104TH CONGRESS
1ST SESSION

S. 7

To provide for health care reform through health insurance market reform and assistance for small business and families, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 4, 1995

Mr. DASCHLE (for himself, Mr. KENNEDY, Mr. REID, Ms. MIKULSKI, Mr. ROCKEFELLER, Mr. DODD, Mr. BREAUX, Ms. MOSELEY-BRAUN, Mr. PELL, Mrs. MURRAY, and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for health care reform through health insurance market reform and assistance for small business and families, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

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TITLE I—HEALTH INSURANCE MARKET REFORM

Subtitle A—Insurance Market Standards

SEC. 1001. NONDISCRIMINATION BASED ON HEALTH STATUS.

(a) IN GENERAL.—Except as provided in subsection (b) and section 1003(d), a health plan may not deny, limit, or condition the coverage under (or benefits of) the plan, or vary the premium, for an individual based on the health status, medical condition, claims experience, receipt of

health care, medical history, anticipated need for health care services, disability, or lack of evidence of insurability.

(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

(1) IN GENERAL.—A health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual only if—

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

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

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

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

(2) CREDITING OF PREVIOUS COVERAGE.—A health plan shall provide that if an individual under such plan is in a period of continuous coverage as of the date of enrollment under such plan, any period of exclusion of coverage with respect to a pre-

existing condition shall be reduced by 1 month for each month in the period of continuous coverage.

(3) DEFINITIONS.—For purposes of this subsection:

(A) PERIOD OF CONTINUOUS COVERAGE.—

(i) IN GENERAL.—The term ''period of continuous coverage'' means the period beginning on the date an individual is enrolled under a health plan or an equivalent health care program and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

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

(I) part A or part B of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.),

(II) the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.),

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

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

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

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

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

(c) LIMITATIONS PROHIBITED.—

(1) IN GENERAL.—A health plan may not impose a lifetime limitation on the provision of benefits under the plan.

(2) RULE OF CONSTRUCTION.—The prohibition contained in paragraph (1) shall not be construed as

prohibiting limitations on the scope or duration of particular items or services covered by a health plan.

SEC. 1002. GUARANTEED ISSUE AND RENEWAL

(a) SMALL GROUP MARKET.—Each health plan offering coverage in the small group market shall guarantee each individual purchaser and small employer (and each eligible employee of such small employer) applying for coverage in such market the opportunity to enroll in the plan.

(b) LARGE EMPLOYER MARKET.—Each health plan offering coverage in the large employer market shall guarantee any individual eligible for coverage under the plan the opportunity to enroll in such plan.

(c) CAPACITY LIMITS.—Notwithstanding this section, a health plan may apply a capacity limit based on limited financial or provider capacity if the plan enrolls individuals in a manner that provides prospective enrollees with a fair chance of enrollment regardless of the method by which the individual seeks enrollment.

(d) RENEWAL OF POLICY.—

(1) SMALL GROUP MARKET.—A health plan issued to a small employer or an individual purchaser in the small group market shall be renewed at the option of the employer or individual, if such employer or individual purchaser remains eligible for coverage under the plan.

(2) LARGE EMPLOYER MARKET.—A health plan issued to an individual eligible for coverage under a large employer plan shall be renewed at the option of the individual, if such individual remains eligible for coverage under the plan.

(e) GROUNDS FOR REFUSAL TO RENEW.—A health plan may refuse to renew a policy only in the case of—

(1) the nonpayment of premiums;

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

(3) the misrepresentation by the employer or individual of material facts relating to an application for coverage of a claim or benefit.

(f) NOTIFICATION OF AVAILABILITY.—Each health plan sponsor shall publicly disclose the availability of each health plan that such sponsor provides or offers in a small group market. Such disclosure shall be accompanied by information describing the method by which eligible employers and individuals may enroll in such plans.

SEC. 1003. RATING LIMITATIONS.

(a) IN GENERAL.—A health plan offering coverage in the small group market shall comply with the standards developed under this section.

(b) ROLE OF NAIC.—The Secretary shall request that the NAIC—

(1) develop specific standards in the form of a model Act and model regulations that provide for the implementation of the rating limitations described in subsection (d); and

(2) report to the Secretary concerning such standards within 6 months after the date of enactment of this Act.

(c) ROLE OF THE SECRETARY.—The Secretary, upon review of the report received under subsection (b)(2), shall not later than January 1, 1997, promulgate final standards implementing this section. Such standards shall be the applicable health plan standards under this section.

(d) RATING STANDARDS.—The standards described in this section shall provide for the following:

(1) A determination of factors that health plans may use to vary the premium rates of such plans. Such factors—

(A) shall be applied in a uniform fashion to all enrollees covered by a plan;

(B) shall include age (as specified in paragraph (3)), family type, and geography; and

(C) except as provided in paragraph (2)(A), shall not include gender, health status, or health expenditures.

(2)(A) Factors prohibited under paragraph (1)(C) shall be phased out over a period not to exceed 3 years after the effective date of this section.

(B) Other rating factors (other than age) may be phased out to the extent necessary to minimize market disruption and maximize coverage rates.

(3) Uniform age categories and age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. By the end of the 3-year period beginning on the effective date of this section, for individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed 3 times the lowest age adjustment factor.

(e) DISCOUNTS.—Standards developed under this section shall permit health plans to provide premium discounts based on workplace health promoting activities.

SEC. 1004. DELIVERY SYSTEM QUALITY STANDARDS.

(a) IN GENERAL.—Each health plan shall comply with the standards developed under this section.

(b) ROLE OF THE SECRETARY.—Not later than 9 months after the date of enactment of this Act, the Secretary, in consultation with the NAIC and other organizations with expertise in the areas of quality assurance (including the Joint Commission on Accreditation of Health Care Organizations, the National Committee for Quality

Assurance, and peer review organizations), shall establish minimum guidelines specified in subsection (c) for the issuance by each State of delivery system quality standards. Such standards shall be the applicable health plan standards under this section.

(c) MINIMUM GUIDELINES.—The minimum guidelines specified in this subsection are as follows:

(1) Establishing and maintaining health plan quality assurance, including—

(A) quality management;

(B) credentialing;

(C) utilization management;

(D) health care provider selection and due process in selection; and

(E) practice guidelines and protocols.

(2) Providing consumer protection for health plan enrollees, including—

(A) comparative standardized consumer information with respect to health plan premiums and quality measures, including health care report cards;

(B) nondiscrimination in plan enrollment, disenrollment, and service provision;

(C) continuation of treatment with respect to health plans that become insolvent; and

(D) grievance procedures.

(3) Ensuring reasonable access to health care services, including access for vulnerable populations in underserved areas.

SEC. 1005. BENCHMARK BENEFITS PACKAGE.

(a) IN GENERAL.—With respect to an individual eligible for enrollment, a sponsor of a health plan—

(1) shall offer the benchmark benefits package described in subsection (b); and

(2) may offer any other health benefits package.

(b) BENCHMARK BENEFITS PACKAGE DESCRIBED.—

(1) IN GENERAL.—

(A) PACKAGE DESCRIBED.—The benchmark benefits package described in this subsection is a benefits package that covers all of the items and services under the categories of health care items and services specified by the Secretary under paragraph (2) when medically necessary or appropriate (as determined in accordance with paragraph (3)) and provides for a cost-sharing schedule specified by the Secretary under paragraph (4).

(B) ACTUARIAL VALUE.—The benchmark benefits package established by the Secretary

under this subsection shall have an actuarial value that equals the actuarial value of the benefits package provided under the health benefits plan offered under chapter 89 of title 5, United States Code, with the highest enrollment during 1994, adjusted for a national population under 65 years of age (as determined by the Secretary).

(2) CATEGORIES OF HEALTH CARE ITEMS AND SERVICES.—

(A) IN GENERAL.—The categories of health care items and services specified by the Secretary under this paragraph shall include at least the categories described in section 1302(1) of the Public Health Service Act (42 U.S.C. 300e-1(a)) and section 8904(a) of title 5, United States Code. The Secretary may add or delete categories of health care items and services under this paragraph as medical practice changes.

(B) SPECIFYING ITEMS AND SERVICES.—

(i) IN GENERAL.—The Secretary shall specify the items and services under the categories specified under subparagraph (A).

(ii) PRIORITIES FOR THE SECRETARY.—In specifying items and services under this subparagraph the Secretary shall take into account the following:

(I) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—With respect to mental health and substance abuse services, the Secretary shall give priority to parity for such services with other medical services with respect to cost-sharing and duration of treatment.

(II) VULNERABLE POPULATIONS AND UNDERSERVED AREAS.—The Secretary shall give priority to the needs of children and vulnerable populations, including those populations in rural, frontier, and underserved areas.

(III) PREVENTION.—The Secretary shall give priority to improving the health of individuals through prevention.

(3) MEDICAL NECESSITY OR APPROPRIATENESS.—The Secretary shall establish general criteria for determining whether an item or service specified

by the Secretary under paragraph (2)(B) is medically necessary or appropriate. Health plans shall make coverage decisions regarding procedures and technologies consistent with such general criteria.

(4) COST-SHARING.—The Secretary shall establish cost-sharing schedules to be provided by a benchmark benefits package. In establishing such cost-sharing schedules, the Secretary shall meet the following requirements:

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

(B) PREVENTIVE SERVICES EXEMPTED.—The Secretary shall exempt from any cost-sharing schedules clinical preventive services and prenatal care services.

