMOUNT OF CONTRIBUTION.—If, in applying the formula under subsection (a), the Secretary of Labor determines that an employer's contributions to the health care coverage costs of its employees exceeds 50 percent of the weighted average premium rate for the purchasing cooperative through which the employer has so contributed (for the year involved), the Secretary shall notify such employer

that such employer is not eligible for a subsidy under this subtitle.

(2) PART-TIME EMPLOYEES.—With respect to subsidies for health care coverage for part-time employee, the Secretary of Labor shall develop a formula for the pro-rata reduction in such subsidies based on the formula described in subsection (a) and the hours of work performed by the employee.

(3) SINGLE SUBSIDY.—An employer shall not be eligible to receive more than one subsidy under this section. The Secretary of Labor shall promulgate regulations to ensure that no employer will receive a second or subsequent subsidy under this subtitle regardless of whether such employer had previously received the previous subsidy as an employer in a capacity different from that of the employer's present capacity.

SEC. 6105. DEFINITION.

For purposes of this Act, an employee who is employed by an employer—

(1) for at least 120 hours in a month shall be deemed to be employed on a full-time basis with respect to that month, or

(2) for at least 40 hours, but less than 120 hours, in a month shall be deemed to be employed on a part-time basis.

TITLE VII—REVENUE PROVISIONS

SEC. 7000. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal 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 a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Financing Provisions

PART 1—INCREASE IN TAX ON TOBACCO PRODUCTS

SEC. 7101. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended by striking paragraph (1) and all that follows and inserting the following:

"(1) SMALL CIGARETTES.—On cigarettes, weighing not more than 3 pounds per thousand, the amount per thousand determined under the following table:

"In the case of cigarettes removed—	The tax per thousand is—
After July 31, 1995, and before January 1, 1997	$19.50

"In the case of cigarettes removed—	The tax per thousand is—
During 1997	$24.50
During 1998	$29.50
After December 31, 1998	$34.50.

1 "(2) LARGE CIGARETTES.—On cigarettes,
2 weighing more than 3 pounds per thousand, removed
3 at any time, an amount per thousand equal to 2.1
4 times the tax per thousand imposed by paragraph
5 (1) on cigarettes removed at such time; except that,
6 if more than 6½ inches in length, they shall be tax-
7 able at the rate prescribed for cigarettes weighing
8 not more than 3 pounds per thousand, counting each
9 2¾ inches, or fraction thereof, of the length of each
10 as one cigarette."
11 (b) CIGARS.—Paragraphs (1) and (2) of section
12 5701(a) are amended to read as follows:
13 "(1) SMALL CIGARS.—On cigars, weighing not
14 more than 3 pounds per thousand, the amount per
15 thousand determined under the following table:

"In the case of cigars removed—	The tax per thousand is—
After July 31, 1995, and before January 1, 1997	$1.83
During 1997	$2.30
During 1998	$2.77
After December 31, 1998	$3.23.

16 "(2) LARGE CIGARS.—On cigars, weighing more
17 than 3 pounds per thousand, the applicable percent-
18 age (determined under the following table) of the
19 price for which sold but not more than the applica-

1 ble limitation (determined under such table) per
2 thousand:

"In the case of cigars removed—	The applicable percentage is—	The limitation is—
After July 31, 1995 and before January 1, 1997	21 percent	$48.75
During 1997	26 percent	$61.26
During 1998	31 percent	$73.74
After December 31, 1998	37 percent	$86.25."

3 (c) CIGARETTE PAPERS.—Subsection (c) of section
4 5701 is amended—
5 (1) by striking "0.75 cent (0.625 cent on ciga-
6 rette papers removed during 1991 or 1992)" and in-
7 serting "the amount determined in accordance with
8 the following table", and
9 (2) by adding at the end the following:

"In the case of cigarette papers removed—	The tax for each 50 papers is—
After July 31, 1995 and before January 1, 1997	1.22 cents
During 1997	1.53 cents
During 1998	1.84 cents
After December 31, 1998	2.16 cents."

10 (d) CIGARETTE TUBES.—Subsection (d) of section
11 5701 is amended—
12 (1) by striking "1.5 cents (1.25 cents on ciga-
13 rette tubes removed during 1991 or 1992)" and in-
14 serting "the amount determined in accordance with
15 the following table", and
16 (2) by adding at the end the following:

"In the case of cigarette tubes removed—	The tax for each 50 tubes is—
After July 31, 1995 and before January 1, 1997	2.44 cents

"In the case of cigarette tubes removed—	The tax for each 50 tubes is—
During 1997	3.06 cents
During 1998	3.69 cents
After December 31, 1998	4.31 cents."

1 (e) SNUFF.—Paragraph (1) of section 5701(e) is
2 amended—
3 (1) by striking "36 cents (30 cents on snuff re-
4 moved during 1991 or 1992)" and inserting "the
5 amount determined in accordance with the following
6 table", and
7 (2) by adding at the end the following:

"In the case of snuff removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	58.5 cents
During 1997	73.5 cents
During 1998	88.5 cents
After December 31, 1998	$1.03½."

8 (f) CHEWING TOBACCO.—Paragraph (2) of section
9 5701(e) is amended—
10 (1) by striking "12 cents (10 cents on chewing
11 tobacco removed during 1991 or 1992)" and insert-
12 ing "the amount determined in accordance with the
13 following table", and
14 (2) by adding at the end the following:

"In the case of chewing tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	19.5 cents
During 1997	24.5 cents
During 1998	29.5 cents
After December 31, 1998	34.5 cents."

15 (g) PIPE TOBACCO.—Subsection (f) of section 5701
16 is amended—

(1) by striking "67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of pipe tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	$1.10
During 1997	$1.38
During 1998	$1.66
After December 31, 1998	$1.94."

(h) APPLICATION OF TAX INCREASE TO PUERTO RICO.—Section 5701 is amended by adding at the end the following new subsection:

"(h) APPLICATION OF TAXES TO PUERTO RICO.—Notwithstanding subsections (b) and (c) of section 7653 and any other provision of law—

"(1) IN GENERAL.—On tobacco products and cigarette papers and tubes, manufactured in or imported into the Commonwealth of Puerto Rico, there is hereby imposed a tax at the rate equal to the excess of—

"(A) the rate of tax applicable under this section to like articles manufactured in the United States, over

"(B) the rate referred to in subparagraph (A) as in effect on the day before the date of the enactment of the Health Security Act.

"(2) SHIPMENTS TO PUERTO RICO FROM THE UNITED STATES.—Only the rates of tax in effect on the day before the date of the enactment of the Health Security Act shall be taken into account in determining the amount of any exemption from, or credit or drawback of, any tax imposed by this section on any article shipped to the Commonwealth of Puerto Rico from the United States.

"(3) SHIPMENTS FROM PUERTO RICO TO THE UNITED STATES.—The rates of tax taken into account under section 7652(a) with respect to tobacco products and cigarette papers and tubes coming into the United States from the Commonwealth of Puerto Rico shall be the rates of tax in effect on the day before the date of the enactment of the Health Security Act.

"(4) DISPOSITION OF REVENUES.—The provisions of section 7652(a)(3) shall not apply to any tax imposed by reason of this subsection."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(j) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States or the Commonwealth of Puerto Rico which are removed before any tax-increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax-increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by

paragraph (1) on each tax-increase date an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding any article on any tax-increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) on any tax-increase date shall be paid on or before the date which is 3 months after such tax-increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax-increase date shall be subject to the taxes imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) TAX-INCREASE DATE.—The term ''tax-increase date'' means August 1, 1995, January 1, 1997, January 1, 1998, and January 1, 1999.

(B) OTHER DEFINITIONS.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, as amended by this Act.

(C) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or his delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 7102. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR EXPORT.—

(1) Subsection (b) of section 5704 is amended by adding at the end the following new sentence: ''Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe.''

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e),

respectively, and by inserting after subsection (b) the following new subsection:

"(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

"(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

"(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

"(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States."

(3) Subsection (a) of section 5761 is amended by striking ''subsection (b)'' and inserting ''subsection (b) or (c)''.

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking ''The penalty imposed by subsection (b)'' and inserting ''The penalties imposed by subsections (b) and (c)''.

(5)(A) Subpart F of chapter 52 is amended by adding at the end the following new section:

''SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

''(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

''(b) CROSS REFERENCE.—

''For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c).''

(B) The table of sections for subpart F of chapter 52 is amended by adding at the end the following new item:

"Sec. 5754. Restriction on importation of previously exported tobacco products."

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763 (b) and (c) are each amended by inserting "or importer" after "manufacturer".

(2) The heading of subsection (b) of section 5763 is amended by inserting "QUALIFIED IMPORTERS," after "MANUFACTURERS,".

(3) The heading for subchapter B of chapter 52 is amended by inserting "**and Importers**" after "**Manufacturers**".

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting "and importers" after "manufacturers".

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking "EMPLOYEE USE OR" in the heading, and

(B) by striking "for use or consumption by employees or" in the text.

(2) Subsection (e) of section 5723 is amended by striking "for use or consumption by their employ-

ees, or for experimental purposes'' and inserting ''for experimental purposes''.

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking ''and manufacturers may similarly remove such articles for use of the United States;''.

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking ''On each book or set of cigarette papers containing more than 25 papers,'' and inserting ''On cigarette papers,''.

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting ''under section 5704'' after ''internal revenue bond''.

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking ''or'' at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

''(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe, or''.

(h) SPECIAL RULES RELATING TO PUERTO RICO AND THE VIRGIN ISLANDS.—Section 7652 is amended by adding at the end the following new subsection:

''(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—For purposes of this section, with respect to taxes imposed under section 5701 or this section on any tobacco product or cigarette paper or tube, the amount covered into the treasuries of Puerto Rico and the Virgin Islands shall not exceed the rate of tax under section 5701 in effect on the article on the day before the date of the enactment of the Health Security Act.''

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after December 31, 1994.

SEC. 7103. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax), as amended by section 7101, is amended by redesignating subsections (g) and (h) as subsections (h) and (i) and by inserting after subsection (f) the following new subsection:

''(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United

States, there shall be imposed a tax of the amount determined in accordance with the following table per pound (and a proportionate tax at the like rate on all fractional parts of a pound).

"In the case of roll-your-own tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	$1.10
During 1997	$1.38
During 1998	$1.66
After December 31, 1998	$1.94."

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end the following new subsection:

"(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes."

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking "and pipe tobacco" and inserting "pipe tobacco, and roll-your-own tobacco".

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking "or pipe tobacco" and inserting "pipe tobacco, or roll-your-own tobacco", and

(B) by striking paragraph (1) and inserting the following new paragraph:

"(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for the person's own personal consumption or use, and".

(3) The chapter heading for chapter 52 is amended to read as follows:

"CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES".

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

"CHAPTER 52. Tobacco products and cigarette papers and tubes."

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before August 1, 1995, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

PART 2—HEALTH RELATED ASSESSMENTS

SEC. 7111. ASSESSMENTS ON INSURED AND SELF-INSURED HEALTH PLANS.

(a) GENERAL RULE.—Subtitle D (relating to miscellaneous excise taxes) is amended by adding after chapter 36 the following new chapter:

"CHAPTER 37—HEALTH RELATED ASSESSMENTS

"SUBCHAPTER A. Insured and self-insured health plans.

"Subchapter A—Insured and Self-Insured Health Plans

"Sec. 4501. Health insurance and health-related administrative services.
"Sec. 4502. Self-insured health plans.
"Sec. 4503. Definitions and special rules.

"SEC. 4501. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

"(a) IMPOSITION OF TAX.—There is hereby imposed—

"(1) on each taxable health insurance policy, a tax equal to 1.75 percent of the premiums received under such policy, and

"(2) on each amount received for health-related administrative services, a tax equal to 1.75 percent of the amount so received.

"(b) LIABILITY FOR TAX.—

"(1) HEALTH INSURANCE.—The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

"(2) HEALTH-RELATED ADMINISTRATIVE SERVICES.—The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

"(c) TAXABLE HEALTH INSURANCE POLICY.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'taxable health insurance policy' means any insurance policy providing accident or health insurance with respect to individuals residing in the United States.

"(2) EXEMPTION OF CERTAIN POLICIES.—The term 'taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

"(A) liabilities incurred under workers' compensation laws,

"(B) tort liabilities,

"(C) liabilities relating to ownership or use of property,

"(D) credit insurance, or

"(E) such other similar liabilities as the Secretary may specify by regulations.

"(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE.—In the case of any taxable health insurance policy under which amounts are payable other than for accident or health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium paid under such policy, there shall be excluded the amount of the charge for the nonaccident or health coverage if—

"(A) the charge for such nonaccident or health coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and

1 "(B) such charge is reasonable in relation
2 to the total charges under the policy.
3 In any other case, the entire amount of the premium
4 paid under such a policy shall be subject to tax
5 under subsection (a)(1).
6 "(4) TREATMENT OF PREPAID HEALTH COV-
7 ERAGE ARRANGEMENTS.—
8 "(A) IN GENERAL.—In the case of any ar-
9 rangement described in subparagraph (B)—
10 "(i) such arrangement shall be treated
11 as a taxable health insurance policy,
12 "(ii) the payments or premiums re-
13 ferred to in subparagraph (B)(i) shall be
14 treated as premiums received for a taxable
15 health insurance policy, and
16 "(iii) the person referred to in sub-
17 paragraph (B)(i) shall be treated as the
18 issuer.
19 "(B) DESCRIPTION OF ARRANGEMENTS.—
20 An arrangement is described in this subpara-
21 graph if under such arrangement—
22 "(i) fixed payments or premiums are
23 received as consideration for any person's
24 agreement to provide or arrange for the
25 provision of accident or health coverage to

residents of the United States, regardless of how such coverage is provided or arranged to be provided, and

"(ii) substantially all of the risks of the rates of utilization of services is assumed by such person or the provider of such services.

"(d) HEALTH-RELATED ADMINISTRATIVE SERVICES.—For purposes of this section, the term 'health-related administrative services' means—

"(1) the processing of claims or performance of other administrative services in connection with accident or health coverage under a taxable health insurance policy if the charge for such services is not included in the premiums under such policy, and

"(2) processing claims, arranging for provision of accident or health coverage, or performing other administrative services in connection with an applicable self-insured health plan (as defined in section 4502(c)) established or maintained by a person other than the person performing the services.

For purposes of paragraph (1), rules similar to the rules of subsection (c)(3) shall apply.

"SEC. 4502. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF TAX.—In the case of any applicable self-insured health plan, there is hereby imposed a tax for each month equal to 1.75 percent of the sum of—

"(1) the accident or health coverage expenditures for such month under such plan, and

"(2) the direct administrative expenditures for such month under such plan.

"(b) LIABILITY FOR TAX.—

"(1) IN GENERAL.—The tax imposed by subsection (a) shall be paid by the plan sponsor.

"(2) PLAN SPONSOR.—For purposes of paragraph (1), the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization, or

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a voluntary employees' beneficiary association under section 501(c)(9), or

"(iii) a plan described in subsection (c)(2)(F),

the association, committee, joint board of trustees, cooperative, or other similar group of representatives of the parties who establish or maintain the plan.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

"(1) any portion of such coverage is provided other than through an insurance policy, and

"(2) such plan is established or maintained—

"(A) by one or more employers for the benefit of their employees or former employees,

"(B) by one or more employee organizations for the benefit of their members or former members,

"(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

"(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

"(E) by any organization described in section 501(c)(6), or

"(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement, a rural electric cooperative, or a rural telephone cooperative association, as such terms are defined in section 3(40) of the Employee Retirement Income Securities Act of 1974.

"(d) ACCIDENT OR HEALTH COVERAGE EXPENDITURES.—For purposes of this section—

"(1) IN GENERAL.—The accident or health coverage expenditures of any applicable self-insured health plan for any month are the aggregate expenditures paid in such month for accident or health coverage provided under such plan to the extent such expenditures are not subject to tax under section 4501.

"(2) TREATMENT OF REIMBURSEMENTS.—In determining accident or health coverage expenditures during any month of any applicable self-insured health plan, reimbursements (by insurance or otherwise) received during such month shall be taken into account as a reduction in accident or health coverage expenditures.

"(3) CERTAIN EXPENDITURES DISREGARDED.—Paragraph (1) shall not apply to any expenditure for

the acquisition or improvement of land or for the acquisition or improvement of any property to be used in connection with the provision of accident or health coverage which is subject to the allowance under section 167, except that, for purposes of paragraph (1), allowances under section 167 shall be considered as expenditures.

''(e) DIRECT ADMINISTRATIVE EXPENDITURES.—For purposes of this section, the term 'direct administrative expenditures' means the administrative expenditures under the plan to the extent such expenditures are not subject to tax under section 4501. In determining the amount of such expenditures, rules similar to the rules of subsection (d)(3) shall apply.

"SEC. 4503. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT OR HEALTH COVERAGE.—The term 'accident or health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a taxable health insurance policy (as defined in section 4501(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument where-

by a contract of insurance is issued, renewed, or extended.

"(3) PREMIUM.—The term 'premium' means the gross amount of premiums and other consideration (including advance premiums, deposits, fees, and assessments) arising from policies issued by a person acting as the primary insurer, adjusted for any return or additional premiums paid as a result of endorsements, cancellations, audits, or retrospective rating. Amounts returned where the amount is not fixed in the contract but depends on the experience of the insurer or the discretion of management shall not be included in return premiums.

"(4) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the taxes imposed by this subchapter except as provided in paragraph (2).

1 "(2) EXEMPT GOVERNMENTAL PROGRAMS.—In
2 the case of an exempt governmental program—
3 "(A) no tax shall be imposed under section
4 4501 on any premium received pursuant to
5 such program or on any amount received for
6 health-related administrative services pursuant
7 to such program, and
8 "(B) no tax shall be imposed under section
9 4502 on any expenditures pursuant to such
10 program.
11 "(3) EXEMPT GOVERNMENTAL PROGRAM.—For
12 purposes of this subchapter, the term 'exempt gov-
13 ernmental program' means—
14 "(A) the insurance programs established
15 by parts A and B of title XVIII of the Social
16 Security Act,
17 "(B) the medical assistance program es-
18 tablished by title XIX of the Social Security
19 Act,
20 "(C) any program established by Federal
21 law for providing medical care (other than
22 through insurance policies) to individuals (or
23 the spouses and dependents thereof) by reason
24 of such individuals being—

"(i) members of the Armed Forces of the United States, or

"(ii) veterans, and

"(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

"(c) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States."

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle D is amended by inserting after the item relating to chapter 36 the following new item:

"CHAPTER 37. Health related assessments."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to premiums received, and expenses incurred, with respect to coverage for periods after December 31, 1995.

SEC. 7112. HIGH COST HEALTH PLAN ASSESSMENT.

(a) IN GENERAL.—Subchapter A of chapter 37 (relating to assessments on insured and self-insured health benefits), as added by section 7111, is amended by adding at the end the following new part:

1 **"PART II—HIGH COST HEALTH PLANS**

"Subpart A. Community-rated plans.
"Subpart B. Experience-rated plans.
"Subpart C. Definitions and special rules.

2 **"Subpart A—Community-Rated Plans**

"Sec. 4511. Community-rated plans.
"Sec. 4512. Reference premiums.

3 **"SEC. 4511. COMMUNITY-RATED PLANS.**

4 "(a) IMPOSITION OF TAX.—

5 "(1) IN GENERAL.—If a community-rated cer-
6 tified standard health plan is a high cost plan for
7 any coverage period beginning after December 31,
8 1996, there is hereby imposed a tax equal to 25 per-
9 cent of the excess premiums of the plan for the pe-
10 riod.

11 "(2) LIABILITY FOR TAX.—The tax imposed by
12 this section shall be paid by the issuer of the high
13 cost plan.

14 "(b) HIGH COST PLAN.—For purposes of this sec-
15 tion—

16 "(1) IN GENERAL.—A plan is a high cost plan
17 for any coverage period if—

18 "(A) it is operating within a noncompeti-
19 tive community rating area, and

20 "(B) it has excess premiums for the pe-
21 riod.

1 "(2) NONCOMPETITIVE COMMUNITY RATING
2 AREA.—A community rating area is a noncompeti-
3 tive community rating area for any coverage period
4 if, for the preceding coverage period—
5 "(A) the weighted average premium per
6 primary insured in community-rated certified
7 standard health plans in the area, exceeded
8 "(B) the weighted average reference pre-
9 mium for all such plans.
10 The determination under this paragraph shall be
11 made on the basis of enrollment during the annual
12 open enrollment period for such preceding coverage
13 period.
14 "(c) EXCESS PREMIUMS.—For purposes of this sec-
15 tion—
16 "(1) IN GENERAL.—The term 'excess pre-
17 miums' means, with respect to a certified standard
18 health plan, the excess (if any) of—
19 "(A) the premiums received under the plan
20 during the coverage period, over
21 "(B) the sum of the amounts determined
22 under paragraph (2) with respect to each class
23 of enrollment.
24 "(2) EXCESS PREMIUM BASELINE.—

"(A) IN GENERAL.—The amount determined under this paragraph for any class of enrollment for any coverage period is an amount equal to the product of the reference premium for such class and the number of primary insureds in such class for the period.

"(B) PROPORTIONATE REDUCTION OF REFERENCE PREMIUM.—The reference premium applicable under subparagraph (A) to an individual who was a primary insured for only a portion of the coverage period shall be proportionately reduced to reflect the period the individual was not a primary insured.

"(3) DISREGARD OF AGE ADJUSTMENT.—The amount determined under paragraph (1)(A) shall be adjusted to reflect the premiums which would have been received if no age adjustment were permitted under section 1116 of the Health Security Act.

"(4) REDUCTION FOR TAXES.—The amount determined under paragraph (1)(A) shall be reduced by the amount of the tax imposed by this section included in determining the amount of the premiums.

"(d) COVERAGE PERIOD.—For purposes of this subpart, the term 'coverage period' means, with respect to any community rating area, the 12-month period for which

1 an individual is covered under a standard health plan if
2 the individual enrolls in the plan during the annual open
3 enrollment period for the area under section 1503 of the
4 Health Security Act.

5 "(e) PLANS COVERING MORE THAN ONE AREA.—
6 For purposes of this subpart, if a community-rated plan
7 covers individuals residing in more than 1 community rat-
8 ing area, the plan shall be treated as a separate plan with
9 respect to each such area.

10 **"SEC. 4512. REFERENCE PREMIUMS.**

11 "(a) ESTABLISHMENT OF REFERENCE PREMIUMS.—
12 For purposes of this subpart—

13 "(1) IN GENERAL.—The Secretary shall, in con-
14 sultation with the Secretary of Health and Human
15 Services, establish for each coverage period a ref-
16 erence premium for each class of enrollment for
17 community-rated plans within a community rating
18 area. The Secretary shall publish such reference pre-
19 miums within a reasonable period of time before the
20 annual open enrollment period for the coverage pe-
21 riod.

22 "(2) METHOD OF DETERMINING REFERENCE
23 PREMIUM.—Each reference premium for a class of
24 enrollment for any coverage period shall be the ref-

1 erence premium in effect for such class for the pre-
2 ceding coverage period—
3 "(A) increased by the target growth rate
4 for the coverage period as provided under sub-
5 section (b)(1), and
6 "(B) adjusted to reflect—
7 "(i) material changes in the charac-
8 teristics of community-rated individuals as
9 provided under subsection (b)(2), and
10 "(ii) changes in the actuarial value of
11 the standard benefits package as provided
12 under subsection (b)(3).
13 "(b) ANNUAL ADJUSTMENTS TO REFERENCE PRE-
14 MIUMS.—For purposes of subsection (a)(2)—
15 "(1) TARGET GROWTH RATE.—The target
16 growth rate for any coverage period is the percent-
17 age increase in the Consumer Price Index (as de-
18 fined in section 1(f)(4)) which the Secretary esti-
19 mates will occur during the coverage period—
20 "(A) increased by 2 percentage points (3
21 and 2.5 percentage points in the case of cov-
22 erage periods beginning in 1997 and 1998, re-
23 spectively), and

"(B) increased or decreased by the amount the estimate under this paragraph was incorrect for the preceding coverage period.

"(2) MATERIAL CHANGES.—

"(A) IN GENERAL.—The Secretary may, in consultation with the Secretary of Health and Human Services and pursuant to such method as the Secretary prescribes, adjust the reference premium to reflect changes in the demographic characteristics (including factors such as age, gender, and socioeconomic status) and health status of community-rated individuals in the community rating area which are materially different when compared to the average changes in such characteristics and status in the United States.

"(B) EFFECT ON WEIGHTED AVERAGE.—Any adjustments under subparagraph (A) for any coverage period shall not result in a change in the weighted average of such factors for all community rating areas in the United States.

"(3) CHANGES IN BENEFIT PACKAGE.—If the actuarial value of the standard benefits package is changed pursuant to subtitle C of title I of the Health Security Act, the Secretary shall adjust the

reference premiums appropriately to reflect such change.

"(c) COMPUTATION OF REFERENCE PREMIUM FOR 1996.—

"(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall compute the reference premium for each class of enrollment for 1996. Each such reference premium shall be the reference premium which is adjusted under subsection (a)(2) in determining the reference premium for coverage periods beginning in 1997.

"(2) METHOD OF DETERMINING REFERENCE PREMIUMS.—Each reference premium under paragraph (1) shall be equal to the national average per capita current coverage health expenditures for 1994 (determined under subsection (d))—

"(A) increased as provided in paragraph (3),

"(B) adjusted to reflect the differences in the community rating area as provided in paragraph (4), and

"(C) modified to reflect the class of enrollment for which it is being determined in the

same manner as premiums are modified under section 1116 of the Health Security Act.

"(3) UPDATING FOR 1995 AND 1996.—The Secretary shall update the national average per capita current coverage health expenditures for 1994 to reflect the annual percentage increases for calendar years 1995 and 1996 in private sector health care spending for items and services included in the standard benefits package. Such increase shall not exceed the current projected increase in per capita private health insurance premiums for such years contained in the estimate of national health insurance expenditures published by the Congressional Budget Office in the fall of 1993.

"(4) AREA ADJUSTMENTS.—

"(A) IN GENERAL.—The Secretary shall, using information of the type described in subparagraph (B), establish an adjustment for each community rating area which takes into account the differences among community rating areas, including variations in health care expenditures, in rates of uninsurance and underinsurance, and in the proportion of expenditures for services provided by academic health centers.

1 "(B) TYPE OF INFORMATION.—The type
2 of information described in this subparagraph
3 is—
4 "(i) information on variations in pre-
5 miums across States and across commu-
6 nity rating areas within a State (based on
7 surveys and other data);
8 "(ii) information on variations in per
9 capita health spending by State, as meas-
10 ured by the Secretary;
11 "(iii) information on variations across
12 States in per capita spending under the
13 medicare program and in such spending
14 among community rating areas within a
15 State under such program; and
16 "(iv) area rating factors commonly
17 used by actuaries.
18 "(C) CONSULTATION PROCESS.—The Sec-
19 retary shall, in cooperation with the Secretary
20 of Health and Human Services, consult with
21 representatives of States and community rating
22 areas before establishing the adjustment under
23 this subsection.
24 "(d) DETERMINATION OF NATIONAL AVERAGE PER
25 CAPITA CURRENT COVERAGE HEALTH EXPENDITURES.—

"(1) IN GENERAL.—The national average per capita current coverage health expenditures are equal to—

"(A) the total amount of covered current health care expenditures described in paragraph (2), divided by

"(B) the estimated population in the United States of community-rated individuals as of 1994 (as determined under paragraph (4)) for whom such expenditures were determined.

The population under subparagraph (B) shall not include SSI recipients.

"(2) COVERED CURRENT HEALTH CARE EXPENDITURES.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'covered current health care expenditures' means the amount of total payments made in the United States during 1994 (other than amounts for cost sharing) for items and services included in the standard benefits package.

"(B) REMOVAL OF CERTAIN EXPENDITURES NOT TO BE COVERED.—The amount determined under subparagraph (A) shall be de-

1 creased by the proportion of such amount that
2 is attributable to any of the following:
3 "(i) Medicare beneficiaries.
4 "(ii) SSI recipients.
5 "(iii) Expenditures which are paid for
6 through workers' compensation or auto-
7 mobile or other liability insurance.
8 "(iv) Any other expenditures by par-
9 ties (including the Federal Government)
10 that the Secretary estimates will not be
11 payable by community-rated plans for cov-
12 erage under the standard benefits package.
13 "(C) ADDITION OF PROJECTED EXPENDI-
14 TURES FOR UNINSURED AND UNDERINSURED
15 INDIVIDUALS.—The amount determined under
16 subparagraph (A) (as adjusted under subpara-
17 graph (B)) shall be increased to take into ac-
18 count increased utilization of, and expenditures
19 for, items and services covered under the stand-
20 ard benefits package likely to occur, as a result
21 of coverage under a community-rated plan of
22 individuals who, as of 1994, were uninsured or
23 underinsured with respect to the standard bene-
24 fits package. In making such determination,
25 such expenditures shall be based on the esti-

mated average cost for such services in 1994 (and not on private payment rates established for such services). In making such determination, the estimated amount of uncompensated care in 1994 shall be reduced to reflect the number and characteristics of the currently uninsured who will become insured by reason of the Health Security Act and will not include adjustments to offset payments below costs by public programs.

