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104TH CONGRESS
1ST SESSION

H. R. 1424

To provide Americans with secure, portable health insurance benefits through tax credits, medical savings accounts, and greater choice of health insurance plans without mandates, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 6, 1995

Mr. STEARNS introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide Americans with secure, portable health insurance benefits through tax credits, medical savings accounts, and greater choice of health insurance plans without mandates, 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 AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Consumer Choice Health Reform Act of 1995''.

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

SEC. 2. PURPOSES.

The purposes of this Act are to—

(1) provide Americans with secure, portable health insurance benefits and greater choice of health insurance plans,

(2) make the American health care system responsive to consumer needs and encourage the provision of quality medical care at reasonable prices through enhanced competition,

(3) provide more equitable tax treatment of health insurance and medical care expenses, and

(4) assist low-income and uninsured Americans in purchasing health insurance and receiving primary medical care.

TITLE I—TAX AND INSURANCE PROVISIONS

Subtitle A—Tax Treatment of Health Care Expenses

SEC. 101. REFUNDABLE HEALTH CARE EXPENSES TAX CREDIT.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable personal credits) is amended by inserting after section 34 the following new section:

"**SEC. 34A. HEALTH CARE EXPENSES.**

''(a) ALLOWANCE OF CREDIT.—In the case of a qualified individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the sum of—

''(1) 22 percent of the sum of the qualified health insurance premiums and the unreimbursed expenses for medical care paid by such individual during the taxable year which does not exceed 10

percent of the adjusted gross income of such individual for such year, plus

''(2) 44 percent of the sum of such premiums and such unreimbursed expenses so paid which exceeds 10 percent but does not exceed 20 percent of such adjusted gross income, plus

''(3) 66 percent of the sum of such premiums and such unreimbursed expenses so paid which exceeds 20 percent of such adjusted gross income.

''(b) QUALIFIED INDIVIDUALS.—For purposes of this section:

''(1) IN GENERAL.—The term 'qualified individual' means the taxpayer, the spouse of the taxpayer, and each dependent of the taxpayer (as defined in section 152) who is enrolled in a federally qualified health insurance plan.

''(2) FEDERALLY COVERED INDIVIDUALS.—The term 'qualified individual' does not include any individual whose medical care is covered under—

''(A) title XVIII or XIX of the Social Security Act,

''(B) chapter 55 of title 10, United States Code,

''(C) chapter 17 of title 38, United States Code, or

''(D) the Indian Health Care Improvement Act.

''(3) SPECIAL RULE IN THE CASE OF CHILD OF DIVORCED PARENTS, ETC.—Any child to whom section 152(e) applies shall be treated as a dependent of both parents.

''(4) MARRIAGE RULES.—The determination of whether an individual is married at any time during the taxable year shall be made in accordance with the provisions of section 6013(d) (relating to determination of status as husband and wife).

''(c) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage for any taxable year is determined by the number of whole months in such year in which the taxpayer is a qualified individual.

''(d) QUALIFIED HEALTH INSURANCE PREMIUMS.—For purposes of this section, the term 'qualified health insurance premiums' means premiums for—

''(1) a federally qualified health insurance plan, and

''(2) any other benefits or plans supplementary to such a federally qualified health insurance plan.

''(e) FEDERALLY QUALIFIED HEALTH INSURANCE PLAN.—For purposes of this section, the term 'federally qualified health insurance plan' means a health insurance

plan which is described in section 111 of the Consumer Choice Health Reform Act of 1995.

''(f) MEDICAL CARE.—For purposes of this section:

''(1) IN GENERAL.—The term 'medical care' means amounts paid—

''(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, and

''(B) for transportation primarily for and essential to medical care referred to in subparagraph (A).

''(2) AMOUNTS PAID FOR CERTAIN LODGING AWAY FROM HOME TREATED AS PAID FOR MEDICAL CARE.—Amounts paid for lodging (not lavish or extravagant under the circumstances) while away from home primarily for and essential to medical care referred to in paragraph (1)(A) shall be treated as amounts paid for medical care if—

''(A) the medical care referred to in paragraph (1)(A) is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital), and

''(B) there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount taken into account under the preceding sentence shall not exceed $50 for each night for each individual.

''(3) COSMETIC SURGERY.—

''(A) IN GENERAL.—The term 'medical care' does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

''(B) COSMETIC SURGERY DEFINED.—For purposes of this paragraph, the term 'cosmetic surgery' means any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

''(4) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

''(g) SPECIAL RULES.—For purposes of this section:

''(1) LIMITATION WITH RESPECT TO MEDICINE AND DRUGS.—

''(A) IN GENERAL.—An amount paid during the taxable year for medicine or a drug shall be taken into account under subsection (a) only if such medicine or drug is a prescribed drug or is insulin.

''(B) PRESCRIBED DRUG.—The term 'prescribed drug' means a drug or biological which requires a prescription of a physician for its use by an individual.

''(2) SPECIAL RULE FOR DECEDENTS.—

''(A) TREATMENT OF EXPENSES PAID AFTER DEATH.—Expenses for the medical care of the taxpayer which are paid out of the taxpayer's estate during the 1-year period beginning with the day after the date of the taxpayer's death shall be treated as paid by the taxpayer at the time incurred.

''(B) LIMITATION.—Subparagraph (A) shall not apply if the amount paid is allowable under section 2053 as a deduction in computing the taxable estate of the decedent, but this subparagraph shall not apply if (within the time

and in the manner and form prescribed by the Secretary) there is filed—

''(i) a statement that such amount has not been allowed as a deduction under section 2053, and

''(ii) a waiver of the right to have such amount allowed at any time as a deduction under section 2053.

''(3) FORM OF INSURANCE CONTRACT.—In the case of an insurance contract under which amounts are payable for other than medical care—

''(A) no amount shall be treated as paid for insurance to which subsection (a) applies unless the charge for such insurance is either separately stated in the contract, or furnished to the policyholder by the insurance company in a separate statement,

''(B) the amount taken into account as the amount paid for such insurance shall not exceed such charge, and

''(C) no amount shall be treated as paid for such insurance if the amount specified in the contract (or furnished to the policyholder by the insurance company in a separate statement) as the charge for such insurance is unreason-

ably large in relation to the total charges under the contract.

''(4) EXCLUSION OF AMOUNTS ALLOWED FOR CARE OF CERTAIN DEPENDENTS.—Any expense allowed as a credit under section 21 shall not be treated as an expense paid for medical care.

''(5) COORDINATION WITH ADVANCE PAYMENT AND MINIMUM TAX.—Rules similar to the rules of subsections (g) and (h) of section 32 shall apply to any credit to which this section applies.

''(6) SUBSIDIZED EXPENSES.—No expense shall be taken into account under subsection (a), if—

''(A) such expense is paid, reimbursed, or subsidized (whether by being disregarded for purposes of another program or otherwise) by the Federal Government, a State or local government, or any agency or instrumentality thereof, and

''(B) the payment, reimbursement, or subsidy of such expense is not includable in the gross income of the recipient.

''(7) COORDINATION WITH MEDICAL SAVINGS ACCOUNTS.—The amount otherwise taken into account under subsection (a) shall be reduced by the amount (if any) of the distributions from any medi-

cal savings account of the taxpayer during the taxable year which is not includible in gross income by reason of being used for qualified medical expenses (as defined in section 25A(c)(2)).

''(h) INDEXING OF PERCENTAGES.—For each year after 1998, the Secretary, in consultation with the Secretary of Health and Human Services, shall adjust the references to 10 percent and 20 percent in subsection (a) by the ratio of—

''(1) the percentage increase in medical care inflation between 1997 and the year before the year involved, to

''(2) the national average percentage increase in adjusted gross income of individuals between such years.

''(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) ADVANCE PAYMENT OF CREDIT.—Chapter 25 of the Internal Revenue Code of 1986 (relating to general provisions relating to employment taxes) is amended by inserting after section 3507 the following new section:

"SEC. 3507A. ADVANCE PAYMENT OF HEALTH EXPENSES CREDIT.

''(a) GENERAL RULE.—Except as otherwise provided in this section, every employer making payment of wages with respect to whom a health care expenses eligibility certificate is in effect shall, at the time of paying such wages, make an additional payment equal to such employee's health care expenses advance amount.

''(b) HEALTH CARE EXPENSES ELIGIBILITY CERTIFICATE.—For purposes of this title, a health care expenses eligibility certificate is a statement furnished by an employee to the employer which—

''(1) certifies that the employee will be eligible to receive the credit provided by section 34A for the taxable year,

''(2) certifies that the employee does not have a health care expenses eligibility certificate in effect for the calendar year with respect to the payment of wages by another employer,

''(3) states whether or not the employee's spouse has a health care expenses eligibility certificate in effect, and

''(4) estimates the amount of premiums for a federally qualified health insurance plan and unreimbursed expenses for medical care (as defined in section 34A) for the calendar year.

For purposes of this section, a certificate shall be treated as being in effect with respect to a spouse if such a certificate will be in effect on the first status determination date following the date on which the employee furnishes the statement in question.