(C) DELIVERY SYSTEMS.—In establishing cost-sharing schedules for benchmark benefits packages, the Secretary shall ensure that the schedules permit a variety of delivery systems, including fee-for-service, preferred provider organizations, point of service, and health maintenance organizations.

SEC. 1006. RISK ADJUSTMENT.

Each health plan offering coverage in the small group market in a State shall participate in a risk adjustment program developed by such State under standards established by the Secretary.

SEC. 1007. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this title shall take effect on January 1, 1996.

(b) RATING LIMITATIONS, BENCHMARK BENEFITS PACKAGES, AND RISK ADJUSTMENTS.—The standards promulgated under sections 1003, 1005, and 1006 shall apply to plans that are issued or renewed after December 31, 1996.

Subtitle B—Establishment and Application of Standards

SEC. 1011. GENERAL RULES.

(a) CONSTRUCTION.—

(1) IN GENERAL.—A requirement or standard imposed on a health plan under this Act shall be deemed to be a requirement or standard imposed on the insurer or sponsor of such plan.

(2) PREEMPTION OF STATE LAW.—

(A) IN GENERAL.—No requirement of this title shall be construed as preempting any State law unless such State law directly conflicts with such requirement. The provision of additional

consumer protections under State law as described in subparagraph (B) shall not be considered to directly conflict with any such requirement.

(B) CONSUMER PROTECTION LAWS.—State laws referred to in subparagraph (A) that are not preempted by this title include—

(i) laws that limit the exclusions or limitations for preexisting medical conditions to periods that are less than those provided for under section 1001;

(ii) laws that limit variations in premium rates beyond the variations permitted under section 1003; and

(iii) laws that would expand the small group market in excess of that provided for under this title.

(b) REGULATIONS.—The Secretary, in consultation with NAIC, and the Secretary of Labor are each authorized to issue regulations as are necessary to implement this Act.

SEC. 1012. ENCOURAGEMENT OF STATE REFORMS.

Nothing in this Act shall be construed as prohibiting States from enacting health care reform measures that exceed the measures established under this Act, including

reforms that expand access to health care services, control health care costs, and enhance quality of care.

SEC. 1013. GRANTS TO STATES FOR SMALL GROUP HEALTH INSURANCE PURCHASING ARRANGEMENTS.

(a) IN GENERAL.—The Secretary shall make grants to States that submit applications meeting the requirements of this section for the establishment and operation of small group health insurance purchasing arrangements.

(b) USE OF FUNDS.—Grant funds awarded under this section to a State may be used to finance administrative costs associated with developing and operating a small group health insurance purchasing arrangement, including the costs associated with—

(1) engaging in marketing and outreach efforts to inform individuals and small employers about the small group health insurance purchasing arrangement, which may include the payment of sales commissions;

(2) negotiating with insurers to provide health insurance through the small group health insurance purchasing arrangement; or

(3) providing administrative functions, such as eligibility screening, claims administration, and customer service.

(c) APPLICATION REQUIREMENTS.—An application submitted by a State to the Secretary shall describe—

(1) whether the program will be operated directly by the State or through 1 or more State-sponsored private organizations and the details of such operation;

(2) program goals for reducing the cost of health insurance for, and increasing insurance coverage in, the small group market;

(3) the approaches proposed for enlisting participation by insurers and small employers, including any plans to use State funds to subsidize the cost of insurance for participating individuals and employers; and

(4) the methods proposed for evaluating the effectiveness of the program in reducing the number of uninsured in the State and on lowering the cost of health insurance for the small group market in the State.

(d) GRANT CRITERIA.—In awarding grants, the Secretary shall consider the potential impact of the State's proposal on the cost of health insurance for the small group market and on the number of uninsured, and the need for regional variation in the awarding of grants. To the extent the Secretary deems appropriate, grants shall

be awarded to fund programs employing a variety of approaches for establishing small group health insurance purchasing arrangements.

(e) PROHIBITION ON GRANTS.—No grant funds shall be paid to States that do not meet the requirements of this title with respect to small group health plans, or to States with group purchasing programs involving small group health plans that do not meet the requirements of this title.

(f) ANNUAL REPORT BY STATES.—States receiving grants under this section shall report to the Secretary annually on the numbers and rates of participation by eligible insurers and small employers, on the estimated impact of the program on reducing the number of uninsured, and on the cost of insurance available to the small group market in the State.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $200,000,000 for fiscal years 1996, 1997, and 1998.

(h) SECRETARIAL REPORT.—The Secretary shall report to Congress by not later than January 1, 1997, on the number and amount of grants awarded under this section, and include with such report an evaluation of the impact of the grant program on the number of uninsured

and cost of health insurance to small group markets in participating States.

SEC. 1014. ENFORCEMENT OF STANDARDS.

(a) IN GENERAL.—Except as provided in subsection (b), each State shall require that each health plan issued, sold, offered for sale, or operated in such State meets the insurance reform standards established under this title pursuant to an enforcement plan filed by the State with, and approved by, the Secretary. If the State does not file an acceptable plan, the Secretary shall enforce such standards until a plan is filed and approved.

(b) SECRETARY OF LABOR.—With respect to any health plan for which the application of State insurance laws are preempted under section 514 of Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144), the enforcement of the insurance reform standards established under this title shall be by the Secretary of Labor.

Subtitle C—Health Care Cost and Access Advisory Commission

SEC. 1021. HEALTH CARE COST AND ACCESS ADVISORY COMMISSION.

There is established a commission to be known as the Health Care Cost and Advisory Commission (in this subtitle referred to as the ''Commission'').

SEC. 1022. DUTIES OF COMMISSION.

(a) IN GENERAL.—The general duties of the Commission are to monitor and respond to trends in national health care spending and health insurance coverage. The Commission may be advised by individuals with expertise concerning the economic, demographic, and insurance market factors that affect the cost and availability of health insurance.

(b) ANNUAL REPORTS.—

(1) IN GENERAL.—The Commission shall report to Congress and the President annually on January 15 (beginning in 1999) on the status of health care spending and health insurance coverage in the nation.

(2) CONTENTS OF REPORT.—Each annual report shall include—

(A) findings regarding—

(i) the characteristics of the insured and uninsured, including demographic characteristics, working status, health status, and geographic distribution;

(ii) the effectiveness of insurance reforms on increasing access to health insurance and making health insurance more affordable; and

(iii) the effectiveness of cost containment strategies at the Federal and State levels and in the private sector; and

(B) recommendations for improving access to health insurance and reducing health care cost inflation.

SEC. 1023. OPERATION OF COMMISSION.

(a) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 11 members appointed by the President and confirmed by the Senate. Members shall be appointed not later than 90 days after the date of enactment of this Act.

(2) CHAIRPERSON.—The President shall designate 1 individual described in paragraph (1) who shall serve as Chairperson of the Commission.

(b) COMPOSITION.—The membership of the Commission shall include individuals with national recognition for their expertise in health care and health care markets. In appointing members of the Commission, the President shall ensure that no more than 6 members of the Commission are affiliated with the same political party.

(c) TERMS.—

(1) IN GENERAL.—The terms of members of the Commission shall be for 6 years, except that of

the members first appointed, 4 shall be appointed for an initial term of 4 years and 4 shall be appointed for an initial term of 2 years.

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

(d) VACANCIES.—

(1) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner as the original appointment, but the individual appointed to fill the vacancy shall serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

(2) NO IMPAIRMENT OF FUNCTION.—A vacancy in the membership of the Commission does not impair the authority of the remaining members to exercise all of the powers of the Commission.

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

(e) MEETINGS; QUORUM.—

(1) MEETINGS.—The Chairperson shall preside at meetings of the Commission, and in the absence

of the Chairperson, the Commission shall elect a member to act as Chairperson pro tempore.

(2) QUORUM.—Six members of the Commission shall constitute a quorum thereof.

(f) ADMINISTRATIVE PROVISIONS.—

(1) PAY AND TRAVEL EXPENSES.—

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

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

(2) EXECUTIVE DIRECTOR.—

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

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

(3) STAFF.—

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

(B) PAY.—The Executive Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of 120 percent of the annual rate of basic pay payable for GS–15 of the General Schedule.

(C) DETAILED PERSONNEL.—Upon request of the Executive Director, the head of any Federal department or agency may detail any of the personnel of that department or agency

to the Commission to assist the Commission in carrying out its duties under this Act.

(4) OTHER AUTHORITY.—

(A) CONTRACT SERVICES.—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

(B) LEASES AND PROPERTY.—The Commission may lease space and acquire personal property to the extent funds are available.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the operation of the Commission.

Subtitle D—Definitions

SEC. 1031. DEFINITIONS.

(a) HEALTH PLAN.—For purposes of this title, the term ''health plan'' means a plan that provides, or pays the cost of, health benefits. Such term does not include the following, or any combination thereof:

(1) Coverage only for accidental death, dismemberment, dental, or vision.

(2) Coverage providing wages or payments in lieu of wages for any period during which the em-

ployee is absent from work on account of sickness or injury.

(3) A medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

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

(5) Worker's compensation or similar insurance.

(6) Automobile medical-payment insurance.