"(D) ADDITION OF HEALTH PLAN ADMINISTRATION COSTS.—The amount determined under subparagraph (A) (as adjusted under the preceding subparagraphs) shall be increased by an estimated percentage (determined by the Secretary, but no more than 15 percent) that reflects the proportion of premiums that are required for administration and for State premium taxes (which taxes shall be limited to such amounts in 1994 as are attributable to the health benefits to be included in the standard benefits package).

"(E) DECREASE FOR COST SHARING.—The amount determined under subparagraph (A) (as adjusted under the preceding subparagraphs)

shall be decreased by a percentage that reflects (i) the estimated average percentage of total amounts payable for items and services covered under the standard benefits package that will be payments in the form of cost sharing under a certified standard benefit plan with a high cost-sharing option, and (ii) the percentage reduction in utilization estimated to result from the application of such cost sharing.

"(3) SPECIAL RULES.—

"(A) BENEFITS USED.—The determinations under this subsection shall be based on the standard benefits package as in effect in 1996.

"(B) ASSUMING NO CHANGE IN EXPENDITURE PATTERN.—The determination under paragraph (2) shall be made without regard to any change in the pattern of expenditures that may result from the enrollment of SSI recipients in community-rated plans.

"(4) ELIGIBLE INDIVIDUALS.—The determination of individuals who are community-rated individuals under this subsection shall be made as though the Health Security Act was fully in effect in each State as of 1994.

"(e) TREATMENT OF CERTAIN STATES.—For purposes of this section—

"(1) NONPARTICIPATING STATES.—In the case of a State that is not a participating State or otherwise has not established community rating areas, the entire State shall be treated as a single community rating area.

"(2) CHANGES IN BOUNDARIES.—In the case of a State that changes the boundaries of its community rating areas, the Secretary shall provide a method for computing reference premiums for each area affected by such change in a manner that—

"(A) reflects the factors taken into account in establishing the adjustment factors under this section, and

"(B) results in the weighted average of the newly computed reference premiums for the areas affected by the change being equal to the weighted average of the reference premiums for the areas as previously established.

"Subpart B—Experience-Rated Plans

"Sec. 4515. Experience-rated plans.

"SEC. 4515. EXPERIENCE-RATED PLANS.

"(a) IMPOSITION OF TAX.—

1 "(1) IN GENERAL.—In the case of any calendar
2 year beginning after December 31, 1999, there is
3 hereby imposed a tax equal to 25 percent of the ex-
4 cess premium equivalents of an experience-rated
5 standard health plan.
6 "(2) LIABILITY FOR TAX.—The tax imposed by
7 this section shall be paid by the plan sponsor.
8 "(b) EXCESS PREMIUM EQUIVALENTS.—For pur-
9 poses of this section—
10 "(1) IN GENERAL.—The term 'excess premium
11 equivalents' means the excess (if any) of—
12 "(A) the premium equivalents of the plan
13 for the calendar year, over
14 "(B) the product of the reference premium
15 and the number of primary insureds covered by
16 the plan during the calendar year.
17 "(2) PROPORTIONATE REDUCTION IN REF-
18 ERENCE PREMIUM.—The reference premium applica-
19 ble under paragraph (1)(B) to a primary insured
20 covered under the plan for only a portion of the cal-
21 endar year shall be proportionately reduced to reflect
22 the period the individual was not a primary insured.
23 "(c) REFERENCE PREMIUM.—For purposes of this
24 section—

1 "(1) IN GENERAL.—The reference premium for
2 any plan for any calendar year shall be the reference
3 premium in effect for the preceding calendar year—
4 "(A) increased by the target growth rate
5 for the calendar year as provided under para-
6 graph (2), and
7 "(B) adjusted to reflect—
8 "(i) material changes in the charac-
9 teristics of individuals covered by the plan
10 as provided under paragraph (3), and
11 "(ii) changes in the actuarial value of
12 the standard benefits package as provided
13 under paragraph (4).
14 "(2) TARGET GROWTH RATE.—The target
15 growth rate for any calendar year is the percentage
16 increase in the Consumer Price Index (as defined in
17 section 1(f)(4)) which the Secretary estimates will
18 occur during the calendar year—
19 "(A) increased by 2 percentage points, and
20 "(B) increased or decreased by the amount
21 the estimate under this paragraph was incorrect
22 for the preceding calendar year.
23 "(3) MATERIAL CHANGES.—The Secretary may,
24 in consultation with the Secretary of Health and
25 Human Services, establish such method as the Sec-

1 retary determines appropriate for adjusting the ref-
2 erence premium for any plan to reflect changes in
3 the demographic characteristics (including factors
4 such as age, gender, socioeconomic status, and class
5 of enrollment) and health status of individuals in the
6 plan which are materially different when compared
7 to the average changes in such characteristics and
8 status in the United States.

9 "(4) CHANGES IN BENEFIT PACKAGE.—If the
10 actuarial value of the standard benefits package is
11 changed pursuant to subtitle C of title I of the
12 Health Security Act, the Secretary shall adjust the
13 reference premiums appropriately to reflect such
14 change.

15 "(d) REFERENCE PREMIUM FOR 1999.—

16 "(1) IN GENERAL.—The reference premium for
17 calendar year 1999 shall be equal to the average of
18 the per capita premium equivalents for calendar
19 years 1997, 1998, and 1999. Such reference pre-
20 mium shall be the reference premium which is ad-
21 justed under subsection (c) for determining the ref-
22 erence premium for calendar year 2000.

23 "(2) PER CAPITA PREMIUM EQUIVALENT.—

24 "(A) IN GENERAL.—The per capita pre-
25 mium equivalent for any calendar year shall be

equal to the premium equivalent for providing the standard benefits package to each primary insured, adjusted as provided under subparagraph (B).

"(B) GROWTH FACTORS.—The amount determined under subparagraph (A)—

"(i) for calendar year 1997 shall be increased by the target growth rates for calendar years 1998 and 1999, and

"(ii) for calendar year 1998 shall be increased by the target growth rate for calendar year 1999.

For purposes of this subparagraph, the target growth rate shall be determined under subsection (c)(2), except that subsection (c)(2)(A) shall be applied for calendar year 1998 by substituting '2.5' for '2'.

"(e) PREMIUM EQUIVALENTS.—For purposes of this section—

"(1) IN GENERAL.—The term 'premium equivalents' means, with respect to any calendar year, the sum of—

"(A) expenditures described in subsections (d) and (e) of section 4502 with respect to coverage under the plan, and

1 "(B) in the case of any coverage provided
2 through an insurance policy, premiums paid for
3 such coverage.
4 "(2) EXCLUSION OF NONSTANDARD COV-
5 ERAGE.—The premium equivalents for any calendar
6 year shall not include amounts with respect to—
7 "(A) any coverage other than coverage for
8 the standard benefits package, or
9 "(B) any cost-sharing coverage.
10 "(3) RISK ADJUSTMENT PAYMENTS.—The pre-
11 mium equivalents for any calendar year shall include
12 payments under any risk adjustment program estab-
13 lished under title I of the Health Security Act.
14 "(4) TAXES DISREGARDED.—The premium
15 equivalents for any calendar year shall not include
16 the amount of any tax imposed by this section.
17 "(f) SPECIAL RULES.—For purposes of this sec-
18 tion—
19 "(1) AGGREGATION RULES.—
20 "(A) PLANS.—All plans maintained by the
21 same plan sponsor shall be treated as 1 plan.
22 "(B) SPONSORS.—All plan sponsors which
23 are treated as a single employer under sub-
24 section (b) or (c) of section 414 shall be treated
25 as 1 plan sponsor.

1 "(2) STARTUP PLANS.—If a plan sponsor first
2 begins operation of an experience-rated plan after
3 1997, the reference premium for the first calendar
4 year for which the plan is in operation and to which
5 this section applies shall, under regulations pre-
6 scribed by the Secretary, be determined as if the ref-
7 erence premium for the preceding calendar year
8 were equal to the average of the reference premiums
9 for all community-rated plans for the preceding cal-
10 endar year in the areas in which the plan is oper-
11 ating, adjusted to reflect the factors described in
12 subsection (c)(3) under the plan which materially
13 differ from such factors under the community-rated
14 plans.

15 "(3) ACQUISITIONS AND DISPOSITIONS.—The
16 reference premium after an acquisition or disposition
17 described in section 41(f)(3) involving the plan spon-
18 sor of an experience-rated plan shall be made pursu-
19 ant to such regulations as the Secretary may pre-
20 scribe.

21 "(4) INFORMATION.—The Secretary may re-
22 quire a plan sponsor of an experience-rated plan to
23 adopt such conventions as are necessary in its ac-
24 counting practices and financial records to assure
25 that only costs related to the standard benefits pack-

1 age are taken into account in determining the pre-
2 mium equivalents with respect to the plan.

3 **"Subpart C—Definitions and Special Rules**

"Sec. 4518. Right of recovery.
"Sec. 4519. Definitions and special rules.

4 **"SEC. 4518. RIGHT OF RECOVERY FROM PROVIDERS.**

5 "(a) GENERAL RULE.—Each issuer or plan sponsor
6 of a certified standard health plan shall be entitled to re-
7 cover from the providers of items or services covered by
8 the plan an amount equal to 50 percent of the amount
9 of any tax imposed by this part on the issuer or sponsor.

10 "(b) RECOVERY.—For purposes of subsection (a)—

11 "(1) any amount recovered from any provider
12 shall not exceed the provider's proportionate share of
13 items or services provided under the plan for the pe-
14 riod the tax was imposed, and

15 "(2) an issuer or plan sponsor may recover an
16 amount from a provider through a reduction in pay-
17 ments under the plan, direct payments from the pro-
18 vider, or such other manner as may be provided
19 under State law adopted pursuant to section 1510 of
20 the Health Security Act.

21 "(c) BALANCE BILLING.—For prohibition of balance
22 billing of any amount recovered from a provider under this
23 section, see section 1128(h)(3) of the Health Security Act.

"SEC. 4519. DEFINITIONS AND SPECIAL RULES.

"(a) HEALTH PLANS.—For purposes of this part—

"(1) STANDARD HEALTH PLAN.—The term 'standard health plan' has the meaning given such term by section 1011(2)(B) of the Health Security Act, except that such term does not include a plan offering the alternative standard benefit package described in 1201(b) of such Act.

"(2) STANDARD BENEFITS PACKAGE.—The term 'standard benefits package' has the meaning given such term by section 1201(a) of such Act.

"(b) COMMUNITY RATING AREAS AND PLANS.—For purposes of this part—

"(1) COMMUNITY RATING AREA.—The term 'community rating area' means an area established under section 1502 of the Health Security Act.

"(2) COMMUNITY-RATED PLAN.—The term 'community-rated plan' means a plan which is community-rated under section 1116 of such Act.

"(3) EXPERIENCE-RATED PLAN.—The term 'experience-rated plan' means any plan which is not a community-rated plan.

"(c) PREMIUMS.—For purposes of this part—

"(1) IN GENERAL.—The term 'premium' has the meaning given such term by section 4503(a)(3).

1 "(2) ADMINISTRATIVE COSTS.—Amounts re-
2 ceived for health-related administrative services (as
3 defined in section 4501(d)) provided in connection
4 with any standard health plan taken into account
5 under section 4511(c)(3) shall be treated as pre-
6 miums.
7 "(3) RISK ADJUSTMENT PAYMENTS.—Payments
8 under a risk adjustment program established under
9 title I of the Health Security Act shall be dis-
10 regarded in computing the amount of any premiums.
11 "(d) INSURANCE POLICY AND PLAN SPONSOR.—For
12 purposes of this part—
13 "(1) INSURANCE POLICY.—The term 'insurance
14 policy' has the meaning given such term by section
15 4503(a)(2).
16 "(2) PLAN SPONSOR.—The term 'plan sponsor'
17 has the meaning given such term by section
18 4502(b)(2), except that in the case of a plan not de-
19 scribed in such section, such term means the person
20 or persons who establish or maintain the plan.
21 "(e) SPECIAL RULES.—For purposes of this part—
22 "(1) DEPOSITS.—The Secretary may require
23 deposits of any taxes imposed by subpart A or B at
24 such times as the Secretary determines appropriate.

"(2) GOVERNMENTAL ENTITIES SUBJECT TO TAX.—The rules of section 4503(b) shall apply for purposes of this part.

"(3) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this part shall be covered over to any possession of the United States.

"(f) REGULATIONS.—The Secretary shall issue such regulations as are necessary to carry out the provisions of this part, including regulations—

"(1) requiring the maintenance of such records, and the reporting of such information as the Secretary determines necessary, and

"(2) which provide that 2 or more plans of a person or any related persons must be aggregated, or a plan must be treated as 2 or more separate plans."

(b) CONFORMING AMENDMENTS.—

(1) Subchapter A of chapter 37, as added by section 7111, is amended by inserting after the subchapter heading the following:

"Part I. Premium and related assessments.
"Part II. High cost health plans.

"PART I—PREMIUM AND RELATED ASSESSMENTS".

(2) Section 4503, as so added, is amended by striking ''subchapter'' each place it appears and inserting ''part''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

PART 3—RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES

SEC. 7121. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 is amended by adding at the end the following new part:

"PART VIII—CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

''Sec. 59B. Recapture of certain health care subsidies.

"SEC. 59B. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES.

''(a) IMPOSITION OF RECAPTURE AMOUNT.—In the case of an individual, if the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount, such taxpayer shall pay (in addition to any other amount imposed by this subtitle) a recapture amount for such taxable year equal to the aggregate of the Medicare part B recapture amounts (if any) for

1 months during such year that a premium is paid under
2 part B of title XVIII of the Social Security Act for the
3 coverage of the individual under such part.

4 "(b) MEDICARE PART B PREMIUM RECAPTURE
5 AMOUNT FOR MONTH.—For purposes of this section, the
6 Medicare part B premium recapture amount for any
7 month is the amount equal to the excess of—

8 "(1) 150 percent of the monthly actuarial rate
9 for enrollees age 65 and over determined for that
10 calendar year under section 1839(b) of the Social
11 Security Act, over

12 "(2) the total monthly premium under section
13 1839 of the Social Security Act (determined without
14 regard to subsections (b) and (f) of section 1839 of
15 such Act).

16 "(c) PHASE-IN OF RECAPTURE AMOUNT.—

17 "(1) IN GENERAL.—If the modified adjusted
18 gross income of the taxpayer for any taxable year
19 exceeds the threshold amount by less than $15,000,
20 the recapture amount imposed by this section for
21 such taxable year shall be an amount which bears
22 the same ratio to the recapture amount which would
23 (but for this subsection) be imposed by this section
24 for such taxable year as such excess bears to
25 $15,000.

"(2) JOINT RETURNS.—If a recapture amount is determined separately for each spouse filing a joint return, paragraph (1) shall be applied by substituting '$30,000' for '$15,000' each place it appears.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $90,000,

"(B) $115,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married (as determined under section 7703) but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) JOINT RETURNS.—In the case of a joint return—

"(A) the recapture amount under subsection (a) shall be the sum of the recapture amounts determined separately for each spouse, and

"(B) subsections (a) and (c) shall be applied by taking into account the combined modified adjusted gross income of the spouses.

"(4) COORDINATION WITH OTHER PROVISIONS.—

"(A) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the recapture amount imposed by this section shall be treated as if it were a tax imposed by section 1.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The recapture amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax under section 55.

"(C) TREATED AS PAYMENT FOR MEDICAL INSURANCE.—The recapture amount imposed by this section shall be treated as an amount paid for insurance covering medical care, within the meaning of section 213(d).

"(5) TAXES IMPOSED BY POSSESSIONS.—The tax imposed by this section shall not apply to a bona fide resident of a possession with respect to which the requirements of section 1509 of the Health Security Act are met."

(b) TRANSFERS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—There are hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund amounts equivalent to the aggregate increase in liabilities under chapter 1 of the Internal Revenue Code of 1986 which is attributable to the application of section 59B(a) of such Code, as added by this section.

(2) TRANSFERS.—The amounts appropriated by paragraph (1) to the Federal Supplementary Medical Insurance Trust Fund shall be transferred from time to time (but not less frequently than

quarterly) from the general fund of the Treasury on the basis of estimates made by the Secretary of the Treasury of the amounts referred to in paragraph (1). Any quarterly payment shall be made on the first day of such quarter and shall take into account the recapture amounts referred to in such section 59B(a) for such quarter. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(c) REPORTING REQUIREMENTS.—

(1) Paragraph (1) of section 6050F(a) (relating to returns relating to social security benefits) is amended by striking ''and'' at the end of subparagraph (B) and by inserting after subparagraph (C) the following new subparagraph:

''(D) the number of months during the calendar year for which a premium was paid under part B of title XVIII of the Social Security Act for the coverage of such individual under such part, and''.

(2) Paragraph (2) of section 6050F(b) is amended to read as follows:

''(2) the information required to be shown on such return with respect to such individual.''

(3) Subparagraph (A) of section 6050F(c)(1) is amended by inserting before the comma "and in the case of the information specified in subsection (a)(1)(D)".

(4) The heading for section 6050F is amended by inserting "**AND MEDICARE PART B COVERAGE**" before the period.

(5) The item relating to section 6050F in the table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting "and Medicare part B coverage" before the period.

(d) WAIVER OF CERTAIN ESTIMATED TAX PENALTIES.—No addition to tax shall be imposed under section 6654 of the Internal Revenue Code of 1986 (relating to failure to pay estimated income tax) for any period before April 16, 1997, with respect to any underpayment to the extent that such underpayment resulted from section 59B(a) of the Internal Revenue Code of 1986, as added by this section.

(e) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end thereof the following new item:

"Part VIII. Certain health care subsidies received by high-income individuals."

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

PART 4—OTHER PROVISIONS

SEC. 7131. INCREASE IN TAX ON CERTAIN HOLLOW POINT AND LARGE CALIBER HANDGUN AMMUNITION.

(a) INCREASE IN MANUFACTURERS TAX.—

(1) IN GENERAL.—Section 4181 (relating to imposition of tax on firearms) is amended—

(A) by striking ''Shells, and cartridges'' and inserting ''Shells and cartridges not taxable at 10,000 percent'', and

(B) by adding at the end the following:

''ARTICLES TAXABLE AT 10,000 PERCENT.—

''Any jacketed, hollow point projectile which may be used in a handgun and the jacket of which is designed to produce, upon impact, sharp-tipped, barb-like projections that extend beyond the diameter of the unfired projectile.

''Any cartridge with a projectile measuring .500 inch or greater in diameter which may be used in a handgun.''

(2) ADDITIONAL TAXES ADDED TO THE GENERAL FUND.—Section 3(a) of the Act of September

2, 1937 (16 U.S.C. 669b(a)), commonly referred to as the "Pittman-Robertson Wildlife Restoration Act", is amended by adding at the end the following new sentence: "There shall not be covered into the fund the portion of the tax imposed by such section 4181 that is attributable to any increase in amounts received in the Treasury under such section by reason of the amendments made by section 7131(a)(1) of the Health Security Act, as estimated by the Secretary."

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to sales after December 31, 1994.

(2) FLOOR STOCKS TAX.—

(A) IN GENERAL.—In the case of any article held on January 1, 1995, which is taxable under section 4181 of the Internal Revenue Code of 1986 on and after such date at a tax rate of 10,000 percent, there is hereby imposed a tax equal to the excess of—

(i) the tax which would be imposed under section 4181 of such Code if the article were sold on such date, over

(ii) the prior tax (if any) imposed under such section on such article.

(B) CREDIT.—Each person shall be allowed as a credit against the taxes imposed by subparagraph (A) an amount equal to the taxes imposed on articles which such person destroys (in such manner as the Secretary may prescribe) after December 31, 1994, and before April 1, 1995.

(C) PAYMENT.—The taxes imposed by subparagraph (A) on any article shall be paid by the person holding the article on January 1, 1995. Such taxes shall be paid before April 1, 1995, in such manner as the Secretary of the Treasury may prescribe.

(D) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on January 1, 1995, shall be subject to the tax imposed by subparagraph (A) if—

(i) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such

date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(ii) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(E) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this paragraph.

(F) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 4181 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by subparagraph (A), to the same extent as if such taxes were imposed by such section 4181. The Secretary may treat any person who bore the ultimate burden of the tax imposed by subparagraph (A) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 7132. MODIFICATION TO SELF-EMPLOYMENT TAX TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS AND PARTNERS.

(a) TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS.—

(1) AMENDMENT TO INTERNAL REVENUE CODE.—Section 1402 (relating to definitions) is amended by adding at the end the following new subsection:

"(k) TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS.—

"(1) IN GENERAL.—In the case of any individual—

"(A) who is a 2-percent shareholder (as defined in section 1372(b)) of an S corporation for any taxable year of such corporation, and

"(B) who provides significant services to or on behalf of such S corporation during such taxable year,

such shareholder's net earnings from self-employment shall include 80 percent of such shareholder's pro rata share (as determined under section 1366(a)) of the taxable income or loss of such corporation for such taxable year from service-related businesses carried on by such corporation, and to the extent provided in regulations, for any other tax-

able year to the extent such income or loss is attributable to such services.

"(2) CERTAIN EXCEPTIONS TO APPLY.—In determining the amount to be taken into account under paragraph (1), the exceptions provided in subsection (a) shall apply, except that, in the case of the exceptions provided in subsection (a)(5), rules similar to the rules of subparagraph (B) thereof shall apply to shareholders in S corporations.

"(3) SERVICE-RELATED BUSINESS.—For purposes of this subsection, the term 'service-related business' means—

"(A) any trade or business involving the performance of services in the fields of health (other than with respect to inpatient personal care facilities), law, engineering, architecture, accounting, actuarial services, performing arts, consulting, athletics, or financial services (other than lending or brokerage services), or

"(B) any other trade or business with respect to which the Secretary determines that capital is an insignificant income-producing factor.

"(4) APPLICATION OF DEFERRED COMPENSATION RULES.—For purposes of subchapter D of

chapter 1 (and any other provision of this title relating thereto), in the case of an individual who is treated as having net earnings from self-employment by reason of paragraph (1)—

"(A) such individual shall not be treated as a self-employed individual (within the meaning of section 401(c)(1)) with respect to services performed for the S corporation, and

"(B) such net earnings shall be treated as compensation received by the individual as an employee of the S corporation."

(2) AMENDMENT TO SOCIAL SECURITY ACT.—Section 211 of the Social Security Act is amended by adding at the end the following new subsection:

"Treatment of Certain S Corporation Shareholders

"(k)(1) In the case of any individual—

"(A) who is a 2-percent shareholder (as defined in section 1372(b) of the Internal Revenue Code of 1986) of an S corporation for any taxable year of such corporation, and

"(B) who provides significant services to or on behalf of such S corporation during such taxable year,

such shareholder's net earnings from self-employment shall include 80 percent of such shareholder's pro rata

share (as determined under section 1366(a) of such Code) of the taxable income or loss of such corporation for such taxable year from service-related businesses (as defined in section 1402(k)(3) of such Code) carried on by such corporation, and to the extent provided in regulations, for any other taxable year to the extent such income or loss is attributable to such services.

''(2) In determining the amount to be taken into account under paragraph (1), the exceptions provided in subsection (a) shall apply, except that, in the case of the exceptions provided in subsection (a)(5), rules similar to the rules of subparagraph (B) thereof shall apply to shareholders in S corporations.''

(b) TREATMENT OF CERTAIN LIMITED PARTNERS.—

(1) AMENDMENT OF THE INTERNAL REVENUE CODE.—Paragraph (13) of section 1402(a) is amended to read as follows:

''(13) there shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than—

''(A) guaranteed payments described in section 707(c) to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are estab-

lished to be in the nature of remuneration for those services, or

"(B) in the case of a limited partner who provides significant services to or on behalf of the partnership for any taxable year of the partnership, 80 percent of the limited partner's distributive share (determined without regard to payments described in subparagraph (A)) of the taxable income or loss of such partnership—

"(i) for such taxable year from service-related businesses (as defined in subsection (k)(3)) of such partnership, and

"(ii) to the extent provided in regulations, for any other taxable year to the extent attributable to such services;".

(2) AMENDMENT OF THE SOCIAL SECURITY ACT.—Paragraph (12) of section 211(a) of the Social Security Act is amended to read as follows:

"(12) there shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than—

"(A) guaranteed payments described in section 707(c) of the Internal Revenue Code of 1986 to that partner for services actually rendered to or on behalf of the partnership to the

extent that those payments are established to be in the nature of remuneration for those services, or

"(B) in the case of a limited partner who provides significant services to or on behalf of the partnership for any taxable year of the partnership, 80 percent of the limited partner's distributive share (determined without regard to payments described in subparagraph (A)) of the taxable income or loss of such partnership—

"(i) for such taxable year from service-related businesses (as defined in section 1402(k)(3) of such Code) of such partnership, and

"(ii) to the extent provided in regulations prescribed by the Secretary of the Treasury, for any other taxable year to the extent attributable to such services;".

(c) INVENTORY INCOME.—Section 1402 (relating to definitions), as amended by subsection (a), is amended by adding at the end the following new subsection:

"(l) INVENTORY INCOME.—

"(1) IN GENERAL.—The net earnings from self-employment of any taxpayer for any taxable year under subsection (a) (determined without regard to

this subsection) shall be reduced by 40 percent of the lesser of—

"(A) the taxpayer's allocable share of net inventory income, or

"(B) the amount of such net earnings in excess of the applicable amount for the taxable year.

"(2) NET INVENTORY INCOME.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'net inventory income' means net income from the sale of property described in section 1221(1).

"(B) DEALERS IN SECURITIES.—For purposes of subparagraph (A)—

"(i) any security described in section 475(c)(2) (without regard to the last sentence thereof) which is held by a person as a dealer in securities (as defined in section 475(c)(1)) shall be treated as property described in section 1221(1), and

"(ii) net income from any such security shall be taken into account to the extent otherwise taken into account in computing net earnings from self-employment.

"(3) APPLICABLE AMOUNT.—For purposes of paragraph (1), the term 'applicable amount' means the excess of—

"(A) $135,000, adjusted, in the case of any taxable year beginning in any calendar year after 1996, in the same manner as is used in adjusting the contribution and benefit base for the calendar year under section 230(b) of the Social Security Act, over

"(B) the amount of wages paid to the individual during the taxable year."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years of individuals beginning after December 31, 1995, and to taxable years of S corporations and partnerships ending with or within such taxable years of individuals.

SEC. 7133. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) IN GENERAL.—

(1) APPLICATION OF HOSPITAL INSURANCE TAX.—Section 3121(u)(2) is amended by striking subparagraphs (C) and (D).

(2) COVERAGE UNDER MEDICARE.—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended by striking paragraphs (3) and (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services performed after September 30, 1995.

(b) TRANSITION IN BENEFITS FOR STATE AND LOCAL GOVERNMENT EMPLOYEES AND FORMER EMPLOYEES.—

(1) IN GENERAL.—

(A) EMPLOYEES NEWLY SUBJECT TO TAX.—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs services during the calendar quarter beginning October 1, 1995, the wages for which are subject to the tax imposed by section 3101(b) of the Internal Revenue Code of 1986 only because of the amendment made by subsection (a), the individual's medicare qualified State or local government employment (as defined in subparagraph (B)) performed before October 1, 1995, shall be considered to be ''employment'' (as defined for purposes of title II of such Act), but only for purposes of providing the individual (or another

person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act for months beginning with October 1995.

(B) MEDICARE QUALIFIED STATE OR LOCAL GOVERNMENT EMPLOYMENT DEFINED.—In this paragraph, the term ''medicare qualified State or local government employment'' means medicare qualified government employment described in section 210(p)(1)(B) of the Social Security Act (determined without regard to section 210(p)(3) of such Act, as in effect before its repeal under subsection (a)(2)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1),

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

(3) INFORMATION TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON STATE AND LOCAL GOVERNMENT EMPLOYMENT.—Section 226(g) of the Social Security Act (42 U.S.C. 426(g)) is amended—

(A) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively,

(B) by inserting ''(1)'' after ''(g)'', and

(C) by adding at the end the following new paragraph:

''(2) The Secretary, in consultation with State and local governments, shall provide procedures designed to assure that individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(7) are fully informed with respect to (A) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII,

(B) the requirements for, and conditions of, such eligibility, and (C) the necessity of timely application as a condition of becoming entitled under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity or retirement benefit and whose eligibility for such annuity or retirement benefit is based on a disability.''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (A) of section 3121(u)(2) is amended by striking ''subparagraphs (B) and (C),'' and inserting ''subparagraph (B),''.