''(c) HEALTH CARE EXPENSES ADVANCE AMOUNT.—

''(1) IN GENERAL.—For purposes of this title, the term 'health expenses advance amount' means, with respect to any payroll period, the amount determined—

''(A) on the basis of the employee's wages from the employer for such period,

''(B) on the basis of the employee's estimated premiums for a federally qualified health insurance plan and unreimbursed expenses for medical care included in the health care expenses eligibility certificate, and

''(C) in accordance with tables provided by the Secretary.

''(2) ADVANCE AMOUNT TABLES.—The tables referred to in paragraph (1)(C) shall be similar in form to the tables prescribed under section 3402 and, to the maximum extent feasible, shall be coordi-

nated with such tables and the tables prescribed under section 3507(c).

''(d) OTHER RULES.—For purposes of this section, rules similar to the rules of subsections (d) and (e) of section 3507 shall apply.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(c) CLERICAL AMENDMENTS.—

(1) The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 34 the following new item:

''Sec. 34A. Health care expenses.''.

(2) The table of sections for chapter 25 of such Code is amended by adding after the item relating to section 3507 the following new item:

''Sec. 3507A. Advance payment of health care expenses credit.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

SEC. 102. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is

amended by inserting after section 25 the following new section:

"SEC. 25A. MEDICAL SAVINGS ACCOUNTS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to 25 percent of the amount paid in cash during such year by or on behalf of such individual to a medical savings account.

''(b) LIMITATIONS.—For purposes of this section:

''(1) ONLY 1 ACCOUNT PER FAMILY.—No credit shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual's spouse, or any dependent (as defined in section 152) of such individual if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

''(2) DOLLAR LIMITATION.—The aggregate amount of contributions which may be taken into account under subsection (a) with respect to any individual for any taxable year shall not exceed the sum of—

''(A) $3,000, plus

''(B) $500 for each individual who is a dependent (as so defined) of the individual for whose benefit the account is established.

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

''(1) MEDICAL SAVINGS ACCOUNT.—

''(A) IN GENERAL.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the individual for whose benefit the trust is established, but only if the written governing instrument creating the trust meets the following requirements:

''(i) Except in the case of a rollover contribution described in subsection (d)(4), no contribution will be accepted unless it is in cash and contributions will not be accepted for any taxable year in excess of the amount determined under subsection (b)(1).

''(ii) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which such per-

son will administer the trust will be consistent with the requirements of this section.

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

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

''(v) The interest of an individual in the balance in such individual's account is nonforfeitable.

''(vi) Under regulations prescribed by the Secretary, rules similar to the rules of section 401(a)(9) shall apply to the distribution of the entire interest of beneficiaries of such trust.

''(B) TREATMENT OF COMPARABLE ACCOUNTS HELD BY INSURANCE COMPANIES.—An account held by an insurance company in the United States shall be treated as a medical savings account (and such company shall be treated as a bank) if—

''(i) such account is part of a federally qualified health insurance plan (as defined in section 34A(e)),

''(ii) such account is exclusively for the purpose of paying the medical expenses of the beneficiaries of such account who are covered under such health insurance plan, and

''(iii) the written instrument governing the account meets the requirements of clauses (i), (v), and (vi) of subparagraph (A).

''(2) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' means amounts paid by the individual for whose benefit the account was established for premiums for a federally qualified health insurance plan (as so defined) and the unreimbursed expenses for medical care (as determined under section 34A) of such individual, the spouse of such individual, and any dependent (as so defined) of such individual.

''(3) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A contribution shall be deemed to be made on the last day of the preceding taxable year if the contribution is made on account of such taxable year

and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, any amount paid or distributed out of a medical savings account shall be included in the gross income of the individual for whose benefit such account was established unless such amount is used exclusively to pay the qualified medical expenses of such individual.

''(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the amount allowable under subsection (b) if—

''(A) such distribution is received on or before the day prescribed by law (including extensions of time) for filing such individual's return for such taxable year,

''(B) no credit is allowed under subsection (a) with respect to such excess contribution, and

''(C) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (C) shall be included in the gross income of the individual for the taxable year in which it is received.

''(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is not used to pay the medical expenses of the individual for whose benefit the account was established, shall be increased by 10 percent of the amount of such payment or distribution which is includible in gross income under paragraph (1).

''(4) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the individual for whose benefit the account is maintained, if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such individual not later than the 60th day after the day on which the individual received the payment or distribution.

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) EXEMPTION FROM TAX.—Any medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) LOSS OF EXEMPTION OF ACCOUNT WHERE INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

''(A) IN GENERAL.—If, during any taxable year of the individual for whose benefit the medical savings account was established, such individual engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a medical savings account as of the first day of that taxable year.

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (d) applies as if there were a distribution on such first day in an amount equal to the fair

market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay qualified medical expenses.

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

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

''(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

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

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sen-

tence, the custodian of such account shall be treated as the trustee thereof.

''(g) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1999, each applicable dollar amount shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment for the calendar year in which the taxable year begins.

''(2) COST-OF-LIVING ADJUSTMENT.—For purposes of paragraph (1), the cost-of-living adjustment for any calendar year is the percentage (if any) by which—

''(A) the deemed average total wages (as defined in section 209(k) of the Social Security Act) for the preceding calendar year, exceeds

''(B) the deemed average total wages (as so defined) for calendar year 1997.

''(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1), the term 'applicable dollar amount' means the $3,000 and $500 amounts in subsection (b)(2).

''(4) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $10, such

amount shall be rounded to the nearest multiple of $10 (or, if such amount is a multiple of $5 and not of $10, such amount shall be rounded to the next highest multiple of $10).

''(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''.

(b) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of the Internal Revenue Code of 1986 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 25A(c)(1)),'',

(3) by striking ''or'' at the end of paragraph (1) of subsection (a), and

(4) by adding at the end thereof the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 25A(c)(1)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount allowable under section 25A(b)(2) for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings account and a distribution to which section 25A(d)(2) applies shall be treated as an amount not contributed.''.

(c) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of the Internal Revenue Code of 1986 (relating to prohibited transactions) is amended—

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

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section

25A(c)(1)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 25A(e)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 25A(c)(1)'' in subsection (e)(1) after ''described in section 408(a)''.

(d) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of the Internal Revenue Code of 1986 (relating to failure to provide reports on individual retirement account or annuities) is amended—

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

(2) by adding at the end of subsection (a) the following: ''The person required by section 25A(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''.

(e) CLERICAL AMENDMENTS.—

(1) The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 25 the following:

''Sec. 25A. Medical savings accounts.''.

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following:

''Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annuities.''.

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

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

SEC. 103. OTHER TAX PROVISIONS.

(a) TERMINATION OF MEDICAL EXPENSE DEDUCTION.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

''(g) TERMINATION.—No amount paid after December 31, 1998, shall be treated as an expense paid for medical care.''.

(b) TERMINATION OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to taxable years beginning after December 31, 1998.

(c) TERMINATION OF EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new sentence: ''The preceding sentence shall not apply to any amount paid after December 31, 1998.''.

Subtitle B—Insurance Provisions

PART I—FEDERALLY QUALIFIED HEALTH INSURANCE PLAN

SEC. 111. FEDERALLY QUALIFIED HEALTH INSURANCE PLAN.

(a) IN GENERAL.—A federally qualified health insurance plan is a health insurance plan offered, issued, or renewed on or after January 1, 1999, which is certified by the applicable regulatory authority as meeting, at a minimum, the requirements of sections 112, 113, 114, and 115, and the regulatory program described in section 117.

(b) GENERAL DEFINITIONS.—As used in this Act:

(1) HEALTH INSURANCE PLAN.—The term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract and, in States which have distinct licensure requirements, a multiple employer welfare arrangement, but does not include any of the following offered by an insurer:

(A) Accident only, dental only, disability only, or long-term care only insurance.

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

(C) Workers' compensation or similar insurance.

(D) Automobile medical-payment insurance.

(2) APPLICABLE REGULATORY AUTHORITY.—The term ''applicable regulatory authority'' means—

(A) in the case of a State with a program described in section 117, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance; or

(B) if the State has not established such a program or such program has been decertified under section 117(b), the Secretary.

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

(4) STATE.—The term ''State'' means each of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, America Samoa, and the Commonwealth of the Northern Mariana Islands.

SEC. 112. FAMILY SECURITY BENEFITS PACKAGE.

(a) REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the requirements of this section are met, if the health insurance plan—

(A) provides coverage for all medically necessary acute medical care described in subsection (b),

(B) does not exclude coverage for selected illnesses or selected treatments if consistent with medically accepted practices, and

(C) meets the patient cost sharing requirements of subsection (c).

(2) ACTUARIAL EQUIVALENTS ALLOWED.—The requirements of this section also are met with respect to a plan if the plan covers medically necessary acute medical care and has an actuarial value at least equivalent to the actuarial value of the benefits otherwise required under paragraph (1).

(b) ACUTE MEDICAL CARE.—Coverage for all medically necessary acute medical care is described in this subsection if such coverage includes—

(1) physician services,

(2) inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization, and

(3) inpatient prescription drugs.

Nothing in this subsection may be construed to require the inclusion of abortion services.

(c) LIMITATION ON COST SHARING.—

(1) IN GENERAL.—A health insurance plan may not require the payment of any deductible, copayment, or coinsurance for an item or service for which coverage is required under this section after an individual or a family covered under the plan has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit for a plan year.