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

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

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

(b) TERMS AND RULES RELATING TO THE SMALL GROUP AND LARGE EMPLOYER MARKETS.—For purposes of this title:

(1) SMALL GROUP MARKET.—The term ''small group market'' means the market for health plans which is composed of small employers and individual purchasers.

(2) SMALL EMPLOYER.—The term ''small employer'' means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed less than 51 employees for some portion of the day.

(3) INDIVIDUAL PURCHASER.—The term ''individual purchaser'' means an individual who is not eligible to enroll in a health plan sponsored by a large or small employer.

(4) LARGE EMPLOYER MARKET.—The term ''large employer market'' means the market for health plans which is composed of large employers.

(5) LARGE EMPLOYER.—The term ''large employer''—

(A) means an employer that is not a small employer; and

(B) includes a multiemployer plan as defined in section 3(37) of the Employment Retirement Income Security Act of 1974 (29 U.S.C. 1002(37)) and a plan which is main-

tained by a rural electric cooperative or a rural telephone cooperative association (within the meaning of section 3(40) of such Act (29 U.S.C. 1002(40)).

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

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

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

TITLE II—IMPROVING ACCESS TO HEALTH CARE COVERAGE

Subtitle A—Coverage Under Qualified Health Plans and Premium Assistance

PART 1—ACCESS TO QUALIFIED HEALTH PLANS

Subpart A—General Provisions

SEC. 2001. ESTABLISHMENT OF STATE PROGRAM.

In order to qualify for payments under part 2, each State shall establish a program under which the State—

(1) makes available at least 1 qualified health plan to each premium subsidy eligible individual residing in the State; and

(2) furnishes premium assistance to such individual in accordance with this part.

The program shall comply with requirements specified under regulations issued by the Secretary and may be in effect for calendar years beginning after 1996.

SEC. 2002. ASSISTANCE WITH HEALTH PLAN PREMIUMS.

(a) IN GENERAL.—An individual who has been determined by a State under subsection (b) to be a premium subsidy eligible individual (as defined in subpart B) shall be eligible for premium assistance in the amount determined under such subpart.

(b) DETERMINATION OF ELIGIBILITY.—

(1) IN GENERAL.—The Secretary shall issue regulations specifying requirements for each State program under this part with respect to determining eligibility for premium assistance, including measures to prevent individuals from knowingly making material misrepresentations of information or providing false information in applications for assistance under the program.

(2) EMPLOYER MAINTENANCE OF EFFORT.—In order to promote employer-based coverage, the Secretary shall issue regulations that provide that an eligible individual may not be a premium subsidy eligible individual described in subsection (a) if a significant employer contribution toward the premium

under a qualified health plan is available to the individual.

(3) STATE MAINTENANCE OF EFFORT.—In order to promote State maintenance of effort, the Secretary shall issue regulations that provide that an eligible individual may not be a premium subsidy eligible individual described in subsection (a) until such individual has been determined to be ineligible for assistance under any other public health insurance program provided by a State or instrumentality thereof.

(c) LIMITATION ON USE OF ASSISTANCE.—A premium subsidy eligible individual who receives premium assistance under this part shall use such assistance only for payments toward the premium under a qualified health plan made available by the State under the program established under section 2001.

Subpart B—Premium Assistance to Eligible Individuals

SEC. 2011. AMOUNT OF PREMIUM ASSISTANCE.

(a) IN GENERAL.—The amount of premium assistance for a month for a premium subsidy eligible individual in a State is an amount equal to the lesser of—

(1) the applicable subsidy percentage multiplied by 1/12th of the annual premium paid for coverage

under a qualified health plan in which the individual is enrolled; or

(2) the applicable subsidy percentage multiplied by 1/12th of the maximum subsidy amount (as determined under subsection (b)).

(b) MAXIMUM SUBSIDY AMOUNT.—For purposes of this section, the maximum subsidy amount for a State shall be the Secretary's estimate of the annual premium of the health plan with the highest enrollment offered under chapter 89 of title 5, United States Code, adjusted to reflect—

(1) coverage of the items and services and cost sharing under the benchmark benefits package; and

(2) the difference in expected health care spending of the population enrolled in such plan offered under such chapter 89 and of the population of premium subsidy eligible individuals in such State.

SEC. 2012. ASSISTANCE TO CHILDREN.

(a) ELIGIBILITY.—A child shall be considered a premium eligible individual under this part if such child—

(1) is not eligible for medical assistance under a State plan under title XIX of the Social Security Act;

(2) has not been enrolled in a health plan offered by an employer (under rules established by the Secretary) during the 6-month period ending on the date the individual submits an application to the State for premium assistance under this part, unless such employer coverage was discontinued as a result of a loss of employment by the individual's parent or guardian; and

(3) has a family income determined under section 2031(3) which does not exceed (except as provided under section 2021(b)(3))—

(A) with respect to 1997, 133 percent of the applicable Federal poverty level;

(B) with respect to 1998, 150 percent of the applicable Federal poverty level;

(C) with respect to 1999, 185 percent of the applicable Federal poverty level;

(D) with respect to 2000, 200 percent of the applicable Federal poverty level;

(E) with respect to 2001 and years thereafter, 240 percent of the applicable Federal poverty level.

(b) APPLICABLE SUBSIDY PERCENTAGE.—For the purposes of this part, the term ''applicable subsidy percentage'' for an individual described in subsection (a)

means 100 percent reduced (but not below zero) by 1.82 percentage points for every 1 percentage point (or portion thereof) by which the premium subsidy eligible individual's family income exceeds 185 percent of the applicable Federal poverty level.

SEC. 2013. ASSISTANCE TO TEMPORARILY UNEMPLOYED INDIVIDUALS.

(a) ELIGIBILITY.—An eligible individual shall be considered a premium subsidy eligible individual under this part if such individual—

(1) has been employed continuously for a 6-month period ending within a month preceding the date the individual submits an application to the State for premium assistance under this part;

(2) has been covered under a health plan during such period of employment;

(3) is not eligible for medical assistance under a State plan under title XIX of the Social Security Act;

(4) has not received a premium subsidy under a program established under this subtitle for more than a 6-month period beginning with the date described in paragraph (1); and

(5) has a family income determined under section 2031(3) which does not exceed (except as provided under section 2021(b)(3))—

(A) with respect to 1997, 100 percent of the applicable Federal poverty level;

(B) with respect to 1998, 125 percent of the applicable Federal poverty level;

(C) with respect to 1999, 150 percent of the applicable Federal poverty level;

(D) with respect to 2000, 200 percent of the applicable Federal poverty level;

(E) with respect to 2001 and years thereafter, 240 percent of the applicable Federal poverty level.

(b) APPLICABLE SUBSIDY PERCENTAGE.—For the purposes of this part, the term ''applicable subsidy percentage'' for an individual described in subsection (a) means 100 percent reduced (but not below zero) by 1 percentage point for each 1 percentage point (or portion thereof) by which the premium subsidy eligible individual's family income exceeds 100 percent of the applicable Federal poverty level.

PART 2—AGGREGATE FEDERAL PAYMENTS

SEC. 2021. AGGREGATE FEDERAL PAYMENTS.

(a) IN GENERAL.—Subject to subsection (b), with respect to any quarter beginning on or after January 1, 1997, a State shall receive payments from the Secretary in an amount equal to the sum of—

(1) the total premium assistance paid on behalf of individuals eligible for such assistance under part 1 for enrollment in qualified health plans; and

(2) 75 percent of the total amount estimated by the Secretary to be expended by the State during such quarter for proper and efficient operation and administration of the program established under this subtitle.

(b) LIMITATIONS.—

(1) BUDGETARY.—

(A) IN GENERAL.—The total amount of payments under subsection (a) to all States with programs established under this subtitle for any calender year shall not exceed the estimate by the Congressional Budget Office on January 1, 1997, of the total amount of payments under subsection (a) for 1997 (assuming participation levels under full implementation of this subtitle), adjusted for such year by population growth and the increase in health care

costs reflected in the cost of providing the benefits package under chapter 89 of title 5, United States Code.

(B) ALLOWABLE ADJUSTMENTS.—If the total payment to States under subsection (a) for any calender year is estimated to be limited under subparagraph (A), corresponding adjustments shall be made to the family income limits under sections 2012(a)(3) and 2013(a)(5) for such year.

(2) REDUCTION IN PAYMENTS FOR ADMINISTRATIVE ERRORS.—

(A) IN GENERAL.—In the case of administrative errors described in subparagraph (B), payments available to a State under subsection (a) shall be reduced by an amount determined appropriate by the Secretary.

(B) ADMINISTRATIVE ERRORS DESCRIBED.—The administrative errors described in this subparagraph include the following:

(i) An eligibility error rate for premium assistance to the extent the applicable error rate exceeds the maximum permissible error rate specified by the Secretary.

(ii) Misappropriations or other expenditures that the Secretary finds are attributable to malfeasance or misfeasance.

(c) REPORTS ON UNEMPLOYMENT.—If there are significant changes in the national unemployment level, the Director of the Office of Management and Budget (in consultation with the Secretary) shall issue a report to Congress on the implications for coverage under State programs established under this subtitle.

(d) AUDITS.—The Secretary shall conduct regular audits of the activities conducted under this subtitle.

(e) BUDGETARY TREATMENT.—This section constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to the States in accordance with this section.

