

103D CONGRESS
1ST SESSION

H. R. 101

To improve access to health insurance and contain health care costs, and
for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

Mr. MICHEL (for himself, Mr. GINGRICH, Mr. HUNTER, Mr. MCCOLLUM, Mr. ARCHER, Mr. CRAPO, Mr. KASICH, Mr. MCDADE, Mr. McMILLAN, Mr. SOLOMON, Mr. BILIRAKIS, Mr. BLILEY, Mr. GOSS, Mr. GRADISON, Mr. GRANDY, Mr. GUNDERSON, Mr. HASTERT, Mr. HOBSON, Mrs. JOHNSON of Connecticut, Mr. ROBERTS, Mr. WALKER, Mr. BAKER of Louisiana, Mr. BARRETT of Nebraska, Mr. DOOLITTLE, Mrs. FOWLER, Mr. GEKAS, Mr. GILLMOR, Mr. GOODLING, Mr. KOLBE, Mr. MCCRERY, Mr. MCHUGH, Mr. MOORHEAD, Mr. OXLEY, Mr. PETRI, Mr. SANTORUM, Mr. SENSENBRENNER, Mr. SHAW, Mr. SHAYS, Mr. SMITH of Oregon, Ms. SNOWE, Mr. TAYLOR of North Carolina, Mr. THOMAS of Wyoming, and Mr. WOLF) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, and the Judiciary

MARCH 24, 1993

Additional sponsors: Mr. HOUGHTON, Mr. SUNDQUIST, Mr. EWING, Mr. GALLEGLY, Mr. INGLIS of South Carolina, Mr. SKEEN, Mr. FRANKS of Connecticut, Mr. MANZULLO, Mr. BALLENGER, Mr. CUNNINGHAM, Mr. LINDER, Mr. QUINN, Mr. BARTLETT of Maryland, Mrs. MEYERS of Kansas, Mr. LEWIS of Florida, Mr. SAM JOHNSON of Texas, Mr. CALVERT, Mr. UPTON, Mr. YOUNG of Alaska, Mr. GRAMS, Mr. BARTON of Texas, Mr. ROTH, Mr. KYL, and Mr. HANCOCK

A BILL

To improve access to health insurance and contain health
care costs, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
 5 “Action Now Health Care Reform Act of 1993”.

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

Sec. 1. Short title; table of contents.

**TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH
 CARE COVERAGE**

**Subtitle A—Increased Affordability and Availability for
 Employees**

- Sec. 101. Establishment and enforcement of standards for health benefit plans.
- Sec. 102. Preemption of State benefit mandates for small employer health benefit plans that meet consumer protection standards.
- Sec. 103. Requirement for small employer carrier offering of MedAccess plans.
- Sec. 104. Limitation on pre-existing condition clauses; assurance of continuity of coverage.
- Sec. 105. Limits on premiums and miscellaneous consumer protections.
- Sec. 106. Requirements relating to renewability generally.
- Sec. 107. Limitation on annual premium increases.
- Sec. 108. Establishment of reinsurance or allocation of risk mechanisms for high risk individuals.
- Sec. 109. Registration of all health benefit plans.
- Sec. 110. Office of Private Health Care Coverage; annual reports on evaluation of health care coverage reform.
- Sec. 111. Research and demonstration projects; development of a health risk pooling model.
- Sec. 112. General definitions.

**Subtitle B—Improved Small Employer Purchasing Power of
 Affordable Health Insurance**

- Sec. 121. Preemption from insurance mandates for qualified small employer purchasing groups.

Subtitle C—Health Deduction Fairness

- Sec. 131. Permanent extension and increase in health insurance tax deduction for self-employed individuals.

Subtitle D—Improved Access to Community Health Services

PART 1—INCREASED AUTHORIZATION FOR COMMUNITY AND MIGRANT
 HEALTH CENTERS

Sec. 141. Grant program to promote primary health care services for underserved populations.

PART 2—GRANTS FOR PROJECTS FOR COORDINATING DELIVERY OF SERVICES

Sec. 151. Projects for coordinating delivery of outpatient primary health services.

Subtitle E—Improved Access to Rural Health Services

PART 1—RURAL EMERGENCY MEDICAL SERVICES AMENDMENTS

Sec. 171. Office of Emergency Medical Services.
 Sec. 172. State offices of emergency medical services.
 Sec. 173. Programs for rural areas.
 Sec. 174. Funding.
 Sec. 175. Conforming amendments.
 Sec. 176. Effective date.

PART 2—AIR TRANSPORT FOR RURAL VICTIMS OF MEDICAL EMERGENCIES

Sec. 181. Grants to States regarding aircraft for transporting rural victims of medical emergencies.

PART 3—EXTENSION OF SPECIAL TREATMENT RULES FOR MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS

Sec. 191. Extension of special treatment rules for medicare-dependent, small rural hospitals.

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

Sec. 201. Federal reform of medical malpractice liability actions.
 Sec. 202. Definitions.
 Sec. 203. Effective date.

PART 2—UNIFORM STANDARDS FOR MEDICAL MALPRACTICE LIABILITY ACTIONS

Sec. 211. Statute of limitations.
 Sec. 212. Requirement for initial resolution of action through alternative dispute resolution.
 Sec. 213. Establishment of process for resolution of claims against United States.
 Sec. 214. Mandatory pre-trial settlement conference.
 Sec. 215. Calculation and payment of damages.
 Sec. 216. Treatment of attorney's fees and other costs.
 Sec. 217. Joint and several liability.
 Sec. 218. Uniform standard for determining negligence.
 Sec. 219. Application of medical practice guidelines in malpractice liability actions.
 Sec. 220. Special provision for certain obstetric services.

Sec. 221. Preemption.

PART 3—REQUIREMENTS FOR ALTERNATIVE DISPUTE RESOLUTION SYSTEMS
(ADR)

Sec. 231. Basic requirements for ADR.

Sec. 232. Certification of State systems; applicability of alternative Federal system.

Sec. 233. Reports on implementation and effectiveness of alternative dispute resolution systems.

PART 4—OTHER REQUIREMENTS AND PROGRAMS

Sec. 241. Facilitating development and use of medical practice guidelines.