(2) Subparagraph (B) of section 210(p)(1) of the Social Security Act (42 U.S.C. 410(p)(1)) is amended by striking ''paragraphs (2) and (3).'' and inserting ''paragraph (2).''

(3) Section 218 of the Social Security Act (42 U.S.C. 418) is amended by striking subsection (n).

(4) The amendments made by this subsection shall apply after September 30, 1995.

Subtitle B—Tax Treatment of Employer-Provided Health Care

PART 1—GENERAL PROVISIONS

SEC. 7201. LIMITATION ON EXCLUSION FOR EMPLOYER-PROVIDED HEALTH BENEFITS.

(a) GENERAL RULE.—Section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) INCLUSION OF CERTAIN BENEFITS NOT PART OF PERMITTED COVERAGE.—

''(1) IN GENERAL.—Effective on and after January 1, 2004, gross income of an employee shall include employer-provided coverage under any accident or health plan which is not permitted coverage.

''(2) PERMITTED COVERAGE.—For purposes of this subsection, the term 'permitted coverage' means any—

1 "(A) coverage under a certified standard
2 health plan (as defined in section 1011(2)(A) of
3 the Health Security Act),
4 "(B) coverage under a certified supple-
5 mental health benefit plan (as defined in section
6 1011(3)(A) of the Health Security Act) which
7 consists of the payment of cost sharing
8 amounts under a certified standard health plan
9 (as so defined) providing the standard benefits
10 package described in part 1 of subtitle C of title
11 I of such Act,
12 "(C) coverage under a qualified long-term
13 care insurance policy (as defined in section
14 7702B(b)),
15 "(D) coverage providing wages or pay-
16 ments in lieu of wages for any period during
17 which the employee is absent from work on ac-
18 count of sickness or injury,
19 "(E) coverage only for accidental death or
20 dismemberment,
21 "(F) coverage under a medicare supple-
22 mental policy (as defined in section 1882(g)(1)
23 of the Social Security Act),

"(G) coverage under an equivalent health care program (as defined in section 1013(3) of the Health Security Act), and

"(H) other coverage to the extent that the Secretary determines that the continuation of an exclusion for such coverage is not inconsistent with the purposes of this subsection.

"(3) SPECIAL RULES FOR FLEXIBLE SPENDING ARRANGEMENTS.—

"(A) IN GENERAL.—To the extent that any employer-provided coverage is provided through a flexible spending or similar arrangement, paragraph (1) shall be applied by substituting 'January 1, 1996,' for 'January 1, 2004'.

"(B) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this paragraph, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(i) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(ii) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage. In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage."

(b) EMPLOYMENT TAX TREATMENT.—

(1) SOCIAL SECURITY TAX.—

(A) Subsection (a) of section 3121 is amended by inserting after paragraph (21) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (21) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b) of the Internal Revenue Code of 1986."

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) is amended by adding at the

end the following new sentence: ''Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b).''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by inserting after paragraph (16) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(4) WAGE WITHHOLDING.—Subsection (a) of section 3401 is amended by adding at the end the following new sentence:

''Nothing in the preceding provisions of this subsection shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall take effect on January 1, 1996.

(2) BENEFITS PROVIDED PURSUANT TO COLLECTIVE BARGAINING AGREEMENTS.—In the case of a flexible spending arrangement maintained pursuant to 1 or more collective bargaining agreements

between employee representatives and 1 or more employers which was ratified before June 30, 1994, the amendments referred to in paragraph (1) shall not apply to benefits pursuant to any such agreement before the later of—

(A) January 1, 1996, or

(B) the earlier of—

(i) the date on which the last of such agreements terminate (determined without regard to any extension thereof on or after June 30, 1994), or

(ii) January 1, 1998.

SEC. 7202. HEALTH BENEFITS MAY NOT BE PROVIDED UNDER CAFETERIA PLANS.

(a) GENERAL RULE.—Subsection (f) of section 125 (defining qualified benefits) is amended by adding at the end the following new sentence: ''Such term shall not include any benefits or coverage under an accident or health plan.''

(b) CONFORMING AMENDMENT.—Subsection (g) of section 125 is amended by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall take effect on January 1, 1997.

(2) BENEFITS PROVIDED PURSUANT TO COLLECTIVE BARGAINING AGREEMENTS.—In the case of a cafeteria plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers which was ratified before June 30, 1994, the amendments referred to in paragraph (1) shall not apply to benefits pursuant to any such agreement before the later of—

(A) January 1, 1997, or

(B) the earlier of—

(i) the date on which the last of such agreements terminate (determined without regard to any extension thereof on or after June 30, 1994), or

(ii) January 1, 1999.

SEC. 7203. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) PROVISION MADE PERMANENT.—

(1) IN GENERAL.—Subsection (l) of section 162 (relating to special rules for health insurance costs

of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to taxable years beginning after December 31, 1993.

(b) AMOUNT OF DEDUCTION.—

(1) IN GENERAL.—Paragraphs (1) and (2) of section 162(l) are amended to read as follows:

"(1) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c), there shall be allowed as a deduction under this section an amount equal to 50 percent of the amount paid during the taxable year for coverage under a certified standard health plan (as defined in section 1011(2)(A) of the Health Security Act).

"(2) LIMITATIONS.—

"(A) LOWER PERCENTAGE IN CERTAIN CASES.—

"(i) IN GENERAL.—If the taxpayer has 1 or more employees in a trade or business with respect to which such taxpayer is treated as an employee within the meaning of section 401(c), the deduction under paragraph (1) shall not exceed the portion of the amount paid which is equiv-

alent to the largest employer contribution made on behalf of any such employee for coverage under a certified standard health plan.

"(ii) EQUIVALENT CONTRIBUTION.—For purposes of clause (i), the amount paid is equivalent to a contribution if—

"(I) it is the same dollar amount as the contribution,

"(II) it represents the same percentage of cost under the plan to which it is made as does the contribution, or

"(III) it represents the same percentage of the weighted average premium for the class of enrollment (as defined in section 1113(c) of the Health Security Act) for the community rating area in which the employee works as does the contribution.

For purposes of applying subclause (II) or (III), any dollar limitation applicable to all employer contributions (whether expressed as a dollar amount or a percentage de-

scribed in subclause (III)) shall be disregarded.

"(B) DEDUCTION LIMITED TO EARNED INCOME.—No deduction shall be allowed under paragraph (1) to the extent that the amount of such deduction exceeds the taxpayer's earned income (within the meaning of section 401(c)).

"(C) OTHER COVERAGE.—Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or the taxpayer's spouse."

(2) CONFORMING AMENDMENT.—Subparagraph (A) of section 162(l)(5) is amended by striking "shall be treated as such individual's earned income" and inserting "shall be included in such individual's earned income".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1995.

SEC. 7204. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS.

(a) GENERAL RULE.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

"(10) LIMITATION ON PREPAYMENTS.—If—

"(A) the taxpayer pays a premium or other amount which constitutes medical care under paragraph (1), and

"(B) such premium or other amount is properly allocable to insurance coverage or care to be provided during periods more than 12 months after the month in which such payment is made,

such premium or other amount shall be treated as paid ratably over the period during which such insurance coverage or care is to be provided. The preceding sentence shall not apply to any premium to which paragraph (7) applies."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid after December 31, 1994.

PART 2—VOLUNTARY EMPLOYER HEALTH CARE CONTRIBUTIONS

SEC. 7111. TAX TREATMENT OF VOLUNTARY EMPLOYER HEALTH CARE CONTRIBUTIONS.

(a) IN GENERAL.—Chapter 37 (relating to health-related taxes), as added by section 7111, is amended by adding at the end the following new subchapter:

"Subchapter B—Voluntary Employer-Provided Health Benefits

"Sec. 4521. Taxable employer-provided health benefits.
"Sec. 4522. Discriminatory employer practices.
"Sec. 4523. Exceptions.
"Sec. 4524. Definitions and special rules.

"SEC. 4521. TAXABLE EMPLOYER-PROVIDED HEALTH BENEFITS.

"(a) IMPOSITION OF TAX.—There is hereby imposed a tax equal to the product of—

"(1) the sum of—

"(A) the taxable employer contributions for any taxable year, plus

"(B) the aggregate employer contributions for permitted coverage described in subparagraph (A) or (B) of subsection (b)(2) during any portion of the taxable year during which there is discriminatory permitted coverage, and

"(2) the highest rate of tax imposed under section 11(b) for the taxable year.

1 "(b) TAXABLE EMPLOYER CONTRIBUTION.—For
2 purposes of this section—
3 "(1) IN GENERAL.—The term 'taxable employer
4 contribution' means any employer contribution under
5 an accident or health plan for coverage of an em-
6 ployee other than permitted coverage.
7 "(2) PERMITTED COVERAGE.—For purposes of
8 this subsection, the term 'permitted coverage'
9 means—
10 "(A) coverage under a certified standard
11 health plan (as defined in section 1011(2)(A) of
12 the Health Security Act),
13 "(B) coverage under a certified supple-
14 mental health benefit plan (as defined in section
15 1011(3)(A) of such Act), except that this sub-
16 paragraph shall not apply to coverage of any
17 employee who is covered under a certified
18 standard health plan which provides the alter-
19 native standard benefits package described in
20 subtitle C of title I of such Act,
21 "(C) coverage under a qualified long-term
22 care insurance policy (as defined in section
23 7702B(b)),
24 "(D) coverage providing wages or pay-
25 ments in lieu of wages for any period during

which the employee is absent from work on account of sickness or injury,

"(E) coverage only for accidental death or dismemberment,

"(F) coverage under a medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act), and

"(G) coverage under an equivalent health care program (as defined in section 1013(3) of the Health Security Act).

"(c) DISCRIMINATORY PERMITTED COVERAGE.—For purposes of this section, the term 'discriminatory permitted coverage' means, with respect to any period, coverage—

"(1) which is permitted coverage described in subparagraph (A) or (B) of subsection (b)(2), and

"(2) with respect to which the requirements of subsection (a) or (b) of section 4522 are not met during such period.

"SEC. 4522. DISCRIMINATORY EMPLOYER PRACTICES.

"(a) HEALTH STATUS REQUIREMENTS.—For purposes of section 4521(c), an employer meets the requirements of this subsection if, with respect to coverage described in such section—

1 "(1) there is no waiting period or denial of cov-
2 erage with respect to an employee, and
3 "(2) the amount of the employer contribution
4 on behalf of an employee is not conditioned, and
5 does not vary,
6 by reason of the employee's health status, claims experi-
7 ence, medical history, receipt of health care, or lack of evi-
8 dence of insurability.
9 "(b) UNIFORM CONTRIBUTION REQUIREMENTS.—
10 "(1) IN GENERAL.—For purposes of section
11 4521(c), an employer meets the requirements of this
12 subsection if the employer contribution on behalf of
13 an employee for coverage described in such section
14 is equivalent to each employer contribution on behalf
15 of all other employees who elect such coverage under
16 plans offered by the employer.
17 "(2) EQUIVALENT CONTRIBUTION.—For pur-
18 poses of paragraph (1), a contribution is equivalent
19 to any other contribution if—
20 "(A) it is the same dollar amount as the
21 other contribution,
22 "(B) it represents the same percentage of
23 cost under the plan to which it is made as does
24 the other contribution, or

"(C) it represents the same percentage of the weighted average premium for the class of enrollment (as defined in section 1113(c) of the Health Security Act) for the community rating area in which the employee works as does the other contribution.

For purposes of applying subparagraph (B) or (C), any dollar limitation applicable to all employer contributions (whether expressed as a dollar amount or a percentage described in subparagraph (C)) shall be disregarded.

"(3) EXCLUDED EMPLOYEES.—

"(A) IN GENERAL.—The following employees of an employer shall be excluded from consideration under this subsection:

"(i) Any employee before the employee has completed 6 months of service with the employer.

"(ii) Any employee who normally works less than 24 hours per week.

"(iii) Any employee who normally works during not more than 6 months of any year.

"(iv) Any employee who has not attained age 18.

"(v) Any employee who is included in a unit of employees covered by an agreement which the Secretary finds to be a collective bargaining agreement between employee representatives and 1 or more employers if there is evidence that employer-provided benefits for standard health benefits coverage was the subject of good faith bargaining between the employee representatives and employer or employers.

"(vi) Any employee who is a nonresident alien and who receives no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

"(vii) Any former employee.

"(B) COVERAGE OF PART-TIME EMPLOYEES.—

"(i) IN GENERAL.—If an employer makes an employer contribution for any period for coverage described in section 4521(c) for any employee who normally works at least 10 hours but less than 24

hours per week, subparagraph (A)(ii) shall be applied by substituting '10 hours' for '24 hours'.

"(ii) REQUIREMENTS MAY BE MET SEPARATELY.—If an employer elects the application of this clause—

"(I) the requirements of this subsection shall be applied separately to employees to whom this subsection applies by reason of clause (i), and

"(II) such employees shall be excluded in determining whether such requirements are met with respect to any other employees.

"(iii) PRO RATA CONTRIBUTIONS PERMISSIBLE.—For purposes of this subsection, contributions on behalf of any employee to which this subsection applies by reason of clause (i) shall not fail to be treated as equivalent solely because they are proportionate to the number of hours the employee works.

"(4) AGGREGATION RULES.—For purposes of this subsection—

"(A) IN GENERAL.—All employers treated as a single employer under subsection (b) or (c) of section 414 shall be treated as a single employer.

"(B) AFFILIATED SERVICE GROUPS.—All employees of members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer.

"(5) SEPARATE LINES OF BUSINESS.—If, under section 414(r), an employer is treated as operating separate lines of business for a year, the employer may apply this subsection separately to employees in each separate line of business.

"SEC. 4523. EXCEPTIONS.

"(a) EXCEPTION FOR REASONABLE DILIGENCE.—No tax shall be imposed by this subchapter during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that the employer had taken any action subject to tax under this subchapter.

"(b) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by this subchapter with respect to any action subject to tax under this subchapter if—

"(1) such action was due to reasonable cause and not to willful neglect, and

"(2) such action is corrected during the 30-day period beginning on the 1st date the employer knew, or exercising reasonable diligence would have known, that such action was subject to such tax.

"(c) WAIVER BY SECRETARY.—In the case of any action subject to tax under this subchapter which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of any tax imposed by this subchapter to the extent that the payment of such tax would be excessive relative to the action involved.

"SEC. 4524. DEFINITIONS AND SPECIAL RULES.

"(a) DEFINITIONS.—For purposes of this subchapter—

"(1) EMPLOYER.—

"(A) IN GENERAL.—The term 'employer' means any person or governmental entity for whom an individual performs services, of whatever nature, as an employee (as defined in section 3401(c)).

"(B) SPECIAL RULES.—

"(i) A partnership shall be treated as the employer of each partner who is an employee within the meaning of section 401(c)(1).

"(ii) An S corporation shall be treated as the employer of each shareholder who is an employee within the meaning of section 401(c)(1).

"(2) EMPLOYER CONTRIBUTIONS.—The term 'employer contribution' means, with respect to coverage under a health plan, a reasonable estimate of the portion of the cost of the coverage which is to be provided by the employer.

"(b) LIABILITY FOR TAX.—Any tax imposed by this subchapter shall be paid by the employer.

"(c) TAXES TO APPLY TO GOVERNMENTAL AND OTHER TAX-EXEMPT ENTITIES.—Notwithstanding any other provision of law or rule of law, none of the following shall be exempt from the taxes imposed by this subchapter:

"(1) The United States, any State or political subdivision thereof, the District of Columbia, and any agency or instrumentality of any of the foregoing.

"(2) Any other entity otherwise exempt from tax under chapter 1.

"(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected

1 under this subchapter shall be covered over to any posses-
2 sion of the United States.

3 "(e) REGULATIONS.—The Secretary shall prescribe
4 such regulations as are necessary to carry out the provi-
5 sions of this subchapter, including regulations providing
6 for the determination of the amount of any employer con-
7 tribution, the aggregation of governmental and tax-exempt
8 entities, and the prevention of the avoidance of any tax
9 imposed by this subchapter through the use of any ar-
10 rangement described in section 414(o)."

11 (b) EMPLOYEE LEASING.—Paragraph (3) of section
12 414(n) is amended by striking "and" at the end of sub-
13 paragraph (B), by striking the period at the end of sub-
14 paragraph (C) and inserting ", and", and by adding at
15 the end the following new subparagraph:

16 "(D) subchapter B of chapter 37."

17 (c) TAX NOT DEDUCTIBLE.—Section 275(a) is
18 amended by adding at the end the following new para-
19 graph:

20 "(7) The taxes imposed by section 4521 (relat-
21 ing to taxable employer-provided health benefits)."

22 (d) CONFORMING AMENDMENT.—The table of sub-
23 chapters for chapter 37 is amended by adding at the end
24 the following new item:

"SUBCHAPTER B. Voluntary employer-provided health benefits."

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

Subtitle C—Exempt Health Care Organizations

PART 1—GENERAL PROVISIONS

SEC. 7301. QUALIFICATION AND DISCLOSURE REQUIREMENTS FOR NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) TREATMENT OF HOSPITALS AND OTHER ENTITIES PROVIDING HEALTH CARE SERVICES.—Section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

"(n) QUALIFICATION OF HEALTH CARE ORGANIZATIONS AS EXEMPT ORGANIZATIONS.—

"(1) IN GENERAL.—An organization which is described in paragraph (3) or (4) of subsection (c) and the predominant activity of which is the provision of health care services shall be exempt from tax under subsection (a) only if—

"(A) such organization, with the participation of community representatives, annually—

"(i) assesses its community's needs for health care services and qualified outreach services, and

"(ii) prepares a written plan to meet those needs,

"(B) pursuant to such plan, such organization provides (directly or indirectly) significant qualified outreach services,

"(C) such organization does not discriminate against individuals in the provision of health care services on the basis of participation in a government-sponsored health plan, and

"(D) such organization does not discriminate against individuals in the provision of emergency health care services on the basis of ability to pay.

"(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization shall not be treated as described in subsection (c)(3) unless substantially all of its primary care health services are provided as described in subsection (m)(6)(A).

"(3) DEFINITIONS AND SPECIAL RULE.—For purposes of this subsection—

1 "(A) QUALIFIED OUTREACH SERVICES.—
2 The term 'qualified outreach services' means
3 health care services (or preventive care, edu-
4 cational, or social services programs related
5 thereto) which are provided—
6 "(i) in 1 or more medically under-
7 served areas,
8 "(ii) at below cost to individuals who
9 are otherwise unable to afford such serv-
10 ices, or
11 "(iii) at emergency care facilities
12 which provide specialty services and which
13 normally operate at a loss.
14 Such term shall not include insurance described
15 in subparagraph (B)(iii) unless such insurance
16 is provided on a subsidized basis.
17 "(B) HEALTH CARE SERVICES.—The term
18 'health care services' means—
19 "(i) any activity which consists of pro-
20 viding medical care (as defined in section
21 213(d)(1)(A)) to individuals,
22 "(ii) in the case of an organization de-
23 scribed in subsection (c)(3), any activity
24 which is treated as accomplishing an ex-
25 empt purpose of the organization solely be-

cause it is carried on as part of an activity described in clause (i), and

"(iii) insurance (other than commercial-type insurance, as defined in subsection (m)) for the activities described in clauses (i) and (ii).

"(C) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' means, with respect to a health care service, any area reasonably determined by the organization (in a manner not inconsistent with regulations prescribed by the Secretary) to have—

"(i) a shortage (relative to the number of individuals needing such service) of health professionals performing such service, or

"(ii) a population group experiencing such a shortage.

Such term includes a health professional shortage area (as defined in section 332 of the Public Health Service Act).

"(4) EXCEPTIONS.—This subsection shall not apply to any organization which—

"(A) demonstrates, in a manner not inconsistent with regulations prescribed by the Sec-

retary, that one of its principal purposes is academic training or medical research, or

"(B) provides health care services exclusively on an uncompensated basis, regardless of ability to pay.

"(5) DISALLOWANCE OF CHARITABLE DEDUCTIONS.—No gift or bequest to an organization which is not exempt from tax by reason of this subsection shall be allowed as a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522.

"(6) REQUIREMENTS SUPPLEMENT OTHER REQUIREMENTS.—The requirements of this subsection are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in paragraph (3) or (4) of subsection (c)."

(b) REPORTING AND DISCLOSURE OF NEEDS ASSESSMENT AND PLAN.—

(1) REPORTING.—

(A) ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3).—Subsection (b) of section 6033 (relating to certain organizations described in section 501(c)(3)) is amended by striking "and" at the end of paragraph (9), by redesignating paragraph (10) as paragraph (12), and

by inserting after paragraph (9) the following new paragraphs:

"(10) in the case of an organization which prepares a plan described in section 501(n)(1)(A) (relating to community needs)—

"(A) a copy of such plan for the year, and

"(B) information on the implementation of such plan for the year (including unrecovered costs and revenues foregone in furtherance of such plan),

"(11) such information as the Secretary may require with respect to any taxable inurement (as defined in section 4958(d)), and".

(B) ORGANIZATIONS DESCRIBED IN SECTION 501(C)(4).—Section 6033 is amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

"(f) CERTAIN ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Every organization described in section 501(c)(4) which is subject to the requirements of subsection (a) and which prepares a plan described in section 501(n)(1)(A) (relating to community needs) for the year—

"(1) shall include a copy of such plan with the return required under subsection (a) for the year, and

"(2) shall include on such return the information referred to in paragraphs (10)(B) and (11) of subsection (b) with respect to such organization."

(2) DISCLOSURE.—

(A) IN GENERAL.—Subsection (e) of section 6104 (relating to public inspection of certain annual returns and applications for exemption) is amended by adding at the end the following new paragraph:

"(3) COMMUNITY HEALTH CARE NEEDS ASSESSMENT AND PLAN.—

"(A) IN GENERAL.—Every organization which is required to prepare a plan described in section 501(n)(1)(A) (relating to community needs)—

"(i) shall make a copy of such plan (and the assessment on which such plan is based) available for inspection during regular business hours by any individual at the principal office of such organization and, if such organization regularly maintains 1 or more regional or district offices

having 3 or more employees, at each such regional or district office, and

"(ii) upon request of an individual made at such principal office or such a regional or district office, shall provide—

"(I) a copy of such plan (and assessment), and

"(II) a copy of the annual return filed under section 6033,

to such individual without charge other than a reasonable fee for any reproduction and mailing costs.

If the request under clause (ii) is made in person, such copies shall be provided immediately and, if made other than in person, shall be provided within 30 days.

"(B) PERIOD OF AVAILABILITY.—Subparagraph (A) shall apply—

"(i) with respect to any plan (and assessment) during the 3-year period after the close of the year for which such plan is prepared, and

"(ii) with respect to any return, during the 3-year period beginning on the filing date (as defined in paragraph (1)(D)).

"(C) LIMITATION.—Subparagraph (A)(ii) shall not apply to any request if the Secretary determines, upon application by an organization, that such request is part of a harassment campaign and that compliance with such request is not in the public interest."

(B) TECHNICAL AMENDMENT.—The heading for subsection (e) of section 6104 is amended by striking "AND APPLICATIONS FOR EXEMPTION" and inserting ", APPLICATIONS FOR EXEMPTION, AND COMMUNITY NEEDS ASSESSMENT AND PLAN FOR HEALTH AND OUTREACH SERVICES".

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on January 1, 1995.

(2) HMO SERVICE REQUIREMENT.—So much of the amendments made by this section as relates to section 501(n)(2) of the Internal Revenue Code of 1986, as added by this section, shall take effect on the date of the enactment of this Act.

SEC. 7302. EXCISE TAXES FOR PRIVATE INUREMENT BY TAX-EXEMPT HEALTH CARE ORGANIZATIONS.

(a) IN GENERAL.—Chapter 42 (relating to private foundations and certain other tax-exempt organizations) is amended by redesignating subchapter D as subchapter E and by inserting after subchapter C the following new subchapter:

"Subchapter D—Private Inurement by Tax-Exempt Health Care Organizations

"Sec. 4958. Taxes on private inurement.
"Sec. 4959. Other definitions.

"SEC. 4958. TAXES ON PRIVATE INUREMENT.

"(a) INITIAL TAXES.—

"(1) ON THE BENEFICIARY.—There is hereby imposed on any taxable inurement a tax equal to 25 percent of the amount thereof. The tax imposed by this paragraph shall be paid by any beneficiary of such inurement.

"(2) ON THE MANAGEMENT.—In any case in which there is a tax imposed by paragraph (1), there is hereby imposed on the participation of any organization manager of an organization in any taxable inurement which occurs with respect to such organization, knowing that it is taxable inurement, a tax equal to 2½ percent of the amount thereof, unless such participation is not willful and is due to reason-

able cause. The tax imposed by this paragraph shall be paid by any organization manager who participated in the taxable inurement.

"(b) ADDITIONAL TAXES.—

"(1) ON THE BENEFICIARY.—In any case in which an initial tax is imposed by subsection (a)(1) on any taxable inurement and such inurement is not corrected within the taxable period, there is hereby imposed a tax equal to 200 percent of the amount of the taxable inurement. The tax imposed by this paragraph shall be paid by any beneficiary of such inurement.

"(2) ON THE MANAGEMENT.—In any case in which an additional tax is imposed by paragraph (1), if an organization manager refused to agree to part or all of the correction, there is hereby imposed a tax equal to 50 percent of the amount of the taxable inurement. The tax imposed by this paragraph shall be paid by any organization manager who refused to agree to part or all of the correction.

"(c) SPECIAL RULES RELATING TO LIABILITY FOR TAX.—For purposes of this section—

"(1) JOINT AND SEVERAL LIABILITY.—If more than one person is liable under any paragraph of subsection (a) or (b) with respect to any one taxable

inurement, all such persons shall be jointly and severally liable under such paragraph with respect to such inurement.

"(2) LIMIT FOR MANAGEMENT.—With respect to any 1 taxable inurement, the maximum amount of the tax imposed by subsection (a)(2) shall not exceed $10,000, and the maximum amount of the tax imposed by subsection (b)(2) shall not exceed $10,000.

"(d) TAXABLE INUREMENT.—For purposes of this section, the term 'taxable inurement' means any inurement not permitted under paragraph (3) or (4) of section 501(c), as the case may be, in a transaction involving an applicable tax-exempt health care organization in which—

"(1) the value of any economic benefit provided to or for the use of a disqualified person exceeds the value of the consideration (including the performance of services) received by the organization for providing such benefit, or

"(2) the amount of any economic benefit provided to or for the use of a disqualified person is determined in whole or in part by the gross or net revenues of 1 or more activities of the organization.

The amount of any taxable inurement with respect to any such transaction shall be the excess described in paragraph (1) or the amount described in paragraph (2). For purposes of paragraph (1), an economic benefit shall not be treated as provided as consideration for the performance of services unless the organization clearly indicated its intent to so treat such benefit.

"(e) OTHER DEFINITIONS.—For purposes of this section—

"(1) DISQUALIFIED PERSON.—The term 'disqualified person' means, with respect to any transaction—

"(A) any person who was, at any time during the 5-year period ending on the date of such transaction—

"(i) an organization manager, or

"(ii) an individual (other than an organization manager)—

"(I) in a position to exercise substantial influence over the affairs of the organization, or

"(II) performing substantial medical services as a physician pursuant to an employment or other con-

tractual relationship with the organization or a related organization,

"(B) a member of the family of an individual described in subparagraph (A), and

"(C) a 35-percent controlled entity.

"(2) ORGANIZATION MANAGER.—The term 'organization manager' means, with respect to any applicable tax-exempt health care organization, any officer, director, or trustee of such organization (or any individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization).

"(3) 35-PERCENT CONTROLLED ENTITY.—

"(A) IN GENERAL.—The term '35-percent controlled entity' means—

"(i) a corporation in which persons described in subparagraph (A) or (B) of paragraph (1) own more than 35 percent of the total combined voting power,

"(ii) a partnership in which such persons own more than 35 percent of the profits interest, and

"(iii) a trust or estate in which such persons own more than 35 percent of the beneficial interest.

"(B) CONSTRUCTIVE OWNERSHIP RULES.—Rules similar to the rules of paragraphs (3) and (4) of section 4946(a) shall apply for purposes of this subsection.