PART 3—DEFINITIONS AND DETERMINATIONS OF INCOME.

SEC. 2031. DEFINITIONS AND DETERMINATIONS OF INCOME.

For purposes of this subtitle:

(1) QUALIFIED HEALTH PLAN.—The term ''qualified health plan'' means a health plan providing the benchmark benefits package as described in section 1005.

(2) CHILD.—The term ''child'' means an individual who is under 19 years of age.

(3) DETERMINATIONS OF INCOME.—

(A) FAMILY INCOME.—The term ''family income'' means, with respect to an individual who—

(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and children who are dependents of the individual; or

(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the other individual's spouse, and children who are dependents of the other individual.

(B) DEPENDENT.—The term ''dependent'' has the meaning given such term in section 152 of the Internal Revenue Code of 1986.

(C) MODIFIED ADJUSTED GROSS INCOME.—The term ''modified adjusted gross income'' means adjusted gross income (as defined

in section 62(a) of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

(ii) increased by—

(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax, and

(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not included in gross income under section 86 of such Code.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

(D) RULES RELATING TO DISREGARD OF CERTAIN INCOME.—The Secretary may promulgate rules under which spousal income may be disregarded in instances in which a spouse is not part of a family unit.

(4) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term ''eligible individual'' means an individual who is residing in the United States and who is—

(i) a citizen or national of the United States; or

(ii) a lawful alien.

(B) EXCLUSION.—The term ''eligible individual'' shall not include an individual who is an inmate of a public institution (except as a patient of a medical institution).

(C) LAWFUL ALIEN.—The term ''lawful alien'' means an individual who is—

(i) an alien lawfully admitted for permanent residence,

(ii) an asylee,

(iii) a refugee,

(iv) an alien whose deportation has been withheld under section 243(h) of the Immigration and Nationality Act, or

(v) a parolee who has been paroled for a period of 1 year or more.

(5) POVERTY LINE.—The term ''poverty line'' means the income official poverty line (as defined by the Office of Management and Budget, and revised

annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) that—

(A) in the case of a family of less than 5 individuals, is applicable to a family of the size involved; and

(B) in the case of a family of more than 4 individuals, is applicable to a family of 4 individuals.

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

SEC. 2032. REFERENCES TO INDIVIDUAL.

For purposes of this subtitle, any reference to an individual shall include a reference to the parent or guardian of such individual.

Subtitle B—Self-Employed Health Insurance Deduction

SEC. 2101. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) PHASE-IN DEDUCTION.—Section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended—

(1) by striking paragraph (6); and

(2) by striking paragraph (1) and inserting the following:

''(1) ALLOWANCE OF DEDUCTION.—

''(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined as follows:

"If the taxable year begins in:	**The applicable percentage is:**
1994, 1995, or 1996	25 percent
1997	50 percent
1998	75 percent
1999 or thereafter	100 percent.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

TITLE III—IMPROVING ACCESS IN RURAL AREAS

Subtitle A—Office of Rural Health Policy

SEC. 3001. OFFICE OF RURAL HEALTH POLICY.

(a) APPOINTMENT OF ASSISTANT SECRETARY.—

(1) IN GENERAL.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended—

(A) by striking ''by a Director, who shall advise the Secretary'' and inserting ''by an Assistant Secretary for Rural Health (in this section referred to as the 'Assistant Secretary'), who shall report directly to the Secretary''; and

(B) by adding at the end the following new sentence: ''The Office shall not be a component of any other office, service, or component of the Department.''.

(2) CONFORMING AMENDMENTS.—(A) Section 711(b) of the Social Security Act (42 U.S.C. 912(b)) is amended by striking ''the Director'' and inserting ''the Assistant Secretary''.

(B) Section 338J(a) of the Public Health Service Act (42 U.S.C. 254r(a)) is amended by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(C) Section 464T(b) of the Public Health Service Act (42 U.S.C. 285p–2(b)) is amended in the matter preceding paragraph (1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(D) Section 6213 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 1395x note) is amended in subsection (e)(1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(E) Section 403 of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. 300ff–11 note) is amended in the matter preceding paragraph (1) of subsection (a) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(3) AMENDMENT TO THE EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (5)'' and inserting ''Assistant Secretaries of Health and Human Services (6)''.

(b) EXPANSION OF DUTIES.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended by striking ''and access to (and the quality of) health care in rural areas'' and inserting ''access to, and quality of, health care in rural areas, and reforms to the health care system and the implications of such reforms for rural areas''.

(c) TRANSFER OF DUTIES.—Effective January 1, 1996, the functions, powers, duties, and authority that were carried out in accordance with Federal law by the Office of Rural Health Policy in the Department of Health and Human Services are transferred to the Office of the Assistant Secretary for Rural Health in the Department of Health and Human Services.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

Subtitle B—Development of Telemedicine in Rural Underserved Areas

SEC. 3101. GRANTS FOR DEVELOPMENT OF RURAL TELEMEDICINE.

(a) IN GENERAL.—

(1) GRANTS AWARDED.—The Secretary, acting through the Office of Rural Health Policy, shall award grants to eligible entities that have applications approved under subsection (b) for the purpose of expanding access to health care services for individuals in rural areas through the use of telemedicine. Grants shall be awarded under this section to encourage the initial development of rural telemedicine networks, expand existing networks, link existing networks together, or link such net-

works to existing fiber optic telecommunications systems.

(2) ELIGIBLE ENTITY.—For purposes of this section, the term ''eligible entity'' includes hospitals and other health care providers in a health care network of community-based providers that includes at least 3 of the following:

(A) Community or migrant health centers.

(B) Local health departments.

(C) Community mental health centers.

(D) Nonprofit hospitals.

(E) Private practice health professionals, including rural health clinics.

(F) Other publicly funded health or social services agencies.

(b) APPLICATION.—To be eligible to receive a grant under this section an entity shall submit to the Secretary an application containing such information as the Secretary may require, including the anticipated need for the grant and the source and amount of non-Federal funds the entity would pledge for the project.

(c) PREFERENCE.—The Secretary shall, in awarding grants under this section, give preference to applicants that—

(1) are health care providers in rural health care networks or providers that propose to form such networks in medically underserved or health professional shortage areas;

(2) propose to use Federal funds to develop plans for, or to establish, telemedicine systems that will link rural hospitals and rural health care providers to other hospitals and health care providers; and

(3) demonstrate financial, institutional, and community support for the long range viability of the network.

(d) USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall be utilized for the development of telemedicine networks. Such amounts may be used to cover the costs associated with the development of telemedicine networks and the acquisition of telemedicine equipment and modifications or improvements of telecommunications facilities as approved by the Secretary.

(e) PROHIBITED USES.—Amounts received under a grant awarded under this section may not be used for any of the following:

(1) Expenditures to purchase or lease equipment to the extent the expenditures would exceed more than 60 percent of the total grant funds.

(2) Expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 10 percent of the total grant funds.

SEC. 3102. REPORT AND EVALUATION OF TELEMEDICINE.

Not later than October 1, 1995, the White House Information Infrastructure Task Force shall prepare and submit to Congress a report that evaluates the cost effectiveness and utility of telemedicine and includes recommendations for a coordinated Federal strategy to increase access to health care through telemedicine.

SEC. 3103. REGULATIONS ON REIMBURSEMENT OF TELEMEDICINE.

Not later than July 1, 1996, the Secretary, in consultation with the Assistant Secretary for Rural Health and the Administrator of the Health Care Financing Administration, shall issue regulations concerning reimbursement for telemedicine services provided under title XVIII of the Social Security Act.

SEC. 3104. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $20,000,000 for each of fiscal years 1996, 1997, 1998, 1999, and 2000, to carry out this subtitle.

SEC. 3105. DEFINITIONS.

For purposes of this subtitle:

(1) RURAL HEALTH CARE NETWORK.—The term ''rural health care network'' means a group of rural hospitals or other rural health care providers (including clinics, physicians and non-physicians primary care providers) that have entered into a relationship with each other or with nonrural hospitals and health care providers for the purpose of strengthening the delivery of health care services in rural areas or specifically to improve their patients' access to telemedicine services. At least 75 percent of hospitals and other health care providers participating in the network shall be located in rural areas.

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

Subtitle C—Rural Health Plan Demonstration Projects

SEC. 3201. RURAL HEALTH PLAN DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall establish and implement not more than 3 demonstration projects for the designation of rural health plan areas. To be designated as a rural health plan area under this section, an area must be a rural area (as defined in section 1866(d)(2)(D) of the Social Security Act

(42 U.S.C. 1395cc(d)(2)(D))) or an underserved non-urban area in accordance with other criteria specified by the Secretary of Health and Human Services.

(b) APPLICATION.—To be eligible to conduct a demonstration project under this section, an entity shall prepare and submit to the Secretary of Health and Human Services an application containing such information as the Secretary may require to ensure that project participants meet the goals described in subsection (d). An application submitted under this section shall—

(1) identify the area in which the demonstration project will be conducted; and

(2) provide assurances that the area described in paragraph (1) meets the requirements of subsection (a).

(c) REQUIREMENTS.—An entity offering a health plan (as defined in section 1031(a)) through a demonstration project under this section shall—

(1) have a recognized, long-standing relationship with the rural community in which the project is being conducted; and

(2) ensure that the plan meets the requirements for health plans under title I.