Sec. 242. Permitting State professional societies to participate in disciplinary activities.

Sec. 243. Requirements for risk management programs.

Sec. 244. Grants for medical safety promotion.

Sec. 245. Study of barriers to voluntary service by physicians.

Subtitle B—Administrative Cost Savings

PART 1—STANDARDIZATION OF CLAIMS PROCESSING

Sec. 251. Adoption of data elements, uniform claims, and uniform electronic transmission standards.

Sec. 252. Application of standards.

Sec. 253. Periodic review and revision of standards.

Sec. 254. Health benefit plan defined.

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

Sec. 261. Medical data standards for hospitals and other providers.

Sec. 262. Application of electronic data standards to certain hospitals.

Sec. 263. Electronic transmission to Federal agencies.

Sec. 264. Limitation on data requirements where standards in effect.

Sec. 265. Advisory commission.

PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE
INFORMATION

Sec. 271. State comparative value information programs for health care purchasing.

Sec. 272. Federal implementation.

Sec. 273. Comparative value information concerning Federal programs.

Sec. 274. Development of model systems.

PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS; RESEARCH AND
DEMONSTRATIONS

Sec. 281. Standards relating to use of Medicare and Medicaid magnetized health benefit cards; secondary payor data bank.

Sec. 282. Preemption of State quill pen laws.

Sec. 283. Use of standard identification numbers.

Sec. 284. Coordination of benefit standards.

Sec. 285. Research and demonstrations.

Subtitle C—Medical Savings Accounts (Medisave)

Sec. 291. Medical savings accounts.

Subtitle D—Medicaid Program Flexibility

Sec. 301. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under medicaid.

Sec. 302. Period of certain waivers.

Subtitle E—Limitations on Physician Self-Referrals

Sec. 311. Extension of physician self-referral limitations to all payors.

Sec. 312. Extension of physician self-referral limitations to certain additional services.

Sec. 313. Changes in exceptions.

Sec. 314. Study and report on changes in costs.

Sec. 315. Effective date.

Subtitle F—Removing Restrictions on Managed Care

Sec. 321. Removing restrictions on managed care.

Subtitle G—Medicare Payment Changes

Sec. 331. Revisions to methodology for determining updates to Medicare hospital payments.

Sec. 332. Reduction in Medicare payment for clinical diagnostic laboratory tests.

Subtitle H—Limitation of Antitrust Recovery for Certain Hospital Joint Ventures

Sec. 341. Purpose.

Sec. 342. Definitions.

Sec. 343. Limitation on damages for antitrust violations.

Sec. 344. Disclosure of hospital joint venture.

Sec. 345. Interagency committee on competition, antitrust policy, and health care.

Subtitle I—Encouraging Enforcement Activities of Medical Self-Regulatory Entities

PART 1—APPLICATION OF THE CLAYTON ACT TO MEDICAL SELF-REGULATORY ENTITIES

Sec. 351. Antitrust exemption for medical self-regulatory entities.

Sec. 352. Definitions.

PART 2—CONSULTATION BY FEDERAL AGENCIES

Sec. 357. Consultation with medical self-regulatory entities respecting medical professional guidelines and standards.

1 **TITLE I—IMPROVED ACCESS TO**
2 **AFFORDABLE HEALTH CARE**
3 **COVERAGE**

4 **Subtitle A—Increased Affordability**
5 **and Availability for Employees**

6 **SEC. 101. ESTABLISHMENT AND ENFORCEMENT OF STAND-**
7 **ARDS FOR HEALTH BENEFIT PLANS.**

8 (a) ESTABLISHMENT OF GENERAL STANDARDS.—

9 (1) ROLE OF NAIC.—The Secretary of Health
10 and Human Services shall request the National As-
11 sociation of Insurance Commissioners (in this sub-
12 title referred to as the “NAIC”) to develop, within
13 9 months after the date of the enactment of this
14 Act, model regulations that specify standards with
15 respect to each of the following:

16 (A) MEDACCESS STANDARDS.—(i) The re-
17 quirement, under section 103(a), that small em-
18 ployer carriers make available MedAccess plans.

19 (ii) The uniform benefit levels to be in-
20 cluded in MedAccess basic and standard plans
21 under section 103(b).

22 (iii) The requirements of guaranteed avail-
23 ability of MedAccess plans to small employers
24 under section 103(c).

1 (B) CONSUMER PROTECTION STAND-
2 ARDS.—(i) The requirements of section 104 (re-
3 lating to limitations on treatment of pre-exist-
4 ing conditions and assurance of continuity of
5 coverage).

6 (ii) The requirements of section 105 (relat-
7 ing to limits on premiums and miscellaneous
8 consumer protections).

9 (iii) The requirements of section 106 (re-
10 lating to renewability generally).

11 (iv) The requirement of section 107 (relat-
12 ing to limitation on annual premium increases).

13 If the NAIC develops recommended regulations
14 specifying such standards within such period, the
15 Secretary shall review the standards. Such review
16 shall be completed within 60 days after the date the
17 regulations are developed. Unless the Secretary de-
18 termines within such period that the standards do
19 not meet the requirements, such standards shall
20 serve as the standards under this section, with such
21 amendments as the Secretary deems necessary.

22 (2) CONTINGENCY.—If the NAIC does not de-
23 velop such model regulations within such period or
24 the Secretary determines that such regulations do
25 not specify standards that meet the requirements de-

1 scribed in paragraph (1), the Secretary shall specify,
2 within 15 months after the date of the enactment of
3 this Act, standards to carry out those requirements.

4 (3) EFFECTIVE DATES.—

5 (A) MEDACCESS STANDARDS.—The
6 MedAccess standards (as defined in section
7 112(8)) shall apply to carriers in a State on or
8 after the date the standards are implemented in
9 the State under subsection (b).

10 (B) CONSUMER PROTECTION STAND-
11 ARDS.—For employer health benefit plans other
12 than MedAccess plans, the consumer protection
13 standards (as defined in section 112(2)) shall
14 apply to plans offered or renewed on or after 4
15 years after the date such standards are imple-
16 mented in the State under subsection (b).