(2) LIMIT ON OUT-OF-POCKET EXPENSES.—As used in this paragraph:

(A) OUT-OF-POCKET EXPENSES DEFINED.—The term ''out-of-pocket expenses'' means, with respect to an individual or a family in a plan year, amounts payable under the plan as deductibles, coinsurance, and copayments with respect to items and services provided under the plan and furnished in the plan year on behalf of the individual or the family covered under the plan.

(B) OUT-OF-POCKET LIMIT DEFINED.—

(i) IN GENERAL.—The term ''out-of-pocket limit'' means—

(I) the amount specified under clause (ii), or

(II) 10 percent of the adjusted gross income of the family involved,

whichever is greater.

(ii) MINIMUM AMOUNT.—The amount specified in this clause for a plan year beginning in—

(I) a calendar year prior to 1999, is $5,000; or

(II) for a subsequent calendar year, is the amount specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the amount computed under subclause (II) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

SEC. 113. RATING PRACTICES.

(a) IN GENERAL.—The requirements of this section are met, if, except as provided in subsection (b), the health insurance plan provides for—

(1) a variation in premium rates only on the basis of age, sex, and geography, and

(2) a charge of the same premium rates to new applicants and existing policyholders with the same age, sex, and geographic characteristics.

(b) INCENTIVE DISCOUNTS.—A plan may discount an individual's premium rate as an incentive for participating in a program, approved by the applicable regulatory authority to be offered in conjunction with the coverage, which has as its objective, 1 or more of the following:

(1) To promote healthy behavior.

(2) To prevent or delay the onset of illness.

(3) To provide for screening or early detection of illness.

SEC. 114. GUARANTEED ISSUE.

(a) IN GENERAL.—Except as provided in paragraph (2), in the case of applications made on and after January 1, 2000, the following rules apply:

(1) IN GENERAL.—The requirements of this section are met, if, except as provided in paragraph (2), the health insurance plan—

(A) provides guaranteed issue at standard rates to all applicants, and

(B) does not exclude from coverage, or limit coverage for, any preexisting medical condition of any applicant who, on the date the application is made, has been continuously insured for a period of at least 1 year prior to the date of the application under 1 or more of the following health insurance plans or programs:

(i) Another federally qualified health insurance plan.

(ii) An employer-sponsored group health insurance plan in effect before the date of the enactment of this Act.

(iii) An individual health insurance plan in effect before such date.

(iv) A program described in—

(I) title XVIII or XIX of the Social Security Act,

(II) chapter 55 of title 10, United States Code,

(III) chapter 17 of title 38, United States Code,

(IV) chapter 89 of title 5, United States Code, or

(V) the Indian Health Care Improvement Act.

(2) BREAK IN COVERAGE.—In the case of an applicant who has not been continuously insured for a period of 1 year prior to the date the application is made, the health insurance plan may exclude from coverage, or limit coverage for, any preexisting medical condition for a period no greater than the lesser of—

(A) the number of months immediately prior to the date of the application during which the individual was not insured since the illness or condition in question was first diagnosed, or

(B) 1 year.

(b) TRANSITION RULE.—In the case of applications made in 1999, the requirements of this section are met, if the health insurance plan—

(1) provides guaranteed issue at standard rates to all applicants, and

(2) does not exclude from coverage, or limit coverage for, any preexisting medical condition of any applicant.

SEC. 115. GUARANTEED RENEWABILITY.

The requirements of this section are met, if the health insurance plan provides the policyholder with a contractual right to renew the coverage which stipulates that the insurer cannot cancel or refuse to renew the coverage except for cases of—

(1) nonpayment of premiums by the policyholder, or

(2) fraud or misrepresentation by the policyholder.

PART II—CERTIFICATION OF FEDERALLY QUALIFIED HEALTH INSURANCE PLANS

SEC. 117. ESTABLISHMENT OF REGULATORY PROGRAM FOR CERTIFICATION OF PLANS.

(a) IN GENERAL.—Each State shall establish no later than January 1, 1999, a regulatory program which meets the standards referred to in section 118.

(b) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAM.—The Secretary periodically shall review each State regulatory program to determine if such program continues to meet and enforce the standards referred to in section 118. If the Secretary initially determines that a State regulatory program no longer meets and enforces such standards, the Secretary shall provide the State an opportunity to adopt a plan of correction that would bring such program into compliance with such

standards. If the Secretary makes a final determination that the State regulatory program fails to meet and enforce such standards after such an opportunity, the Secretary shall decertify such program and assume responsibility with respect to health insurance plans in the State.

SEC. 118. STANDARDS FOR REGULATORY PROGRAMS.

(a) IN GENERAL.—The Secretary, in consultation with the National Association of Insurance Commissioners (hereafter in this section referred to as ''NAIC'') shall develop by not later than 1 year after the date of the enactment of this Act, in the form of model Acts and model regulations, State regulatory program standards which include—

(1) procedures for certifying that the requirements of part I of this subtitle have been met by a health insurance plan applying for certification as a federally qualified health insurance plan,

(2) the requirements described in subsections (b), (c), and (d),

(3) requirements with respect to solvency standards and guaranty funds for carriers of federally qualified health insurance plans, and

(4) reporting requirements under which carriers report to the Internal Revenue Service regarding the acquisition and termination by individuals of cov-

erage under federally qualified health insurance plans.

(b) PASSBACK OF CLAIMS AND PREMIUMS.—The requirements of this subsection are met, if, in the case of an applicant who has been continuously insured, as described in section 114(b)(1)(B), and is at the time of the application receiving treatment for a preexisting medical condition—

(1) the federally qualified health insurance plan is allowed to pass back to the applicant's previous plan any claims relating to such condition, together with a portion of the premium, and

(2) such previous plan is required to pay such claims and premium incurred during the lesser of—

(A) the duration of the course of the treatment or spell of illness, or

(B) 2 years from the date at which coverage commenced under the federally qualified health insurance plan.

(c) MARKETING PRACTICES.—The requirements of this subsection are met, if the carrier offering the federally qualified health insurance plan retains the right to select agents with whom such plan contracts and to determine the amount and form of compensation to such agents, except that—

(1) if the carrier chooses to contract with an agent, the carrier may not terminate or refuse to renew the agency contract for any reason related to the age, sex, health status, claims experience, occupation, or geographic location of the insureds placed by the agent with such plan, and

(2) the carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for, or results in, any consideration provided to such agent for the issuance or renewal of such a plan to vary on account of the age, sex, health status, claims experience, occupation, or geographic location of the insureds placed by the agent with such plan.

(d) RISK ADJUSTMENT OR REINSURANCE PROGRAMS.—The requirements of this subsection are met, if the carrier offering the federally qualified health insurance plan participates in a State-administered risk adjustment program (or, at the option of the State, a reinsurance program) designed to compensate for the potential occurrence of grossly disproportionate distributions of above-standard or below-standard insured risks among federally qualified health insurance plans.

(e) NONBINDING STANDARDS.—The Secretary, in consultation with NAIC, shall also develop within the 1-

year period described in subsection (a), nonbinding standards for premium rating practices and guaranteed renewability of coverage which, if the insurer so elects, is more generous (additional benefits or lower cost sharing or both) than the requirements under part I of this subtitle for federally qualified health insurance plans.

Subtitle C—Employer Provisions

SEC. 121. GENERAL PROVISIONS RELATING TO EMPLOYERS.

(a) PREMIUMS WITHHELD.—Each employer shall—

(1) withhold from each employee's wages the amount of the employee's health insurance premium and remit, directly or indirectly, such premium to the insurance plan of the employee's choice according to an agreed upon schedule, and

(2) within the first 30 days of any calendar year or the date of the hire of an employee, notify each employee of the employee's right to claim an advance refundable tax credit for such premium under section 34A of the Internal Revenue Code of 1986.

(b) EFFECTIVE DATE.—The requirements under subsection (a) shall apply with respect to calendar year 1999 and thereafter.

SEC. 122. CONVERSION OF NON-SELF-INSURED PLANS.

In the case of an employer-sponsored health insurance plan in force on the date of the enactment of this Act, and which is not a self-insured plan, the insurer from whom the plan was purchased (or, in the event such insurer refuses, any new subsidiary, corporation, insurer, union, cooperative, or association willing to become the new sponsor of the plan) shall—

(1) notify, not later than October 1, 1998, all of the primary insured beneficiaries of the employer-sponsored plan of their rights to convert their insurance coverage to a federally qualified health insurance plan (as defined in section 111) offered by the insurer with benefits identical to, or actuarially equivalent to, those of the employer-sponsored plan and the rates of that coverage, and provide such beneficiaries 60 additional days to decline or accept the new coverage, and

(2) offer such coverage beginning January 1, 1999, at premium rates which vary only by age, sex, and geography, except that the combined total of the new rates charged separately to the various beneficiaries may not exceed the total group rate paid by the employer or employees or both under the employer-sponsored plan on the last day it is, or was, in force.

SEC. 123. PROVISIONS RELATING TO EXISTING SELF-INSURED PLANS.