"(4) FAMILY MEMBERS.—The members of an individual's family shall be determined under section 4946(d); except that such members also shall include the brothers and sisters (whether by the whole or halfblood) of the individual and their spouses.

"(f) TREATMENT OF PREVIOUSLY EXEMPT ORGANIZATIONS.—

"(1) IN GENERAL.—For purposes of this section, the status of any organization as an applicable tax-exempt health care organization shall be terminated only if—

"(A)(i) such organization notifies the Secretary (at such time and in such manner as the Secretary may by regulations prescribe) of its intent to accomplish such termination, or

"(ii) there is a final determination by the Secretary that such status has terminated, and

"(B)(i) such organization pays the tax imposed by paragraph (2) (or any portion not abated pursuant to paragraph (3)), or

"(ii) the entire amount of such tax is abated pursuant to paragraph (3).

"(2) IMPOSITION OF TAX.—There is hereby imposed on each organization referred to in paragraph (1) a tax equal to the lesser of—

"(A) the amount which the organization substantiates by adequate records or other corroborating evidence as the aggregate tax benefit resulting from its exemption from tax under section 501(a), or

"(B) the value of the net assets of such organization.

"(3) ABATEMENT OF TAX.—The Secretary may abate the unpaid portion of the assessment of any tax imposed by paragraph (2), or any liability in respect thereof, if the applicable tax-exempt health care organization distributes all of its net assets to 1 or more organizations each of which has been in existence, and described in section 501(c)(3), for a continuous period of at least 60 calendar months. If the distributing organization is described in section 501(c)(4), the preceding sentence shall be applied by treating the reference to section 501(c)(3) as including a reference to section 501(c)(4).

"(4) CERTAIN RULES MADE APPLICABLE.—Rules similar to the rules of subsections (d), (e), and (f) of section 507 shall apply for purposes of this subsection.

"SEC. 4959. OTHER DEFINITIONS.

"(a) APPLICABLE TAX-EXEMPT HEALTH CARE ORGANIZATION.—For purposes of this subchapter, the term 'applicable tax-exempt health care organization' means any organization—

"(1) the predominant activity of which is the provision of health care services (as defined in section 501(n)(3)), and

"(2) which (without regard to any taxable inurement) would be described in paragraph (3) or (4) of section 501(c) and exempt from tax under section 501(a).

Such term does not include a private foundation (as defined in section 509(a)).

"(b) TAXABLE PERIOD; CORRECTION.—For purposes of this subchapter—

"(1) TAXABLE PERIOD.—The term 'taxable period' means, with respect to any taxable inurement, the period beginning with the date on which the inurement occurs and ending on the earliest of—

"(A) the date of mailing a notice of deficiency under section 6212 with respect to the tax imposed by subsection (a)(1) of section 4958, or

"(B) the date on which the tax imposed by such subsection (a)(1) is assessed.

"(2) CORRECTION.—The terms 'correction' and 'correct' mean, with respect to any taxable inurement, undoing the inurement to the extent possible, establishing safeguards to prevent future such inurement, and where fully undoing the inurement is not possible, such additional corrective action as is prescribed by the Secretary by regulations."

(b) APPLICATION OF PRIVATE INUREMENT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Paragraph (4) of section 501(c) is amended by inserting "(A)" after "(4)" and by adding at the end the following:

"(B) Subparagraph (A) shall not apply to an entity the predominant activity of which is the provision of health care services (as defined in subsection (n)(3)) unless no part of the net earnings of such entity inures to the benefit of any private shareholder or individual."

(c) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 4955 is amended—

(A) by striking ''SECTION 4945'' in the heading and inserting ''SECTIONS 4945 and 4958'', and

(B) by inserting before the period ''or a taxable inurement for purposes of section 4958''.

(2) Subsections (a), (b), and (c) of section 4963 are each amended by inserting ''4958,'' after ''4955,''.

(3) Subsection (e) of section 6213 is amended by inserting ''4958 (relating to private inurement),'' before ''4971''.

(4) Paragraphs (2) and (3) of section 7422(g) are each amended by inserting ''4958,'' after ''4955,''.

(5) Subsection (b) of section 7454 is amended by inserting ''or whether an organization manager (as defined in section 4958(f)) has 'knowingly' participated in taxable inurement (as defined in section 4958(d)),'' after ''section 4912(b),''.

(6) The table of subchapters for chapter 42 is amended by striking the last item and inserting the following:

"SUBCHAPTER D. Private inurement by tax-exempt health care organizations.
"SUBCHAPTER E. Abatement of first and second tier taxes in certain cases."

1 (d) EFFECTIVE DATES.—

2 (1) IN GENERAL.—Except as provided in para-
3 graph (2), the amendments made by this section
4 shall apply to inurement occurring on or after June
5 30, 1994.

6 (2) APPLICATION OF BINDING CONTRACT RULE
7 TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DE-
8 SCRIBED IN SECTION 501(C)(4).—The amendments
9 made by this section shall not apply to any
10 inurement involving an organization described in
11 section 501(c)(4) of the Internal Revenue Code of
12 1986 occurring before July 1, 1996, pursuant to a
13 written contract which was binding on June 29,
14 1994, and at all times thereafter before such
15 inurement occurred.

16 **SEC. 7303. TREATMENT OF HEALTH MAINTENANCE ORGA-**
17 **NIZATIONS, PARENT ORGANIZATIONS, AND**
18 **HEALTH INSURANCE PURCHASING COOPERA-**
19 **TIVES.**

20 (a) INSURANCE PROVIDED BY HEALTH MAINTE-
21 NANCE ORGANIZATIONS.—

22 (1) IN GENERAL.—Section 501(m) (relating to
23 certain organizations providing commercial-type in-

1 surance not exempt from tax) is amended by adding
2 at the end the following new paragraph:
3 "(6) CERTAIN ACTIVITIES PROVIDED BY
4 HEALTH MAINTENANCE ORGANIZATIONS NOT TREAT-
5 ED AS COMMERCIAL-TYPE INSURANCE.—For pur-
6 poses of this subsection, the provision of (or the ar-
7 ranging for the provision of) medical care on a pre-
8 paid basis by a health maintenance organization
9 shall not be treated as providing commercial-type in-
10 surance if (and only if) such care is—
11 "(A) care provided by such organization to
12 its members at its own facilities through health
13 care professionals who do not provide substan-
14 tial health care services other than on behalf of
15 such organization,
16 "(B) care provided by a health care profes-
17 sional to a member of such organization on a
18 basis under which substantially all of the risks
19 of the rates of utilization is assumed by the
20 provider of such care,
21 "(C) care (other than primary care) pro-
22 vided to a member of such organization pursu-
23 ant to a referral by such organization, or

"(D) emergency care provided to a member of such organization at a location outside such member's area of residence."

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (3) of section 501(m) is amended by striking subparagraph (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

(B) Paragraph (5) of section 501(m) is amended by striking "paragraph (3)(E)" and inserting "paragraph (3)(D)".

(b) TREATMENT OF PARENT ORGANIZATIONS OF HEALTH CARE PROVIDERS.—Section 509(a) (defining private foundation) is amended by striking "and" at the end of paragraph (3), by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

"(4) an organization which is organized and operated for the benefit of, and which directly or indirectly controls, an organization described in section 170(b)(1)(A)(iii), and".

(c) PURCHASING COOPERATIVES EXEMPT FROM TAX.—

(1) IN GENERAL.—Subsection (c) of section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by adding at the end the following new paragraph:

''(26)(A) Any health insurance purchasing cooperative described in section 1013(12) of the Health Security Act.

''(B) Such a cooperative shall not be exempt from tax pursuant to any provision other than this paragraph.

''(C) Such a cooperative shall not be exempt from tax unless—

''(i) no part of the net earnings of such cooperative inures to the benefit of any private shareholder or individual,

''(ii) no substantial part of the activities of such cooperative is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and

''(iii) such cooperative does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.''

(2) CERTAIN PROVISIONS APPLICABLE TO ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3) MADE APPLICABLE TO PURCHASING COOPERATIVES.—Section 501 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

"(o) CERTAIN PROVISIONS MADE APPLICABLE TO HEALTH INSURANCE PURCHASING COOPERATIVES.—A health insurance purchasing cooperative described in subsection (c)(26) shall be treated—

"(1) as described in subsection (c)(3) for purposes of applying subsection (h) (relating to expenditures by public charities to influence legislation), section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and section 4958 (relating to private inurement), and

"(2) as described in subsection (h)(4)."

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 7304. TAX TREATMENT OF TAXABLE ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.

(a) GENERAL RULE.—Section 831 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) TREATMENT OF ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.—

"(1) GENERAL RULE.—Any organization to which this subsection applies shall be taxable under this part in the same manner as if it were an insurance company other than a life insurance company.

"(2) ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any organization—

"(A) which is not exempt from taxation under this subtitle,

"(B) which is not taxable as a life insurance company under part I of this subchapter, and

"(C) the primary and predominant business activity of which during the taxable year consists of 1 or more of the following:

"(i) Issuing accident and health insurance contracts or the reinsuring of risks

1 undertaken by other insurance companies
2 under such contracts.
3 ''(ii) Operating as a health mainte-
4 nance organization.
5 ''(iii) Entering into arrangements
6 under which—
7 ''(I) fixed payments or premiums
8 are received as consideration for the
9 organization's agreement to provide or
10 arrange for the provision of health
11 care services, regardless of how the
12 health care services are provided or
13 arranged to be provided, and
14 ''(II) substantially all of the risks
15 of the rates of utilization of such serv-
16 ices is assumed by such organization
17 or the provider of such services.
18 In the case of an organization which has as a mate-
19 rial business activity the issuing of accident and
20 health insurance contracts or the reinsuring of risks
21 undertaken by other insurance companies under
22 such contracts, the administering of accident and
23 health insurance contracts by such organization shall
24 be treated as part of such business activity for pur-
25 poses of subparagraph (C)(i).''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall apply to taxable years beginning after December 31, 1994.

(2) TRANSITIONAL RULES.—

(A) ORGANIZATIONS TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any organization to which section 831(c) of the Internal Revenue Code of 1986 (as added by subsection (a)) applies for such organization's first taxable year beginning after December 31, 1994; except that this paragraph shall not apply if such organization treated itself as an insurance company taxable under part II of subchapter L of chapter 1 of such Code on its original Federal income tax return for its taxable year beginning in 1992 and for all of its taxable years thereafter beginning before January 1, 1995.

(B) TREATMENT OF CURRENTLY TAXABLE COMPANIES.—Except as provided in regulations prescribed by the Secretary of the Treasury or his delegate, in the case of any organization to which this paragraph applies—

(i) the amendments made by this section shall be treated as a change in the method of accounting, and

(ii) all adjustments required to be taken into account under section 481 of the Internal Revenue Code of 1986 shall be taken into account for such company's first taxable year beginning after December 31, 1994.

(C) TREATMENT OF CURRENTLY TAX-EXEMPT COMPANIES.—Except as provided in regulations prescribed by the Secretary of the Treasury or his delegates, in the case of any organization to which this paragraph applies and which was exempt from tax under chapter 1 of the Internal Revenue Code of 1986 for such organization's last taxable year beginning before January 1, 1995—

(i) no adjustment shall be made under section 481 (or any other provision) of such Code on account of a change in its method of accounting required by this section for its first taxable year beginning after December 31, 1994, and

(ii) for purposes of determining gain or loss, the adjusted basis of any asset held by such organization on the first day of such taxable year shall be treated as equal to its fair market value as of such day.

SEC. 7305. REPEAL OF SECTION 833.

(a) REPEAL OF SECTION 833.—

(1) IN GENERAL.—Section 833 (relating to treatment of Blue Cross and Blue Shield and similar organizations) is hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Section 56(c) is amended by striking paragraph (3).

(B) The table of sections for part II of subchapter L of chapter 1 is amended by striking the item relating to section 833.

(b) APPLICATION OF SECTION 833 PRIOR TO REPEAL.—

(1) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

''(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

"(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

"(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

"(i) is organized and governed by State laws which are specifically and exclusively applicable to not-for-profit insurance or health-service type organizations, and

"(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization."

(2) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1986.

(c) EFFECTIVE DATE OF REPEAL.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by subsection (a) shall apply to taxable years beginning after December 31, 1996.

(2) TRANSITION RULES FOR BLUE CROSS AND BLUE SHIELD AND SIMILAR ORGANIZATIONS.—

(A) PRIOR FRESH START PRESERVED.—The adjusted basis of any asset determined under section 1012(c)(3)(A)(ii) of the Tax Reform Act of 1986 shall not be affected by the amendments made by this section.

(B) RECOUPMENT OF PRIOR RESERVE BENEFIT.—In the case of any organization entitled to the benefits of section 833(a)(3) of the Internal Revenue Code of 1986 (as in effect after the amendment made by subsection (a)) for such organization's last taxable year beginning before January 1, 1997, the amount determined under paragraph (4) of section 832(b) of such Code for each of such organization's first 6 taxable years beginning after December 31, 1996, shall be increased by an amount equal to 3⅓ percent of its unearned premiums on outstanding business as of the close of such organization's last taxable year beginning before January 1, 1997.

SEC. 7306. TAX EXEMPTION FOR HIGH-RISK INSURANCE POOLS.

Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

"(27)(A) In the case of taxable years beginning after December 31, 1989, and before January 1, 1997, a qualified high risk health insurance pool.

"(B) For purposes of subparagraph (A), the term 'qualified high risk health insurance pool' means an entity—

"(i) which was established by a State or political subdivision thereof to provide health insurance on a nonprofit basis to persons unable to obtain health insurance because of health conditions,

"(ii) with respect to which the State or political subdivision—

"(I) participates in the ongoing governance of the entity, and

"(II) subsidizes the operation of the entity, and

"(iii) no part of the net earnings of which inure to the benefit of any private shareholder, member, or individual."

PART 2—TAX TREATMENT OF SECTION 501(c)(3) BONDS

SEC. 748. TAX TREATMENT OF 501(c)(3) BONDS SIMILAR TO GOVERNMENTAL BONDS.

(a) IN GENERAL.—Subsection (a) of section 150 (relating to definitions and special rules) is amended by strik-

ing paragraphs (2) and (4), by redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively, and by inserting after paragraph (1) the following new paragraph:

"(2) EXEMPT PERSON.—

"(A) IN GENERAL.—The term 'exempt person' means—

"(i) a governmental unit, or

"(ii) a 501(c)(3) organization, but only with respect to its activities which do not constitute unrelated trades or businesses as determined by applying section 513(a).

"(B) GOVERNMENTAL UNIT NOT TO INCLUDE FEDERAL GOVERNMENT.—The term 'governmental unit' does not include the United States or any agency or instrumentality thereof.

"(C) 501(c)(3) ORGANIZATION.—The term '501(c)(3) organization' means any organization described in section 501(c)(3) and exempt from tax under section 501(a)."

(b) REPEAL OF QUALIFIED 501(c)(3) BOND DESIGNATION.—Section 145 (relating to qualified 501(c)(3) bonds) is repealed.

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (3) of section 141(b) is amended—

(A) by striking ''government use'' in subparagraph (A)(ii)(I) and subparagraph (B)(ii) and inserting ''exempt person use'',

(B) by striking ''a government use'' in subparagraph (B) and inserting ''an exempt person use'',

(C) by striking ''related business use'' in subparagraph (A)(ii)(II) and subparagraph (B) and inserting ''related private business use'',

(D) by striking ''RELATED BUSINESS USE'' in the heading of subparagraph (B) and inserting ''RELATED PRIVATE BUSINESS USE'', and

(E) by striking ''GOVERNMENT USE'' in the heading thereof and inserting ''EXEMPT PERSON USE''.

(2) Subparagraph (A) of section 141(b)(6) is amended by striking ''a governmental unit'' and inserting ''an exempt person''.

(3) Paragraph (7) of section 141(b) is amended—

(A) by striking ''government use'' and inserting ''exempt person use'', and

(B) by striking ''GOVERNMENT USE'' in the heading thereof and inserting ''EXEMPT PERSON USE''.

(4) Section 141(b) is amended by striking paragraph (9).

(5) Paragraph (1) of section 141(c) is amended by striking ''governmental units'' and inserting ''exempt persons''.

(6) Section 141 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) CERTAIN ISSUES USED TO PROVIDE RESIDENTIAL RENTAL HOUSING FOR FAMILY UNITS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of this title, the term 'private activity bond' includes any bond issued as part of an issue if any portion of the net proceeds of the issue are to be used (directly or indirectly) by an exempt person described in section 150(a)(2)(A)(ii) to provide residential rental property for family units. This paragraph shall not apply if the bond would not be a private activity bond if the section 501(c)(3) organization were not an exempt person.

''(2) EXCEPTION FOR BONDS USED TO PROVIDE QUALIFIED RESIDENTIAL RENTAL PROJECTS.—

Paragraph (1) shall not apply to any bond issued as part of an issue if the portion of such issue which is to be used as described in paragraph (1) is to be used to provide—

"(A) a residential rental property for family units if the first use of such property is pursuant to such issue,

"(B) qualified residential rental projects (as defined in section 142(d)), or

"(C) property which is to be substantially rehabilitated in a rehabilitation beginning within the 2-year period ending 1 year after the date of the acquisition of such property.

"(3) SUBSTANTIAL REHABILITATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), rules similar to the rules of section 47(c)(1)(C) shall apply in determining for purposes of paragraph (2)(C) whether property is substantially rehabilitated.

"(B) EXCEPTION.—For purposes of subparagraph (A), clause (ii) of section 47(c)(1)(C) shall not apply, but the Secretary may extend the 24-month period in section 47(c)(1)(C)(i) where appropriate due to circumstances not within the control of the owner.

"(4) CERTAIN PROPERTY TREATED AS NEW PROPERTY.—Solely for purposes of determining under paragraph (2)(A) whether the 1st use of property is pursuant to tax-exempt financing—

"(A) IN GENERAL.—If—

"(i) the 1st use of property is pursuant to taxable financing,

"(ii) there was a reasonable expectation (at the time such taxable financing was provided) that such financing would be replaced by tax-exempt financing, and

"(iii) the taxable financing is in fact so replaced within a reasonable period after the taxable financing was provided,

then the 1st use of such property shall be treated as being pursuant to the tax-exempt financing.

"(B) SPECIAL RULE WHERE NO OPERATING STATE OR LOCAL PROGRAM FOR TAX-EXEMPT FINANCING.—If, at the time of the 1st use of property, there was no operating State or local program for tax-exempt financing of the property, the 1st use of the property shall be treated as pursuant to the 1st tax-exempt financing of the property.

"(C) DEFINITIONS.—For purposes of this paragraph:

"(i) TAX-EXEMPT FINANCING.—The term 'tax-exempt financing' means financing provided by tax-exempt bonds.

"(ii) TAXABLE FINANCING.—The term 'taxable financing' means financing which is not tax-exempt financing."

(7) Section 141(f), as redesignated by paragraph (6), is amended—

(A) by adding "or" at the end of subparagraph (E),

(B) by striking ", or" at the end of subparagraph (F), and inserting in lieu thereof a period, and

(C) by striking subparagraph (G).

(8) The last sentence of section 144(b)(1) is amended by striking "(determined" and all that follows to the period.

(9) Clause (ii) of section 144(c)(2)(C) is amended by striking "a governmental unit" and inserting "an exempt person".

(10) Section 146(g) is amended—

(A) by striking paragraph (2), and

(B) by redesignating the remaining paragraphs after paragraph (1) as paragraphs (2) and (3), respectively.

(11) The heading of section 146(k)(3) is amended by striking ''GOVERNMENTAL'' and inserting ''EXEMPT PERSON''.

(12) The heading of section 146(m) is amended by striking ''GOVERNMENT'' and inserting ''EXEMPT PERSON''.

(13) Subsection (h) of section 147 is amended to read as follows:

''(h) CERTAIN RULES NOT TO APPLY TO MORTGAGE REVENUE BONDS AND QUALIFIED STUDENT LOAN BONDS.—Subsections (a), (b), (c), and (d) shall not apply to any qualified mortgage bond, qualified veterans' mortgage bond, or qualified student loan bond.''

(14) Section 147 is amended by striking paragraph (4) of subsection (b) and redesignating paragraph (5) of such subsection as paragraph (4).

(15) Subparagraph (F) of section 148(d)(3) is amended—

(A) by striking ''or which is a qualified 501(c)(3) bond'', and

(B) by striking ''GOVERNMENTAL USE BONDS AND QUALIFIED 501(c)(3)'' in the heading thereof and inserting ''EXEMPT PERSON''.

(16) Subclause (II) of section 148(f)(4)(B)(ii) is amended by striking ''(other than a qualified 501(c)(3) bond)''.

(17) Clause (iv) of section 148(f)(4)(C) is amended—

(A) by striking ''a governmental unit or a 501(c)(3) organization'' each place it appears and inserting ''an exempt person'',

(B) by striking ''qualified 501(c)(3) bonds,'', and

(C) by striking the comma after ''private activity bonds'' the first place it appears.

(18) Subparagraph (A) of section 148(f)(7) is amended by striking ''(other than a qualified 501(c)(3) bond)''.

(19) Paragraph (2) of section 149(d) is amended—

(A) by striking ''(other than a qualified 501(c)(3) bond)'', and

(B) by striking ''CERTAIN PRIVATE'' in the heading thereof and inserting ''PRIVATE''.

(20) Section 149(e)(2) is amended—

(A) by striking ''which is not a private activity bond'' in the second sentence and inserting ''which is a bond issued for an exempt person described in section 150(a)(2)(A)(i)'', and

(B) by adding at the end the following new sentence: ''Subparagraph (D) shall not apply to any bond which is not a private activity bond but which would be such a bond if the 501(c)(3) organization using the proceeds thereof were not an exempt person.''

(21) The heading of subsection (b) of section 150 is amended by striking ''TAX-EXEMPT PRIVATE ACTIVITY BONDS'' and inserting ''CERTAIN TAX-EXEMPT BONDS''.

(22) Paragraph (3) of section 150(b) is amended—

(A) by inserting ''owned by a 501(c)(3) organization'' after ''any facility'' in subparagraph (A),

(B) by striking ''any private activity bond which, when issued, purported to be a tax-exempt qualified 501(c)(3) bond'' in subparagraph (A) and inserting ''any bond which, when issued, purported to be a tax-exempt bond, and which would be a private activity bond if the

501(c)(3) organization using the proceeds thereof were not an exempt person'', and

(C) by striking the heading thereof and inserting ''BONDS FOR EXEMPT PERSONS OTHER THAN GOVERNMENTAL UNITS.—''.

(23) Paragraph (5) of section 150(b) is amended—

(A) by striking ''private activity'' in subparagraph (A),

(B) by inserting ''and which would be a private activity bond if the 501(c)(3) organization using the proceeds thereof were not an exempt person'' after ''tax-exempt bond'' in subparagraph (A),

(C) by striking subparagraph (B) and inserting the following new subparagraph:

''(B) such facility is required to be owned by an exempt person, and'', and

(D) by striking ''GOVERNMENTAL UNITS OR 501(C)(3) ORGANIZATIONS'' in the heading thereof and inserting ''EXEMPT PERSONS''.

(24) Section 150 is amended by adding at the end the following new subsection:

''(f) CERTAIN RULES TO APPLY TO BONDS FOR EXEMPT PERSONS OTHER THAN GOVERNMENTAL UNITS.—

"(1) IN GENERAL.—Nothing in section 103(a) or any other provision of law shall be construed to provide an exemption from Federal income tax for interest on any bond which would be a private activity bond if the 501(c)(3) organization using the proceeds thereof were not an exempt person unless such bond satisfies the requirements of subsections (b) and (f) of section 147.

"(2) SPECIAL RULE FOR POOLED FINANCING OF 501(C)(3) ORGANIZATION.—

"(A) IN GENERAL.—At the election of the issuer, a bond described in paragraph (1) shall be treated as meeting the requirements of section 147(b) if such bond meets the requirements of subparagraph (B).

"(B) REQUIREMENTS.—A bond meets the requirements of this subparagraph if—

"(i) 95 percent or more of the net proceeds of the issue of which such bond is a part are to be used to make or finance loans to 2 or more 501(c)(3) organizations or governmental units for acquisition of property to be used by such organizations,

"(ii) each loan described in clause (i) satisfies the requirements of section 147(b)

(determined by treating each loan as a separate issue),

"(iii) before such bond is issued, a demand survey was conducted which shows a demand for financing greater than an amount equal to 120 percent of the lendable proceeds of such issue, and

"(iv) 95 percent or more of the net proceeds of such issue are to be loaned to 501(c)(3) organizations or governmental units within 1 year of issuance and, to the extent there are any unspent proceeds after such 1-year period, bonds issued as part of such issue are to be redeemed as soon as possible thereafter (and in no event later than 18 months after issuance).

A bond shall not meet the requirements of this subparagraph if the maturity date of any bond issued as part of such issue is more than 30 years after the date on which the bond was issued (or, in the case of a refunding or series of refundings, the date on which the original bond was issued)."

(25) Section 1302 of the Tax Reform Act of 1986 is repealed.

(26) Subparagraph (C) of section 57(a)(5) is amended by striking clause (ii) and redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(27) Paragraph (3) of section 103(b) is amended by inserting ''and section 150(f)'' after ''section 149''.

(28) Paragraph (3) of section 265(b) is amended—

(A) by striking clause (ii) of subparagraph (B) and inserting the following:

''(ii) CERTAIN BONDS NOT TREATED AS PRIVATE ACTIVITY BONDS.—For purposes of clause (i)(II), there shall not be treated as a private activity bond any obligation issued to refund (or which is part of a series of obligations issued to refund) an obligation issued before August 8, 1986, which was not an industrial development bond (as defined in section 103(b)(2) as in effect on the day before the date of the enactment of the Tax Reform Act of 1986) or a private loan bond (as defined in section 103(o)(2)(A), as so in effect, but without regard to any exemption from such

definition other than section 103(o)(2)(A)).''; and

(B) by striking ''(other than a qualified 501(c)(3) bond, as defined in section 145)'' in subparagraph (C)(ii)(I).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds (including refunding bonds) issued after December 31, 1994.

Subtitle D—Tax Treatment of Long-Term Care Insurance and Services

SEC. 7401. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in subsection (g)), or''.

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to the deduction for medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

1 "(g) QUALIFIED LONG-TERM CARE SERVICES.—For
2 purposes of this section—
3 "(1) IN GENERAL.—The term 'qualified long-
4 term care services' means necessary diagnostic, cur-
5 ing, mitigating, treating, preventive, therapeutic, and
6 rehabilitative services, and maintenance and per-
7 sonal care services (whether performed in a residen-
8 tial or nonresidential setting) which—
9 "(A) are required by an individual during
10 any period the individual is an incapacitated in-
11 dividual (as defined in paragraph (2)),
12 "(B) have as their primary purpose—
13 "(i) the provision of needed assistance
14 with 1 or more activities of daily living (as
15 defined in paragraph (3)), or
16 "(ii) protection from threats to health
17 and safety due to severe cognitive impair-
18 ment, and
19 "(C) are provided pursuant to a continuing
20 plan of care prescribed by a licensed profes-
21 sional (as defined in paragraph (4)).
22 "(2) INCAPACITATED INDIVIDUAL.—The term
23 'incapacitated individual' means any individual
24 who—

"(A) is unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), at least 2 activities of daily living as defined in paragraph (3), or

"(B) has severe cognitive impairment as defined by the Secretary in consultation with the Secretary of Health and Human Services.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless a licensed professional within the preceding 12-month period has certified that such individual meets such requirements.

"(3) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

"(A) Eating.

"(B) Toileting.

"(C) Transferring.

"(D) Bathing.

"(E) Dressing.