17 (b) APPLICATION OF STANDARDS THROUGH
18 STATES.—

19 (1) APPLICATION OF MEDACCESS STAND-
20 ARDS.—

21 (A) IN GENERAL.—Each State shall sub-
22 mit to the Secretary, by the deadline specified
23 in subparagraph (B), a report on steps the
24 State is taking to implement and enforce the
25 MedAccess standards with respect to small em-

1 employer carriers, and small employer health bene-
2 fit plans offered, not later than such deadline.

3 (B) DEADLINE FOR REPORT.—

4 (i) 1 YEAR AFTER STANDARDS ESTAB-
5 LISHED.—Subject to clause (ii), the dead-
6 line under this subparagraph is 1 year
7 after the date the MedAccess standards
8 are established under subsection (a).

9 (ii) EXCEPTION FOR LEGISLATION.—

10 In the case of a State which the Secretary
11 identifies, in consultation with the NAIC,
12 as—

13 (I) requiring State legislation
14 (other than legislation appropriating
15 funds) in order for carriers and health
16 benefit plans offered to small employ-
17 ers to meet the MedAccess standards
18 established under subsection (a), but

19 (II) having a legislature which is
20 not scheduled to meet in 1994 in a
21 legislative session in which such legis-
22 lation may be considered,

23 the date specified in this subparagraph is
24 the first day of the first calendar quarter
25 beginning after the close of the first legis-

1 lative session of the State legislature that
2 begins on or after January 1, 1996. For
3 purposes of the previous sentence, in the
4 case of a State that has a 2-year legislative
5 session, each year of such session shall be
6 deemed to be a separate regular session of
7 the State legislature.

8 (2) APPLICATION OF CONSUMER PROTECTION
9 STANDARDS TO NON-MEDACCESS EMPLOYER
10 HEALTH BENEFIT PLANS.—Each State shall submit
11 to the Secretary, by not later than 4 years after the
12 date consumer protection standards are established
13 under subsection (a), a report on steps the State is
14 taking to implement and enforce the consumer pro-
15 tection standards with respect to all employer health
16 benefit plans (other than MedAccess plans) which
17 are subject to regulation by the State and which are
18 offered or renewed not later than 4 years after the
19 date the standards were established.

20 (3) FEDERAL ROLE.—

21 (A) SECRETARIAL AUTHORITY.—

22 (i) IN GENERAL.—If the Secretary de-
23 termines that a State has failed to submit
24 a report by the deadline specified under
25 paragraph (1) or (2) or finds that the

1 State has not implemented and provided
2 adequate enforcement of the MedAccess
3 standards or consumer protection stand-
4 ards under the respective paragraph, the
5 Secretary shall notify the State and pro-
6 vide the State a period of 60 days in which
7 to submit such report or to implement and
8 enforce such standards under the respec-
9 tive paragraph. If, after such 60-day pe-
10 riod, the Secretary finds that such a fail-
11 ure has not been corrected, the Secretary
12 shall provide for such mechanism for the
13 implementation and enforcement of the ap-
14 plicable standards in the State as the Sec-
15 retary determines to be appropriate. Such
16 implementation and enforcement shall take
17 effect with respect to carriers, and health
18 benefit plans offered or renewed, on or
19 after 3 months after the date of the Sec-
20 retary's finding under the previous sen-
21 tence, and until the date the Secretary
22 finds that such a failure has been cor-
23 rected. In exercising authority under this
24 subparagraph, the Secretary shall deter-
25 mine whether the use of a risk-allocation

1 mechanism, described in section 103(d),
2 would be more consistent with the small
3 employer group health coverage market in
4 the State than the guaranteed availability
5 provisions of section 103(c).

6 (ii) NON-STATE REGULATED ENTI-
7 TIES.—In the case of carriers that are not
8 subject to State regulation, the Secretary
9 shall be responsible for implementation and
10 enforcement of standards under this sub-
11 title.

12 (B) ENFORCEMENT THROUGH EXCISE
13 TAX.—

14 (i) IN GENERAL.—Chapter 43 of the
15 Internal Revenue Code of 1986 (relating to
16 qualified pension, etc., plans) is amended
17 by adding at the end thereof the following
18 new section:

19 **“SEC. 4980C. FAILURE TO COMPLY WITH EMPLOYER**
20 **HEALTH BENEFIT PLAN STANDARDS.**

21 “(a) IMPOSITION OF TAX.—

22 “(1) IN GENERAL.—There is hereby imposed a
23 tax on the failure of a carrier or an employer health
24 benefit plan to comply with the applicable standards

1 established under section 101(a) of the Action Now
2 Health Care Reform Act of 1993.

3 “(2) EXCEPTION.—Paragraph (1) shall not
4 apply to a failure by a small employer carrier or
5 plan in a State if the Secretary of Health and
6 Human Services determines that the State has in ef-
7 fect a regulatory enforcement mechanism that pro-
8 vides adequate sanctions with respect to such a fail-
9 ure by such a carrier or of such a plan.

10 “(b) AMOUNT OF TAX.—

11 “(1) IN GENERAL.—Subject to paragraph (2),
12 the tax imposed by subsection (a) shall be an
13 amount not to exceed 25 percent of the amounts re-
14 ceived by the carrier or under the plan for coverage
15 during the period such failure persists.

16 “(2) LIMITATION IN CASE OF INDIVIDUAL FAIL-
17 URES.—In the case of a failure that only relates to
18 specified individuals or employers (and not to the
19 plan generally), the amount of the tax imposed by
20 subsection (a) shall not exceed the aggregate of
21 \$100 for each day during which such failure persists
22 for each individual to which such failure relates. A
23 rule similar to the rule of section 4980B(b)(3) shall
24 apply for purposes of this section.

1 “(c) LIABILITY FOR TAX.—The tax imposed by this
2 section shall be paid by the carrier.

3 “(d) EXCEPTIONS.—

4 “(1) CORRECTIONS WITHIN 30 DAYS.—No tax
5 shall be imposed by subsection (a) by reason of any
6 failure if—

7 “(A) such failure was due to reasonable
8 cause and not to willful neglect, and

9 “(B) such failure is corrected within the
10 30-day period beginning on earliest date the
11 carrier knew, or exercising reasonable diligence
12 would have known, that such failure existed.