(a) IN GENERAL.—In the case of an employer-sponsored health insurance plan in force on the date of the enactment of this Act, and which is a self-insured plan, the employer sponsoring the plan may, at anytime following such date sell, transfer, or assign the plan to any existing or new, subsidiary, corporation, insurer, union, cooperative or association, willing to become the new sponsor of the plan, except that—

(1) such sale, transfer, or assignment may not take effect unless first approved by a two-thirds majority vote of all the primary-insured beneficiaries of the plan, and

(2) the terms or conditions and benefits or coverage of the plan, and the eligibility criteria for participation in the plan, may not be altered before such date.

(b) PROVISIONS GOVERNING PLAN.—As of the date of the enactment of this Act, the sponsor of the plan described in subsection (a) becomes subject to all laws governing the operation of a corporation selling health insurance in the applicable State or States and to the provisions of section 122.

SEC. 124. CONTINUATION OF EMPLOYER-PROVIDED HEALTH COVERAGE REQUIRED UNTIL EFFECTIVE DATE OF NEW COVERAGE UNDER THIS ACT.

(a) IN GENERAL.—Clause (i) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 (relating to period of coverage) is amended by inserting after subclause (V) the following new subclause:

''(VI) QUALIFYING EVENT INVOLVING END OF PLAN.—In the case of an event described in paragraph (3)(G), December 31, 1998.''.

(b) QUALIFYING EVENT INVOLVING END OF PLAN.—Paragraph (3) of section 4980B(f) of the Internal Revenue Code of 1986 (defining qualifying event) is amended by inserting after subparagraph (F) the following new subparagraph:

''(G) The termination by the employer of the group health plan after the date of the enactment of the Consumer Choice Health Reform Act of 1995.''.

(c) CONFORMING AMENDMENT.—Clause (ii) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended by striking ''The date'' and inserting ''Except in the case of a qualifying event described in paragraph (3)(G), the date''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring after the date of the enactment of this Act.

SEC. 125. REQUIREMENTS WITH RESPECT TO CASHING OUT EMPLOYER-SPONSORED PLANS.

(a) NON-FEDERAL EMPLOYERS.—

(1) IN GENERAL.—Each employer contributing in whole or in part to an employer-sponsored health insurance plan on December 1, 1998, shall, within 30 days after such date—

(A) notify each employee participating in the plan of the amount spent by the employer on the employee's health insurance, as determined under paragraph (2),

(B) add such amount to the cash wages of the employee commencing with pay periods beginning on and after January 1, 1999, and

(C) hold each employee harmless for the employer's share of any payroll taxes due under chapter 31 of the Internal Revenue Code of 1986 on such amount.

(2) AMOUNT OF INCLUSION.—The amount described in paragraph (1)(A) shall equal the actuarial value of the employer's contribution for group health issuance coverage apportioned to the plan's bene-

ficiaries according to the new premiums for individual and family coverage determined by the insurer.

(3) PRIOR TERMINATION.—Any beneficiary of an employer-sponsored health insurance plan who voluntarily terminates coverage under such a plan before December 1, 1998, forfeits the right to receive the value of the beneficiary's coverage in cash.

(b) COMMISSION ON CASHING OUT FEHBP BENEFITS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is established an independent board to be known as the ''Benefits Cash Out Commission'' (in this subtitle, referred to as the ''Commission'').

(B) DUTIES.—The Commission shall study and propose a procedure under which individuals may cash out health benefits under chapter 89 of title 5, United States Code, and pay scales and retirement benefits would be adjusted accordingly. The Commission shall report to Congress regarding such study and proposal not later than 1 year after the date of the enactment of this Act.

(C) MEMBERSHIP.—

(i) IN GENERAL.—The Commission shall be composed of 13 members appointed by the President by and with the advice and consent of the Senate.

(ii) CONSULTATION.—In selecting individuals for nominations for appointments for the Commission, the President should consult with—

(I) the Speaker of the House of Representatives concerning the appointment of 3 members;

(II) the Majority Leader of the Senate concerning the appointment of 3 members;

(III) the Minority Leader of the House of Representatives concerning the appointment of 3 members; and

(IV) the Minority Leader of the Senate concerning the appointment of 3 members.

(iii) CHAIR.—The President shall designate 1 individual described in clause (ii) who shall serve as Chair of the Commission.

(iv) COMPOSITION OF COMMISSION.—The membership of the Commission shall include individuals with national recognition for expertise in the valuation of health insurance benefits and of Federal civilian pay and retirement benefits.

(D) ADMINISTRATIVE PROVISIONS.—

(i) MEETINGS.—Each meeting of the Commission shall be open to the public.

(ii) PAY AND TRAVEL EXPENSES.—

(I) IN GENERAL.—Each member, other than the Chair, 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.

(II) CHAIR.—The Chair shall be paid for each day referred to in subclause (I) at a rate equal to the daily equivalent of the minimum an-

nual rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

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

(iii) STAFF.—

(I) IN GENERAL.—Subject to subclauses (II) and (III), the Chair, with the approval of the Commission, may appoint and fix the pay of additional personnel.

(II) PAY.—The Chair 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.

(III) DETAILED PERSONNEL.—Upon request of the Chair, 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.

(iv) OTHER AUTHORITY.—

(I) 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.

(II) LEASES, ETC.—The Commission may lease space and acquire

personal property to the extent funds are available.

(2) CONSIDERATION.—

(A) IN GENERAL.—The proposal described in paragraph (1)(B) shall be considered by the Congress under the procedures for consideration of an ''approval resolution'' as described in subparagraph (D).

(B) EFFECTIVE DATE OF IMPLEMENTATION.—The provisions of the proposal shall become effective on January 1, 1998.

(C) PERIOD FOR RESUBMISSION OF PROPOSAL IN CASE OF NONAPPROVAL.—If the proposal of the Commission described in subparagraph (A) is not approved by Congress, the Commission shall by not later than January 1, 1997, submit a new proposal to Congress.

(D) RULES GOVERNING CONGRESSIONAL CONSIDERATION.—

(i) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This subparagraph is enacted by the Congress—

(I) as an exercise of the rulemaking power of the House of Representatives and the Senate, respec-

tively, 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 approval resolutions described in clause (ii), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(II) 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.

(ii) TERMS OF THE RESOLUTION.—For purposes of subparagraph (A), the term ''approval resolution'' means only a joint resolution of the 2 Houses of the Congress, providing in—

(I) the matter after the resolving clause of which is as follows: ''That the Congress approves the recommendations of the Benefits Cash

Out Commission as submitted by the Commission on _____'', the blank space being filled in with the appropriate date; and

(II) the title of which is as follows: ''Joint Resolution approving the recommendation of the Benefits Cash Out Commission''.

(iii) INTRODUCTION AND REFERRAL.—On the day on which the recommendation of the Commission is transmitted to the House of Representatives and the Senate, an approval resolution with respect to such recommendation 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 such recommendation is transmitted, the approval resolution with respect to such recommendation 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 approval resolution introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(iv) AMENDMENTS PROHIBITED.—No amendment to an approval resolution shall be in order in either the House of Representatives or the Senate; and no motion to suspend the application of this clause 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 clause by unanimous consent.

(v) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(I) IN GENERAL.—Except as provided in subclause (II), if the committee or committees of either House to which an approval resolution has been referred have not reported it at the close of the 30th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the approval resolution and it shall be placed on the appropriation calendar. A vote on final passage of the approval resolution shall be taken in each House on or before the close of the 30th day after the approval resolution 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 approval resolution. If prior to the passage by 1 House of an approval resolution of that House, that House receives the same approval resolution from the other House then the proce-

dure in that House shall be the same as if no approval resolution had been received from the other House, but the vote on final passage shall be on the approval resolution of the other House.

(II) COMPUTATION OF DAYS.—For purposes of subclause (I), in computing a number of days in either House, there shall be excluded any day on which the House is not in session.

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

(I) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an approval resolution 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.

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

(III) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of an approval resolution, and motions to proceed to the consideration of other business, shall be decided without debate.

(IV) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the pro-

cedure relating to an approval resolution shall be decided without debate.

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

(vii) FLOOR CONSIDERATION IN THE SENATE.—

(I) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration of an approval resolution 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.

(II) GENERAL DEBATE.—Debate in the Senate on an approval resolution, 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.

(III) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an approval resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the approval resolution, except that in the event the manager of the approval resolution 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 approval resolution, allot additional time to any Senator during the consideration of any debatable motion or appeal.

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

SEC. 126. ENFORCEMENT.

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

"SEC. 5000A. FAILURE OF EMPLOYERS WITH RESPECT TO HEALTH INSURANCE.

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any person to comply with the requirements of sections 121 and 125(a) of the Consumer Choice Health Reform Act of 1995 with respect to any employee of the person.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to an employee shall be $50 for each day in the noncompliance period with respect to such failure.

''(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

''(A) beginning on the date such failure first occurs, and

''(B) ending on the date such failure is corrected.

''(3) CORRECTION.—A failure of a person to comply with the requirements of section 121 or 125(a) of the Consumer Choice Health Reform Act of 1995 with respect to any employee of the person shall be treated as corrected if—

''(A) such failure is retroactively undone to the extent possible, and

''(B) the employee is placed in a financial position which is as good as such employee would have been in had such failure not occurred.

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

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

''(B) such failure is corrected during the 30-day period beginning on the first date any of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

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

''(d) LIABILITY FOR TAX.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the following shall be liable for the tax imposed by subsection (a) on a failure:

''(A) In the case of a health insurance plan other than a multiemployer plan, the employer.