"(4) LICENSED PROFESSIONAL.—The term 'licensed professional' means—

"(A) a physician or registered professional nurse, or

"(B) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

"(5) CERTAIN SERVICES NOT INCLUDED.—The term 'qualified long-term care services' shall not include any services provided to an individual—

"(A) by a relative (directly or through a partnership, corporation, or other entity) unless the relative is a licensed professional with respect to such services, or

"(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a)."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

"(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supple-

1 mentary medical insurance for the aged) cov-
2 ering medical care referred to in—
3 "(i) subparagraphs (A) and (B), or
4 "(ii) subparagraph (C), but only if
5 such insurance is provided under a quali-
6 fied long-term care insurance policy (as de-
7 fined in section 7702B(b)) and the amount
8 paid for such insurance is not disallowed
9 under section 7702B(d)(4)."
10 (2) Paragraph (6) of section 213(d) is amend-
11 ed—
12 (A) by striking "subparagraphs (A) and
13 (B)" and inserting "subparagraph (A), (B),
14 and (C)", and
15 (B) by striking "paragraph (1)(C)" in sub-
16 paragraph (A) and inserting "paragraph
17 (1)(D)".
18 (d) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to taxable years beginning after
20 December 31, 1995.
21 **SEC. 7402. TREATMENT OF LONG-TERM CARE INSURANCE.**
22 (a) GENERAL RULE.—Chapter 79 (relating to defini-
23 tions) is amended by inserting after section 7702A the fol-
24 lowing new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance policy (as defined in subsection (b)) shall be treated as an accident or health insurance contract,

''(2) amounts (other than policyholder dividends (as defined in section 808) or premium refunds) received under a qualified long-term care insurance policy shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a qualified long-term care insurance policy shall be treated as an accident or health plan with respect to such coverage,

''(4) except as provided in subsection (d)(4), amounts paid for a qualified long-term care insurance policy providing the benefits described in subsection (b)(6)(B) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance policy shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

1 "(b) QUALIFIED LONG-TERM CARE INSURANCE POL-
2 ICY.—For purposes of this title:
3 "(1) IN GENERAL.—The term 'qualified long-
4 term care insurance policy' means any certified long-
5 term care policy (as defined in section 1011(4)(A))
6 of the Health Security Act) that—
7 "(A) limits benefits under such policy to
8 individuals who are certified by a licensed pro-
9 fessional (as defined in section 213(g)(4)) with-
10 in the preceding 12-month period—
11 "(i) as being unable to perform, with-
12 out substantial assistance from another in-
13 dividual (including assistance involving
14 cueing or substantial supervision), 2 or
15 more activities of daily living (as defined in
16 section 213(g)(3)), or
17 "(ii) having a severe cognitive impair-
18 ment (as defined in section 213(g)(2)(B)),
19 and
20 "(B) satisfies the requirements of para-
21 graphs (2), (3), (4), (5), and (6).
22 "(2) PREMIUM REQUIREMENTS.—The require-
23 ments of this paragraph are met with respect to a
24 policy if such policy provides that premium pay-
25 ments may not be made earlier than the date such

payments would have been made if the contract provided for level annual payments over the life expectancy of the insured or 20 years, whichever is shorter. A policy shall not be treated as failing to meet the requirements of the preceding sentence solely by reason of a provision in the policy providing for a waiver of premiums if the insured becomes an individual certified in accordance with paragraph (1)(A).

"(3) PROHIBITION OF CASH VALUE.—The requirements of this paragraph are met if the policy does not provide for a cash value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, other than as provided in paragraph (4).

"(4) REFUNDS OF PREMIUMS AND DIVIDENDS.—The requirements of this paragraph are met with respect to a policy if such policy provides that—

"(A) policyholder dividends are required to be applied as a reduction in future premiums or, to the extent permitted under paragraph (6), to increase benefits described in subsection (a)(2),

"(B) refunds of premiums upon a partial surrender or a partial cancellation are required

to be applied as a reduction in future premiums, and

"(C) any refund on the death of the insured, or on a complete surrender or cancellation of the policy, cannot exceed the aggregate premiums paid under the contract.

Any refund on a complete surrender or cancellation of the policy shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

"(5) COORDINATION WITH OTHER ENTITLEMENTS.—The requirements of this paragraph are met with respect to a policy if such policy does not pay, or provide reimbursement for, expenses incurred to the extent that such expenses are also paid or reimbursed under title XVIII of the Social Security Act or are paid or reimbursed under a certified standard health plan (as defined in section 1011(2)(A)) of the Health Security Act).

"(6) MAXIMUM BENEFIT.—

"(A) IN GENERAL.—The requirements of this paragraph are met if the benefits payable under the policy for any period (whether on a periodic basis or otherwise) may not exceed the dollar amount in effect for such period.

"(B) NONREIMBURSEMENT PAYMENTS PERMITTED.—Benefits shall include all payments described in subsection (a)(2) to or on behalf of an insured individual without regard to the expenses incurred during the period to which the payments relate. For purposes of section 213(a), such payments shall be treated as compensation for expenses paid for medical care.

"(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $150 per day (or the equivalent amount within the calendar year in the case of payments on other than a per diem basis).

"(D) ADJUSTMENTS FOR INCREASED COSTS.—

"(i) IN GENERAL.—In the case of any calendar year after 1996, the dollar amount in effect under subparagraph (C) for any period or portion thereof occurring during such calendar year shall be equal to the sum of—

"(I) the amount in effect under subparagraph (C) for the preceding

calendar year (after application of this subparagraph), plus

"(II) the product of the amount referred to in subclause (I) multiplied by the cost-of-living adjustment for the calendar year.

"(ii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (i), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iii) for the preceding calendar year exceeds such index for the second preceding calendar year.

"(iii) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure increases in costs of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

"(iv) SPECIAL RULE FOR CALENDAR YEAR 1997.—Notwithstanding clause (ii), for purposes of clause (i), the cost-of-living

adjustment for calendar year 1997 is the sum of 1.5 percent plus the percentage by which the CPI for calendar year 1996 (as defined in section 1(f)(4)) exceeds the CPI for calendar year 1995 (as so defined).

"(E) PERIOD.—For purposes of this paragraph, a period begins on the date that an individual has a condition which would qualify for certification under subsection (b)(1)(A) and ends on the earlier of the date upon which—

"(i) such individual has not been so certified within the preceding 12-months, or

"(ii) the individual's condition ceases to be such as to qualify for certification under subsection (b)(1)(A).

"(F) AGGREGATION RULE.—For purposes of this paragraph, all policies issued with respect to the same insured shall be treated as one policy.

"(c) TREATMENT OF LONG-TERM CARE INSURANCE POLICIES.—For purposes of this title, any amount received or coverage provided under a long-term care insurance policy that is not a qualified long-term care insurance policy shall not be treated as an amount received for per-

1 sonal injuries or sickness or provided under an accident
2 or health plan and shall not be treated as excludible from
3 gross income under any provision of this title.

4 "(d) TREATMENT OF COVERAGE PROVIDED AS PART
5 OF A LIFE INSURANCE CONTRACT.—Except as otherwise
6 provided in regulations prescribed by the Secretary, in the
7 case of any long-term care insurance coverage (whether
8 or not qualified) provided by rider on a life insurance con-
9 tract—

10 "(1) IN GENERAL.—This section shall apply as
11 if the portion of the contract providing such cov-
12 erage is a separate contract or policy.

13 "(2) PREMIUMS AND CHARGES FOR LONG-TERM
14 CARE COVERAGE.—Premium payments for coverage
15 under a long-term care insurance policy and charges
16 against the life insurance contract's cash surrender
17 value (within the meaning of section 7702(f)(2)(A))
18 for such coverage shall be treated as premiums for
19 purposes of subsection (b)(2).

20 "(3) APPLICATION OF SECTION 7702.—Section
21 7702(c)(2) (relating to the guideline premium limi-
22 tation) shall be applied by increasing the guideline
23 premium limitation with respect to a life insurance
24 contract, as of any date—

"(A) by the sum of any charges (but not premium payments) described in paragraph (2) made to that date under the contract, less

"(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

"(4) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the coverage provided by the rider is a qualified long-term care insurance policy under subsection (b).

"(5) AMOUNT OF DISTRIBUTION UNDER RIDER.—This subsection shall not apply to any rider on a life insurance contract unless the percentage reduction in the cash surrender value of the contract by reason of any payment under the rider does not exceed the percentage reduction in the death benefit payable under the contract by reason of the payment.

For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract

that are in addition to the terms and benefits under the contract without regard to the coverage under a long-term care insurance policy, except that the coverage under a rider described in this subsection shall not fail to be treated as such an addition by reason of a reduction in the contract's death benefit or cash surrender value resulting from any payment under the rider.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing long-term care insurance coverage under a life insurance contract and to provide for the proper allocation of amounts between the long-term care and life insurance portions of a contract.''

(b) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: ''Such term does not include any coverage or benefits under a qualified long-term care policy (as defined in section 7702B).''

(c) RESERVES.—Clause (iii) of section 807(d)(3)(A) is amended by inserting ''(other than a qualified long-term care insurance policy within the meaning of section 7702(B))'' after ''contract''.

1 (d) CLERICAL AMENDMENT.—The table of sections
2 for chapter 79 is amended by inserting after the item re-
3 lating to section 7702A the following new item:

"Sec. 7702B. Treatment of long-term care insurance."

4 (e) EFFECTIVE DATE.—
5 (1) IN GENERAL.—The amendments made by
6 this section shall apply to policies issued after De-
7 cember 31, 1995, except that a policy issued before
8 January 1, 1996, which, on January 1, 1996, satis-
9 fies the requirements of a qualified long-term care
10 insurance policy as set forth in section 7702B(b) of
11 the Internal Revenue Code of 1986 shall be treated
12 as having been issued on January 1, 1996.
13 (2) TRANSITION RULE.—If, after the date of
14 enactment of this Act and before January 1, 1996,
15 a policy providing for long-term care insurance cov-
16 erage is exchanged solely for a qualified long-term
17 care insurance policy (as defined in section
18 7702B(b) of such code), no gain or loss shall be rec-
19 ognized on the exchange, except that gain (if any)
20 shall be recognized to the extent of the sum of the
21 money and the fair market value of the other prop-
22 erty received. For purposes of this paragraph, the
23 cancellation of a policy providing for long-term care
24 insurance coverage and reinvestment of the cancella-
25 tion proceeds in a qualified long-term care insurance

policy within 60 days thereafter shall be treated as an exchange.

(3) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying section 101(f), 7702, or 7702A of such Code to any contract, the issuance of a rider on a life insurance contract providing long-term care insurance coverage shall not be treated as a modification or material change of such contract.

SEC. 7403. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount received under a life insurance contract on the life of an insured who is a terminally ill individual shall be treated as an amount paid by reason of the death of such insured.

''(2) NECESSARY CONDITIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any amount received unless—

"(i) the total amount received is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

"(ii) the percentage reduction in the cash surrender value of the contract by reason of the distribution does not exceed the percentage reduction in the death benefit payable under the contract by reason of such distribution.

"(B) PRESENT VALUE.—The present value of the reduction in the death benefit shall be determined by—

"(i) using a discount rate which is based on an interest rate which does not exceed the highest interest rate set forth in subparagraph (C), and

"(ii) assuming that the death benefit (or the portion thereof) would have been paid on the date which is 12 months after the date of the certification referred to in paragraph (3).

"(C) RATES.—The interest rates set forth in this subparagraph are the following:

"(i) the 90-day Treasury bill yield,

"(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined, and

"(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum.

"(D) SPECIAL RULES RELATING TO LIENS.—If a lien is imposed against a life insurance contract with respect to any amount referred to in paragraph (1)—

"(i) for purposes of subparagraph (A), the amount of such lien shall be treated as a reduction (at the time of receipt) in the death benefit or cash surrender value to the extent that such benefit or value, as the case may be, is (or may become) subject to the lien, and

"(ii) paragraph (1) shall not apply to the amount received unless any rate of in-

terest with respect to any amount in connection with which such lien is imposed does not exceed the highest rate set forth in subparagraph (C).

"(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

"(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured having a financial interest in any trade or business carried on by the taxpayer."

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by this section shall

apply to amounts received after the date of the enactment of this Act.

(2) DELAY IN APPLICATION OF DISCOUNT RULES.—Clause (i) of section 101(g)(2)(A) of the Internal Revenue Code of 1986 shall not apply to any amount received before January 1, 1995.

(3) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying section 101(f), 7702, or 7702A of the Internal Revenue Code of 1986 to any contract, the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)) shall not be treated as a modification or material change of such contract.

SEC. 7404. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

"(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

"(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract which provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(3))."

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995.

Subtitle E—Other Revenue Provisions

PART 1—EMPLOYMENT STATUS PROVISIONS

SEC. 7501. EMPLOYMENT STATUS PROPOSAL REQUIRED FROM DEPARTMENT OF THE TREASURY.

Not later than January 1, 1996, the Secretary of the Treasury shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a legislative proposal providing statutory standards for the classification of workers as employees or independent contractors.

SEC. 7502. INCREASE IN SERVICES REPORTING PENALTIES.

(a) INCREASE IN PENALTY.—Section 6721(a) (relating to imposition of penalty) is amended by adding at the end the following new paragraph:

"(3) INCREASED PENALTY FOR RETURNS INVOLVING PAYMENTS FOR SERVICES.—

"(A) IN GENERAL.—Subject to the overall limitation of paragraph (1), the amount of the penalty under paragraph (1) for any failure with respect to any applicable return shall be equal to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

"(B) EXCEPTION WHERE SUBSTANTIAL COMPLIANCE.—Subparagraph (A) shall not apply to failures with respect to applicable returns required to be filed by a person during any calendar year if the aggregate amount which is timely and correctly reported on applicable returns filed by the person for the calendar year is at least 97 percent of the aggregate amount which is required to be reported on applicable returns by the person for the calendar year.

"(C) APPLICABLE RETURN.—For purposes of this paragraph, the term 'applicable return'

means any information return required to be filed under—

"(i) section 6041(a) but only if such return relates to payments to any person for services performed by such person (other than as an employee), or

"(ii) section 6041A(a)."

(b) CONFORMING AMENDMENT.—Section 6721(a)(1) is amended by striking "In" and inserting "Except as provided in paragraph (3), in".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to returns the due date for which (without regard to extensions) is more than 30 days after the date of the enactment of this Act.

PART 2—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS

SEC. 7511. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 22 the following new section:

"SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

"(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

"(1) the number of months during such taxable year—

"(A) during which the taxpayer is a qualified primary health services provider, and

"(B) which are within the taxpayer's eligible service period, and

"(2) $1,000 ($500 in the case of a qualified practitioner who is not a physician).

"(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who—

"(A) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is providing primary health services,

"(B) is providing primary health services full time in the health professional shortage area identified in such certification, and

"(C) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

"(2) SPECIAL RULES RELATING TO SHORTAGE AREAS.—

"(A) AREAS CEASING TO BE SHORTAGE AREAS.—For purposes of paragraph (1)(B) and subsection (e)(2), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area on the first day of the provider's eligible service period.

"(B) AREAS WITHIN METROPOLITAN AREAS.—A qualified practitioner who is providing services within a metropolitan statistical area (as defined in section 143(k)(2)) shall not be treated as meeting the requirements of paragraph (1)(B) unless such services are provided for, or on behalf of, a governmental or nonprofit entity.

"(3) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physi-

cian assistant, a nurse practitioner, or a certified nurse-midwife.

"(c) ELIGIBLE SERVICE PERIOD.—For purposes of this section, the term 'eligible service period' means the period of 36 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider (as specified in the certification under subsection (b)(1)(A)). A taxpayer shall not have more than 1 eligible service period.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

"(2) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

"(3) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

"(4) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to

1 such term by section 1861(gg)(2) of the Social Secu-
2 rity Act.
3 "(5) PRIMARY HEALTH SERVICES.—The term
4 'primary health services' has the meaning given such
5 term by section 330(b)(1) of the Public Health Serv-
6 ice Act.
7 "(6) HEALTH PROFESSIONAL SHORTAGE
8 AREA.—The term 'health professional shortage area'
9 has the meaning given such term by section
10 332(a)(1)(A) of the Public Health Service Act.
11 "(7) PRACTITIONER CURRENTLY PRACTICING IN
12 SHORTAGE AREAS.—In the case of a qualified practi-
13 tioner who, on December 31, 1994, was providing
14 primary health services in any health professional
15 shortage area—
16 "(A) the practitioner's eligible service pe-
17 riod shall begin on January 1, 1995, and
18 "(B) if such practitioner is a physician,
19 subsection (a)(2) shall be applied by sub-
20 stituting '$500' for '$1,000'.
21 "(e) RECAPTURE OF CREDIT.—
22 "(1) IN GENERAL.—If there is a recapture
23 event during any taxable year, then—

"(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

"(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the aggregate credits allowed to such taxpayer under this section for all prior taxable years.

"(2) RECAPTURE EVENT DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider during any of the first 24 months during the taxpayer's eligible service period.

"(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

"(3) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any cred-

it under subpart A, B, or D of this part or for purposes of section 55.''

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

''Sec. 23. Primary health services providers.''

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

SEC. 7512. EXPENSING OF MEDICAL EQUIPMENT.

(a) IN GENERAL.—Paragraph (1) of section 179(b) (relating to dollar limitation on expensing of certain depreciable business assets) is amended to read as follows:

''(1) DOLLAR LIMITATION.—

''(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $17,500.

''(B) HEALTH CARE PROPERTY.—The aggregate cost which may be taken into account under subsection (a) shall be increased by the lesser of—

''(i) the cost of section 179 property which is health care property placed in service during the taxable year, or

"(ii) $10,000."

(b) DEFINITION.—Section 179(d) (relating to definitions) is amended by adding at the end the following new paragraph:

"(11) HEALTH CARE PROPERTY.—

"(A) IN GENERAL.—For purposes of this section, the term 'health care property' means section 179 property—

"(i) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

"(ii) which is owned (directly or indirectly) and used by 1 or more physicians (as defined in section 1861(r) of the Social Security Act) in the active conduct of the full-time trade or business of all such physicians of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), and

"(iii) substantially all the use of which is in such area.

"(B) SPECIAL RULE FOR METROPOLITAN STATISTICAL AREAS.—A physician who is providing services within a metropolitan statistical area (as defined in section 143(k)(2)) shall not be treated as meeting the requirements of subparagraph (A)(ii) unless such services are provided for, or on behalf of, a governmental or nonprofit entity."

(c) RECAPTURE.—Paragraph (10) of section 179(d) is amended by inserting "and with respect to any health care property which ceases (other than by an area failing to be treated as a health professional shortage area) to be health care property at any time" before the period.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service in taxable years beginning after December 31, 1994.

PART 3—MISCELLANEOUS PROVISIONS

SEC. 7521. POST-RETIREMENT MEDICAL AND LIFE INSURANCE RESERVES.

(a) MINIMUM PERIOD FOR WORKING LIVES.—Section 419A(c)(2) (relating to additional reserves for post-retirement medical and life insurance benefits) is amended

by inserting "(but not less than 10 years)" after "working lives of the covered employees".

(b) SEPARATE ACCOUNTING.—

(1) REQUIREMENT.—Section 419A(c)(2) is amended by adding at the end the following new flush sentence:

"Such reserve shall be maintained as a separate account."

(2) USE OF RESERVE FOR OTHER PURPOSES.—Paragraph (1) of section 4976(b) (defining disqualified benefit) is amended by striking "and" at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ", and", and by adding after subparagraph (C) the following new subparagraph:

"(D) any payment to which subparagraph (C) does not apply which is out of an account described in section 419A(c)(2) and which is not used to provide a post-retirement medical benefit or life insurance benefit."

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions paid or accrued after December 31, 1994, in taxable years ending after such date.

(2) SEPARATE ACCOUNTING.—The amendments made by subsection (b) shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

SEC. 7522. CREDIT FOR COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits), as amended by section 7511, is amended by inserting after section 23 the following new section:

"SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

"(a) ALLOWANCE OF CREDIT.—

"(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each $5,000 by which the modified adjusted gross income (as defined in sec-

tion 59B(d)(2)) of the taxpayer for the taxable year exceeds $45,000. In the case of a married individual filing a separate return, the preceding sentence shall be applied by substituting '$2,500' for '$5,000' and '$22,500' for '$45,000'.

''(b) LIMITATION.—The amount of personal assistance expenses for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of—

''(1) $15,000, or

''(2) such individual's earned income (as defined in section 32(c)(2)) for the taxable year.

In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

''(c) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any substantial gainful activity without personal assistance services appropriate to carry out activities of daily living. An individual shall not be treated as an eligible individual unless such individual

1 furnishes such proof thereof (in such form and manner,
2 and at such times) as the Secretary may require.
3 "(d) OTHER DEFINITIONS.—For purposes of this
4 section—
5 "(1) PERSONAL ASSISTANCE EXPENSES.—The
6 term 'personal assistance expenses' means expenses
7 for—
8 "(A) personal assistance services appro-
9 priate to carry out activities of daily living in or
10 outside the home,
11 "(B) homemaker/chore services incidental
12 to the provision of such personal assistance
13 services,
14 "(C) in the case of an individual with a
15 cognitive impairment, assistance with life skills,
16 "(D) communication services,
17 "(E) work-related support services,
18 "(F) coordination of services described in
19 this paragraph,
20 "(G) assistive technology and devices, in-
21 cluding assessment of the need for particular
22 technology and devices and training of family
23 members, and
24 "(H) modifications to the principal place of
25 abode of the individual to the extent the ex-

1 penses for such modifications would (but for
2 subsection (e)(2)) be expenses for medical care
3 (as defined by section 213) of such individual.
4 "(2) ACTIVITIES OF DAILY LIVING.—The term
5 'activities of daily living' means eating, toileting,
6 transferring, bathing, and dressing.
7 "(e) SPECIAL RULES.—
8 "(1) PAYMENTS TO RELATED PERSONS.—No
9 credit shall be allowed under this section for any
10 amount paid by the taxpayer to any person who is
11 related (within the meaning of section 267 or
12 707(b)) to the taxpayer.
13 "(2) COORDINATION WITH MEDICAL EXPENSE
14 DEDUCTION.—Any amount taken into account in de-
15 termining the credit under this section shall not be
16 taken into account in determining the amount of the
17 deduction under section 213.
18 "(3) BASIS REDUCTION.—For purposes of this
19 subtitle, if a credit is allowed under this section for
20 any expense with respect to any property, the in-
21 crease in the basis of such property which would
22 (but for this paragraph) result from such expense
23 shall be reduced by the amount of the credit so al-
24 lowed.

"(f) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning after 1996, the $45,000 and $22,500 amounts in subsection (a)(2) and the $15,000 amount in subsection (b) shall be increased by an amount equal to—

"(1) such dollar amount, multiplied by

"(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 1995' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $1,000, such increase shall be rounded to the nearest multiple of $1,000."

(b) TECHNICAL AMENDMENT.—Subsection (a) of section 1016 is amended by striking "and" at the end of paragraph (24), by striking the period at the end of paragraph (25) and inserting ", and", and by adding at the end thereof the following new paragraph:

"(26) in the case of any property with respect to which a credit has been allowed under section 24, to the extent provided in section 24(e)(3)."

(c) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1

is amended by inserting after the item relating to section 23 the following new item:

"Sec. 24. Cost of personal assistance services required by employed individuals."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7523. DISCLOSURE OF RETURN INFORMATION FOR ADMINISTRATION OF CERTAIN PROGRAMS UNDER THE HEALTH SECURITY ACT.

(a) IN GENERAL.—Section 6103(l) (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

"(15) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF HEALTH SECURITY ACT.—

"(A) IN GENERAL.—The Secretary shall, upon written request, disclose current return information described in subparagraph (B) to any Federal, State, or local agency administering an assistance program under the Health Security Act.

"(B) INFORMATION.—The information described in this subparagraph is information which consists only of adjusted gross income, the untaxed portion of social security benefits,

tax-exempt interest income, marital status, and dependents.

"(C) RESTRICTION ON DISCLOSURE.—The Secretary shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, determining eligibility for, or the correct amount of, assistance provided under the Health Security Act.

"(D) EXCLUSION FROM MATCHING PROGRAM.—Any matches of information under this paragraph shall not be treated as a matching program for purposes of section 552a of title 5, United States Code."

(b) CONFORMING AMENDMENTS.—

(1) Section 6103(9)(2) is amended by inserting "or (15)" after "subsection (l)(7)(D)".

(2) Section 6103(p)(3)(A) is amended by striking "or (14)" and inserting "(14), or (15)".

(3) Section 6103(p)(4) is amended—

(A) by striking "or (12)" in the matter preceding subparagraph (A) and inserting "(12), or (15)", and

(B) by striking "or (14)" in subparagraph (F)(ii) and inserting "(14), or (15)".

(4) Section 7213(a)(2) is amended by striking "or (12)" and inserting "(12), or (15)".

Subtitle F—Graduate Medical Education and Academic Health Centers Trust Fund

SEC. 7601. ESTABLISHMENT OF GRADUATE MEDICAL EDUCATION AND ACADEMIC HEALTH CENTERS TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 (relating to establishment of trust funds) is amended by adding at the end the following new part:

"PART II—HEALTH CARE TRUST FUNDS

"Sec. 9551. Graduate Medical Education and Academic Health Centers Trust Fund

"SEC. 9551. GRADUATE MEDICAL EDUCATION AND ACADEMIC HEALTH CENTERS TRUST FUND.

"(a) CREATION OF TRUST FUND.—

"(1) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the 'Graduate Medical Education and Academic Health Centers Trust Fund', consisting of such amounts as may be appropriated or credited to the Academic Health Centers Trust Fund as provided in this section or section 9602(b).

"(2) ACCOUNTS IN THE TRUST FUND.—The Graduate Medical Education and Academic Health

1 Centers Trust Fund shall consist of the following 2
2 accounts:
3 "(A) The Graduate Medical Education Ac-
4 count.
5 "(B) The Academic Health Centers Ac-
6 count.
7 Each such account shall consist of such amounts as
8 are allocated to it under this section.
9 "(b) TRANSFERS TO THE TRUST FUND.—
10 "(1) TAXES.—There are hereby appropriated to
11 the Graduate Medical Education and Academic
12 Health Centers Trust Fund amounts received in the
13 Treasury under sections 4501 and 4502 (relating to
14 assessments on insured and self-insured health
15 plans) to the extent attributable to the rates of such
16 taxes not in excess of 1.5 percent.
17 "(2) TRANSFERS FROM OTHER TRUST
18 FUNDS.—The Secretary of Health and Human Serv-
19 ices shall transfer each fiscal year to the Graduate
20 Medical Education and Academic Health Centers
21 Trust Fund from the Federal Hospital Insurance
22 Trust Fund and the Federal Supplementary Medical
23 Insurance Trust Fund established under the Social
24 Security Act the sum of—

"(A) the amount that would have been paid from the Federal Hospital Insurance Trust Fund in such fiscal year under section 1886(d)(5)(B) of such Act (as in effect before the date of the enactment of the Health Security Act), plus

"(B) the amount that would have been paid from such trust funds in such fiscal year under section 1886(h) of such Act (as so in effect).

"(c) GRADUATE MEDICAL EDUCATION ACCOUNT.—

"(1) TRANSFERS.—There is allocated to the Graduate Medical Education Account each fiscal year an amount equal to the sum of—

"(A) amounts described in subsection (b)(2)(B), plus

"(B) the excess of—

"(i) the amounts made available under section 3033 of the Health Security Act, over

"(ii) the amount described in subparagraph (A).

"(2) EXPENDITURES.—Amounts in the Graduate Medical Education Account are appropriated to make the payments described in sections 3031 and

3055 of the Health Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

"(d) ACADEMIC HEALTH CENTERS ACCOUNT.—

"(1) TRANSFERS.—There is allocated to the Academic Health Centers Account each fiscal year an amount equal to the sum of—

"(A) amounts described in subsection (b)(2)(A), plus

"(B) the excess of—

"(i) the amounts made available under section 3053 of the Health Security Act, over

"(ii) the amount described in subparagraph (A).

"(2) EXPENDITURES.—Amounts in the Academic Health Centers Account are appropriated to make the payments described in section 3051 of the Health Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

"(e) RULES RELATING TO ACCOUNTS.—

1 "(1) INSUFFICIENT FUNDS.—If, for any fiscal
2 year, the sum of the amounts required to be allo-
3 cated under subsections (c) and (d) exceeds the
4 amounts received in the Graduate Medical Edu-
5 cation and Academic Health Centers Trust Fund,
6 then each of such amounts required to be so allo-
7 cated shall be reduced to an amount which bears the
8 same ratio to such amount as the amounts received
9 in the trust fund bear to the amounts required to be
10 so allocated (without regard to this paragraph).
11 "(2) ALLOCATION OF EXCESS FUNDS AND IN-
12 TEREST.—Amounts received in the Graduate Med-
13 ical Education and Academic Health Centers Trust
14 Fund in excess of the amounts required to be allo-
15 cated under subsections (c) and (d), and amounts
16 credited to such trust fund under section 9602(b),
17 for any fiscal year shall be allocated to each account
18 ratably on the basis of the amounts allocated to the
19 account for the fiscal year (without regard to this
20 paragraph).".
21 (b) CONFORMING AMENDMENT.—Subchapter A of
22 chapter 98 is amended by inserting after the subchapter
23 heading the following new items:

"Part I. General trust funds.
"Part II. Health care trust funds.

"PART I—GENERAL TRUST FUNDS".

TITLE VIII—OTHER FEDERAL PROGRAMS

Subtitle A—Indian Health Service

SEC. 8101. PURPOSES.