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

19 “(e) DEFINITIONS.—For purposes of this section, the
20 terms ‘carrier’, ‘employer health benefit plan’, and ‘small
21 employer carrier’ have the respective meanings given such
22 terms in section 112 of the Action Now Health Care Re-
23 form Act of 1993.”

24 (ii) CLERICAL AMENDMENT.—The
25 table of sections for chapter 43 of such

1 Code is amended by adding at the end
2 thereof the following new items:

“Sec. 4980C. Failure to comply with employer health plan stand-
ards.”.

3 (iii) EFFECTIVE DATE.—The amend-
4 ments made by this subparagraph shall
5 apply to plan years beginning after Decem-
6 ber 31, 1993.

7 **SEC. 102. PREEMPTION OF STATE BENEFIT MANDATES FOR**
8 **SMALL EMPLOYER HEALTH BENEFIT PLANS**
9 **THAT MEET CONSUMER PROTECTION STAND-**
10 **ARDS.**

11 (a) FINDING.—Congress finds that health benefit
12 plans offered with respect to small employers affect inter-
13 state commerce.

14 (b) PREEMPTION.—In the case of a MedAccess plan
15 or other small employer health benefit plan that meets the
16 consumer protection standards, no provision of State law
17 shall apply that requires the offering, as part of the health
18 benefit plan with respect to such an employer, of any serv-
19 ices, category of care, or services of any class or type of
20 provider.

21 **SEC. 103. REQUIREMENT FOR SMALL EMPLOYER CARRIER**
22 **OFFERING OF MEDACCESS PLANS.**

23 (a) IN GENERAL.—

1 (1) IN GENERAL.—Each carrier that makes
2 available in a State any small employer health bene-
3 fit plan shall make available to each small employer
4 in the State—

5 (A) a MedAccess basic plan, and

6 (B) a MedAccess standard plan.

7 (2) EXCEPTION IF ALTERNATE PLAN IN A
8 STATE.—Paragraph (1) shall not apply to a carrier
9 in a State if the State is providing access to each
10 small employer in the State to a MedAccess basic
11 plan and to a MedAccess standard plan under a risk
12 allocation mechanism described in subsection (d).

13 (b) MEDACCESS PLAN DEFINED.—In this subtitle:

14 (1) IN GENERAL.—The term “MedAccess plan”
15 means a health benefits plan (whether a managed-
16 care plan, indemnity plan, or other plan) that—

17 (A) subject to paragraph (3)—

18 (i) is designed to provide benefits typi-
19 cal of the benefits offered in the small em-
20 ployer health coverage market, or

21 (ii)(I) is designed to provide only ben-
22 efits for essential preventive and medical
23 services and (II) has an average actuarial
24 value (in the overall small employer group
25 market for the same type of coverage)

1 which does not exceed 60 percent of the
2 average actuarial value of the benefits de-
3 scribed in clause (i) for such type of cov-
4 erage;

5 (B) meets the applicable requirements of
6 subsection (c) (relating to guaranteed issue);
7 and

8 (C) meets the consumer protection stand-
9 ards.

10 (2) MEDACCESS BASIC AND STANDARD
11 PLANS.—The terms “MedAccess basic plan” and
12 “MedAccess standard plan” mean a MedAccess plan
13 that provides for benefit levels described in clause
14 (ii) or clause (i), respectively, of paragraph (1)(A).

15 (3) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—With respect to a carrier
16 that—
17 that—

18 (A) is a Federally qualified health mainte-
19 nance organization (as defined in section
20 1301(a) of the Public Health Service Act), the
21 benefits required under paragraphs (1)(A) or
22 (2)(A) shall be modified to the extent required
23 to be consistent with the requirements for the
24 plans of such an organization under title XIII
25 of such Act, or

1 (B) is not such an organization but is rec-
2 cognized under State law as a health mainte-
3 nance organization, the benefits required under
4 paragraph (1)(A) shall be modified to the ex-
5 tent required to be consistent with the require-
6 ments for the plans of such an organization
7 under State law.

8 (4) REVIEW OF BENEFIT STANDARDS.—The
9 NAIC is requested to periodically review the stand-
10 ards for benefits described in paragraph (1)(A). The
11 NAIC is requested to submit to the Secretary and
12 the Congress its recommendations on changes that
13 should be made in such standards.

14 (c) GUARANTEED AVAILABILITY OF MEDACCESS
15 PLANS.—Subject to subsection (d)—

16 (1) IN GENERAL.—Subject to paragraph (2),
17 each MedAccess plan in a State—

18 (A) must accept every small employer in
19 the State that applies for coverage under the
20 plan; and

21 (B) must accept for enrollment every eligi-
22 ble individual (as defined in paragraph (4)) who
23 applies for enrollment on a timely basis (con-
24 sistent with paragraph (3)) and may not place
25 any restriction on the eligibility of an individual

1 to enroll so long as such individual is an eligible
2 individual.

3 (2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a plan of-
4 fered by a health maintenance organization, the plan
5 shall—
6

7 (A) limit the employers that may apply for
8 coverage to those with eligible individuals resid-
9 ing in the service area of the plan,

10 (B) limit the individuals who may be en-
11 rolled under the plan to those who reside in the
12 service area of the plan, and

13 (C) within the service area of the plan,
14 deny coverage to such employers if the plan
15 demonstrates that—

16 (i) it will not have the capacity to de-
17 liver services adequately to enrollees of any
18 additional groups because of its obligations
19 to existing group contract holders and en-
20 rollees, and

21 (ii) it is applying this subparagraph
22 uniformly to all employers without regard
23 to the health status, claims experience, or
24 duration of coverage of those employers
25 and their employees.

1 (3) CLARIFICATION OF TIMELY ENROLL-
2 MENT.—

3 (A) GENERAL INITIAL ENROLLMENT RE-
4 QUIREMENT.—Except as provided in this para-
5 graph, a MedAccess plan may consider enroll-
6 ment of an eligible individual not to be timely
7 if the eligible employee or dependent fails to en-
8 roll in the plan during an initial enrollment pe-
9 riod, if such period is at least 30 days long.