''(B) In the case of a multiemployer plan, the plan.

''(C) Each person who is responsible (other than in a capacity as an employee) for administering or providing benefits under the health insurance plan and whose act or failure to act caused (in whole or in part) the failure.

''(2) SPECIAL RULES FOR PERSONS DESCRIBED IN PARAGRAPH (1)(C).—A person described in subparagraph (C) (and not in subparagraphs (A) and (B)) of paragraph (1) shall be liable for the tax imposed by subsection (a) on any failure only if such person assumed (under a legally enforceable written agreement) responsibility for the performance of the act to which the failure relates.

"SEC. 5000B. FAILURE OF CARRIERS WITH RESPECT TO HEALTH INSURANCE.

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any carrier offering any health insurance plan to comply with the requirements of sections 122 and 123 of the Consumer Choice Health Reform Act of 1995.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 50 percent of the gross premiums received during such taxable

year with respect to all health insurance plans issued by the carrier on whom such tax is imposed.

''(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any health insurance contract.

''(3) CONTROLLED GROUPS.—For purposes of paragraph (1)—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 carrier. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

''(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

''(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or business (whether or not incor-

porated) which are under common control shall be treated as 1 carrier. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the carrier on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

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

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

''(B) such failure is corrected during the 30-day period beginning on the 1st date any of the carriers on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

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

(b) CLERICAL AMENDMENTS.—The table of sections for such chapter 47 is amended by adding at the end thereof the following new items:

''Sec. 5000A. Failure of employers with respect to health insurance.
''Sec. 5000B. Failure of carriers with respect to health insurance.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1998.

Subtitle D—Federal Preemption

SEC. 131. FEDERAL PREEMPTION OF CERTAIN STATE LAWS.

All State laws in existence on January 1, 1999, in the following areas are preempted:

(1) MANDATED INSURANCE BENEFIT LAWS.—Laws requiring health insurance policies to cover specific diseases, services, or providers.

(2) ANTI-MANAGED CARE LAWS.—Laws restricting the ability of managed care plans to selectively contract with providers of their choice.

(3) MANDATED COST-SHARING LAWS.—Laws restricting the extent to which insurers may require

enrollee cost sharing as part of their plans, or restricting the extent to which managed care plans may impose different levels of cost sharing on enrollee claims for treatment by providers not participating in the plan.

TITLE II—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

SEC. 201. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health insurance plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and billing codes for uses with such forms and including information on other health insurance plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 202. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 201 with respect to classes of services, that a significant number of claims for benefits for such services under health insurance plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health insurance plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic trans-

mission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health insurance plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health insurance plan may reject any claim subject to the standards adopted under section 201 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health insurance plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 201(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health insurance plan (other than a health insurance plan described in

paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health insurance plan—

(A) that is subject to regulation by a State, and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 201, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall per-

mit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 203. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 201;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 201, then, in the case of any claim for benefits submitted under a health insurance plan more than the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 202 instead of the standards previously promulgated.

SEC. 204. HEALTH INSURANCE PLAN DEFINED.

In this title, the term ''health insurance plan'' has the meaning given such term in section 111(b) and includes—

(1) the medicare program (under title XVIII of the Social Security Act) and medicare supplemental health insurance, and

(2) a State medicaid plan (approved under title XIX of such Act).

Subtitle B—Electronic Medical Data Standards

SEC. 211. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1995, and January 1, 1996, the Secretary shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 201.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not

hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 215, and with other affected providers, health insurance plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

SEC. 212. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1996, subject to paragraph (2), each hospital, as a requirement of

each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 211(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 211(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements

with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the Medicare program.

(2) WAIVER.—The Secretary of Veterans Affairs may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

SEC. 213. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or transmission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 211, described in paragraph (4) or (5) of section 211(b).

SEC. 214. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 211 with respect to a class of provider, a health insurance plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

(1) provide any data element not in the set of comprehensive data elements specified under such standards, or

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health insurance plan (other than a health insurance plan described in paragraph (2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health insurance plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 215. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this subtitle, and

(2) operational concerns about the implementation of such standards under this subtitle.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1995 through 2000 to carry out this section.

Subtitle C—Development and Distribution of Comparative Value Information

SEC. 221. STATE COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING.

(a) PURPOSE.—In order to assure the availability of comparative value information to purchasers of health care in each State, the Secretary shall determine whether each State is developing and implementing a health care value information program that meets the criteria and schedule set forth in subsection (b).

(b) CRITERIA AND SCHEDULE FOR STATE PROGRAMS.—The criteria and schedule for a State health care value information program in this subsection shall be specified by the Secretary as follows:

(1) The State begins promptly after enactment of this Act to develop (directly or through contractual or other arrangements with 1 or more States, coalitions of health insurance purchasers, other entities, or any combination of such arrangements) information systems regarding comparative health values.

(2) The information contained in such systems covers at least the average prices of common health care services (as defined in subsection (d)) and

health insurance plans, and, where available, measures of the variability of these prices within a State or other market areas.

(3) The information described in paragraph (2) is made available within the State beginning not later than 1 year after the date of the enactment of this Act, and is revised as frequently as reasonably necessary, but at intervals of no greater than 1 year.

(4) Not later than 6 years after the date of the enactment of this Act the State has developed information systems that provide comparative costs, quality, and outcomes data with respect to health insurance plans and hospitals and made the information broadly available within the relevant market areas.

Nothing in this section shall preclude a State from providing additional information, such as information on prices and benefits of different health insurance plans available.

(c) GRANTS TO STATES FOR THE DEVELOPMENT OF STATE PROGRAMS.—

(1) GRANT AUTHORITY.—The Secretary may make grants to each State to enable such State to plan the development of its health care value information program and, if necessary, to initiate the implementation of such program. Each State seeking such a grant shall submit an application therefor,

containing such information as the Secretary finds necessary to assure that the State is likely to develop and implement a program in accordance with the criteria and schedule in subsection (b).

(2) OFFSET AUTHORITY.—If, at any time within the 3-year period following the receipt by a State of a grant under this subsection, the Secretary is required by section 222 to implement a health care information program in the State, the Secretary may recover the amount of the grant under this subsection by offset against any other amount payable to the State under the Social Security Act. The amount of the offset shall be made available (from the appropriation account with respect to which the offset was taken) to the Secretary to carry out such section.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to make grants under this subsection, to remain available until expended.

(d) COMMON HEALTH CARE SERVICES DEFINED.—In this section, the term ''common health care services'' includes such procedures as the Secretary may specify and any additional health care services which a State may wish to include in its comparative value information program.

(e) STATE DEFINED.—In this title, the term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 222. FEDERAL IMPLEMENTATION.

(a) IN GENERAL.—If the Secretary finds, at any time, that a State has failed to develop or to continue to implement a health care value information program in accordance with the criteria and schedule in section 221(b), the Secretary shall take the actions necessary, directly or through grants or contract, to implement a comparable program in the State.

(b) FEES.—Fees may be charged by the Secretary for the information materials provided pursuant to a program under this section. Any amounts so collected shall be deposited in the appropriation account from which the Secretary's costs of providing such materials were met, and shall remain available for such purposes until expended.

SEC. 223. COMPARATIVE VALUE INFORMATION CONCERNING FEDERAL PROGRAMS.

(a) DEVELOPMENT.—The head of each Federal agency with responsibility for the provision of health insurance or of health care services to individuals shall promptly develop health care value information relating to each program that such head administers and covering the same

types of data that a State program meeting the criteria of section 221(b) would provide.

(b) DISSEMINATION OF INFORMATION.—Such information shall be made generally available to States and to providers and consumers of health care services.

Subtitle D—Preemption of State Quill Pen Laws

SEC. 231. PREEMPTION OF STATE QUILL PEN LAWS.

(a) IN GENERAL.—Effective January 1, 1996, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic form.

(b) SECRETARIAL AUTHORITY.—The Secretary may issue regulations to carry out subsection (a). Such regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, with respect to controlled substances, and in such other cases as the Secretary deems appropriate.

TITLE III—ANTI-FRAUD

Subtitle A—Criminal Prosecution of Health Care Fraud

SEC. 301. PENALTIES FOR 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) OFFENSE.—Whoever, being a health care provider, knowingly engages in any scheme or artifice to defraud any person in connection with the provision of health care shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) DEFINITION.—In this section, the term 'health care provider' means—

''(1) a physician, nurse, dentist, therapist, pharmacist, or other professional provider of health care; and

''(2) a hospital, health maintenance organization, pharmacy, laboratory, clinic, or other health care facility or a provider of medical services, medical devices, medical equipment, or other medical supplies.

(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 new item:

''1347. Health care fraud.''.

SEC. 302. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

''(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1101.

''(2) A person is not eligible for a payment under paragraph (1) if—

''(A) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

''(B) the person knowingly participated in the offense;

''(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

''(i) in a criminal, civil, or administrative proceeding;

''(ii) in a congressional, administrative or General Accounting Office report, hearing, audit, or investigation; or

''(iii) by the news media, unless the person is the original source of the information; or

''(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

''(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

''(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.''.

Subtitle B—Coordination of Health Care Anti-Fraud and Abuse Activities

SEC. 311. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO ALL FRAUD AND ABUSE AGAINST ANY HEALTH INSURANCE PLAN.