The purposes of this subtitle are as follows:

(1) To ensure the delivery of health care services to American Indians and Alaska Natives in a culturally appropriate manner in fulfillment of the unique trust responsibility of the Federal Government and legal obligation to American Indian and Alaska Native people—

(A) derived from the province of international law; and

(B) founded in the treaties, Constitution, statutes, and court decisions of the United States.

(2) To provide sufficient funding for the provision of the standard benefit package as it applies to all eligible beneficiaries under this subtitle.

(3) To ensure that funding levels for services and benefits that are not part of the standard benefits package described in this subtitle are not diluted or diminished.

(4) To raise the health status of American Indians and Alaska Natives to the highest possible level.

(5) To raise the quality of health care delivery to American Indians and Alaska Natives to the highest possible level.

(6) To ensure that health care services provided to American Indians and Alaska Natives are provided in a manner consistent with, and carries out, the recognized Indian self-determination and tribal self-governance policy of the United States.

SEC. 8102. DEFINITIONS.

For the purposes of this subtitle—

(1) the term ''American Indian'' has the meaning provided the term ''Indian'' under paragraph (6);

(2) the term ''Alaska Native'' has the meaning provided the term ''Native'' under section 3(b) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b));

(3) the term ''health program of the Indian Health Service'' means a program which provides or is responsible for obtaining health services under this Act or any other applicable law through programs operated by the Indian Health Service, Indian tribes, or tribal organizations, including Indian tribes or tribal organizations operating under the au-

thority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

(4) the term ''reservation'' means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.);

(5) the term ''urban Indian program'' means any program operated pursuant to title V of the Indian Health Care Improvement Act; and

(6) the terms ''Indian'', ''Indian tribe'', ''tribal organization'', ''urban Indian'', ''urban Indian organization'', and ''service unit'' have the same meaning as given such terms under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

SEC. 8103. ELIGIBILITY AND HEALTH SERVICE COVERAGE OF INDIANS.

(a) COVERAGE.—The programs of the Indian Health Service shall remain as the principal provider of health care for Indians, except that nothing in this subtitle shall limit the ability of Indians to seek care from providers outside the programs of the Indian Health Service.

(b) ELIGIBILITY.—An Indian is eligible for services under a program of the Indian Health Service if the individual is—

(1) eligible to receive services pursuant to sections 36.1 through 36.14 of title 42, Code of Federal Regulations (as in effect on the day before the date of enactment of this Act);

(2) an urban Indian residing in an area served by an urban Indian program; or

(3) an Indian described in section 809(b) of the Indian Health Care Improvement Act (25 U.S.C. 1679(b)).

(c) LIMITATION ON CHARGES.—An eligible Indian (as defined in subsection (b)) receiving services from or being referred by a health program of the Indian Health Service shall not be subject to any charge for deductibles, copayments, coinsurance, or any other cost for health services provided under such program.

SEC. 8104. SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.

(a) IN GENERAL.—All individuals described in section 8103(b) shall remain eligible for such benefits under the laws administered by the Indian Health Service as supplement the standard benefit package. The individual

shall not be subject to any charge or any other cost for such benefits.

(b) MAINTENANCE OF EFFORT.—The Secretary shall ensure that the requirements of this subtitle do not result in a reduction of the level of supplemental benefits provided by or through the Indian Health Service.

SEC. 8105. PROVISION OF HEALTH SERVICES TO NON-INDIANS.

(a) CONTRACTS WITH HEALTH PLANS.—A health program of the Indian Health Service may enter into a contract with a health plan for the provision of health care services to individuals enrolled in such health plan if—

(1) the appropriate official of the program determines that the provision of such health services will not result in a denial or diminishment of health services to any individual described in section 8103(b); and

(2) each tribe or urban Indian organization served by the program authorizes or has authorized the provision of services to such individuals.

(b) FAMILY TREATMENT.—A health program of the Indian Health Service may provide health care services to insured non-Indian family members of individuals described in section 8103(b) under the same restrictions as those described in subsection (a).

(c) APPLICABLE INDIVIDUAL CHARGES.—Non-Indians receiving services in a program under subsection (b) shall be subject to any applicable deductibles, copayments, coinsurance, or any other cost for health services provided.

SEC. 8106. ESSENTIAL COMMUNITY PROVIDERS.

A health program of the Indian Health Service automatically certified as an essential community provider under section 1462 may elect to accept certification—

(1) only for eligible individuals described in section 8103(b);

(2) for non-Indian individuals if each tribe or tribal organization served by the program authorizes or has authorized serving non-Indians; or

(3) for eligible individuals described in section 8103(b) and family members of such individuals described in section 8505(b) who are enrolled in a plan other than a health program of the Indian Health Service, if each tribe or urban Indian organization served by the program authorizes or has authorized serving such family members.

SEC. 8107. PAYMENT BY OTHER PROVIDERS.

(a) PAYMENT FOR SERVICES PROVIDED BY INDIAN HEALTH SERVICE PROGRAMS.—Nothing in this subtitle shall be construed as amending section 206, 401, or 402 of the Indian Health Care Improvement Act (25 U.S.C.

1621e, 1641, or 1642) or any other provision of law relating to payments on behalf of Indians for health services from other Federal programs or from other third party payers.

(b) PAYMENT FOR SERVICES PROVIDED BY CONTRACTORS.—Nothing in this subtitle shall be construed as affecting any other provision of law, regulation, or judicial or administrative interpretation of law or policy concerning the status of the Indian Health Service as the payer of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

(c) PAYMENT FOR SERVICES BY MEDICARE.—Programs of the Indian Health Service shall be eligible for payments for services provided to Medicare beneficiaries.

(d) RETENTION OF RECEIPTS.—Notwithstanding any other provision of law, the collections made by a health program of the Indian Health Service shall remain with the health program if the receipts are used to—

(1) expand or improve its services;

(2) increase the number of persons it is able to serve;

(3) construct, expand or modernize its health care facilities;

(4) improve the administration of its health service programs; or

(5) develop or improve linkages with other health care providers.

(e) COLLECTION.—Each health program of the Indian Health Service shall make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are covered by public or private health insurance programs.

SEC. 8108. CONTRACTING AUTHORITY.

Section 601(d)(1)(B) of the Indian Health Care Improvement Act (25 U.S.C. 1661(d)(1)(B)) is amended by inserting ''(including personal services for the provision of direct health care services)'' after ''goods and services''.

SEC. 8109. CONSULTATION.

(a) OMB AND SECRETARY.—The Director of the Office of Management and Budget and the Secretary shall consult, on an annual basis, with representatives of Indian tribes, tribal organizations, and urban Indian organizations concerning health care reform initiatives that affect Indian communities, and policy, funding, and administration of health programs of the Indian Health Service. The Secretary shall solicit and consider the views and recommendations provided by Indian tribes, tribal organizations, and representatives of urban Indian organizations

in making determinations that affect Indians and Indian tribes and shall resolve any differences in favor of Indians and Indian tribes.

(b) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group to assess all aspects of the development and administration of the budget for programs of the Indian Health Service and advise the Office of Management and Budget, the Secretary and Congress with respect to such aspects.

(2) COMPOSITION.—The advisory group shall be comprised of—

(A) not less than one representative from each area of the Indian Health Service to be appointed by the Secretary from nominees of tribes and tribal organizations in the respective areas;

(B) not less than one urban Indian representative from each area the Indian Health Service with an urban Indian (as defined in section 4(f) of the Indian Health Care Improvement Act (25 U.S.C. 1603(f)) program to be appointed by the Secretary; and

(C) such other appointees as the Secretary determines appropriate, on the condition that a

majority of the members are selected from nominations submitted to the Secretary by a tribe or tribal organization.

SEC. 8110. TRANSITIONAL STUDIES.

(a) IN GENERAL.—The Secretary shall conduct planning, feasibility, or similar health services studies related to the transition of the health programs of the Indian Health Service under health care reform. Such studies shall take into account the measurements and the means to accomplish the Healthy People 2000 objectives as required under sections 3 and 214 of the Indian Health Care Improvement Act. Such studies shall include an assessment of—

(1) the feasibility of developing an Indian health plan or plans;

(2) the financing necessary to provide the same level of standard benefits to American Indians and Alaska Natives as will be available to all other Americans;

(3) the staffing, program and infrastructure enhancements required to deliver the standard benefits package;

(4) the facility and capital construction needs necessary to provide the standard benefit package; and

(5) the administrative improvements necessary to network, share and access patient data, quality management and improvement data, and financial information.

(b) ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group to provide the Secretary with advise concerning the focus, content and conduct of studies under subsection (a).

(2) COMPOSITION.—The advisory group shall be comprised of—

(A) not less than one representative from each area of the Indian Health Service to be appointed by the Secretary from among nominees of tribes and tribal organizations in the respective areas;

(B) not less than one urban Indian representative from each area of the Indian Health Service which an urban Indian (as defined in section 4(f) of the Indian Health Care Improvement Act (25 U.S.C. 1603(f)) program to appointed by the Secretary; and

(C) other appointees as the Secretary determines appropriate, except that the Secretary shall ensure that a majority of the members so

appointed are selected from nominations submitted to the Secretary by tribes or tribal organizations.

(c) RECOMMENDATIONS.—Not later than June 30, 1997, the Secretary shall submit to Congress recommendations based on the studies conducted under this section, including recommendations for changes in the structure of Indian Health Services. A time-table for implementing health care reform activities shall be included in such final recommendations.

SEC. 8111. LOANS AND LOAN GUARANTEES.

The Secretary may make loans, and guarantee the payment of principal and interest, to Federal and non-Federal lenders on behalf of health programs of the Indian Health Service for the purpose of improving and expanding such facilities. Loans and loan guarantees under this section shall be provided under such terms and conditions as the Secretary may prescribe.

SEC. 8112. SIMPLIFICATION OF BILLING.

The Secretary shall take such action as may be necessary to ensure that health programs of the Indian Health Service may submit all claims for benefits or payment for services entitled to reimbursement in a manner consistent with that of all other health care providers.

SEC. 8113. LONG-TERM CARE DEMONSTRATIONS.

Subject to the availability of appropriations under subtitle B of title II (for home and community-based long-term care services), the Secretary shall establish a demonstration program to provide five grants to health programs of the Indian Health Service to enable such Programs to plan and implement innovative methods of providing enhanced home and community-based long-term care services.

SEC. 8114. TECHNICAL ASSISTANCE.

Indian tribes shall be eligible for funds made available under this Act for technical assistance or transitional support.

SEC. 8115. PUBLIC HEALTH PROGRAMS.

Health programs of the Indian Health Service shall be eligible to apply for funding under public health programs authorized under title III of this Act (including those under section 3695(b)(14)), as deemed appropriate by the Secretary.

SEC. 8116. SURVEY OF HEALTH SERVICES AVAILABLE TO INDIAN VETERANS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Veterans Affairs, Indian tribes and tribal organizations, shall conduct a survey to assess the availability and accessibility of health care services for Indian veterans residing on Indian reservations.

(b) REPORT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall submit a report to Congress that shall include recommendations concerning the survey conducted under subsection (a).

SEC. 8117. RULE OF CONSTRUCTION.

Unless otherwise provided in this Act, no part of this Act shall be construed to rescind or otherwise modify any obligations, findings, or purposes contained in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) and in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq).

SEC. 8118. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—

(1) IN GENERAL.—For the purpose of carrying out this subtitle, including transitional costs and the purchase of additional contract health care services for individual eligible Indians, there are authorized to be appropriated $515,000,000 for fiscal year 1995, $930,000,000 for fiscal year 1996, and $1,150,000,000 for each of the fiscal years 1997 through 2004.

(2) SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.—In addition to amounts otherwise authorized to be appropriated (including the amounts authorized to be appropriated under paragraph (1)),

for the purpose of carrying out section 8104, there are authorized to be appropriated $360,000,000 for fiscal year 1995, $400,000,000 for each of the fiscal years 1996 through 1999, and such sums as may be necessary for fiscal year 2000 and each fiscal year thereafter.

(3) LOANS AND LOAN GUARANTEES.—In addition to amounts otherwise authorized to be appropriated (including the amounts authorized to be appropriated under paragraph (1)), for the purpose of carrying out section 8111, there are authorized to be appropriated $500,000,000 for the principal of the loan. The authority of the Secretary to make loans and to guarantee loans under such section shall be subject to such amounts as may be provided for in each fiscal year in advance in an appropriations Act.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established under this subtitle are in addition to any other authorizations of appropriations that are available for the purposes of carrying out this subtitle.

SEC. 8119. FUNDING METHODOLOGY.

The Secretary shall establish new methodologies, consistent with the Indian Health Care Improvement Act, for the distribution to Indian tribes of all new funds that be-

come available for health care initiatives under this subtitle. New distribution methodologies should consider differences in local resources, status of health (as declared under section 3 of such Act), socioeconomic status of tribal people, and facilities, equipment and staff available in concert with the establishment of Indian epidemiological centers under such Act.

Subtitle B—Department of Veterans Affairs

SEC. 8101. SHORT TITLE.

This Act may be cited as the ''Veterans Health Care Reform Act of 1994''.

SEC. 8102. BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DEPARTMENT OF VETERANS AFFAIRS AS A PARTICIPANT IN HEALTH CARE REFORM.—

(1) IN GENERAL.—Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter:

''CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER HEALTH SECURITY ACT

''SUBCHAPTER I—GENERAL

''1801. Definitions.

''SUBCHAPTER II—ENROLLMENT

''1811. Enrollment: veterans.
''1812. Enrollment: CHAMPVA eligibles.

"1813. Enrollment: family members.

"SUBCHAPTER III—BENEFITS

"1821. Benefits for VA enrollees.
"1822. Chapter 17 benefits.
"1823. Supplemental health benefits plans.
"1824. Limitation regarding veterans enrolled with health plans outside Department.

"SUBCHAPTER IV—FINANCIAL MATTERS

"1831. Premiums, copayments, and other charges.
"1832. Medicare coverage and reimbursement.
"1833. Recovery of cost of certain care and services.
"1834. Health Plan Fund.

"SUBCHAPTER I—GENERAL

"§ 1801. Definitions

"For purposes of this chapter:

"(1) The term 'health plan' means an entity that has been certified under the Health Security Act as a health plan.

"(2) The term 'VA health plan' means a health plan that is operated by the Secretary under section 7341 of this title.

"(3) The term 'VA enrollee' means an individual enrolled under the Health Security Act in a VA health plan.

"(4) The term 'standard benefit package' means the package of benefits required to be provided by a health plan under the Health Security Act.

1 "SUBCHAPTER II—ENROLLMENT

2 **"§ 1811. Enrollment: veterans**

3 "Each veteran may enroll with a VA health plan. A
4 veteran who wants to receive the standard benefit package
5 through the Department shall enroll with a VA health
6 plan.

7 **"§ 1812. Enrollment: CHAMPVA eligibles**

8 "An individual who is eligible for benefits under sec-
9 tion 1713 of this title may enroll with a VA health plan
10 in the same manner as a veteran.

11 **"§ 1813. Enrollment: family members**

12 "(a) The Secretary may authorize a VA health plan
13 to enroll members of the family of an enrollee under sec-
14 tion 1811 or 1812 of this title, subject to payment of pre-
15 miums, deductibles, copayments, and coinsurance as re-
16 quired under the Health Security Act.

17 "(b) For purposes of subsection (a), an enrollee's
18 family is those individuals (other than the enrollee) in-
19 cluded within the term 'family' as defined in section
20 1113(b) of the Health Security Act.

21 "SUBCHAPTER III—BENEFITS

22 **"§ 1821. Benefits for VA enrollees**

23 "The Secretary shall ensure that each VA health plan
24 provides to each individual enrolled with it the items and
25 services in the standard benefit package under the Health

1 Security Act, to the extent that such items and services
2 can be provided consistent with appropriations for that
3 purpose. In the event that appropriations are insufficient
4 the Secretary may revise the standard benefit package
5 available to enrolled individuals.

6 **"§ 1822. Chapter 17 benefits**

7 ''The Secretary shall provide to a veteran the care
8 and services not included in the standard benefit package
9 that are authorized to be provided under chapter 17 of
10 this title in accordance with the terms and conditions ap-
11 plicable to that veteran and that care under such chapter,
12 to the extent that such items and services can be provided
13 consistent with appropriations for that purpose. In the
14 event that appropriations are insufficient the Secretary
15 may revise the standard benefit package available to en-
16 rolled individuals.

17 **"§ 1823. Supplemental health benefits plans**

18 ''(a) As part of a VA health plan, the Secretary may
19 offer to veterans—

20 ''(1) supplemental health benefits plans (as that
21 term is defined in section 1011(3)(B) of the Health
22 Security Act) for the care and services described in
23 subsection (b); and

"(2) cost-sharing plans consistent with the requirements of part 4 of subtitle B of title I of the Health Security Act.

"(b) The care and services referred to in subsection (a) are care and services that—

"(1) are not available under the standard benefit package; and

"(2) can be provided by the Secretary at reasonable cost.

"§ 1824. Limitation regarding veterans enrolled with health plans outside Department

"A veteran who is residing in a community-rated area in which the Department operates a health plan and who is enrolled in a health plan that is not operated by the Department may be provided the items and services in the standard benefit package by a VA health plan only if the plan is reimbursed for the care provided.

"SUBCHAPTER IV—FINANCIAL MATTERS

"§ 1831. Premiums, copayments, and other charges

"(a) Except as provided in paragraph (2), the Secretary may not impose on or collect from a veteran described in subsection (b) who is a VA enrollee a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) for items

1 and services in the standard benefit package that a VA
2 health plan provides.
3 "(b) The veterans referred to in subsection (a) are
4 the following:
5 "(1) Any veteran with a compensable service-
6 connected disability.
7 "(2) Any veteran whose discharge or release
8 from the active military, naval or air service was for
9 a disability incurred or aggravated in the line of
10 duty.
11 "(3) Any veteran who is in receipt of, or who,
12 but for a suspension pursuant to section 1151 of
13 this title (or both such a suspension and the receipt
14 of retired pay), would be entitled to disability com-
15 pensation, but only to the extent that such a vet-
16 eran's continuing eligibility for such care is provided
17 for in the judgment or settlement provided for in
18 such section.
19 "(4) Any veteran who is a former prisoner of
20 war.
21 "(5) Any veteran of the Mexican border period
22 or World War I.
23 "(6) Any veteran who is unable to defray the
24 expenses of necessary care as determined under sec-
25 tion 1722(a) of this title.

1 "(7) Any veteran referred to in subparagraph
2 (A), (B), or (C) of section 1710(e) of this title.
3 "(c)(1) Except as provided in paragraph (2), in the
4 case of a VA enrollee who is not described in subsection
5 (b), the Secretary shall charge premiums and establish co-
6 payments, deductibles, and coinsurance amounts for care
7 and services provided under this chapter. The premium
8 rate, and the rates for deductibles and copayments, for
9 each VA health plan shall be established by that health
10 plan based on rules established under the Health Security
11 Act.
12 "(2) The Secretary may not charge a veteran referred
13 to in paragraph (1) a premium for any care or service
14 that the Secretary provides the veteran under a supple-
15 mental health benefits plan offered under section 1823 of
16 this title if the Secretary is required to provide such care
17 or service under chapter 17 of this title.
18 **"§ 1832. Medicare coverage and reimbursement**
19 "(a) For purposes of any program administered by
20 the Secretary of Health and Human Services under title
21 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.),
22 a Department facility shall be deemed to be a Medicare
23 provider.
24 "(b)(1) A VA health plan shall be considered to be
25 a Medicare HMO.

1 ''(2) For purposes of this section, the term 'Medicare
2 HMO' means an eligible organization under section 1876
3 of the Social Security Act.

4 ''(c) In the case of care provided under this chapter
5 to a veteran (other than a veteran described in section
6 1831(b) of this title), or to a family member of a veteran,
7 who is eligible for benefits under the Medicare program
8 under title XVIII of the Social Security Act, the Secretary
9 of Health and Human Services shall reimburse a VA
10 health plan or Department health-care facility providing
11 services as a Medicare provider or Medicare HMO in the
12 same amounts and under the same terms and conditions
13 as that Secretary reimburses other Medicare providers or
14 Medicare HMOs, respectively. The Secretary of Health
15 and Human Services shall include with each such reim-
16 bursement a Medicare explanation of benefits.

17 ''(d) When the Secretary provides care to a veteran,
18 or a family member of a veteran, for which the Secretary
19 receives reimbursement under this section, the Secretary
20 shall require the veteran to pay to the Department any
21 applicable deductible or copayment that is not covered by
22 Medicare.

23 **"§ 1833. Recovery of cost of certain care and services**

24 ''(a) In the case of an individual provided care or
25 services through a VA health plan who has coverage under

a supplemental health benefits plan pursuant to part 4 of subtitle B of title I of the Health Security Act, a Medicare supplemental health insurance plan, or any other provision of law, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

''(b) In the case of a veteran referred to in section 1831(b) of this title who is enrolled in a health plan other than a VA health plan and who is provided care or services for a service-connected disability by a VA health plan, the Secretary has the right to recover or collect charges for such care and services from the party operating the health plan to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

''(c) The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims

by the United States under subsection (a) or (b) in the same manner as they apply to claims under subsection (a) of that section.

"§ 1834. Health Plan Fund

''(a) There is hereby established in the Treasury a revolving fund to be known as the 'Department of Veterans Affairs Health Plan Fund'.

''(b)(1) Subject to paragraphs (2) and (3), amounts collected or recovered by the Department under this subchapter by reason of the furnishing of care and services to an individual by a VA health plan or the enrollment of an individual with a VA health plan (including amounts received as premiums, premium discount payments, copayments or coinsurance, and deductibles, amounts received as third-party reimbursements or reimbursements from Medicare, and amounts received as reimbursements from another health plan for care furnished to one of its enrollees) shall be credited to the revolving fund.

''(2) Premiums collected by the Department under this subchapter during fiscal year 1996 or 1997 by reason of the furnishing of care and services under a VA health plan to a veteran referred to in section 1831(b) of this title shall be credited to the revolving fund established under subsection (a) only if the amount of funds appropriated to the Veterans Health Care Investment Fund es-

1 tablished under subsection (a)(1) of section 7346 of this
2 title for the fiscal year concerned is less than the amount
3 specified to be credited to that fund for that fiscal year
4 under subsection (c) of such section 7346.

5 "(3) Premiums received by the Department under
6 this subchapter in any fiscal year after fiscal year 1997
7 by reason of the furnishing of care and services under a
8 VA health plan to a veteran referred to in paragraph (2)
9 shall be credited to the revolving fund established under
10 subsection (a) only if the cost of providing such care and
11 services is not covered by appropriations. The amount so
12 credited shall be the amount of such premiums received
13 that is necessary to cover the difference between the cost
14 of such care and services and such appropriations.

15 "(c) The Secretary shall establish in the revolving
16 fund a separate account for each VA health plan. The Sec-
17 retary shall credit any amount received under subsection
18 (b) by reason of the furnishing of care and services in or
19 through a VA health plan or the enrollment of an indi-
20 vidual with a VA health plan.

21 "(d) Amounts credited to the account of the revolving
22 fund for a VA health plan under subsection (b) are hereby
23 made available to the VA health plan for the expenses of
24 the delivery by the VA health plan of the items and serv-

ices in the standard benefit package and any supplemental health benefits plan offered by the VA health plan.''.

(2) The table of chapters at the beginning of title 38, United States Code, and at the beginning of part II of such title, is amended by inserting after the item relating to chapter 17 the following new item:

''18. Benefits and Eligibility Under Health Security Act ..... 1801.''.

(b) PRESERVATION OF EXISTING BENEFITS FOR FACILITIES NOT OPERATING AS HEALTH PLANS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

''§ 1705. Facilities not operating within health plans

''The provisions of this chapter shall apply with respect to the furnishing of care and services by any facility of the Department when it is not operating as or within a health plan certified as a health plan under the Health Security Act.''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

''1705. Facilities not operating within health plans.''.

SEC. 8103. ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS HEALTH PLANS.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter IV:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"§ 7341. Organization of health care facilities as health plans

"(a)(1) The Secretary may, subject to the availability of appropriations, organize health plans and operate Department facilities as or within health plans under the Health Security Act.

"(2)(A) The Secretary may prescribe regulations establishing standards for the operation of Department health care facilities as or within health plans under that Act. In prescribing such standards, the Secretary shall ensure that they conform, to the extent possible under the requirements of section 1821, to the requirements for health plans generally set forth in part 1 of subtitle B of title I of the Health Security Act.

"(B) Not later than 30 days after prescribing such standards, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report describing the differences, if any, be-

1 tween such standards and the requirements for health
2 plans generally referred to in subparagraph (A).
3 ''(b) Health care facilities of the Department located
4 within an area or region may be organized to operate as
5 a single health plan encompassing all Department facili-
6 ties within that area or region or may be organized to op-
7 erate as several health plans.
8 ''(c) In carrying out responsibilities under the Health
9 Security Act, a State (or a State-established entity)—
10 ''(1) may not impose any standard or require-
11 ment on a VA health plan that is inconsistent with
12 this chapter or any regulation prescribed under this
13 chapter or other Federal laws regarding the oper-
14 ation of this chapter; and
15 ''(2) may not deny certification of a VA health
16 plan under the Health Security Act on the basis of
17 a conflict between a rule of a State and this chapter
18 or regulations prescribed under this chapter or other
19 Federal laws regarding the operation of this chapter.
20 **''§ 7342. Contract authority for facilities operating as**
21 **or within health plans**
22 ''(a) The Secretary shall designate a health plan di-
23 rector for each VA health plan organized and operated
24 under this subchapter.

"(b) The health plan director of a VA health plan may enter into contracts and agreements for the provision of care and services to be provided under the VA health plan and contracts and agreements for other services (including procurement of equipment, maintenance and repair services, and other services related to the provision of health care services) consistent with section 1821 of this title.

"(c) Contracts and agreements (including leases) under subsection (a) shall not be subject to the following provisions of law:

"(1) Section 8110(c) of this title, relating to the contracting of services at Department health-care facilities.

"(2) Section 8122(a)(1) of this title, relating to the lease of Department property.

"(3) Section 8125 of this title, relating to local contracts for the procurement of health-care items.

"(4) Section 702 of title 5, relating to the right of review of agency wrongs by courts of the United States.

"(5) Sections 1346(a)(2) and 1491 of title 28, relating to the jurisdiction of the district courts of the United States and the United States Court of

Federal Claims, respectively, for the actions enumerated in such sections.

"(6) Subchapter V of chapter 35 of title 31, relating to adjudication of protests of violations of procurement statutes and regulations.

"(7) Sections 3526 and 3702 of such title, relating to the settlement of accounts and claims, respectively, of the United States.

"(8) Subsections (b)(7), (e), (f), (g), and (h) of section 8 of the Small Business Act (15 U.S.C. 637(b)(7), (e), (f), (g), and (h)), relating to requirements with respect to small businesses for contracts for property and services.

"(9) The provisions of law assembled for purposes of codification of the United States Code as section 471 through 544 of title 40 that relate to the authority of the Administrator of General Services over the lease and disposal of Federal Government property.

"(10) The provisions of the Office of Federal Procurement Policy Act (41 U.S.C. 401 et seq.), relating to the procurement of property and services by the Federal Government.

"(11) Chapter 3 of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 251

et seq.), relating to the procurement of property and services by the Federal Government.

"(12) Office of Management and Budget Circular A–76.

"(c)(1) Contracts and agreements for the provision of care and services under subsection (a) may include any contract or other agreement that the health plan director of a VA health plan determines is consistent with section 1821 of this title and appropriate in order to provide care and services under the VA health plan.

"(2) Contracts and agreements under this subsection may be entered into without prior review by the Central Office of the Department.

"(d)(1) The entry into a contract or agreement under this section for services other than the services referred to in subsection (c) (including contracts and agreements for procurement of equipment, maintenance and repair services, and other services related to the provision of health care services) shall not be subject to prior review by the Central Office if the contract is consistent with section 1821 of this title and the amount of the contract or agreement is less than $250,000.

"(2) The Central Office may conduct a prior review of a contract or agreement referred to in paragraph (1)

if the amount of the contract or agreement is $250,000 or greater.

"§ 7343. Resource sharing authority

''(a) The Secretary may, consistent with section 1821 of this title, enter into agreements under section 8153 of this title with other health care plans, with health care providers, and with other health industry organizations, and with individuals, for the sharing of resources of the Department under a VA health plan.

''(b) The Secretary may, consistent with section 1821 of this title, enter into agreements with other departments and agencies of the Federal Government for the sharing of resources of the Department and such departments and agencies in order to provide care and services under a VA health plan.