10 (B) ENROLLMENT DUE TO LOSS OF PRE-
11 VIOUS EMPLOYER COVERAGE.—Enrollment in a
12 MedAccess plan is considered to be timely in
13 the case of an eligible individual who—

14 (i) was covered under another em-
15 ployer health benefit plan at the time of
16 the individual's initial enrollment period,

17 (ii) stated at the time of initial enroll-
18 ment period that coverage under another
19 employer health benefit plan was the rea-
20 son for declining enrollment,

21 (iii) lost coverage under another em-
22 ployer health benefit plan (as a result of
23 the termination of the other plan's cov-
24 erage, termination or reduction of employ-
25 ment, or other reason), and

1 (iv) requests enrollment within 30
2 days after termination of coverage under
3 another employer health benefit plan.

4 (C) REQUIREMENT APPLIES DURING OPEN
5 ENROLLMENT PERIODS.—Each MedAccess plan
6 shall provide for at least one period (of not less
7 than 30 days) each year during which enroll-
8 ment under the plan shall be considered to be
9 timely.

10 (D) EXCEPTION FOR COURT ORDERS.—
11 Enrollment of spouse or minor child of an em-
12 ployee shall be considered to be timely if—

13 (i) a court has ordered that coverage
14 be provided for the spouse or child under
15 a covered employee’s health benefit plan,
16 and

17 (ii) a request for enrollment is made
18 within 30 days after the date the court is-
19 sues the order.

20 (E) ENROLLMENT OF SPOUSES AND DE-
21 PENDENTS.—

22 (i) IN GENERAL.—Enrollment of the
23 spouse (including a child of the spouse)
24 and any child (including an adopted child)
25 of an eligible employee shall be considered

1 to be timely if a request for enrollment is
2 made either—

3 (I) within 30 days of the date of
4 the marriage or of the date of the
5 birth or adoption of a child, if family
6 coverage is available as of such date,
7 or

8 (II) within 30 days of the date
9 family coverage is first made avail-
10 able.

11 (ii) COVERAGE.—If a plan makes
12 family coverage available and enrollment is
13 made under the plan on a timely basis
14 under clause (i)(I), the coverage shall be-
15 come effective not later than the first day
16 of the first month beginning after the date
17 of the marriage or the date of birth or
18 adoption of the child (as the case may be).

19 (4) ELIGIBLE INDIVIDUAL DEFINED.—In this
20 subsection, the term “eligible individual” means,
21 with respect to a small employer—

22 (A) an individual who is a full-time em-
23 ployee of the employer, and

24 (B) if family coverage is offered, the em-
25 ployee’s spouse and the employee’s dependents

1 who are under 19 years of age or who are full-
2 time students and under 25 years of age.

3 (d) STATE OPTION OF GUARANTEED AVAILABILITY
4 THROUGH ALLOCATION OF RISK (RATHER THAN
5 THROUGH GUARANTEED ISSUE).—The requirement of
6 subsection (c) shall not apply in a State if the State has
7 provided (in accordance with standards established under
8 this subtitle) a mechanism under which—

9 (1) each carrier offering a health benefit plan
10 to a small employer in the State must participate in
11 a program for assigning high-risk small employer
12 groups (or individuals within such a group) among
13 some or all such carriers, and

14 (2) the carriers to which such high-risk small
15 employer groups or individuals are so assigned com-
16 plies with the requirement of subsection (c).

17 **SEC. 104. LIMITATION ON PRE-EXISTING CONDITION**
18 **CLAUSES; ASSURANCE OF CONTINUITY OF**
19 **COVERAGE.**

20 (a) LIMITATIONS ON TREATMENT OF PRE-EXISTING
21 CONDITIONS.—A carrier may not impose (or require an
22 employer to impose through a waiting period for coverage
23 under a health benefit policy or similar requirement) a
24 limitation or exclusion of benefits under an employer
25 health benefit plan relating to treatment of a condition

1 based on the fact that the condition pre-existed the effec-
2 tiveness of the policy if—

3 (1) the condition relates to a condition that was
4 not diagnosed or treated within 3 months before the
5 date of coverage under the plan;

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

9 (3) the limitation or exclusion applies to an in-
10 dividual who, as of the date of birth, was covered
11 under the plan; or

12 (4) the limitation or exclusion relates to preg-
13 nancy.

14 In the case of an individual who is eligible for coverage
15 under an employer health benefit plan but for a waiting
16 period imposed by the employer, in applying paragraphs
17 (1) and (2), the individual shall be treated as have been
18 covered under the plan as of the earliest date of the begin-
19 ning of the waiting period.

20 (b) ASSURANCE OF CONTINUITY OF COVERAGE
21 THROUGH PREVIOUS SATISFACTION OF PRE-EXISTING
22 CONDITION REQUIREMENT.—

23 (1) IN GENERAL.—Each carrier shall waive any
24 period applicable to a preexisting condition for simi-
25 lar benefits with respect to an individual to the ex-

1 tent that the individual was covered for the condi-
2 tion under any health benefit plan (as defined in
3 paragraph (3)) that was in effect before the date of
4 the enrollment under the carrier's plan.

5 (2) CONTINUOUS COVERAGE REQUIRED.—

6 (A) IN GENERAL.—Paragraph (1) shall no
7 longer apply if there is a continuous period of
8 more than 60 days (or, in the case of an indi-
9 vidual described in subparagraph (C), 6
10 months) on which the individual was not cov-
11 ered under an health benefit plan.

12 (B) TREATMENT OF WAITING PERIODS.—

13 In applying subparagraph (A), any waiting pe-
14 riod imposed by an employer before an em-
15 ployee is eligible to be covered under a policy
16 shall be treated as a period in which the em-
17 ployee was covered under a health benefit plan.

18 (C) JOB TERMINATION.—An individual is
19 described in this subparagraph if the individual
20 loses coverage under an employer health plan
21 due to termination of employment.

22 (3) EXCLUSION OF CASH-ONLY AND DREAD
23 DISEASE POLICIES.—In this subsection, the term
24 “health benefit plan” does not include any insurance
25 which is offered primarily to provide—

1 (A) coverage for a specified disease or ill-
2 ness, or

3 (B) hospital or fixed indemnity policy, un-
4 less the Secretary (or in the case of a plan in
5 a State, the State) determines that such a pol-
6 icy provides sufficiently comprehensive coverage
7 of a benefit so that it should be treated as a
8 health benefit plan under this subsection.