(a) CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended as follows:

(1) In subsection (a)(1), in the matter before subparagraph (A), by inserting ''or of any health insurance plan,'' after ''subsection (i)(1)),''.

(2) In subsection (b)(1)(A), by inserting ''or under a health insurance plan'' after ''title XIX''.

(3) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) With respect to amounts recovered arising out of a claim under a health insurance plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan.''.

(4) In subsection (i)—

(A) in paragraph (2), by inserting ''or under a health insurance plan'' before the period at the end, and

(B) in paragraph (5), by inserting ''or under a health insurance plan'' after ''or XX''.

(b) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended as follows:

(A) In the heading, by adding at the end the following: ''OR HEALTH INSURANCE PLANS''.

(B) In subsection (a)(1)—

(i) by striking ''title XVIII or'' and inserting ''title XVIII,'', and

(ii) by adding at the end the following: ''or a health insurance plan (as defined in section 1128(i)),''.

(C) In subsection (a)(5), by striking ''title XVIII or a State health care program'' and inserting ''title XVIII, a State health care program, or a health insurance plan''.

(D) In the second sentence of subsection (a)—

(i) by inserting after ''title XIX'' the following: ''or a health insurance plan'', and

(ii) by inserting after ''the State'' the following: ''or the plan''.

(E) In subsection (b)(1), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''title XVIII, a State health care program, or a health insurance plan''.

(F) In subsection (b)(2), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''title XVIII, a State health care program, or a health insurance plan''.

(G) In subsection (b)(3), by striking ''title XVIII or a State health care program'' each place it appears in subparagraphs (A) and (C) and inserting ''title XVIII, a State health care program, or a health insurance plan''.

(H) In subsection (d)(2)—

(i) by striking ''title XIX,'' and inserting ''title XIX or under a health insurance plan,'', and

(ii) by striking ''State plan,'' and inserting ''State plan or the health insurance plan,''.

(2) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(f) In addition to the fines that may be imposed under subsection (a), (b), or (c), any individual found to have violated the provisions of any of such subsections may be subject to treble damages.''.

(3) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is further amended by adding at the end the following new subsection:

''(g) The Secretary shall—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

(c) HEALTH INSURANCE PLAN DEFINED.—Section 1128 of such Act (42 U.S.C. 1320a–7) is amended by redesignating subsection (i) as subsection (j) and by inserting after subsection (h) the following new subsection:

''(i) HEALTH INSURANCE PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health insurance plan' means a health insurance program other than the medicare program, the medicaid program, or a State health care program.''.

(d) CONFORMING AMENDMENT.—Section 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a–7(b)(8)(B)(ii)) is amended by striking ''1128A'' and inserting ''1128A (other than a penalty arising from a health insurance plan, as defined in subsection (i))''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1995.

TITLE IV—ANTITRUST PROVISIONS

SEC. 401. EXEMPTION FROM ANTITRUST LAWS FOR CERTAIN COMPETITIVE AND COLLABORATIVE ACTIVITIES.

(a) EXEMPTION DESCRIBED.—An activity relating to the provision of health care services shall be exempt from the antitrust laws if—

(1) the activity is within one of the categories of safe harbors described in section 402;

(2) the activity is within an additional safe harbor designated by the Attorney General under section 403; or

(3) the activity is specified in and in compliance with the terms of a certificate of review issued by the Attorney General under section 404 and the activity occurs—

(A) while the certificate is in effect, or

(B) in the case of a certificate issued during the 2-year period beginning on the date of the enactment of this Act, at any time on or after the first day of the 2-year period that ends on the date the certificate takes effect.

(b) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(1) IN GENERAL.—If any person brings an action alleging a claim under the antitrust laws and the activity on which the claim is based is found by the court to be exempt from such laws under subsection (a), the court shall, at the conclusion of the action—

(A) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(B) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(2) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to paragraph (1) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

SEC. 402. SAFE HARBORS.

The following activities are safe harbors for purposes of section 401(a)(1):

(1) COMBINATIONS WITH MARKET SHARE BELOW THRESHOLD.—Activities relating to health care services of any combination of health care providers if the number of each type or specialty of pro-

vider in question does not exceed 20 percent of the total number of such type or specialty of provider in the relevant market area.

(2) ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—

(A) IN GENERAL.—Subject to subparagraph (B), any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care provided to patients.

(B) EXCEPTION.—No activity of a medical self-regulatory entity may be deemed to fall under the safe harbor established under this paragraph if the activity is conducted for purposes of financial gain.

(3) PARTICIPATION IN SURVEYS.—The participation of a provider of health care services in a written survey of the prices of services, reimbursement levels, or the compensation and benefits of employees and personnel, but only if—

(A) the survey is conducted by a third party, such as a purchaser of health care services, governmental entity, institution of higher education, or trade association;

(B) the information provided by participants in the survey is based on prices charged, reimbursements received, or compensation and benefits paid prior to the third month preceding the month in which the information is provided; and

(C) if the results of the survey are disseminated, the results are aggregated in a manner that ensures that no recipient of the results may identify the prices charged, reimbursement received, or compensation and benefits paid by any particular provider.

(4) JOINT VENTURES FOR HIGH TECHNOLOGY AND COSTLY EQUIPMENT AND SERVICES.—Any activity of a health care cooperative venture relating to the purchase, operation, or marketing of high technology or other expensive medical equipment, or the provision of high cost or complex services, but only if the number of participants in the venture does not exceed the lowest number needed to support the venture. Other providers may be included in the venture, but only if such other providers could not purchase, operate, or market such equipment or provide a competing service either alone or through the formation of a competing venture.

(5) HOSPITAL MERGERS.—Activities relating to a merger of 2 hospitals if, during the 3-year period preceding the merger, one of the hospitals had an average of 150 or fewer operational beds and an average daily inpatient census of less than 50 percent of such beds.

(6) JOINT PURCHASING ARRANGEMENTS.—Any joint purchasing arrangement among health care providers if—

(A) the purchases under the arrangement represent less than 35 percent of the total sales of the product or service purchased in the relevant market; and

(B) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each participant in the joint purchasing arrangement.

(7) NEGOTIATIONS.—Activities consisting of good faith negotiations to carry out any activity—

(A) described in this section,

(B) within an additional safe harbor designated by the Attorney General under section 403,

(C) that is the subject of an application for a certificate of review under section 404, or

(D) that is deemed a submission of a notification under section 405(a)(2)(B),

without regard to whether such an activity is carried out.

SEC. 403. DESIGNATION OF ADDITIONAL SAFE HARBORS.

(a) IN GENERAL.—

(1) SOLICITATION OF PROPOSALS.—Not later than 30 days after the date of the enactment of this Act, the Attorney General shall publish a notice in the Federal Register soliciting proposals for additional safe harbors.

(2) REVIEW AND REPORT ON PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary of Health and Human Services and the Chair of the Federal Trade Commission) shall—

(A) review the proposed safe harbors submitted under paragraph (1); and

(B) submit a report to Congress describing the proposals to be included in the publication of additional safe harbors described in para-

graph (3) and the proposals that are not to be so included, together with explanations therefor.

(3) PUBLICATION OF ADDITIONAL SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary of Health and Human Services and the Chair of the Federal Trade Commission) shall publish in the Federal Register proposed additional safe harbors for purposes of section 401(a)(2) for providers of health care services. Not later than 180 days after publishing such proposed safe harbors in the Federal Register, the Attorney General shall issue final rules establishing such safe harbors.

(b) CRITERIA FOR SAFE HARBORS.—In establishing safe harbors under subsection (a), the Attorney General shall take into account the following:

(1) The extent to which a competitive or collaborative activity will accomplish any of the following:

(A) An increase in access to health care services.

(B) The enhancement of the quality of health care services.

(C) The establishment of cost efficiencies that will be passed on to consumers, including economies of scale and reduced transaction and administrative costs.

(D) An increase in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(E) An improvement in the utilization of health care resources or the reduction in the inefficient duplication of the use of such resources.

(2) Whether the designation of an activity as a safe harbor under subsection (a) will result in the following outcomes:

(A) Health plans and other health care insurers, consumers of health care services, and health care providers will be better able to negotiate payment and service arrangements which will reduce costs to consumers.

(B) Taking into consideration the characteristics of the particular purchasers and providers involved, competition will not be unduly restricted.

(C) Equally efficient and less restrictive alternatives do not exist to meet the criteria described in paragraph (1).

(D) The activity will not unreasonably foreclose competition by denying competitors a necessary element of competition.

SEC. 404. CERTIFICATES OF REVIEW.

(a) ESTABLISHMENT OF PROGRAM.—In consultation with the Secretary and the Chair, the Attorney General shall (not later than 180 days after the date of the enactment of this Act) issue certificates of review in accordance with this section for providers of health care services and advise and assist any person with respect to applying for such a certificate of review.

(b) PROCEDURES FOR APPLICATION FOR CERTIFICATE.—

(1) FORM; CONTENT.—To apply for a certificate of review, a person shall submit to the Attorney General a written application which—

(A) specifies the activities relating to the provision of health care services which satisfy the criteria described in section 403(b) and which will be included in the certificate; and

(B) is in a form and contains any information, including information pertaining to the

overall market in which the applicant operates, required by rule or regulation promulgated under section 407.