"§ 7344. Administrative and personnel flexibility

''(a) Notwithstanding any other provision of law, the Secretary may—

''(1) appoint health care personnel to positions in any facility of the Department operating as or within a VA health plan in accordance with such qualifications for such positions as the Secretary may establish; and

"(2) promote and advance personnel serving in such positions in accordance with such qualifications as the Secretary may establish.

"(b) Subject to the provisions of section 1125 of the Health Security Act, the Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of VA health plans.

"§ 7345. Expenditure authority

"(a)(1) To the extent that appropriations are available, the director of a VA health plan may expend funds available to a VA health plan (including funds available under section 1834(c) of this title, funds available under section 7346(d)(2)(B) of this title, and funds otherwise made available to the VA health plan by the Secretary) for any purpose, and in any amount, that the director determines appropriate in order to ensure that the VA health plan meets the requirements and the requirements of furnishing care and services to veterans under chapter 17 of this title.

"(2) Funds may be expended under this subsection in order to cover the following costs:

"(A) The costs of marketing and advertising under a VA health plan.

1 "(B) The costs of legal services provided to a
2 VA health plan by the General Counsel of the De-
3 partment.
4 "(C) The costs of acquisition (including acquisi-
5 tion of land), construction, repair, or renovation of
6 facilities.
7 "(3) The exercise by a health plan director of the au-
8 thority provided in paragraph (1) shall not be subject to
9 prior review by the Central Office of the Department.
10 "(b) Subsection (a) shall not apply to expenditures
11 of funds provided to a facility by the Central Office of
12 the Department exclusively for the purpose of the provi-
13 sion of the following services:
14 "(1) Services relating to post-traumatic stress
15 disorder.
16 "(2) Services relating to spinal-cord dysfunc-
17 tion.
18 "(3) Services relating to substance abuse.
19 "(4) Services relating to the rehabilitation of
20 blind veterans.
21 **"§ 7346. Veterans Health Care Investment Fund**
22 "(a) There is hereby established in the Treasury of
23 the United States a fund to be known as the Veterans
24 Health Care Investment Fund (in this section referred to
25 as the 'Fund').

1 "(b) There is hereby authorized to be appropriated
2 to the Department, in addition to amounts otherwise au-
3 thorized to be appropriated to the Department for VA
4 health plans, such amounts as are necessary for the Sec-
5 retary of the Treasury to fulfill the requirement of sub-
6 section (c).

7 "(c) For each of fiscal years 1995, 1996, and 1997,
8 the Secretary of the Treasury shall, subject to the avail-
9 ability of appropriated funds, credit to the Fund an
10 amount in that fiscal year as follows:

11 "(1) For fiscal year 1995, $1,225,000,000.

12 "(2) For fiscal year 1996, $600,000,000.

13 "(3) For fiscal year 1997, $1,700,000,000.

14 "(d)(1) Subject to paragraph (2), amounts in the
15 Fund shall be available to the Secretary only for the VA
16 health plans organized and operated under this sub-
17 chapter.

18 "(2)(A) For each of fiscal years 1996 and 1997, the
19 Secretary shall estimate the total amount to be collected
20 or recovered under sections 1831, 1832, and 1833 of this
21 title by reason of the provision of care and services
22 through VA health plans under chapter 18 of this title
23 or the enrollment of individuals in such plans under that
24 chapter. The Secretary shall estimate the amount to be

so collected or recovered with respect to each VA health plan and with respect to all VA health plans.

"(B) For each such fiscal year, the Secretary shall make available to each VA health plan an amount that bears the same relationship to the total amount available in the Fund for the fiscal year as the amount estimated to be collected or recovered by the VA health plan during the fiscal year bears to the total amount estimated to be collected or recovered by all VA health plans during that fiscal year.

"(e) Not later than March 1, 1997, the Secretary shall submit to Congress a report concerning the operation of the Department of Veterans Affairs health care system in preparing for, and operating under, national health care reform under the Health Security Act during fiscal years 1995 and 1996. The report shall include a discussion of—

"(1) the adequacy of amounts in the Fund for the operation of VA health plans;

"(2) the quality of care provided by such plans; and

"(3) the ability of such plans to attract patients.

"§ 7347. Funding provisions: grants and other sources of assistance

''The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations and that but for this section is unavailable to facilities of the Department or to health plans operated by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

''SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

''7341. Organization of health care facilities as health plans.
''7342. Contract authority for facilities operating as or within health plans.
''7343. Resource sharing authority.
''7344. Administrative and personnel flexibility.
''7345. Expenditure authority.
''7346. Veterans Health Care Investment Fund.
''7347. Funding provisions: grants and other sources of assistance.

''SUBCHAPTER V—RESEARCH CORPORATIONS''.

TITLE IX—WORKERS COMPENSATION MEDICAL SERVICES

SEC. 9000. APPLICATION OF INFORMATION REQUIREMENTS.

(a) IN GENERAL.—The provisions of subtitle B of title V shall apply to the provision of workers compensation medical services provided by a health plan or health care provider in the same manner as such provisions apply with respect to the provision of services included in the standard benefit package.

(b) INFORMATION.—Subject to the provisions of subtitle C of title V, health plans and health care providers that render workers compensation medical services shall provide to the worker and to the workers compensation carrier, the employer or both, as appropriate, relevant health care information necessary to assist the worker in the safe and timely return to work.

(c) COMPLIANCE WITH DUTIES AND REQUIREMENTS.—A health plan to which this section applies and its providers shall comply with legal duties and reporting requirements under State workers compensation laws, and other Federal and State laws, including laws regarding the reporting of occupational injuries and diseases.

(d) RULES.—The Secretary of Labor shall promulgate rules to clarify the responsibilities of health plans and

1 health care providers in carrying out the provisions re-
2 ferred to in subsection (a).

3 **SEC. 9001. PROVISION OF CARE IN DISPUTED CASES.**

4 (a) IN GENERAL.—In cases in which a workers com-
5 pensation claim is challenged by the employer, the workers
6 compensation carrier, or both, a health plan shall provide
7 or pay for all medical care included in the standard benefit
8 package according to the applicable workers compensation
9 fee schedule, if any, until such time as a determination
10 is made through the adjudication process that the claim
11 is compensable as a workers compensation claim. If such
12 a determination is made, the workers compensation carrier
13 (or the employer, if self-insured) shall reimburse the
14 health plan (for the cost of services delivered to the mem-
15 ber for the work-related illness or injury) and the worker
16 (for any copayments, deductibles or coinsurance costs in-
17 curred for such services).

18 (b) APPLICABILITY.—Subsection (a) shall not apply
19 in a case where compensation has been accepted by the
20 insurer or the employer, or paid without prejudice.

21 **SEC. 9002. DEMONSTRATION PROJECTS.**

22 (a) AUTHORIZATION.—The Secretary of Health and
23 Human Services and the Secretary of Labor are author-
24 ized to conduct demonstration projects under this section

in one or more States with respect to treatment of work-related injuries and illnesses.

(b) DEVELOPMENT OF WORK-RELATED PROTOCOLS.—

(1) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor, in consultation with the States and such experts on work-related injuries and illnesses as each such Secretary finds appropriate, shall develop protocols for the appropriate treatment of work-related conditions.

(2) TESTING OF PROTOCOLS.—The Secretary of Health and Human Services and the Secretary of Labor shall enter into contracts with one or more community-rated health plans to test the validity of the protocols developed under subsection (a).

(c) DEVELOPMENT OF CAPITATION PAYMENT MODELS.—The Secretary of Health and Human Services and the Secretary of Labor shall develop, using protocols developed under subsection (b) if possible, methods of providing for payment by workers compensation carriers to health plans on a per case basis, capitated payment for the treatment of specified work-related injuries and illnesses.

SEC. 9003. COMMISSION ON WORKERS COMPENSATION MEDICAL SERVICES.

(a) ESTABLISHMENT.—There is hereby established a Commission on Workers Compensation Medical Services (hereafter in this section referred to as the ''Commission'').

(b) COMPOSITION.—

(1) IN GENERAL.—The Commission shall consist of 15 members appointed in accordance with paragraph (2). Members of the Commission shall include—

(A) one or more individuals representing State workers compensation commissioners;

(B) one or more individuals representing State workers compensation funds;

(C) one or more individuals representing labor organizations;

(D) one or more individuals representing employers (other than workers compensation insurance carriers);

(E) one or more individuals representing workers compensation insurance carriers;

(F) one or more members of the medical profession having expertise in occupational health; and

(G) one or more educators or researchers having expertise in the field of occupational health.

Eight members of the Commission shall constitute a quorum.

(2) APPOINTMENTS.—Members of the Commission shall be appointed by the President and shall include—

(A) three members appointed from among individuals recommended by the Speaker of the House of Representatives;

(B) three members appointed from among individuals recommended by the Minority Leader of the House of Representatives;

(C) three members appointed from among individuals recommended by the Majority Leader of the Senate; and

(D) three members appointed from among individuals recommended by the Minority Leader of the Senate.

(3) NO COMPENSATION EXCEPT TRAVEL EXPENSES.—Members of the Commission shall serve without compensation, but each member shall receive travel expenses, including per diem in lieu of subsist-

ence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(c) DUTIES.—

(1) IN GENERAL.—The Commission shall study the relationship of workers compensation medical services to the new health system under this Act in terms of impact on the cost of workers compensation medical services, access to appropriate care for injured workers, and quality of medical care and its impact on functional and vocational outcomes for injured workers.

(2) EVALUATION ISSUES TO BE ADDRESSED.—In its deliberations under paragraph (1), the Commission shall consider the following issues in examining the relationship between health plans and workers compensation medical services:

(A) The impact of health reform on workers compensation medical costs and premium rates charged to employers for workers compensation insurance.

(B) The extent and impact of cost-shifting and price discrimination between the workers compensation medical system and traditional health insurers.

(C) The impact of experience rating adjustments resulting from workers compensation medical services on workplace safety.

(D) The advantages and disadvantages of maintaining separate financing, payment and delivery systems for workers compensation medical services, including the impact on—

(i) the quality of medical care delivered to workers injured or made ill on the job;

(ii) the incentives for employers to maintain safe work-places; and

(iii) workers compensation indemnity benefit costs, medical costs and the overall costs of the workers compensation system.

(E) The advisability and appropriateness of transferring financial responsibility for some or all workers compensation medical benefits to health plans.

(F) The impact of State-to-State variations in medical and rehabilitation benefits on costs, access and quality of care.

(G) The options that are available to accomplish the delivery of workers compensation

1 benefits not included in the standard benefit
2 package in integrated systems
3 (H) Whether capitated rates can be devel-
4 oped for workers compensation medical bene-
5 fits, and the impact of using such rates on med-
6 ical and indemnity costs, access, and quality of
7 care.
8 (I) The impact of provider choice, with re-
9 spect to an injured worker, on workers com-
10 pensation medical costs, wage-loss benefits
11 costs, and quality of care.
12 (d) STAFF SUPPORT.—The Secretary of Health and
13 Human Services and the Secretary of Labor shall provide
14 staff support for the Commission.
15 (e) REPORTS.—Not later than October 1, 2000, the
16 Commission shall submit a final report on its work to the
17 President, the Committee on Labor and Human Resources
18 of the Senate and the Committee on Education and Labor
19 of the House of Representatives. Such report shall include
20 a recommendation as to whether a transfer of financial
21 responsibility for some or all medical benefits to health
22 plans should be effected, and a detailed implementation
23 plan should such a transfer be recommended. Prior to the
24 submission of the final report, the Commission shall sub-
25 mit such interim reports on issues addressed by the Com-

mission as the members of the Commission determine to be appropriate.

TITLE X—PREMIUM FINANCING

Subtitle A—National Health Care Cost and Coverage Commission

SEC. 10001. NATIONAL HEALTH CARE COST AND COVERAGE COMMISSION.

There is established a commission to be known as the National Health Care Cost and Coverage Commission (hereafter in this title referred to as the ''Commission'').

SEC. 10002. COMPOSITION.

(a) COMPOSITION.—The Commission shall be composed of 7 members appointed by the President and confirmed by the Senate. Members shall be appointed not later than 9 months after the date of the enactment of this Act based on their expertise and national recognition in the fields of health economics including insurance practices, health care benefit design, health care provider organization and reimbursement, and labor markets. In appointing members of the Commission, the President shall ensure that no more than 4 members of the Commission are affiliated with the same political party.

(b) CHAIRPERSON.—The President shall designate 1 individual described in subsection (a) who shall serve as Chairperson of the Commission.

(c) TERMS.—

(1) IN GENERAL.—The terms of members of the Commission shall be for 6 years to commence on January 1, 1996, except that of the members first appointed, 3 shall be appointed for an initial term of 4 years, 3 shall be appointed for an initial term of 5 years and the chairperson shall be appoint for an initial term of 6 years.

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

(d) VACANCIES.—

(1) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner as the original appointment, but the individual appointed to fill the vacancy shall serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

(2) NO IMPAIRMENT OF FUNCTION.—A vacancy in the membership of the Commission does not impair the authority of the remaining members to exercise all of the powers of the Commission.

(3) ACTING CHAIRPERSON.—The Commission may designate a member to act as Chairperson dur-

ing any period in which there is no Chairperson designated by the President.

SEC. 10003. DUTIES OF COMMISSION.

(a) IN GENERAL.—The general duties of the Commission are to monitor and respond to—

(1) trends in health care coverage; and

(2) changes in per-capita premiums and other indicators of health care inflation.

The Commission may be advised by individuals with expertise concerning the economic, demographic, and insurance market factors that affect the cost and coverage of health insurance.

(b) ANNUAL REPORTS.—

(1) IN GENERAL.—The Commission shall report to Congress annually on January 1 (beginning in 1997) concerning trends in health care coverage and costs. Such reports shall categorize such information on a national basis, a State by State basis, and a community rating area basis.

(2) HEALTH CARE COVERAGE.—For purposes of this title, the term ''health care coverage'' means coverage under—

(A) a certified standard health plan providing a standard benefits package or an alternative standard benefits package;

(B) the medicare program under title XVIII of the Social Security Act;

(C) the medicaid program under title XIX of the Social Security Act;

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

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

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

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

(H) a State single-payer system approved under subpart B of part 3 of subtitle F of title I; or

(I) any governmental health care program for institutionalized individuals.

(3) CONTENTS OF REPORT.—Each report under paragraph (1) shall include the findings of the Commission with respect to the following:

(A) Demographics and employment status of the uninsured individuals, and findings on why such individuals are uninsured.

(B) Structure of delivery systems.

(C) Status of insurance reforms.

(D) Development and operation of purchasing cooperatives and other buyer reforms.

(E) Success of market and other mechanisms in expanding coverage and controlling health expenditures and premium costs among employers and families.

(F) Success of the tax imposed under section 4521 of the Internal Revenue Code of 1986.

(G) Success and adequacy of the individual and employer subsidy programs under title VI in expanding coverage through employers and families.

(H) Per capita cost of health care, including—

(i) the rate of growth in health care costs categorized by type of health care provider and type of payor in States and community rating areas;

(ii) the expected rate of growth in per capita health care costs;

(iii) the causes of such growth; and

(iv) proposed strategies for controlling such growth.

(I) The percentage of the resident population in the United States, and each State, that has health care coverage.

(4) BENEFITS ISSUES.—The Commission shall consult with the National Health Benefits Board in gathering data and in making recommendations concerning issues that effect the standard benefit package.

(c) AFFORDABILITY REPORTS.—

(1) IN GENERAL.—As part of each annual report under subsection (b), beginning with the report for 1999, the Commission shall include information on—

(A) the affordability of health care coverage for families and employers; and

(B) the success of market incentives and other provisions of this Act in achieving health care cost containment.

(2) DETERMINATION AND RECOMMENDATIONS.—If the Commission determines for any year

that health care coverage is unaffordable (as described in paragraph (3)) or that cost containment efforts under this Act are unsuccessful, the Commission shall submit recommendations in the annual report for systematic improvements as provided for in paragraph (4).

(3) COST OF COVERAGE.—The Commission shall make a determination of unaffordability under paragraph (2) if the Commission finds that, with respect to the year for which the report is submitted, fewer than 35 percent of those eligible to enroll in community-rated health plans were able to enroll in plans with a premium that was at or below the reference premium for the community rating area involved.

(4) RECOMMENDATIONS.—If the Commission makes a finding under paragraph (3) with respect to any year, the Commission shall recommend to Congress a means of controlling health care costs in order to ensure that the growth in the per capita premium for community-rated plans is at or below the growth in the target per capita premium for the community rating area involved. The Commission may recommend alternative target per capita pre-

mium growth if the Commission determines that such alternative would be more appropriate.

(5) CONGRESSIONAL CONSIDERATION.—The recommendations of the Commission under paragraph (4) shall be submitted to Congress in the form of an implementing bill which contains such statutory provisions as the Commission determines are necessary or appropriate to implement such recommendations. Such bill shall be considered under the procedures established under section 10004.

(d) COVERAGE TRIGGER.—

(1) COMMISSION DETERMINATION.—By January 1, 2000, the Commission shall make a determination as to the percentage of the resident population in the United States, and each State, that has health care coverage.

(2) ATTAINMENT OF COVERAGE GOAL.—

(A) IN GENERAL.—If, under paragraph (1), the Commission determines that health care coverage of at least 95 percent of the resident population in the United States has been attained, the Commission shall submit recommendations (under subparagraph (B)) in its annual report to Congress on January 1, 2000.

1 (B) RECOMMENDATION REQUIREMENT.—
2 The recommendations of the Commission under
3 subparagraph (A) shall include methods to ex-
4 pand health care coverage to those who are not
5 covered. Such recommendations shall address
6 all relevant parties, including States, employers,
7 employees, unemployed and low-income individ-
8 uals, and public program participants.
9 (3) COVERAGE GOAL NOT ATTAINED.—
10 (A) IN GENERAL.—If, under paragraph
11 (1), the Commission determines that health
12 care coverage of at least 95 percent of the resi-
13 dent population in the United States has not
14 been attained by January 1, 2000, the Commis-
15 sion shall submit recommendations (under sub-
16 paragraph (B)) in its annual report to Congress
17 not later than May 15, 2000.
18 (B) RECOMMENDATION REQUIREMENTS.—
19 The recommendations of the Commission under
20 paragraph (1) shall include one or more legisla-
21 tive proposals for expanding health care cov-
22 erage to cover the remaining uninsured popu-
23 lation. Such recommendations shall address all
24 relevant parties, including States, employers,

employees, unemployed and low-income individuals, and public program participants.

(C) CONGRESSIONAL CONSIDERATION.—The recommendations of the Commission under subparagraph (A) shall be submitted to Congress in the form of one or more implementing bills which contains such statutory provisions as the Commission determines are necessary or appropriate to implement such recommendations. Such bill shall be considered under the procedures established under section 10004.

SEC. 10004. CONGRESSIONAL CONSIDERATION OF COMMISSION RECOMMENDATIONS.

(a) IMPLEMENTING BILLS.—

(1) IN GENERAL.—Except as provided in paragraph (2), an implementing bill described in section 10003(c)(5) or section 10003(d)(3)(C) shall be considered by Congress under the procedures for consideration described in subsection (b), except that with respect to an implementing bill described in section 10003(c)(5), the date described in subsection (b)(3) shall not apply.

(2) GAO CONSIDERATION.—With respect to an implementing bill described in section 10003(d)(3)(C), to be eligible for Congressional con-

sideration under subsection (b), the General Accounting Office must certify that, if implemented, the legislative proposals in such bill would expand health care coverage to cover the remaining uninsured population.

(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 supersedes 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 that House, as provided in the preceding sentence, on the first day thereafter on which that House is in session. If the implementing bill is not introduced within 5 days of its transmission, any Member of the House and of the Senate may introduce such bill. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(3) PERIOD FOR COMMITTEE CONSIDERATION.—If the committee or committees of either House to which an implementing bill has been referred have not reported the bill at the close of July 1, 2000 (or if such House is not in session, the next day such House is in session), such committee or committees shall be automatically discharged from further consideration of the implementing bill and it shall be placed on the appropriate calendar.

(4) FLOOR CONSIDERATION IN THE SENATE.—

(A) IN GENERAL.—Within 5 days after the implementing bill is placed on the calendar, the Majority Leader, at a time to be determined by the Majority Leader in consultation with the Minority Leader, shall proceed to the consideration of the bill. If on the sixth day after the bill is placed on the calendar, the Senate has not proceeded to consideration of the bill, then the presiding officer shall automatically place the bill before the Senate for consideration. 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) TIME LIMITATION ON CONSIDERATION OF BILL.—

(i) IN GENERAL.—Debate in the Senate on an implementing bill, and all amendments and debatable motions and appeals in connection therewith, shall be limited to not more than 30 hours. The time shall be equally divided between, and controlled by, the Majority Leader and the Minority Leader or their designees.

(ii) DEBATE OF AMENDMENTS, MOTIONS, POINTS OF ORDER, AND APPEALS.—In the Senate, no amendment which is not relevant to the bill shall be in order. Debate in the Senate on any amendment, debatable motion or appeal, or point of order in connection with an implementing bill shall be limited to—

(I) not more than 2 hours for each first degree relevant amendment,

(II) one hour for each second degree relevant amendment, and

(III) 30 minutes for each debatable motion or appeal, or point of order submitted to the Senate,

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 amendment, motion, appeal, or point of order, the time in opposition thereto, shall be controlled by the Minority Leader or designee of the Minority Leader. The Majority Leader and Minority Leader, 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 amendment, debatable motion or appeal, or point of order.

(C) OTHER MOTIONS.—A motion to recommit an implementing bill is not in order.

(D) FINAL PASSAGE.—Upon the expiration of the 30 hours available for consideration of the implementing bill, it shall not be in order to offer or vote on any amendment to, or motion with respect to, such bill. Immediately following

the conclusion of debate in the Senate on an implementing bill that was introduced in the Senate, such bill shall be deemed to have been read a third time and the vote on final passage of such bill shall occur without any intervening action or debate.

(E) DEBATE ON DIFFERENCES BETWEEN THE HOUSES.—Debate in the Senate on motions and amendments appropriate to resolve the differences between the Houses, at any particular stage of the proceedings, shall be limited to not more than 5 hours.

(F) DEBATE ON CONFERENCE REPORT.—Debate in the Senate on the conference report shall be limited to not more than 10 hours.

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

(A) PROCEED TO CONSIDERATION.—On the sixth day after the implementing bill is placed on the calendar, it shall be privileged for any Member to move without debate that the House resolve itself into the Committee of the Whole House on the State of the Union, for the consideration of the bill, and the first reading of the bill shall be dispensed with.

(B) GENERAL DEBATE.—After general debate, which shall be confined to the implementing bill and which shall not exceed 4 hours, to be equally divided and controlled by the Chairman and Ranking Minority Member of the Committee or Committees to which the bill had been referred, the bill shall be considered for amendment by title under the 5-minute rule and each title shall be considered as having been read. The total time for considering all amendments shall be limited to 26 hours of which the total time for debating each amendment under the 5-minute rule shall not exceed one hour.

(C) RISE AND REPORT.—At the conclusion of the consideration of the implementing bill for amendment, the Committee of the Whole on the State of the Union shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and the amendments thereto, and the House shall proceed to vote on final passage without intervening motion except one motion to recommit.

(6) COMPUTATION OF DAYS.—For purposes of this subsection, in computing a number of days in either House, there shall be excluded—

(A) 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

(B) any Saturday and Sunday not excluded under subparagraph (A) when either House is not in session.

(7) POINTS OF ORDER BASED ON EXPANDING COVERAGE.—

(A) IN GENERAL.—It shall not be in order in the Senate to consider—

(i) any bill;

(ii) any bill prior to third reading; or

(iii) any conference report;

under the procedures described in this subsection if such bill or conference report has not been certified by the General Accounting Office under subsection (a)(2) as expanding coverage to cover the remaining uninsured.

(B) WAIVER OR SUSPENSION.—Subparagraph (A) may be waived or suspended in the Senate only by the affirmative vote of ⅗ of the

members duly chosen and sworn. An affirmative vote of 3/5 of the members of the Senate duly chosen and sworn shall be required in the Senate to sustain an appeal of the ruling of the chair on a point of order raised under this paragraph.

(c) FAILURE TO ENACT LEGISLATION.—If Congress fails to enact legislation with respect to an implementing bill under section 10003(d)(3)(C) by December 31, 2000, the employer and individual premium financing provisions of subtitle B shall become effective on January 1, 2002 with respect to those States determined by the Commission under 10003(d)(3)(A) to have health care coverage for less than 95 percent of the resident populations of each such State.

SEC. 10005. OPERATION OF THE COMMISSION.

(a) MEETINGS; QUORUM.—

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

(2) QUORUM.—Four members of the Commission shall constitute a quorum thereof.

(b) ADMINISTRATIVE PROVISIONS.—

(1) FACA NOT APPLICABLE.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

(2) PAY AND TRAVEL EXPENSES.—

(A) PAY.—Each member of the Commission shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level IV 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 Commission.

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

(3) EXECUTIVE DIRECTOR.—

(A) IN GENERAL.—The Commission 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.

(4) STAFF.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Executive Director, with the approval of the Commission, 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 Commission to assist the Commission in carrying out its duties under this Act.

(5) OTHER AUTHORITY.—

(A) CONTRACT SERVICES.—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

(B) LEASES AND PROPERTY.—The Commission may lease space and acquire personal property to the extent funds are available.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the operation of the Commission.

Subtitle B—Employer and Individual Premium Requirements and Assistance

SEC. 10101. APPLICATION OF SUBTITLE.

(a) IN GENERAL.—The provisions of the subtitle shall apply as provided in section 10003(c).

(b) APPLICATION WITH RESPECT TO INDIVIDUALS.—

(1) LAWFUL RESIDENTS.—

(A) IN GENERAL.—This subtitle shall only apply with respect to an individual who is residing in a State involved and who is—

(i) a citizen or national of the United States; or

(ii) an alien permanently residing in the United States under color of law (as defined in subparagraph (B)).

(B) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term ''alien permanently residing in the United States under color of law'' means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

(i) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(ii) An alien who is granted asylum under section 208 of such Act.

(iii) An alien whose deportation is withheld under section 243(h) of such Act.

(iv) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(v) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

(vi) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(2) INDIVIDUAL RESPONSIBILITIES.—With respect to a State to which this subtitle applies, each individual described in paragraph (1)(A)—

(A) must enroll in (or be covered under) a health plan for the individual, and

(B) must pay any premium required, consistent with this Act, with respect to such enrollment.

1 (3) INDIVIDUALS COVERED UNDER EQUIVALENT
2 HEALTH CARE PROGRAMS.—This subtitle shall not
3 apply with respect to an individual covered under an
4 equivalent health care program.
5 (4) EQUIVALENT HEALTH CARE PROGRAM.—As
6 used in paragraph (1), the term ''equivalent health
7 care program'' means—
8 (A) part A or part B of the medicare pro-
9 gram under title XVIII of the Social Security
10 Act,
11 (B) the medicaid program under title XIX
12 of the Social Security Act,
13 (C) the health care program for active
14 military personnel under title 10, United States
15 Code,
16 (D) the veterans health care program
17 under chapter 17 of title 38, United States
18 Code,
19 (E) the Civilian Health and Medical Pro-
20 gram of the Uniformed Services (CHAMPUS),
21 as defined in section 1073(4) of title 10, United
22 States Code,
23 (F) the Indian health service program
24 under the Indian Health Care Improvement Act
25 (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.

(5) INMATES.—This subtitle shall not apply with respect to an individual who is an inmate of a public institution (except as a patient of a medical institution).

(6) EXEMPTION.—

(A) IN GENERAL.—The requirements of this subtitle shall not apply with respect to an individual granted a qualified religious exemption.

(B) QUALIFIED RELIGIOUS EXEMPTION.—

(i) IN GENERAL.—The term 'qualified religious exemption' means an exemption granted by the Secretary to an individual—

(I) who is a member of a recognized religious sect or division thereof with respect to which such Secretary makes the findings referred to in subparagraphs (C), (D), and (E) of section 1402(g)(1) of the Internal Revenue Code of 1986,

(II) who is an adherent of established tenets or teachings of such sect or division as described in such section, and

(III) who submits an application for such exemption which contains or is accompanied by the evidence described in section 1402(g)(1)(A) of such Act and a waiver described in section 1402(g)(1)(B) of such Act.

(C) LIMITATION.—An exemption granted under this paragraph shall cease to apply beginning on the date such Secretary determines that the individual, or the sect or division, ceased to meet the requirements of subparagraph (B).

SEC. 10102. DEFINITIONS.