9 **SEC. 105. LIMITS ON PREMIUMS AND MISCELLANEOUS**
10 **CONSUMER PROTECTIONS.**

11 (a) LIMITS ON PREMIUMS.—

12 (1) LIMIT ON VARIATION OF INDEX RATES BE-
13 TWEEN CLASSES OF BUSINESS.—

14 (A) IN GENERAL.—As a standard under
15 section 101(a)(1)(B)(ii), the index rate for a
16 rating period for any class of business of a
17 small employer carrier may not exceed by more
18 than 20 percent the index rate for any other
19 class of business.

20 (B) EXCEPTIONS.—The limitation of sub-
21 paragraph (A) shall not apply to a class of busi-
22 ness if—

23 (i) the class is one for which the car-
24 rier does not reject, and never has rejected,
25 small employers included within the defini-

1 tion of employers eligible for the class of
2 business or otherwise eligible employees
3 and dependents who enroll on a timely
4 basis, based upon their claim experience or
5 health status,

6 (ii) the carrier does not involuntarily
7 transfer, and never has involuntarily trans-
8 ferred, a health benefit plan into or out of
9 the class of business, and

10 (iii) the class of business is currently
11 available for purchase.

12 (2) LIMIT ON VARIATION OF PREMIUM RATES
13 WITHIN A CLASS OF BUSINESS.—For a class of busi-
14 ness of a small employer carrier, as a standard
15 under section 101(a)(1)(B)(ii), the premium rates
16 charged during a rating period to small employers
17 with similar demographic or other objective charac-
18 teristics (not relating to claims experience, health
19 status, or duration of coverage) for the same or
20 similar coverage, or the rates which could be charged
21 to such employers under the rating system for that
22 class of business, shall not vary from the index rate
23 by more than 25 percent of the index rate.

24 (3) OBJECTIVE BASIS FOR DIFFERENCES IN
25 PREMIUMS FOR STANDARD AND BASIC MEDACCESS

1 PLANS.—The difference between the index rate for
2 the MedAccess basic plan and the index rate for the
3 MedAccess standard plan shall be reasonable and
4 shall reflect the difference in plan design and shall
5 not take into account differences due to the nature
6 of the groups assumed to select particular health
7 plans.

8 (4) LIMIT ON TRANSFER OF EMPLOYERS
9 AMONG CLASSES OF BUSINESS.—As a standard
10 under section 101(a)(1)(B)(ii), a small employer car-
11 rier may not involuntarily transfer a small employer
12 into or out of a class of business. A small employer
13 carrier may not offer to transfer a small employer
14 into or out of a class of business unless such offer
15 is made to transfer all small employers in the class
16 of business without regard to demographic charac-
17 teristics, claim experience, health status, or duration
18 since issue.

19 (5) DEFINITIONS.—In this subsection:

20 (A) BASE PREMIUM RATE.—The term
21 “base premium rate” means, for each class of
22 business for each rating period, the lowest pre-
23 mium rate charged or which could have been
24 charged under a rating system for that class of
25 business by the small employer carrier to small

1 employers with similar demographic or other
2 objective characteristics (not relating to claims
3 experience, health status, or duration of cov-
4 erage) for health benefit plans with the same or
5 similar coverage.

6 (B) CLASS OF BUSINESS.—The term
7 “class of business” means, with respect to a
8 carrier, all (or a distinct group of) small em-
9 ployers as shown on the records of the carrier.

10 (C) RULES FOR ESTABLISHING CLASSES
11 OF BUSINESS.—For purposes of subparagraph
12 (B)—

13 (i) a carrier may establish, subject to
14 clause (ii), a distinct group of small em-
15 ployers on the basis that the applicable
16 health benefit plans either—

17 (I) are marketed and sold
18 through individuals and organizations
19 which are not participating in the
20 marketing or sale of other distinct
21 groups of small employers for the car-
22 rier,

23 (II) have been acquired from an-
24 other carrier as a distinct group, or

1 (III) are provided through an as-
2 sociation that has a membership of
3 not less than 100 small employers and
4 that has been formed for purposes
5 other than obtaining health coverage;

6 (ii) a carrier may not establish more
7 than 2 groupings under each class of busi-
8 ness based on the carrier's use of man-
9 aged-care techniques if the techniques are
10 expected to produce substantial variation
11 in health care costs; and

12 (iii) notwithstanding clauses (i) and
13 (ii), a State commissioner of Insurance of
14 a State, upon application and if authorized
15 under State law, may approve additional
16 distinct groups upon a finding that such
17 approval would enhance the efficiency and
18 fairness of the small employer marketplace.

19 (D) INDEX RATE.—The term “index rate”
20 means, with respect to a class of business, the
21 arithmetic average of the applicable base pre-
22 mium rate and the corresponding highest pre-
23 mium rate for the class.

24 (E) DEMOGRAPHIC CHARACTERISTICS.—
25 Except as otherwise permitted under the stand-

1 ard under section 101(b)(1)(B)(ii), the term
2 “demographic characteristics” means age, gen-
3 der, industry, geographic area, family composi-
4 tion, and group size.

5 (b) FULL DISCLOSURE OF RATING PRACTICES.—At
6 the time a carrier offers a health benefit plan to a small
7 employer, the carrier shall fully disclose to the employer
8 rating practices for small employer health benefit plans,
9 including rating practices for different industries, popu-
10 lations, and benefit designs.

11 (c) ACTUARIAL CERTIFICATION.—Each carrier shall
12 file annually with the State commissioner of insurance a
13 written statement by a member of the American Academy
14 of Actuaries (or other individual acceptable to the commis-
15 sioner) that, based upon an examination by the individual
16 which includes a review of the appropriate records and of
17 the actuarial assumptions of the carrier and methods used
18 by the carrier in establishing premium rates for applicable
19 small employer health benefit plans—

20 (1) the carrier is in compliance with the appli-
21 cable provisions of this section, and

22 (2) the rating methods are actuarially sound.