(d) GOALS.—The goals referred to in this subsection are as follows:

(1) To develop a reliable supply of health care providers and rural health service delivery infrastructures with a sound financial footing.

(2) To develop a mechanism to begin to provide the benefits of networking found in urban health systems to rural Americans living in rural health plan areas.

(e) REPORT.—Not later than 360 days after the date on which the first demonstration project is implemented under this section, and annually thereafter for each year in which a project is being conducted, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the effectiveness of such projects. Such reports shall include any legislative recommendations determined appropriate by the Secretary.

Subtitle D—Antitrust Safe Harbors for Rural Health Providers

SEC. 3301. ANTITRUST SAFE HARBORS FOR RURAL HEALTH PROVIDERS.

(a) IN GENERAL.—The Attorney General of the United States, in consultation with the Commissioner of the Federal Trade Commission, shall establish policy guidelines to assist rural health care providers in complying with safe harbor requirements with respect to the conduct

of activities relating to the provision of health care services in rural areas.

(b) DISSEMINATION OF INFORMATION.—The Attorney General, in consultation with the Commissioner of the Federal Trade Commission and the Assistant Secretary for Rural Health, shall develop methods for the dissemination of the guidelines established under subsection (a) to rural health care providers.

(c) PUBLICATION OF ADDITIONAL SAFE HARBORS.—Not later than 120 days after the date of enactment of this Act, the Attorney General shall publish in the Federal Register the guidelines established under subsection (a) together with any proposed additional safe harbors for rural providers of health care services.

TITLE IV—QUALITY AND CONSUMER PROTECTION

Subtitle A—Administrative Simplification

PART 1—PURPOSE AND DEFINITIONS

SEC. 4001. PURPOSE.

(a) IN GENERAL.—It is the purpose of this subtitle to promote administrative simplification, enhance the usefulness of health information, and protect privacy through the establishment of a national framework for health information.

(b) GOALS OF FRAMEWORK.—By standardizing data elements, code sets, and electronic transactions, and by assuring a secure environment for the transmission and exchange of health information, it is the goal of the national framework to reduce the burden of administrative complexity, paper work, and cost on the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act. It is the further goal of the national framework to enable the information routinely collected in the health care and claims processes to be used for other health related purposes, including promoting access and quality of care, achieving public health objectives, improving the detection of fraud and abuse, and advancing medical research.

SEC. 4002. DEFINITIONS.

(a) DEFINITIONS FOR TITLE.—For purposes of this title:

(1) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person furnishing health care services or supplies.

(2) HEALTH INFORMATION.—The term ''health information'' means any information, whether oral or recorded in any form or medium that—

(A) is created or received by a health care provider, health plan, health oversight agency (as defined in section 4101), health researcher, public health authority (as defined in section 4101), employer, life insurer, school or university, or certified health information network service; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(3) HEALTH INFORMATION PROTECTION ORGANIZATION.—The term ''health information protection organization'' means a private entity or an entity operated by a State, certified under section 4022, that accesses standard data elements of health information through the health information network and—

(A) stores such information; and

(B) processes such information into nonidentifiable health information and discloses such information in accordance with subtitle B.

(4) HEALTH PLAN.—The term ''health plan'' has the meaning given such term in section 1031(a)

except that such term shall include paragraphs (3), (4), (5), (6), (7), (8), and (9) of such section.

(5) NON-IDENTIFIABLE HEALTH INFORMATION.—The term ''non-identifiable health information'' means health information that is not protected health information as defined in section 4101.

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

(b) DEFINITIONS FOR SUBTITLE.—For purposes of this subtitle:

(1) CODE SET.—The term ''code set'' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) COORDINATION OF BENEFITS.—The term ''coordination of benefits'' means determining and coordinating the financial obligations of health plans when health care benefits are payable under 2 or more health plans.

(3) HEALTH INFORMATION NETWORK.—The term ''health information network'' means the health information system that is formed through the application of the requirements and standards established under this subtitle.

(4) STANDARD.—The term ''standard'', when referring to an information transaction or to data elements of health information, means the transaction or data elements meet any standard adopted by the Secretary under part 2 that applies to such information transaction or data elements.

PART 2—STANDARDS FOR DATA ELEMENTS AND INFORMATION TRANSACTIONS

SEC. 4011. GENERAL REQUIREMENTS ON SECRETARY.

The Secretary shall adopt standards and modifications to standards under this subtitle relying, if possible, on standards in use and generally accepted or developed or modified by the standards setting organizations accredited by the American National Standard Institute (ANSI).

SEC. 4012. STANDARDS FOR HEALTH INFORMATION TRANSACTIONS AND DATA ELEMENTS.

(a) IN GENERAL.—The Secretary shall adopt standards for transactions, data elements, and code sets, to make uniform and able to be exchanged electronically health information that is—

(1) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information in the case of health care providers that do not file claims, claims attachments, enrollment and

disenrollment, eligibility, payment and remittance advice, premium payments, first report of injury, claims status, and referral certification and authorization;

(2) related to other transactions determined appropriate by the Secretary consistent with the goals of improving the health care system and reducing administrative costs; and

(3) related to inquiries by a health information protection organization with respect to information standardized under paragraph (1) or (2).

(b) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system.

(c) CODE SETS.—

(1) IN GENERAL.—The Secretary shall, if possible, select code sets from among the code sets that have been developed, and shall establish efficient and low-cost procedures for distribution of code sets and modifications made to such code sets under section 4013(b).

(2) ADDITIONS AND MODIFICATIONS TO CODE SETS.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhance-

ment, and expansion of code sets to accommodate changes in biomedical science and health care delivery. Modified code sets shall be adopted not more frequently than once every 6 months.

(d) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this subtitle and written signatures on medical records and prescriptions.

(e) SPECIAL RULES FOR COORDINATION OF BENEFITS.—Any standards adopted under subsection (a) that relate to coordination of benefits shall provide that a claim for reimbursement for medical services furnished is tested by an algorithm specified by the Secretary against all records that are electronically available through the health information network relating to enrollment and eligibility for the individual who received such services to determine any primary and secondary obligers for payment.

PART 3—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

SEC. 4021. REQUIREMENTS ON HEALTH PLANS AND HEALTH CARE PROVIDERS.

(a) IN GENERAL.—A health plan or health care provider shall conduct transactions described in section 4012(a) as standard transactions.

(b) COMPLIANCE.—Not later than 12 months after the date on which a standard is adopted under part 2, a health plan or health care provider shall comply with the requirement under subsection (a) with respect to such standard.

(c) RESPONSE TO ELECTRONIC INQUIRY.—If a health plan or health care provider conducts a transaction in compliance with subsection (a), such transaction and the standard data elements of such transaction shall be made available electronically, in accordance with section 4031, in response to an electronic inquiry from a health information protection organization.

SEC. 4022. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION PROTECTION ORGANIZATIONS.

(a) STANDARDS FOR OPERATION.—The Secretary shall establish standards with respect to the operation and certification of health information protection organizations, including standards ensuring that—

(1) such organizations have capabilities, policies, and procedures in place that are consistent with the privacy requirements under subtitle B; and

(2) such organizations, if part of a larger organization, have policies and procedures in place which isolate their information processing activities in a manner that prevents unauthorized access to such information by such larger organization.

(b) CERTIFICATION BY PRIVATE ENTITIES.—The Secretary may designate private entities to conduct the certification procedures established by the Secretary under this section.

PART 4—ACCESSING HEALTH INFORMATION

SEC. 4031. ACCESS FOR AUTHORIZED PURPOSES.

(a) IN GENERAL.—The Secretary shall adopt technical standards for appropriate persons to locate and access the health information that is available through the health information network. Such technical standards shall ensure that any request to locate or access information shall be authorized under subtitle B.

(b) GOVERNMENT AGENCIES.—

(1) IN GENERAL.—Health information protection organizations shall make available to a Federal or State agency pursuant to a Federal Acquisition Regulation (or an equivalent State system), any non-

identifiable health information that is requested by such agency.

(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection organization described in paragraph (1) needs information from a health plan, health care provider, or other health information protection organization in order to comply with a request of a Federal or State agency under this Act, such plan, provider, or other organization shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information.

(c) MODIFICATIONS TO STANDARDS.—Rules similar to rules under section 4012(c)(2) shall apply to modifications to standards under this part.

PART 5—PENALTIES

SEC. 4041. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

(a) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person that violates a requirement or standard imposed under this subtitle a penalty of not more than $1,000 for each violation. The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the

imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

(b) LIMITATIONS.—

(1) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in subsection (a).

(2) FAILURES DUE TO REASONABLE CAUSE.—A penalty may not be imposed under subsection (a) if the failure to comply was due to reasonable cause and not to willful neglect, and the failure to comply is corrected during the time period established by the Secretary.

(3) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (2) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

PART 6—MISCELLANEOUS PROVISIONS

SEC. 4051. EFFECT ON STATE LAW.

(a) IN GENERAL.—Except as provided in subsection (b), a provision, requirement, or standard under this subtitle shall supersede any contrary provision of State law, including—

(1) any law that requires medical or health plan records (including billing information) to be maintained or transmitted in writing, and

(2) a provision of State law which provides for requirements or standards that are more stringent than the requirements or standards under this subtitle;

except if the Secretary determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

(b) PUBLIC HEALTH REPORTING.—Nothing in this subtitle shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

SEC. 4052. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subtitle.