For purposes of this title:

(1) FULL-TIME EQUIVALENT EMPLOYEES; PART-TIME EMPLOYEES.—

(A) IN GENERAL.—A qualifying employee who is employed by an employer—

(i) for at least 120 hours in a month, is counted as 1 full-time equivalent em-

ployee for the month and shall be deemed to be employed on a full-time basis, or

(ii) for at least 40 hours, but less than 120 hours, in a month, is counted as a fraction of a full-time equivalent employee in the month equal to the full-time employment ratio (as defined in subparagraph (B)) for the employee and shall be deemed to be employed on a part-time basis.

(B) FULL-TIME EMPLOYMENT RATIO DEFINED.—The term ''full-time employment ratio'' means, with respect to a qualifying employee of an employer in a month, the lesser of 1 or the ratio of—

(i) the number of hours of employment such employee is employed by such employer for the month, to

(ii) 120 hours.

(C) FULL-TIME EMPLOYEE.—The term ''full-time employee'' means, with respect to an employer, an employee who is employed on a full-time basis (as specified in subparagraph (A)) by the employer.

(D) PART-TIME EMPLOYEE.—The term ''part-time employee'' means, with respect to an employer, an employee who is employed on a part-time basis (as specified in subparagraph (A)) by the employer.

(E) CONSIDERATION OF INDUSTRY PRACTICE.—As provided under rules established by the Secretary of Labor, an employee who is not described in subparagraph (C) or (D) shall be considered to be employed on a full-time or part-time basis by an employer (and to be a full-time or part-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into account the structure or nature of employment in the industry, represents full or part-time employment in that industry.

(F) QUALIFYING EMPLOYEE.—

(i) The term ''qualifying employee'' means, with respect to an employer for a month, an employee who is employed by the employer for at least 40 hours in the month, subject to the limitation set forth in clause (ii).

(i) The term qualifying employee shall not include, with respect to an employer for a month, an employee of a nonelecting employer.

(2) FAMILY ADJUSTED INCOME.—

(A) IN GENERAL.—Except as otherwise provided, the term ''family adjusted income'' means, with respect to a family, the sum of the adjusted incomes (as defined in subparagraph (B)) for all members of the family.

(B) ADJUSTED INCOME.—In subparagraph (A), the term ''adjusted income'' means, with respect to an individual, adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

(ii) increased by the amount of interest received or accrued by the individual which is exempt from tax.

(C) PRESENCE OF ADDITIONAL DEPENDENTS.—At the option of an individual, a family may include (and not be required to separate out) the income of other individuals who are

claimed as dependents of the family for income tax purposes, but such individuals shall not be counted as part of the family for purposes of determining the size of the family.

(3) NONENROLLING EMPLOYEE.—The term ''nonenrolling employee'' means an employee of an employer who does not enroll in a health plan offered by the employer.

(4) REFERENCE PREMIUM.—The term ''reference premium'' means the reference premium established under section 4512 of the Internal Revenue Code of 1986.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Labor.

(6) SELF-EMPLOYED INDIVIDUAL.—The term ''self-employed individual'' means, for a year, an individual who has net earnings (as defined in section 1402(a) of the Internal Revenue Code of 1986) from self-employment for the year.

(7) WEIGHTED AVERAGE PREMIUM.—The term ''weighted average premium'' has the same meaning given such term in section 6002(b)(1)(C).

PART 1—EMPLOYER PREMIUM PAYMENTS

SEC. 10111. OBLIGATION.

(a) IN GENERAL.—Except as otherwise provided in this subtitle, a contributing employer (as defined in subsection (b)) shall make health care coverage premium payments on behalf of the qualifying employees of the employer in accordance with this subtitle.

(b) CONTRIBUTING EMPLOYER.—As used in subsection (a), the term ''contributing employer'' means an employer that—

(1) employs, on average, 25 or more employees; or

(2) employs less than 25 employees that elects under subsection (c) to be a contributing employee.

(c) ELECTION.—

(1) IN GENERAL.—An employer that does not meet the requirements of subsection (b) may elect to be treated as a community-rated employer under the procedures to be developed by the Secretary.

(2) COMMUNITY-RATED EMPLOYER.—An exempt employer shall be treated as a community-rated employer as of the first date of the first year following an election made under paragraph (1).

(3) SELF-EMPLOYED.—A self-employed individual that does not employ at least one full-time

employee may not make an election under paragraph (1).

SEC. 10112. COMMUNITY-RATED EMPLOYERS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each community-rated contributing employer for a month shall pay at least an amount equal to the sum across all qualifying employees of the amount specified in subsection (b) for each such qualifying employee of the employer. Such payments shall be made in accordance with standards established by the Secretary.

(2) TREATMENT OF CERTAIN EMPLOYMENT BY EXPERIENCE-RATED EMPLOYERS.—An experience-rated employer shall be deemed, for purposes of this subtitle, to be a community-rated employer with respect to qualifying employees who are not experience rate eligible individuals.

(b) PREMIUM PAYMENT AMOUNT.—

(1) GENERAL RULE.—The amount of the employer premium payment under subsection (a) for a month for each qualifying employee of the employer who is residing in a community rating area, shall be equal to the sum of—

(A) 50 percent of the weighted average premium of the purchasing cooperative through

which the employer offered health plan coverage with respect to each such employee in such area; and

(B) the employer collection shortfall add-on described in paragraph (2).

(2) EMPLOYER COLLECTION SHORTFALL ADD-ON.—The employer collection shortfall add-on for a month for each qualifying employee of the employer residing in a community rating area shall be equal to 50 percent of the amount described in section 10134 with respect to each such employee.

(3) PART-TIME EMPLOYEES.—With respect to a part-time employee, the payment required under paragraph (1) (and the add-on described in paragraph (2)) shall be based on a pro-rated share (to be established by the Secretary) of the weighted average premium of the purchasing cooperative involved (or, with respect to the shortfall add-on, the amount described in paragraph (2)).

SEC. 10113. EXPERIENCE RATED EMPLOYERS.

(a) REQUIREMENT.—Each experience-rated employer that in a month employs a qualifying employee who is—

(1) enrolled in an experienced-rated health plan sponsored by the employer, shall provide for a payment toward the premium for the plan for such em-

ployee in an amount specified under subsection (b); or

(2) is not so enrolled, shall make employer premium payments with respect to such employee in an amount that is equal to 50 percent of the weighted average premium (for the applicable class of family enrollment) of the community rating area in which the employee resides.

(b) PREMIUM PAYMENT AMOUNT.—

(1) GENERAL RULE.—The amount of the experience rated employer premium payment under subsection (a)(1) for a month for each qualifying employee of the employer, shall be equal to 50 percent of the weighted average premium of the health plans offered by the employer.

(2) SELF-INSURED PLANS.—In the case of a self-insured health plan, the amount of the premium payment under subsection (a) shall be equal to the premium equivalent of the self-insured health plan.

(3) PART-TIME EMPLOYEES.—With respect to a part-time employee, the payment required under paragraph (1) shall be a pro-rated share (to be established by the Secretary) of the amount described in subsection (a)(2).

(4) PREMIUM AREAS.—An experience-rated plan sponsor employer may, based on regulations promulgated by the Secretary, establish premium areas. Experience rated employers may base their payments under this section on the weighted average premium of the health plans offered in such premium areas.

PART 2—FAMILY PAYMENT RESPONSIBILITIES

Subpart A—Family Share

SEC. 10131. ENROLLMENT AND PREMIUM PAYMENTS.

(a) REQUIREMENT.—Each family enrolled in a community-rated health plan or in a experienced-rated health plan in a class of family enrollment is responsible for payment of the family share of premium payable respecting such enrollment. Such premium may be paid by an employer or other person on behalf of such a family.

(b) FAMILY SHARE OF PREMIUM DEFINED.—In this part, the term ''family share of premium'' means, with respect to enrollment of a family—

(1) in a community-rated health plan, the amount specified in section 10132(a) for the class; or

(2) in an experienced-rated health plan, the amount specified in section 10132(b) for the class.

SEC. 10132. FAMILY SHARE OF PREMIUMS.

(a) COMMUNITY-RATED HEALTH PLANS.—

(1) IN GENERAL.—The family share of premiums for a family enrolled in a community-rated health plan based on a class of family enrollment shall equal the sum of the base amounts described in paragraph (2) reduced (but not below zero) by the sum of the amounts described in paragraph (3).

(2) BASE.—The base amounts described in this paragraph (for a plan for a class of enrollment) are—

(A) the applicable premium specified in section 10133(a) with respect to such class of enrollment;

(B) 50 percent of the applicable collection shortfall add-on (computed under section 10134 for such class); and

(C) any applicable marketing fee as described in section 1112(f).

(3) CREDITS AND DISCOUNTS.—The amounts described in this paragraph (for a plan for a class of enrollment) are—

(A) the amount of the family credit under section 10135(a); and

(B) the amount of any premium discount provided under section 10136(a)(1).

(b) EXPERIENCE-RATED HEALTH PLANS.—

(1) IN GENERAL.—The family share of premiums for a family enrolled in an experience-rated health plan based on a class of family enrollment shall equal the premium described in paragraph (2) reduced (but not below zero) by the sum of the amounts described in paragraph (3).

(2) PREMIUM.—The premium described in this paragraph (for a plan for a class of enrollment) is the applicable plan premium specified in section 10133(b) with respect to the plan and class of enrollment involved.

(3) CREDITS AND DISCOUNTS.—The amounts described in this paragraph (for a plan for a class of enrollment) are—

(A) the amount of the family credit under section 10135(a); and

(B) the amount of any premium discount provided under section 10136(a).

(4) MULTISTATE EMPLOYERS.—For purposes of this subsection, the Secretary shall establish alternative contribution rules for multistate self-insured employers.

SEC. 10133. AMOUNT OF PREMIUM.

(a) COMMUNITY-RATED PLANS.—The amount of the applicable premium charged by a community-rated health plan for all families in a class of family enrollment under a community-rated health plan offered in the health care coverage area is equal to the product of—

(1) the final community rate for the plan; and

(2) the premium class factor established by the Secretary of Health and Human Service for that class under subpart D of part 1 of subtitle E of title I;

increased for any applicable plan marketing fees (described in section 1112(f)) and purchasing cooperative membership fees (described in section 1324).

(b) REFERENCE TO OTHER PREMIUMS.—The amount of the premium charged by an experience-rated employer for all families in a class of family enrollment under an experience-rated health plan is specified under section 10113.

SEC. 10134. COLLECTION SHORTFALL ADD-ON.

(a) IN GENERAL.—The collection shortfall add-on for a community rating area for a class of enrollment for a year, is a per enrollee amount (determined under rules developed by the Secretary of Health and Human Services), adjusted proportionately by the premium class factors described in section 10133(a)(2), such that the total of the

1 adjusted per enrollee amounts in the community rating
2 area equals the aggregate collection shortfall as deter-
3 mined under subsection (b).

4 (b) AGGREGATE COLLECTION SHORTFALL.—

5 (1) IN GENERAL.—Each State shall estimate,
6 for each community rating area for each year (be-
7 ginning with the first year for which this section ap-
8 plies) the total amount of payments which the State
9 can reasonably identify as owed to community-rated
10 health plans under this Act for the year and not
11 likely to be collected during a period specified by the
12 Secretary beginning on the first day of the year.

13 (2) EXCLUSION OF GOVERNMENT DEBTS.—The
14 amount under paragraph (1) shall not include any
15 payments owed to a community-rated health plan by
16 the Federal, State, or local governments.

17 (3) ADJUSTMENT FOR PREVIOUS SHORTFALL
18 ESTIMATION DISCREPANCY.—The amount estimated
19 under this subsection for a year shall be adjusted to
20 reflect over (or under) estimations in the amounts so
21 computed under this subsection for previous years
22 (based on actual collections), taking into account in-
23 terest payable based upon borrowings (or savings)
24 attributable to such over or under estimations.

SEC. 10135. FAMILY CREDIT.

(a) IN GENERAL.—The credit provided under this section for a family enrolled through an employer in a community-rated or experience-rated plan for a class of family enrollment is equal to the amount of the minimum employer premium payment required under part 1 with respect to the family.

(b) FAMILY NOT ENROLLED THROUGH EMPLOYER.—The credit provided under this section for a family that is not enrolled in a community-rated or experience-rated plan through an employer for a class of family enrollment is equal to 50 percent of the premium of the plan in which the family is enrolled. In no case shall such amount exceed the weighted average premium in the community rating area involved.

SEC. 10136. PREMIUM SUBSIDY.

(a) IN GENERAL.—Except as otherwise provided in this section, each family enrolled with a community-rated or experience-rated plan is entitled to a premium discount under this section, in the amount specified in subsection (b)(1).

(b) AMOUNT OF PREMIUM DISCOUNT.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the amount of the premium discount under this subsection for a family under a class of family enrollment is equal to—

(A) 50 percent of the lesser of—

(i) the weighted average premium for community-rated plans offered in the community-rating area involved, increased by any amount provided under paragraph (2); or

(ii)(I) in the case of a family enrolled through a community-rated employer, the weighted average premium for the purchasing cooperative through which the family obtains coverage; or

(II) in the case of a family enrolled through an experience-rated employer, the weighted average premium for the premium area of the health plans offered by the employer; less

(B) the sum of—

(i) the family obligation amount described in subsection (c); and

(ii) the amount of any voluntary employer payment (not required under part 1) towards the family share of premiums for covered members of the family.

(2) INCREASE FOR COMMUNITY-RATED FAMILIES TO ASSURE ENROLLMENT IN AT-OR-BELOW-AV-

1 ERAGE-COST PLAN.—In the case of a family enrolled
2 in a community-rated plan, if a State determines
3 that a family eligible for a discount under this sec-
4 tion is unable to enroll in an at-or-below-average-
5 cost plan (as defined in paragraph (3)) that serves
6 the area in which the family resides, the amount of
7 the premium discount under this subsection is in-
8 creased to the extent that such amount will permit
9 the family to enroll in a community-rated plan with-
10 out the need to pay a family share of premium
11 under this part in excess of the sum described in
12 paragraph (1)(B).

13 (3) AT-OR-BELOW-AVERAGE-COST PLAN DE-
14 FINED.—In this section, the term ''at-or-below-aver-
15 age-cost plan'' means a community-rated plan the
16 premium for which does not exceed, for the class of
17 family enrollment involved, the weighted average
18 premium for the community-rating area.

19 (c) FAMILY OBLIGATION AMOUNT.—

20 (1) DETERMINATION.—Subject to paragraphs
21 (2) and (3), the family obligation amount under this
22 subsection is determined as follows:

23 (A) NO OBLIGATION IF INCOME BELOW IN-
24 COME THRESHOLD AMOUNT.—If the family ad-
25 justed income of the family is less than the in-

1 come threshold amount (specified in paragraph
2 (4)), the family obligation amount is zero.
3 (B) INCOME ABOVE INCOME THRESHOLD
4 AMOUNT.—If such income is at least such in-
5 come threshold amount, the family obligation
6 amount is the sum of the following:
7 (i) FOR INCOME (ABOVE INCOME
8 THRESHOLD AMOUNT) UP TO THE POV-
9 ERTY LEVEL.—The product of the initial
10 marginal rate for the applicable class of
11 family enrollment (specified in paragraph
12 (2)) and the amount by which—
13 (I) the family adjusted income
14 (not including any portion that ex-
15 ceeds the applicable poverty level for
16 the class of family involved), exceeds;
17 (II) such income threshold
18 amount.
19 (ii) GRADUATED PHASE OUT OF DIS-
20 COUNT UP TO 200 PERCENT OF POVERTY
21 LEVEL.—The product of the final marginal
22 rate for the applicable class of family en-
23 rollment (specified in paragraph (2)) and
24 the amount by which the family adjusted
25 income exceeds 100 percent (but is less

than 200 percent) of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1), for a year:

(A) INITIAL MARGINAL RATE.—The initial marginal rate is the ratio of—

(i) 4 percent of the applicable poverty level for the class of enrollment involved for the year; to

(ii) the amount by which such poverty level exceeds such income threshold amount.

(B) FINAL MARGINAL RATE.—The final marginal rate is 12 percent.

(3) LIMITATION TO 8 PERCENT FOR ALL FAMILIES.—

(A) IN GENERAL.—In no case shall the family obligation amount under this subsection for the year exceed 8 percent of the adjusted income of the family.

(B) FAMILIES ABOVE 200 percent of poverty.—With respect to a family with a family adjusted income that exceeds 200 percent of the applicable poverty level, the family obligation

amount shall be equal to 8 percent of such family adjusted income.

(4) INCOME THRESHOLD AMOUNT.—

(A) IN GENERAL.—For purposes of this subtitle, the income threshold amount specified in this paragraph is $1,000 (adjusted under subparagraph (B)).

(B) INDEXING.—For the 1-year period beginning on January 1, 1995, the income threshold amount specified in subparagraph (A) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31. 1993.

(C) ROUNDING.—Any increase or decrease under subparagraph (B) for a year shall be rounded to the nearest multiple of $10.

SEC. 10137. NO LOSS OF COVERAGE.

In no case shall the failure to pay amounts owed under this Act result in an individual's or family's loss of coverage.

Subpart B—Payment of Family Credit by Certain Families

SEC. 10141. PAYMENT OF FAMILY CREDIT BY NONWORKING AND PART-TIME CERTAIN FAMILIES.

Subject to the limitations described in section 10142, a family with an employer contribution for a month that is less than the family credit amount described in section 10135, shall be liable for payment of an amount equal to the family credit amount less any employer contributions for the family for the month.

SEC. 10142. LIMITATION OF LIABILITY BASED ON INCOME.

(a) IN GENERAL.—In the case of an eligible family described in subsection (b), the repayment amount required under section 10141 with respect to a year shall not exceed the amount of liability described in subsection (c) for the year.

(b) ELIGIBLE FAMILY DESCRIBED.—An eligible family described in this subsection is a family which is determined by the State for the community rating area in which the family resides, to have wage-adjusted income (as defined in subsection (d)) below 200 percent of the applicable poverty level.

(c) AMOUNT OF LIABILITY.—

(1) DETERMINATION.—Subject to subsection (f), in the case of a family enrolled in a class of enrollment with wage-adjusted income (as defined in

subsection (d)), the amount of liability under this subsection is determined as follows:

(A) NO OBLIGATION IF INCOME BELOW INCOME THRESHOLD AMOUNT.—If such income is less than the income threshold amount (specified in section 10136(c)(4)), the amount of liability is zero.

(B) INCOME ABOVE INCOME THRESHOLD AMOUNT.—If such income is at least such income threshold amount, the amount of liability is the sum of the following:

(i) INITIAL MARGINAL RATE.—The initial marginal rate (specified in paragraph (2)(A)) of the amount by which—

(I) the wage-adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds

(II) such income threshold amount.

(ii) FINAL MARGINAL RATE.—Where wage-adjusted income exceeds 100 percent of the applicable poverty level, the final marginal rate (specified in paragraph (2)(B)) of the amount by which the wage-

adjusted income exceeds 100 percent of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1)—

(A) INITIAL MARGINAL RATE.—The initial marginal rate, for a year for a class of enrollment, is the ratio of—

(i) 4 percent of the applicable poverty level for the class of enrollment for the year, to

(ii) the amount by which such poverty level exceeds such income threshold amount.

(B) FINAL MARGINAL RATE.—The final marginal rate, for a year for a class of enrollment, is the ratio of—

(i) the amount by which (I) 50 percent of the weighted average premium in the community rating area (for the class and year) exceeds (II) 4 percent of applicable poverty level (for the class and year); to

(ii) 100 percent of such poverty level.

(d) WAGE-ADJUSTED INCOME DEFINED.—In this subtitle, the term ''wage-adjusted income'' means, for a

family, family adjusted income of the family, reduced by the sum of the following:

(1)(A) Subject to subparagraph (B), the amount of any wages included in such family's income that is received for employment which is taken into account in the computation of the amount of employer premiums under part 1.

(B) The reduction under subparagraph (A) shall not exceed for a year $5,000 (adjusted under section 10136(c)(3)(B)) multiplied by the number of months (including portions of months) of employment with respect to which employer premiums were payable under part 1.

(2) The amount of unemployment compensation included in income under section 85 of the Internal Revenue Code of 1986.

(e) DETERMINATIONS.—A family's wage-adjusted income and the amount of liability under subsection (c) shall be determined by the State upon application by a family.

TITLE XI—ENSURING HEALTH CARE REFORM FINANCING

SEC. 11001. ENSURING HEALTH CARE REFORM FINANCING.

(a) PURPOSE.—The purpose of this section is to ensure that the enactment of this Act does not result in unanticipated increases in the Federal deficit.

1 (b) LEGAL ENTITLEMENTS CONTINGENT.—Any enti-
2 tlement provided by this Act, including those to premium
3 assistance, shall be subject to the operation of this section.
4 (c) DETERMINATION OF UNFINANCED HEALTH
5 SPENDING.—
6 (1) INITIAL HEALTH CARE BASELINE.—Not
7 later than the date that is 60 days after the date of
8 enactment of this Act, the President shall, using up-
9 to-date estimates, issue an order setting forth the
10 initial health care baseline for fiscal year 1995 and
11 for each subsequent fiscal year through 2004, which
12 shall consist of estimates (for each year) projecting
13 the following:
14 (A) total direct spending outlays resulting
15 from this Act and under the Medicare and Med-
16 icaid programs; and
17 (B) total revenues resulting from this Act.
18 (2) PRESIDENT'S BUDGET TO INCLUDE A CUR-
19 RENT HEALTH CARE BASELINE.—When the Presi-
20 dent submits the budget for fiscal year 1997 (as re-
21 quired by section 1105 of title 31), and for each fis-
22 cal year through 2004, the President shall include—
23 (A) a current health care baseline (as spec-
24 ified in paragraph (3)) with respect to the cur-

rent fiscal year, the budget year, and the 4 following fiscal years; and

(B) an estimate of the difference between the current health care baseline and the initial health care baseline for the current fiscal year, the budget year, and the 4 following fiscal years.

(3) CURRENT HEALTH CARE BASELINE.—The current health care baseline shall, for the applicable fiscal year, consist of—

(A) updated spending and revenue amounts contained in the initial projection (as set forth in paragraph (1)); plus or minus

(B) other outlays or revenue changes contained in legislation enacted after the date of enactment of this Act offsetting outlays or revenues resulting from this Act.

(4) COMPARING INITIAL AND CURRENT HEALTH CARE BASELINES.—Once OMB has determined the difference between the initial and current health care baselines, OMB shall remove from that difference any health care variable not attributable either to this Act or to any legislation described in paragraph (3)(B).

(d) OFFSETTING UNFINANCED HEALTH SPENDING.—

(1) REQUIREMENT FOR SEQUESTRATION TO FULLY OFFSET UNFINANCED HEALTH SPENDING.—If the President's budget includes a determination that the current health care baseline exceeds the initial health care baseline pursuant to subsection (c)(2)(B) for the budget year and the current fiscal year by more than $10,000,000,000 in total, such determination shall be accompanied by a proposed order to become effective on October 1 of that calendar year which fully offsets in the budget year and the following fiscal year the sum of such excess (for the budget year and the current fiscal year) in the manner provided in this subsection. Such proposed order shall be accompanied by such proposed regulations as the President deems necessary to carry out the sequester.

(2) OFFSETS.—

(A) IN GENERAL.—The offsets required by this subsection shall be accomplished through a combination of—

(i) subject to the provisions of subparagraph (B), in the case of the premium assistance program, reducing the percent-

ages otherwise in effect for the fiscal year under subparagraphs (A), (B), and (C) of section 6002(a)(2);

(ii) adjusting the deductible for Medicare drugs as provided in section 1834(d)(1)(B)(i) of the Social Security Act; and

(iii) reducing each direct spending program provided in the Act by a uniform percentage,

to the extent (subject to paragraph (3)) necessary to accomplish all of the sequestrations necessary to fully offset the amounts required for that fiscal year.

(B) ELIGIBILITY PERCENTAGE FOR PREGNANT WOMEN AND CHILDREN REDUCED LAST.—Any reduction under subparagraph (A)(i)—

(i) shall be made first by reducing the percentages under section 6002(a)(2)(A); and

(ii) to the extent sufficient offsets may not be made under subparagraph (A), shall then be made by reducing the percentages under section 6002(a)(2) (B) and (C).

(3) PROPORTIONALITY.—The President shall apply the offset mechanisms provided in paragraph (2)(A) (i), (ii), and (iii) proportionally (based on the ratio of the outlays caused by each program to the total outlays of all sequesterable programs under paragraph (2)(A)), to the extent possible, in the budget year and the following fiscal year, but in no case shall the total amount of offsets be less than the amount required by paragraph (1).

(4) EFFECTIVE PERIOD.—For purposes of a fiscal year not subject to an order under this section following a fiscal year subject to an order under this section, this Act and the amendments made by this Act shall be assumed to continue as if the order had not been issued.

(5) CONSULTATION.—The President shall confer with the National Health Benefits Board and the National Health Care Cost and Coverage Commission in carrying out this subsection.

(e) FINAL SEQUESTER DETERMINATION.—Using the same economic and technical assumptions as used in making the preliminary determination under subsection (c), the President shall reestimate the current health care baselines on September 15 based on legislation in effect as of September 10. If the aggregate difference between

the initial and updated baseline is more than $10,000,000,000 in the current fiscal year and budget year combined, the President shall issue a final order (and accompanying final regulations) following the procedure set forth in subsection (d).

(f) SUSPENSION IN THE EVENT OF WAR OR LOW GROWTH.—

(1) LOW GROWTH.—The President shall not issue either a proposed or final order under this section if the Office of Management and Budget notifies the Congress that—

(A) during the period consisting of the quarter during which such notification is given, the quarter preceding such notification, and the 4 quarters following such notification, the Office of Management and Budget has determined that real economic growth is projected or estimated to be less than zero with respect to each of any 2 consecutive quarters within such period; or

(B) the most recent of the Department of Commerce's advance preliminary or final reports of actual real economic growth indicate that the rate of real economic growth for each of the most recently reported quarter and the

1 immediately preceding quarter is less than 1
2 percent.
3 (2) WAR.—The President shall not issue either
4 a proposed or final order under this section if a dec-
5 laration of war is in effect.
6 (g) RECOMMENDATIONS FOR ALTERNATIVE REDUC-
7 TIONS.—If the President's budget for a fiscal year is ac-
8 companied by an order under subsection (d)(1), the Na-
9 tional Health Benefits Board shall, within a reasonable
10 time, transmit to the President, the Speaker of the House
11 of Representatives, and the President of the Senate a re-
12 port including alternative proposals to offset the projected
13 excess set forth in subsection (c)(4).
14 (h) GAO AUDIT OF REDUCTIONS.—If the President
15 has issued an order under subsection (d)(1), the General
16 Accounting Office shall report to Congress, as soon there-
17 after as possible following the date of transmittal of the
18 President's budget, an analysis of whether the order has
19 fully complied with the requirements of this section.
20 (i) ADDITIONAL OMB REPORTING REQUIREMENTS
21 TO BE INCLUDED IN PRESIDENT'S BUDGET.—
22 (1) ADJUSTED ESTIMATE OF TOTAL FEDERAL
23 HEALTH CARE COSTS.—
24 (A) IN GENERAL.—When the President
25 submits the budget for fiscal year 1997, and

1 each fiscal thereafter through 2004, the Presi-
2 dent shall include an estimate of total Federal
3 health care costs as described in subparagraph
4 (B).

5 (B) TOTAL FEDERAL HEALTH CARE
6 COSTS.—Total Federal health care costs are—

7 (i) Federal spending in the current
8 health care baseline (as determined under
9 subsection (c)(3)); plus

10 (ii) discretionary health care spending
11 on—

12 (I) the health care program for
13 active military personnel under title
14 10, United States Code;

15 (II) the veterans health care pro-
16 gram under chapter 17 of title 38,
17 United States Code;

18 (III) the Civilian Health and
19 Medical Program of the Uniformed
20 Services (CHAMPUS), as defined in
21 section 1073(4) of title 10, United
22 States Code;

23 (IV) the Federal Employee
24 Health Benefit Plan under chapter 89

of title 5, United States Code (FEHB); and

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

(2) COST AS A PERCENT OF TOTAL REVENUES.—The President shall include with the estimate required by this subsection a calculation by OMB of the percentage of personal and corporate income taxes needed to pay for total Federal health care costs, as adjusted by this subsection, in excess of dedicated health revenues. OMB shall assume that all dedicated health revenues resulting from amendments made by this Act will be allocated for total Federal health care costs, as adjusted by this subsection.

(j) ADDITIONAL COMMISSION REPORTING REQUIREMENTS.—Effective beginning in 1997, the National Health Care Commission shall report annually on how health care expenses are being financed. Among other things, this report shall include—

(1) how much is spent annually in premiums, out-of-pocket expenses, and third party expenses; and

(2) the number of businesses that provide health insurance and a profile of businesses that do not provide health insurance, including the earnings of such businesses.

○