23 Each carrier shall retain a copy of such statement for ex-
24 amination at its principal place of business.

1 (d) REGISTRATION AND REPORTING.—Each carrier
2 that issues any small employer health benefit plan in a
3 State shall be registered or licensed with the State com-
4 missioner of insurance and shall comply with any report-
5 ing requirements of the commissioner relating to such a
6 plan.

7 (e) USE OF MINIMUM PARTICIPATION REQUIRE-
8 MENT.—A carrier may condition issuance, or renewal, of
9 a health benefit plan to a small employer on the enroll-
10 ment of a minimum number (or percentage) of its full-
11 time employees, only in accordance with standards estab-
12 lished to carry out this section. Such standards shall re-
13 quire that any such conditions be imposed uniformly on
14 employers of the same size.

15 **SEC. 106. REQUIREMENTS RELATING TO RENEWABILITY**
16 **GENERALLY.**

17 (a) IN GENERAL.—A carrier may not cancel an em-
18 ployer health benefit plan or deny renewal of coverage
19 under such a plan other than—

20 (1) for nonpayment of premiums,

21 (2) for fraud or other misrepresentation by the
22 insured,

23 (3) for noncompliance with plan provisions,

24 (4) for failure to maintain (in accordance with
25 standards established under section 105(e)) the

1 number of enrollees under the plan at the number
2 (or percentage) required under the plan,

3 (5) for misuse of a provider network provision,
4 or

5 (6) because the carrier is ceasing to provide any
6 employer health benefit plan in a State, or, in the
7 case of a health maintenance organization, in a geo-
8 graphic area.

9 (b) **LIMITATION ON MARKET REENTRY.**—If a carrier
10 terminates the offering of employer health benefit plans
11 in an area, the carrier may not offer such a health benefit
12 plan to any employer in the area until 5 years have elapsed
13 since the date of the termination.

14 **SEC. 107. LIMITATION ON ANNUAL PREMIUM INCREASES.**

15 A carrier may not provide for an increase in the pre-
16 mium charged a small employer for a small employer
17 health benefit plan in a percentage that exceeds the per-
18 centage change in the premium charged under the plan
19 for a newly covered employer within the same class of busi-
20 ness rate plus 15 percentage points.

21 **SEC. 108. ESTABLISHMENT OF REINSURANCE OR ALLOCA-**
22 **TION OF RISK MECHANISMS FOR HIGH RISK**
23 **INDIVIDUALS.**

24 (a) **ESTABLISHMENT OF STANDARDS.**—

1 (1) ROLE OF NAIC.—The Secretary of Health
2 and Human Services shall request the NAIC to de-
3 velop, within 9 months after the date of the enact-
4 ment of this Act, models for reinsurance or alloca-
5 tion of risk mechanisms (each in this section re-
6 ferred to as a “reinsurance or allocation of risk
7 mechanism”) for individuals and small employers
8 who are enrolled under a small employer health ben-
9 efit plan that meets the consumer protection stand-
10 ards and for whom a carrier is at risk of incurring
11 high costs under the plan. If the NAIC develops
12 such models within such period, the Secretary shall
13 review such models to determine if they provide for
14 an effective reinsurance or allocation of risk mecha-
15 nism. Such review shall be completed within 30 days
16 after the date the models are developed. Unless the
17 Secretary determines within such period that such a
18 model is not an effective reinsurance or allocation of
19 risk mechanism, such remaining models shall serve
20 as the models under this section, with such amend-
21 ments as the Secretary deems necessary.

22 (2) CONTINGENCY.—If the NAIC does not de-
23 velop such models within such period or the Sec-
24 retary determines that all such models do not pro-
25 vide for an effective reinsurance or allocation of risk

1 mechanism, the Secretary shall specify, within 15
2 months after the date of the enactment of this Act,
3 models to carry out this section.

4 (b) IMPLEMENTATION OF REINSURANCE OR ALLOCA-
5 TION OF RISK MECHANISMS.—

6 (1) BY STATES.—Each State shall establish
7 and fund one or more reinsurance or allocation of
8 risk mechanisms that are consistent with a model es-
9 tablished under subsection (a) by not later than the
10 deadline specified in section 101(b)(1)(B). In order
11 to assure the financial solvency of the mechanism,
12 the State may, notwithstanding any provision of law
13 to the contrary, impose charges on any entity pro-
14 viding employee-related health benefits, so long as
15 such charges do not discriminate with respect to en-
16 tities that would (but for this provision) not be sub-
17 ject to such charges.

18 (2) FEDERAL ROLE.—

19 (A) IN GENERAL.—If the Secretary deter-
20 mines that a State has failed to establish a re-
21 insurance or allocation of risk mechanism in ac-
22 cordance with paragraph (1), the Secretary
23 shall establish such a reinsurance or allocation
24 of risk mechanism meeting the requirements of
25 this paragraph.

1 (B) REINSURANCE MECHANISM.—Unless
2 the Secretary determines under subparagraph
3 (C) that an allocation of risk mechanism is the
4 appropriate mechanism to use in a State under
5 this paragraph, the Secretary shall establish for
6 use under this section for each State an appro-
7 priate reinsurance mechanism.

8 (C) ALLOCATION OF RISK MECHANISM.—If
9 the Secretary determines that, due to the na-
10 ture of the health coverage market in the State
11 (including a relatively small number of small
12 employer health benefit plans offered or a rel-
13 atively small number of uninsurable small em-
14 ployers or individuals), an allocation of risk
15 mechanism would be a better mechanism than
16 a reinsurance mechanism, the Secretary shall
17 establish for use under this section for a State
18 an allocation of risk mechanism under which
19 uninsurable individuals and small employers
20 would be equitably assigned among small em-
21 ployer health benefit plans.

22 (D) FINANCING DEFICIT FOR REINSUR-
23 ANCE MECHANISMS.—

24 (i) IN GENERAL.—Chapter 43 of the
25 Internal Revenue Code of 1986 (relating to

1 qualified pension plans, etc.) is amended
2 by adding at the end thereof the following
3 new section:

4 **“SEC. 4980D. ADDITIONAL TAX TO FUND REINSURANCE IN**
5 **STATES UNDER FEDERAL REINSURANCE.**

6 “(a) IMPOSITION OF TAX.—There is hereby imposed
7 a tax on the providing of any health benefit plan which
8 covers any employee in a Federal reinsurance State.