(2) PUBLICATION OF NOTICE IN FEDERAL REGISTER.—Within 10 days after an application submitted under paragraph (1) is received by the Attorney General, the Attorney General shall publish in the Federal Register a notice that announces that an application for a certificate of review has been submitted, identifies each person submitting the application, and describes the conduct for which the application is submitted.

(3) ESTABLISHMENT OF PROCEDURES FOR ISSUANCE OF CERTIFICATE.—In consultation with the Chair and the Secretary, the Attorney General shall establish procedures to be used in applying for and in determining whether to approve an application for a certificate of review under this title. Under such procedures the Attorney General shall approve an application if the Attorney General determines that the activities to be covered under the certificate will satisfy the criteria described in section 403(b) for additional safe harbors designated under such section and that the benefits of the issuance of the cer-

tificate will outweigh any disadvantages that may result from reduced competition.

(4) TIMING FOR DECISION ON APPLICATION.—

(A) IN GENERAL.—Within 90 days after the Attorney General receives an application for a certificate of review, the Attorney General shall determine whether the applicant's health care market activities are in accordance with the procedures described in paragraph (3). If the Attorney General, with the concurrence of the Secretary, determines that such procedures are met, the Attorney General shall issue to the applicant a certificate of review. The certificate of review shall specify—

(i) the health care market activities to which the certificate applies,

(ii) the person to whom the certificate of review is issued, and

(iii) any terms and conditions the Attorney General or the Secretary deems necessary to assure compliance with the applicable procedures described in paragraph (3).

(B) APPLICATIONS DEEMED APPROVED.—If the Attorney General does not reject an ap-

plication before the expiration of the 90-day period beginning on the date the Attorney General receives the application, the Attorney General shall be deemed to have approved the application and to have issued a certificate of review relating to the applicant's health care market activities covered under the application.

(5) EXPEDITED ACTION.—If the applicant indicates a special need for prompt disposition, the Attorney General and the Secretary may expedite action on the application, except that no certificate of review may be issued within 30 days of publication of notice in the Federal Register under subsection (b)(2).

(6) ACTIONS UPON DENIAL.—

(A) NOTIFICATION.—If the Attorney General denies in whole or in part an application for a certificate, the Attorney General shall notify the applicant of the Attorney General's determination and the reasons for it.

(B) REQUEST FOR RECONSIDERATION.—An applicant may, within 30 days of receipt of notification that the application has been denied in whole or in part, request the Attorney General to reconsider the determination. The Attor-

ney General, with the concurrence of the Secretary, shall notify the applicant of the determination upon reconsideration within 30 days of receipt of the request.

(C) RETURN OF DOCUMENTS.—If the Attorney General denies an application for the issuance of a certificate of review and thereafter receives from the applicant a request for the return of documents submitted by the applicant in connection with the application for the certificate, the Attorney General and the Secretary shall return to the applicant, not later than 30 days after receipt of the request, the documents and all copies of the documents available to the Attorney General and the Secretary, except to the extent that the information has been made public under an exception to the rule against public disclosure described in subsection (g)(2)(B).

(7) FRAUDULENT PROCUREMENT.—A certificate of review shall be void ab initio with respect to any health care market activities for which the certificate was procured by fraud.

(c) AMENDMENT AND REVOCATION OF CERTIFICATES.—

(1) NOTIFICATION OF CHANGES.—Any applicant who receives a certificate of review—

(A) shall promptly report to the Attorney General any change relevant to the matters specified in the certificate; and

(B) may submit to the Attorney General an application to amend the certificate to reflect the effect of the change on the conduct specified in the certificate.

(2) AMENDMENT TO CERTIFICATE.—An application for an amendment to a certificate of review shall be treated as an application for the issuance of a certificate. The effective date of an amendment shall be the date on which the application for the amendment is submitted to the Attorney General.

(3) REVOCATION.—

(A) GROUNDS FOR REVOCATION.—In accordance with this paragraph, the Attorney General may revoke in whole or in part a certificate of review issued under this section. The following shall be considered grounds for the revocation of a certificate:

(i) After the expiration of the 2-year period beginning on the date a person's certificate is issued, the activities of the

person have not substantially accomplished the purposes for the issuance of the certificate.

(ii) The person has failed to comply with any of the terms or conditions imposed under the certificate by the Attorney General or the Secretary under subsection (b)(4).

(iii) The activities covered under the certificate no longer satisfy the criteria set forth in section 403(b).

(B) REQUEST FOR COMPLIANCE INFORMATION.—If the Attorney General or Secretary has reason to believe that any of the grounds for revocation of a certificate of review described in subparagraph (A) may apply to a person holding the certificate, the Attorney General shall request such information from such person as the Attorney General or the Secretary deems necessary to resolve the matter of compliance. Failure to comply with such request shall be grounds for revocation of the certificate under this paragraph.

(C) PROCEDURES FOR REVOCATION.—If the Attorney General or the Secretary deter-

mines that any of the grounds for revocation of a certificate of review described in subparagraph (A) apply to a person holding the certificate, or that such person has failed to comply with a request made under subparagraph (B), the Attorney General shall give written notice of the determination to such person. The notice shall include a statement of the circumstances underlying, and the reasons in support of, the determination. In the 60-day period beginning 30 days after the notice is given, the Attorney General shall revoke the certificate or modify it as the Attorney General or the Secretary deems necessary to cause the certificate to apply only to activities that meet the procedures for the issuance of certificates described in subsection (b)(2).

(D) INVESTIGATION AUTHORITY.—For purposes of carrying out this paragraph, the Attorney General may conduct investigations in the same manner as the Attorney General conducts investigations under section 3 of the Antitrust Civil Process Act, except that no civil investigative demand may be issued to a person

to whom a certificate of review is issued if such person is the target of such investigation.

(d) REVIEW OF DETERMINATIONS.—

(1) AVAILABILITY OF REVIEW FOR CERTAIN ACTIONS.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or modifies a certificate pursuant to paragraph (3), the applicant or certificate holder (as the case may be) may, within 30 days of the denial or revocation, bring an action in any appropriate district court of the United States to set aside the determination on the ground that such determination is erroneous based on the preponderance of the evidence.

(2) NO OTHER REVIEW PERMITTED.—Except as provided in paragraph (1), no action by the Attorney General or the Secretary pursuant to this title shall be subject to judicial review.

(3) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or amends a certificate, neither the negative determination nor the statement of reasons therefore shall be admissible in evidence, in any administrative or judicial pro-

ceeding, concerning any claim under the antitrust laws.

(e) PUBLICATION OF DECISIONS.—The Attorney General shall publish a notice in the Federal Register on a timely basis of each decision made with respect to an application for a certificate of review under this section or the amendment or revocation of such a certificate, in a manner that protects the confidentiality of any proprietary information relating to the application.

(f) ANNUAL REPORTS.—Every person to whom a certificate of review is issued shall submit to the Attorney General an annual report, in such form and at such time as the Attorney General may require, that contains any necessary updates to the information required under subsection (b) and a description of the activities of the holder under the certificate during the preceding year.

(g) RESTRICTIONS ON DISCLOSURE OF INFORMATION.—

(1) WAIVER OF DISCLOSURE REQUIREMENTS UNDER ADMINISTRATIVE PROCEDURE ACT.—Information submitted by any person in connection with the issuance, amendment, or revocation of a certificate of review shall be exempt from disclosure under section 552 of title 5, United States Code.

(2) RESTRICTIONS ON DISCLOSURE OF COMMERCIAL OR FINANCIAL INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), no officer or employee of the United States shall disclose commercial or financial information submitted in connection with the issuance, amendment, or revocation of a certificate of review if the information is privileged or confidential and if disclosure of the information would cause harm to the person who submitted the information.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply with respect to information disclosed—

(i) upon a request made by the Congress or any committee of the Congress,

(ii) in a judicial or administrative proceeding, subject to appropriate protective orders,

(iii) with the consent of the person who submitted the information,

(iv) in the course of making a determination with respect to the issuance, amendment, or revocation of a certificate of review, if the Attorney General deems

disclosure of the information to be necessary in connection with making the determination,

(v) in accordance with any requirement imposed by a statute of the United States, or

(vi) in accordance with any rule or regulation promulgated under subsection (i) permitting the disclosure of the information to an agency of the United States or of a State on the condition that the agency will disclose the information only under the circumstances specified in clauses (i) through (v).

(3) PROHIBITION AGAINST USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—Any information disclosed in an application for a certificate of review under this section shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing that a person is entitled to the protection provided by such a certificate.

SEC. 405. NOTIFICATIONS PROVIDING REDUCTION IN CERTAIN PENALTIES UNDER ANTITRUST LAW FOR HEALTH CARE COOPERATIVE VENTURES.

(a) NOTIFICATIONS DESCRIBED.—

(1) SUBMISSION OF NOTIFICATION BY VENTURE.—Any party to a health care cooperative venture, acting on such venture's behalf, may, not later than 90 days after entering into a written agreement to form such venture or not later than 90 days after the date of the enactment of this Act, whichever is later, file with the Attorney General a written notification disclosing—

(A) the identities of the parties to such venture,

(B) the nature and objectives of such venture, and

(C) such additional information as the Attorney General may require by regulation.