Subtitle B—Privacy of Health Information

PART 1—DEFINITIONS

SEC. 4101. DEFINITIONS.

For purposes of this subtitle:

(1) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' means any information, including demographic information collected from an individual, whether oral or recorded in any form or medium, that—

(A) is created or received by a health care provider, health plan, health oversight agency, health researcher, public health authority, employer, life insurer, school or university, or health information protection organization; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies an individual; or

(ii) with respect to which there is a reasonable basis to believe that the infor-

mation can be used to identify an individual.

(2) DISCLOSE.—The term ''disclose'', when used with respect to protected health information, means to provide access to the information, but only if such access is provided to a person other than the individual who is the subject of the information.

(3) HEALTH INFORMATION TRUSTEE.—The term ''health information trustee'' means—

(A) a health care provider, health plan, health oversight agency, health information protection organization, employer, life insurer, or school or university insofar as it creates, receives, maintains, uses, or transmits protected health information;

(B) any person who obtains protected health information under section 4108, 4111, 4116, 4117, 4118, 4121, 4122, 4126, or 4131; and

(C) any employee or agent of a person covered under subparagraphs (A) or (B).

(4) HEALTH OVERSIGHT AGENCY.—The term ''health oversight agency'' means a person who—

(A) performs or oversees the performance of an assessment, evaluation, determination, or

investigation relating to the licensing, accreditation, or certification of health care providers; or

(B)(i) performs or oversees the performance of an assessment, evaluation, determination, investigation, or prosecution relating to the effectiveness of, compliance with, or applicability of legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery of, or payment for health care or relating to health care fraud or fraudulent claims for payment regarding health care; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a Federal or State law governing the assessment, evaluation, determination, investigation, or prosecution described in clause (i).

(5) PUBLIC HEALTH AUTHORITY.—The term ''public health authority'' means an authority or instrumentality of the United States, a State, or a political subdivision of a State that is—

(A) responsible for public health matters; and

(B) engaged in such activities as injury reporting, public health surveillance, and public health investigation or intervention.

(6) INDIVIDUAL REPRESENTATIVE.—The term ''individual representative'' means any individual legally empowered to make decisions concerning the provision of health care to an individual (if the individual lacks the legal capacity under State law to make such decisions) or the administrator or executor of the estate of a deceased individual.

(7) PERSON.—The term ''person'' includes an authority of the United States, a State, or a political subdivision of a State.

PART 2—AUTHORIZED DISCLOSURES

Subpart A—General Provisions

SEC. 4106. GENERAL RULES REGARDING DISCLOSURE.

(a) GENERAL RULE.—A health information trustee may disclose protected health information only for a purpose that is authorized under this subtitle.

(b) DISCLOSURE WITHIN A TRUSTEE.—A health information trustee may disclose protected health information to an officer, employee, or agent of the trustee for a purpose that is compatible with and related to the purpose for which the information was collected or received by that trustee.

(c) SCOPE OF DISCLOSURE.—Every disclosure of protected health information by a health information trustee shall be limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed.

(d) NO GENERAL REQUIREMENT TO DISCLOSE.—Nothing in this subtitle that permits a disclosure of health information shall be construed to require such disclosure.

(e) USE AND REDISCLOSURE OF INFORMATION.—Protected health information about an individual that is disclosed under this subtitle may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual unless the action or investigation arises out of or is directly related to the law enforcement inquiry for which the information was obtained.

(f) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—When engaging in a permitted disclosure, a health information trustee shall clearly identify protected health information as such and as protected by this subtitle, unless the disclosure is made under section 4112 or is a routine disclosure made under a written agreement which satisfies this subsection.

(g) DIRECTORY INFORMATION.—A health care provider and a person receiving protected health information

under section 4112 may disclose protected health information to any person if the information consists only of 1 or more of the following items:

(1) The name of the individual who is the subject of the information.

(2) If the individual who is the subject of the information is receiving health care from a health care provider on a premises controlled by the provider—

(A) the location of the individual on the premises; and

(B) the general health status of the individual, described as critical, poor, fair, stable, or satisfactory, or in terms denoting similar conditions.

(h) NEXT OF KIN.—A health care provider or person who receives protected health information under section 4112 may disclose protected health information to the next of kin, an individual representative of the individual who is the subject of the information, or an individual with whom that individual has a close personal relationship if—

(1) the individual who is the subject of the information—

(A) has been notified of the individual's right to object and has not objected to the disclosure;

(B) is not competent to be notified about the right to object; or

(C) is subject to exigent circumstances such that it would not be practicable to notify the individual of the right to object; and

(2) the information disclosed relates to health care currently being provided to that individual.

(i) INFORMATION IN WHICH PROVIDERS ARE IDENTIFIED.—The Secretary may issue regulations protecting information identifying providers in order to promote the availability of health care services.

SEC. 4107. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) WRITTEN AUTHORIZATIONS.—A health information trustee may disclose protected health information pursuant to an authorization executed by the individual who is the subject of the information under regulations issued by the Secretary.

(b) WRITTEN OBJECTIONS TO DISCLOSURE.—Except if required by law, nothing in this subtitle that permits a disclosure shall allow such disclosure if the subject of

the protected health information has previously objected to disclosure in writing.

SEC. 4108. HEALTH INFORMATION PROTECTION ORGANIZATIONS.

A health information trustee may disclose protected health information to a health information protection organization for the purpose of creating non-identifiable health information.

Subpart B—Specific Disclosures Relating to Patient

SEC. 4111. DISCLOSURES FOR TREATMENT AND FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) HEALTH CARE TREATMENT.—A health care provider, health plan, employer, or person who receives protected health information under section 4112, may disclose protected health information to a health care provider for the purpose of providing health care to an individual.

(b) DISCLOSURE FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health care provider or employer may disclose protected health information to a health care provider or health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

SEC. 4112. EMERGENCY CIRCUMSTANCES.

A health care provider, health plan, employer, or person who receives protected health information under this section may disclose protected health information in emergency circumstances when necessary to protect the health or safety of an individual from imminent harm.

Subpart C—Disclosure for Oversight, Public Health, and Research Purposes

SEC. 4116. OVERSIGHT.

A health information trustee may disclose protected health information to a health oversight agency for an oversight function authorized by law.

SEC. 4117. PUBLIC HEALTH.

A health care provider, health plan, public health authority, employer, or person who receives protected health information under section 4112 may disclose protected health information to a public health authority or other person authorized by law for use in a legally authorized—

(1) disease or injury reporting;

(2) public health surveillance; or

(3) public health investigation or intervention.

SEC. 4118. HEALTH RESEARCH.

(a) IN GENERAL.—A health information trustee may disclose protected health information to a health researcher if an institutional review board determines that the research project engaged in by the health researcher—

(1) requires use of the protected health information for the effectiveness of the project; and

(2) is of sufficient importance to outweigh the intrusion into the privacy of the individual who is the subject of the information that would result from the disclosure.

(b) RESEARCH REQUIRING DIRECT CONTACT.—A health care provider or health plan may disclose protected health information to a health researcher for a research project that includes direct contact with an individual who is the subject of protected health information if an institutional review board determines that direct contact is necessary and will be made in a manner that minimizes the risk of harm, embarrassment, or other adverse consequences to the individual.

(c) OBLIGATIONS OF RECIPIENT.—A person who receives protected health information under subsection (a) shall use such information solely for the purposes of the approved research project and shall remove or destroy, at the earliest opportunity consistent with the purposes of the project, information that would enable an individual to be identified.

Subpart D—Disclosure For Judicial, Administrative, and Law Enforcement Purposes

SEC. 4121. JUDICIAL AND ADMINISTRATIVE PURPOSES.

A health care provider, health plan, health oversight agency, or employer may disclose protected health information, subject to a court's rules of procedure—

(1) in connection with litigation or proceedings to which the individual who is the subject of the information is a party and in which the individual has placed the individual's physical or mental condition at issue;

(2) if the protected health information is developed in response to a court-ordered physical or mental examination; or

(3) pursuant to a law requiring the reporting of specific medical information to law enforcement authorities.

SEC. 4122. LAW ENFORCEMENT.

(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 4112 may disclose protected health information to a law enforcement agency (other than a health oversight agency governed by section 4116) if the information is requested for use—

(1) in an investigation or prosecution of a health information trustee;

(2) in the identification of a victim or witness in a law enforcement inquiry; or

(3) in connection with the investigation of criminal activity committed against the trustee or on premises controlled by the trustee.

(b) WRITTEN CERTIFICATION.—If a law enforcement agency (other than a health oversight agency) requests that a health information trustee disclose protected health information under this section, such agency shall provide the trustee with a written certification that—

(1) specifies the information requested;

(2) states that the information is needed for a lawful purpose under this section; and

(3) is signed by a supervisory official of a rank designated by the head of the agency.

Subpart E—Disclosure Pursuant to Government Subpoena or Warrant

SEC. 4126. GOVERNMENT SUBPOENAS AND WARRANTS.

A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 4112 may disclose protected health information under this section if the disclosure is pursuant to—

(1) an administrative subpoena or summons, a judicial subpoena or warrant, or a grand jury subpoena, and the trustee is provided written certification that section 4127 has been complied with by the person seeking the subpoena or summons; or

(2) an administrative subpoena or summons, a judicial subpoena or warrant, or a grand jury subpoena, and the disclosure otherwise meets the conditions of section 4116, 4117, 4118, 4121, or 4122.

SEC. 4127. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS AND WARRANTS.

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about an individual under paragraph (1) or (2) of section 4126 for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

(b) WARRANTS.—A government authority that obtains protected health information about an individual under circumstances described in subsection (a) and pursuant to a warrant shall, not later than 30 days after the date the warrant was executed, serve the individual with, or mail to the last known address of the individual, a notice that protected health information about the individual

was so obtained, together with a notice of the individual's right to challenge the warrant.

(c) SUBPOENA OR SUMMONS.—Except as provided in subsection (d), a government authority may not obtain protected health information about an individual under circumstances described in subsection (a) and pursuant to a subpoena or summons unless a copy of the subpoena or summons has been served on the individual on or before the date of return of the subpoena or summons, together with notice of the individual's right to challenge the subpoena or summons. No disclosure may be made until after the 15th day after the individual has been served or after a court order allowing disclosure.

(d) APPLICATION FOR DELAY.—

(1) IN GENERAL.—A government authority may apply ex parte and under seal to an appropriate court to delay (or extend a delay) serving a notice or copy of a warrant, subpoena, or summons required under subsection (b) or (c). The initial period of delay may not exceed 90 days.

(2) EX PARTE ORDER.—The court shall enter an ex parte order delaying or extending the delay of notice, an order prohibiting the disclosure of the request for, or disclosure of, the protected health information, and an order requiring the disclosure of

the protected health information if the court finds that—

(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry;

(C) the government authority's need for the information outweighs the privacy interest of the individual who is the subject of the information; and

(D) there is reasonable ground to believe that receipt of notice by the individual will result in—

(i) endangering the life or physical safety of any individual;

(ii) flight from prosecution;

(iii) destruction of or tampering with evidence or the information being sought;

(iv) intimidation of potential witnesses; or

(v) disclosure of the existence or nature of a confidential law enforcement investigation or grand jury investigation is likely to seriously jeopardize such investigation.

SEC. 4128. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT WARRANTS, SUBPOENAS, AND SUMMONS.

(a) MOTION TO QUASH.—Within 15 days after the date of service of a notice of execution or a copy of a warrant, subpoena, or summons of a government authority seeking protected health information about an individual under paragraph (1) or (2) of section 4126, the individual may file a motion to quash.

(b) STANDARD FOR DECISION.—The court shall grant a motion under subsection (a) unless the government demonstrates that there is probable cause to believe the protected health information is relevant to a legitimate law enforcement inquiry being conducted by the government authority and the government authority's need for the information outweighs the privacy interest of the individual.

Subpart F—Disclosure Pursuant to Party Subpoena

SEC. 4131. PARTY SUBPOENAS.

A health care provider, health plan, employer, or person who receives protected health information under section 4112 may disclose protected health information under this section if the disclosure is pursuant to a subpoena issued on behalf of a party who has complied with the access provisions of section 4132.

SEC. 4132. ACCESS PROCEDURES FOR PARTY SUBPOENAS.

A party may not obtain protected health information about an individual pursuant to a subpoena unless a copy of the subpoena together with a notice of the individual's right to challenge the subpoena in accordance with section 4133 has been served upon the individual on or before the date of return of the subpoena.

SEC. 4133. CHALLENGE PROCEDURES FOR PARTY SUBPOENAS.

(a) MOTION TO QUASH SUBPOENA.—After service of a copy of the subpoena seeking protected health information under section 4131, the individual who is the subject of the protected health information may file in any court of competent jurisdiction a motion to quash the subpoena.

(b) STANDARD FOR DECISION.—The court shall grant a motion under subsection (a) unless the respondent demonstrates that—

(1) there is reasonable ground to believe the information is relevant to a lawsuit or other judicial or administrative proceeding; and

(2) the need of the respondent for the information outweighs the privacy interest of the individual.

PART 3—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

Subpart A—Establishment of Safeguards

SEC. 4136. ESTABLISHMENT OF SAFEGUARDS.

A health information trustee shall establish and maintain appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of protected health information created or received by the trustee.

SEC. 4137. ACCOUNTING FOR DISCLOSURES.

A health information trustee shall create and maintain, with respect to any protected health information disclosed in exceptional circumstances, a record of the disclosure in accordance with regulations issued by the Secretary.

Subpart B—Review of Protected Health Information By Subjects of the Information

SEC. 4141. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Except as provided in subsection (b), a health care provider or health plan shall permit an individual who is the subject of protected health information or the individual's designee to inspect any such information that the provider or plan maintains. A health care provider or health plan may require an individual to reimburse the provider or plan for the cost of such inspection.

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

(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes, and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the notes would cause sufficient harm.

(2) ENDANGERMENT TO LIFE OR SAFETY.—The provider or plan determines that disclosure of the information could reasonably be expected to endanger the life or physical safety of any individual.

(3) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of a person (other than a health care provider) who provided information under a promise of confidentiality to a health care provider concerning the individual who is the subject of the information.

(4) ADMINISTRATIVE PURPOSES.—The information is used by the provider or plan solely for administrative purposes and not in the provision of health care to the individual who is the subject of the information.

SEC. 4142. AMENDMENT OF PROTECTED HEALTH INFORMATION.

A health care provider or health plan shall, within 45 days after receiving a written request to correct or amend protected health information from the individual who is the subject of the information—

(1) correct or amend such information; or

(2) provide the individual with a statement of the reasons for refusing to correct or amend such information and include a copy of such statement in the provider's or plan's records.

SEC. 4143. NOTICE OF INFORMATION PRACTICES.

A health care provider or health plan shall provide written notice of the provider's or plan's information prac-

tices, including notice of individual rights with respect to protected health information.

PART 4—SANCTIONS

Subpart A—Civil Sanctions

SEC. 4151. CIVIL PENALTY.

(a) VIOLATION.—Any health information trustee who the Secretary determines has substantially failed to comply with this subtitle shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $10,000 for each such violation.

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a), other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under such section 1128A.

SEC. 4152. CIVIL ACTION.

(a) IN GENERAL.—An individual who is aggrieved by negligent conduct in violation of this subtitle may bring a civil action to recover—

(1) the greater of actual damages or liquidated damages of $5,000;

(2) punitive damages;

(3) a reasonable attorney's fee and expenses of litigation;

(4) costs of litigation; and

(5) such preliminary and equitable relief as the court determines to be appropriate.

(b) LIMITATION.—No action may be commenced under this section more than 3 years after the date on which the violation was or should reasonably have been discovered.

Subpart B—Criminal Sanctions

SEC. 4161. WRONGFUL DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) OFFENSE.—A person who knowingly—

(1) obtains protected health information relating to an individual in violation of this subtitle; or

(2) discloses protected health information to another person in violation of this subtitle,

shall be punished as provided in subsection (b).

(b) PENALTIES.—A person described in subsection (a) shall—

(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

(3) if the offense is committed with intent to sell, transfer, or use protected health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

PART 5—ADMINISTRATIVE PROVISIONS

SEC. 4166. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as provided in subsections (b), (c), and (d), this subtitle preempts State law.

(b) LAWS RELATING TO PUBLIC OR MENTAL HEALTH.—Nothing in this subtitle shall be construed to preempt or operate to the exclusion of any State law relating to public health or mental health that prevents or regulates disclosure of protected health information otherwise allowed under this subtitle.

(c) PRIVILEGES.—Nothing in this subtitle is intended to preempt or modify State common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the State. This subtitle does not supersede or modify Federal common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the United States. Authorizations pursuant to section 4107 shall not be construed as a waiver of any such privilege.

(d) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This subtitle shall not be construed to preempt, supersede, or modify the operation of—

(1) any law that provides for the reporting of vital statistics such as birth or death information;

(2) any law requiring the reporting of abuse or neglect information about any individual;

(3) subpart II of part E of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-81 et seq.) (relating to notifications of emergency response employees of possible exposure to infectious diseases); or

(4) any Federal law or regulation governing confidentiality of alcohol and drug patient records.

SEC. 4167. RIGHTS OF INCOMPETENTS.

Except as provided in section 4168, if an individual has been declared to be incompetent by a court of competent jurisdiction, the rights of the individual under this subtitle shall be exercised and discharged in the best interests of the individual through the individual's representative.

SEC. 4168. EXERCISE OF RIGHTS.

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual; or

(2) who, acting alone, has the legal right, as determined by State law, to apply for and obtain a type of medical examination, care, or treatment and who has sought such examination, care, or treatment, the individual shall exercise all rights of an individual under this subtitle with respect to protected health information relating to such examination, care, or treatment.

(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

(1) under 14 years of age, all the individual's rights under this subtitle shall be exercised through the parent or legal guardian of the individual; or

(2) 14, 15, 16, or 17 years of age, the rights of inspection and amendment, and the right to authorize disclosure of protected health information of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.

Subtitle C—Enhanced Penalties for Health Care Fraud

SEC. 4201. ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1996, the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary''), acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act (42 U.S.C. 1320a-7, 1320a-7a, and 1320a-7b) and other statutes applicable to health care fraud and abuse, and

(D) to provide for the modification and establishment of safe harbors and to issue interpretative rulings and special fraud alerts.