(2) ACTIVITIES DEEMED SUBMISSION OF NOTIFICATION.—The following health care cooperative ventures shall be deemed to have filed a written notification with respect to the venture under paragraph (1):

(A) SUBMISSION OF APPLICATION FOR CERTIFICATE OF REVIEW.—Any health care co-

operative venture for which an application for a certificate of review is filed with the Attorney General under section 403.

(B) CERTAIN VENTURES.—Any health care cooperative venture meeting the following requirements:

(i) The venture consists of a network of non-institutional providers not greater than—

(I) in the case of a nonexclusive network in which the participating members are permitted to create or join other competing networks, 50 percent of the providers of health care services in the relevant geographic area and 50 percent of the members of the provider specialty group in the relevant market; or

(II) in the case of an exclusive network in which the participating members are not permitted to create or join other competing networks, 35 percent of the providers of health care services in the relevant geographic area and 35 percent of the members

of the provider specialty group in the relevant market.

(ii) Each member of the venture assumes substantial financial risk for the operation of the venture through risk-sharing arrangements, including (but not limited to)—

(I) the acceptance of capitation contracts;

(II) the acceptance of contracts with fee withholding mechanisms relating to the ability to meet established goals for utilization review and management; and

(III) the holding by members of significant ownership or equity interests in the venture, where the capital contributed by the members is used to fund the operational costs of the venture such as administration, marketing, and computer-operated medical information, if the venture develops and operates comprehensive programs for utilization management and quality assurance that include controls

over the use of institutional, specialized, and ancillary medical services.

(3) SUBMISSION OF ADDITIONAL INFORMATION.—

(A) REQUEST OF ATTORNEY GENERAL.—At any time after receiving a notification filed under paragraph (1), the Attorney General may require the submission of additional information or documentary material relevant to the proposed health care cooperative venture.

(B) PARTIES TO VENTURE.—Any party to a health care cooperative venture may submit such additional information on the venture's behalf as may be appropriate to ensure that the venture will receive the protections provided under subsection (b).

(C) REQUIRED SUBMISSION OF INFORMATION ON CHANGES TO VENTURE.—A health care cooperative venture for which a notification is in effect under this section shall submit information on any change in the membership of the venture not later than 90 days after such change occurs.

(4) PUBLICATION OF NOTIFICATION.—

(A) INFORMATION MADE PUBLICLY AVAILABLE.—Not later than 30 days after receiving a notification with respect to a venture under paragraph (1), the Attorney General shall publish in the Federal Register a notice with respect to the venture that identifies the parties to the venture and generally describes the purpose and planned activity of the venture. Prior to its publication, the contents of the notice shall be made available to the parties to the venture.

(B) RESTRICTION ON DISCLOSURE OF OTHER INFORMATION.—All information and documentary material submitted pursuant to this section and all information obtained by the Attorney General in the course of any investigation or case with respect to a potential violation of the antitrust laws by the health care cooperative venture (other than information and material described in subparagraph (A)) shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies except in

a judicial proceeding in which such information and material is subject to any protective order.

(5) WITHDRAWAL OF NOTIFICATION.—Any person who files a notification pursuant to this section may withdraw such notification before a publication by the Attorney General pursuant to paragraph (4). Any person who is deemed to have filed a notification under paragraph (2)(A) shall be deemed to have withdrawn the notification if the certificate of review in question is revoked or withdrawn under section 404.

(6) NO JUDICIAL REVIEW PERMITTED.—Any action taken or not taken by the Attorney General with respect to notifications filed pursuant to this subsection shall not be subject to judicial review.

(b) PROTECTIONS FOR VENTURES SUBJECT TO NOTIFICATION.—

(1) IN GENERAL.—

(A) PROTECTIONS DESCRIBED.—The provisions of paragraphs (2), (3), (4), and (5) shall apply with respect to any action under the antitrust laws challenging conduct within the scope of a notification which is in effect pursuant to subsection (a)(1).

(B) TIMING OF PROTECTIONS.—The protections described in this subsection shall apply to the venture that is the subject of a notification under subsection (a)(1) as of the earlier of—

(i) the date of the publication in the Federal Register of the notice published with respect to the notification; or

(ii) if such notice is not published during the period required under subsection (a)(4), the expiration of the 30-day period that begins on the date the Attorney General receives any necessary information required to be submitted under subsection (a)(1) or any additional information required by the Attorney General under subsection (a)(3)(A).

(2) APPLICABILITY OF RULE OF REASON STANDARD.—In any action under the antitrust laws, the conduct of any person which is within the scope of a notification filed under subsection (a) shall not be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including, but

not limited to, effects on competition in relevant markets.

(3) LIMITATION ON RECOVERY TO ACTUAL DAMAGES AND INTEREST.—Notwithstanding section 4 of the Clayton Act, any person who is entitled to recovery under the antitrust laws for conduct that is within the scope of a notification filed under subsection (a) shall recover the actual damages sustained by such person and interest calculated at the rate specified in section 1961 of title 28, United States Code, for the period beginning on the earliest date for which injury can be established and ending on the date of judgment, unless the court finds that the award of all or part of such interest is unjust under the circumstances.

(4) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(A) IN GENERAL.—In any action under the antitrust laws brought against a health care cooperative venture for conduct that is within the scope of a notification filed under subsection (a), the court shall, at the conclusion of the action—

(i) award to a substantially prevailing claimant the cost of suit attributable to

such claim, including a reasonable attorney's fee, or

(ii) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(B) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to subparagraph (A) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

(5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—

(A) IN GENERAL.—Any information disclosed in a notification submitted under subsection (a)(1) and the fact of the publication of a notification by the Attorney General under

subsection (a)(4) shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing that a party to a health care cooperative venture is entitled to the protections described in this subsection.

(B) ACTIONS OF ATTORNEY GENERAL.—No action taken by the Attorney General pursuant to this section shall be admissible into evidence in any judicial or administrative proceeding for the purpose of supporting or answering any claim under the antitrust laws.

SEC. 406. REVIEW AND REPORTS ON SAFE HARBORS AND CERTIFICATES OF REVIEW.

(a) IN GENERAL.—The Attorney General (in consultation with the Secretary and the Chair) shall periodically review the safe harbors described in section 402, the additional safe harbors designated under section 403, and the certificates of review issued under section 404, and—

(1) with respect to the safe harbors described in section 402, submit such recommendations to Congress as the Attorney General considers appropriate for modifications of such safe harbors;

(2) with respect to the additional safe harbors designated under section 403, issue proposed revi-

sions to such activities and publish the revisions in the Federal Register; and

(3) with respect to the certificates of review, submit a report to Congress on the issuance of such certificates, and shall include in the report a description of the effect of such certificates on increasing access to high quality health care services at reduced costs.

(b) RECOMMENDATIONS FOR LEGISLATION.—The Attorney General shall include in the reports submitted under subsection (a)(3) any recommendations of the Attorney General for legislation to improve the program for the issuance of certificates of review established under this title.

SEC. 407. RULES, REGULATIONS, AND GUIDELINES.

(a) SAFE HARBORS, CERTIFICATES, AND NOTIFICATIONS.—The Attorney General, with the concurrence of the Secretary, shall promulgate such rules, regulations, and guidelines as are necessary to carry out sections 402, 403, 404, and 405, including guidelines defining or relating to relevant geographic and product markets for health care services and providers of health care services.

(b) GUIDANCE FOR PROVIDERS.—

(1) IN GENERAL.—To promote greater certainty regarding the application of the antitrust laws

to activities in the health care market, the Attorney General, in consultation with the Secretary and the Chair, shall (not later than 1 year after the date of the enactment of this Act), taking into account the criteria used to designate additional safe harbors under section 403 and grant certificates of review under section 404, publish guidelines—

(A) to assist providers of health care services in analyzing whether the activities of such providers may be subject to a safe harbor under sections 402 or 403; and

(B) describing specific types of activities which would meet the requirements for a certificate of review under section 404, and summarizing the factual and legal bases on which the activities would meet the requirements.

(2) PERIODIC UPDATE.—The Attorney General shall periodically update the guidelines published under paragraph (1) as the Attorney General considers appropriate.

(3) WAIVER OF ADMINISTRATIVE PROCEDURE ACT.—Section 553 of title 5, United States Code, shall not apply to the issuance of guidelines under paragraph (1).

SEC. 408. DEFINITIONS.

In this title, the following definitions shall apply:

(1) The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) The term ''Chair'' means the Chair of the Federal Trade Commission.

(3) The term ''health insurance plan'' has the meaning given such term in section 111(b).

(4) The term ''health care cooperative venture'' means any activities, including attempts to enter into or perform a contract or agreement, carried out by 2 or more persons for the purpose of providing health care services.

(5) The term ''health care services'' means any services for which payment may be made under a health insurance plan, including services related to the delivery or administration of such services.

(6) The term ''medical self-regulatory entity'' means a medical society or association, a specialty

board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(7) The term ''person'' includes a State or unit of local government.

(8) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(9) The term ''specialty group'' means a medical specialty or subspecialty in which a provider of health care services may be licensed to practice by a State (as determined by the Secretary in consultation with the certification boards for such specialties and subspecialties).

(10) The term ''standard setting and enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

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