(2) REGULATIONS.—The Secretary and the Attorney General shall by regulation establish standards to carry out the program under paragraph (1).

(b) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is hereby established an account to be known as the ''Health Care Fraud and Abuse Control Account'' (in this section referred to as the ''Anti-Fraud Account'').

(B) TRANSFER OF AMOUNTS.—The Secretary of the Treasury shall transfer to the Anti-Fraud Account an amount equal to the sum of the following:

(i) Criminal fines imposed in cases involving a Federal health care offense (as defined in subparagraph (C)).

(ii) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.) (except as otherwise provided by law), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(C) For purposes of this paragraph, the term ''Federal health care offense'' means a violation of, or a criminal conspiracy to violate—

(i) section 1347 of title 18, United States Code;

(ii) section 1128B of the Social Security Act (42 U.S.C. 1320a-7b);

(iii) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud; and

(iv) section 501 or 511 of the Employee Retirement Income Security Act of

1974 (29 U.S.C. 1131 and 1141), if the violation or conspiracy relates to health care fraud.

(2) USE OF FUNDS.—

(A) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and the Attorney General of the United States in carrying out the health care fraud and abuse control program established under subsection (a) (including the administration of the program), and may be used to cover costs incurred in operating the program, including costs (including equipment, salaries and benefits, and travel and training) of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

(iii) financial and performance audits of health care programs and operations;

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of this subtitle.

(4) USE OF FUNDS BY INSPECTOR GENERAL.—The Inspector General is authorized to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payer, or otherwise.

SEC. 4202. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO ALL FRAUD AND ABUSE AGAINST ANY HEALTH PLAN.

(a) APPLICATION OF 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), by inserting ''or of any health plan (as defined in section 1128(i)),'' after ''subsection (i)(1)),''.

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

(3) In subsection (i)—

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

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

(b) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

(c) HEALTH PLAN DEFINED.—Section 1128 of the Social Security 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 PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health plan' has the meaning given such term in section 1031(a) of the Family Health Insurance Protection Act.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

SEC. 4203. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) GENERAL PURPOSE.—Not later than January 1, 1996, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by regulations issued by the Secretary.

(b) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act (42 U.S.C. 1396r–2(d)) is amended by inserting ''and section 4203 of the Family Health Insurance Protection Act'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

SEC. 4204. HEALTH CARE FRAUD.

(a) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of this title), such person shall be imprisoned for any term of years.

''(b) For purposes of this section, the term 'health plan' has the meaning given such term in section 1128(i) of the Social Security Act (42 U.S.C. 1320a–7(i)).''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

Subtitle D—Health Care Malpractice Reform

SEC. 4301. FEDERAL TORT REFORM.

(a) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in section 4302, this subtitle shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this subtitle shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act (42 U.S.C. 300aa–1 et seq.) applies to the claim or action.

(2) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this subtitle shall be construed to—

(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(B) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(3) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

(b) DEFINITIONS.—For purposes of this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is al-

leged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(5) HEALTH PLAN.—The term ''health plan'' has the meaning given such term in section 1031(a).

(6) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice claim.

(7) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a cause of action brought in a State or Federal court against a health care provider or

health care professional by which the plaintiff brings a medical malpractice claim.

(8) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means a claim brought against a health care provider or health care professional in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any claim based on an allegation of an intentional tort;

(B) any claim based on an allegation that a product is defective that is brought against any individual or entity that is not a health care professional or health care provider; or

(C) any claim brought pursuant to a health plan benefit determination review procedure.

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

SEC. 4302. STATE-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) APPLICATION TO MALPRACTICE CLAIMS UNDER PLANS.—Prior to or immediately following the commencement of any medical malpractice action, the parties shall

participate in the alternative dispute resolution system administered by the State under subsection (b). Such participation shall be in lieu of any other provision of Federal or State law or any contractual agreement made by or on behalf of the parties prior to the commencement of the medical malpractice action.

(b) ADOPTION OF MECHANISM BY STATE.—Each State shall—

(1) maintain or adopt at least 1 of the alternative dispute resolution methods satisfying the requirements specified under subsection (c) and (d) for the resolution of medical malpractice claims; and

(2) clearly disclose to enrollees (and potential enrollees) of health plans the availability and procedures for consumer grievances, including a description of the alternative dispute resolution method or methods adopted under this subsection.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The Secretary shall, by regulation, develop alternative dispute resolution methods for the use by States in resolving medical malpractice claims under subsection (a). Such methods shall include at least the following:

(A) ARBITRATION.—The use of arbitration, a nonjury adversarial dispute resolution process which may, subject to subsection (d), result in a final decision as to facts, law, liability, or damages.

(B) CLAIMANT-REQUESTED BINDING ARBITRATION.—For claims involving a sum of money that falls below a threshold amount set by the Secretary, the use of arbitration not subject to subsection (d). Such binding arbitration shall be at the sole discretion of the claimant.

(C) MEDIATION.—The use of mediation, a settlement process coordinated by a neutral third party without the ultimate rendering of a formal opinion as to factual or legal findings.

(D) EARLY NEUTRAL EVALUATION.—The use of early neutral evaluation, in which the parties make a presentation to a neutral attorney or other neutral evaluator for an assessment of the merits, to encourage settlement. If the parties do not settle as a result of assessment and proceed to trial, the neutral evaluator's opinion shall be kept confidential.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution

methods under paragraph (1), the Secretary shall assure that the methods promote the resolution of medical malpractice claims in a manner that is affordable, timely, consistent and fair, and reasonably convenient.

(3) WAIVER AUTHORITY.—Upon application of a State, the Secretary may grant the State the authority to fulfill the requirement of subsection (b) by adopting a mechanism other than a mechanism established by the Secretary pursuant to this subsection, except that such mechanism must meet the standards set forth in paragraph (2).

(d) FURTHER REDRESS.—Except with respect to the claimant-requested binding arbitration method set forth in subsection (c)(1)(B), and notwithstanding any other provision of a law or contractual agreement, a plan enrollee dissatisfied with the determination reached as a result of an alternative dispute resolution method applied under this section may, after the final resolution of the enrollee's claim under the method, initiate or resume a cause of action to seek damages or other redress with respect to the claim to the extent otherwise permitted under State law. The results of any alternative dispute resolution procedure are inadmissible at any subsequent trial, as are all statements, offers, and other communications made during

such procedures, unless otherwise admissible under State law.

SEC. 4303. LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

(a) IN GENERAL.—An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with such action (including the resolution of the claim that is the subject of the action under any alternative dispute resolution system) in excess of—

(1) 33⅓ percent of the first $150,000 of the total amount recovered by judgment or settlement in such action; plus

(2) 25 percent of any amount recovered above the amount described in paragraph (1);

unless otherwise determined under State law. Such amount shall be computed after deductions are made for all the expenses associated with the claim other than those attributable to the normal operating expenses of the attorney.

(b) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency

fee under subsection (a) may, in the discretion of the court, be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(c) CONTINGENCY FEE DEFINED.—For purposes of this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 4304. PERIODIC PAYMENT OF AWARDS.

(a) IN GENERAL.—A party to a medical malpractice liability action may petition the court to instruct the trier of fact to award any future damages on an appropriate periodic basis. If the court, in its discretion, so instructs the trier of fact, and damages are awarded on a periodic basis, the court may require the defendant to purchase an annuity or other security instrument (typically based on future damages discounted to present value) adequate to assure payments of future damages.

(b) FAILURE OR INABILITY TO PAY.—With respect to an award of damages described in subsection (a), if a defendant fails to make payments in a timely fashion, or if the defendant becomes or is at risk of becoming insol-

vent, upon such a showing the claimant may petition the court for an order requiring that remaining balance be discounted to present value and paid to the claimant in a lump-sum.

(c) MODIFICATION OF PAYMENT SCHEDULE.—The court shall retain authority to modify the payment schedule based on changed circumstances.

(d) FUTURE DAMAGES DEFINED.—For purposes of this section, the term ''future damages'' means any economic or noneconomic loss other than that incurred or accrued as of the time of judgment.

SEC. 4305. ALLOCATION OF PUNITIVE DAMAGE AWARDS FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVITIES.

(a) IN GENERAL.—With respect to the total amount of any punitive damages awarded in a medical malpractice liability action, 50 percent of such amount shall be paid to the State in which the action is brought (or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided) for the purposes of carrying out the activities described in subsection (b).

(b) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to subsection (a) to carry out ac-

tivities to ensure the safety and quality of health care services provided in the State, including—

(1) licensing or certifying health care professionals and health care providers in the State;

(2) implementing health care quality assurance and quality improvement programs;

(3) carrying out programs to reduce malpractice-related costs for providers volunteering to provide services in medically underserved areas; and

(4) providing resources for additional investigation and disciplinary activities by the State licensing board.

(c) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to subsection (a) to supplement and not to replace amounts spent by the State for the activities described in subsection (b).

TITLE V—BUDGET NEUTRALITY

SEC. 5001. ASSURANCE OF BUDGET NEUTRALITY.

Notwithstanding any other provision of this Act, no provision of, or amendment made by, this Act shall take effect until legislation is enacted which by its terms specifically provides for the Federal budget neutrality of this Act.

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