9 “(b) AMOUNT OF TAX.—

10 “(1) IN GENERAL.—The tax imposed by sub-
11 section (a) shall be equal to the applicable percent-
12 age of the amount received by the carrier for provid-
13 ing such plan in such Federal reinsurance State.

14 “(2) APPLICABLE PERCENTAGE.—For purposes
15 of paragraph (1), the term ‘applicable percentage’
16 means, with respect to any State for any period, the
17 lowest percentage estimated by the Secretary as gen-
18 erating sufficient revenues to carry out section
19 108(b)(2) of the Action Now Health Care Reform
20 Act of 1993 in such State for such period.

21 “(c) LIABILITY FOR TAX.—The tax imposed by this
22 section shall be paid by the carrier.

23 “(d) DEFINITIONS.—For purposes of this section—

1 “(1) CARRIER.—The term ‘carrier’ has the
2 meaning given such term in section 112(2) of the
3 Action Now Health Care Reform Act of 1993.

4 “(2) FEDERAL REINSURANCE STATE.—The
5 term ‘Federal reinsurance State’ means any State
6 with respect to which a determination is in effect
7 under section 108(b)(2) of the Action Now Health
8 Care Reform Act of 1993 and for which the Sec-
9 retary of Health and Human Services has estab-
10 lished a reinsurance mechanism under subparagraph
11 (B) of such section for the State.”

12 (ii) CLERICAL AMENDMENT.—The
13 table of sections for chapter 43 of such
14 Code is amended by adding at the end
15 thereof the following new item:

“Sec. 4980D. Additional tax to fund reinsurance in States under
Federal reinsurance.”

16 (c) CONSTRUCTION.—Nothing in this section shall be
17 construed to prohibit reinsurance or allocation of risk ar-
18 rangements, whether on a State or regional basis, not re-
19 quired under this section.

20 **SEC. 109. REGISTRATION OF ALL HEALTH BENEFIT PLANS.**

21 (a) IN GENERAL.—Notwithstanding any other provi-
22 sion of law, each State commissioner of insurance may,
23 under State law, require each employer health benefit plan
24 (including a self-insured plan)—

1 (1) to be registered with such official, if the
2 plan is not otherwise required to be registered or li-
3 censed with the official under section 105(d), and

4 (2) to provide the official with such information
5 on the plan as may be necessary to carry out section
6 108.

7 Insofar as the Secretary is exercising authority under sec-
8 tion 108(b)(2), the Secretary may impose the requirement
9 under the previous sentence in the same manner as a
10 State commissioner of insurance may impose the require-
11 ment.

12 (b) PROVISION OF LIST TO SECRETARY.—By not
13 later than the deadline specified in section 101(b)(1)(B),
14 each State shall provide the Secretary with a list of all
15 employer health benefit plans registered in the State under
16 subsection (a).

17 **SEC. 110. OFFICE OF PRIVATE HEALTH CARE COVERAGE;**
18 **ANNUAL REPORTS ON EVALUATION OF**
19 **HEALTH CARE COVERAGE REFORM.**

20 (a) IN GENERAL.—In order to carry out the respon-
21 sibilities of the Secretary under this subtitle, the Secretary
22 shall establish an Office of Private Health Care Coverage,
23 to be headed by a Director appointed by the Secretary.

24 (b) ANNUAL REPORT.—

1 (1) IN GENERAL.—The Director shall submit to
2 Congress an annual report on the implementation of
3 this subtitle.

4 (2) INFORMATION TO BE INCLUDED.—Each an-
5 nual report shall include information concerning at
6 least the following:

7 (A) Implementation and enforcement of
8 the applicable MedAccess standards and
9 consumer protection standards under this sub-
10 title by the States and by the Secretary.

11 (B) An evaluation of the impact of the re-
12 forms under this subtitle on the availability of
13 affordable health coverage for small employers
14 that purchase group health coverage and for
15 their employees, and, in particular, the impact
16 of—

17 (i) guaranteed availability of health
18 coverage,

19 (ii) limitations of restrictions from
20 coverage of preexisting conditions,

21 (iii) requirement for continuity of cov-
22 erage,

23 (iv) risk-management mechanisms for
24 health coverage,

25 (v) limits on premium variations,

1 (vi) limits on annual premium in-
2 creases, and

3 (vii) preemption of State benefit man-
4 dates.

5 In performing such evaluation, the Secretary
6 shall seek to discount the effect of the insur-
7 ance cycle on health insurance premiums.

8 (C) An assessment of the implications of
9 the reforms on adverse selection among small
10 employer health benefit plans and the distribu-
11 tion of risk among small employer health bene-
12 fit plans.

13 (c) ADVISORY COMMITTEE.—The Secretary shall pro-
14 vide for appointment of an advisory committee to advise
15 the Director concerning activities of the Office under this
16 subtitle. Membership on the committee shall consist of 17
17 individuals and shall include individuals from the general
18 public, small and large business, labor, insurance and
19 other health benefit plans, and health care providers, and
20 shall include experts in the fields of the actuarial science,
21 health economics, and health services research. The Sec-
22 retary may include, as additional, ex officio members of
23 the committee, such representatives of government agen-
24 cies as the Secretary deems appropriate. The chairperson
25 of the committee shall not be a health care provider or

1 receive any direct or indirect compensation from an in-
2 surer, health benefit plan, or a health care provider.

3 **SEC. 111. RESEARCH AND DEMONSTRATION PROJECTS; DE-**
4 **VELOPMENT OF A HEALTH RISK POOLING**
5 **MODEL.**

6 (a) RESEARCH AND DEMONSTRATIONS.—The Direc-
7 tor is authorized, directly, by contract, and through grants
8 and cooperative agreements within the Department of
9 Health and Human Services and outside the Depart-
10 ment—

11 (1) to conduct research on the the impact of
12 this subtitle on the availability of affordable health
13 coverage for employees and dependents in the small
14 employers group health care coverage market and
15 other topics described in section 110(b), and

16 (2) to conduct demonstration projects relating
17 to such topics.

18 (b) DEVELOPMENT OF METHODS OF MEASURING
19 RELATIVE HEALTH RISK.—

20 (1) IN GENERAL.—The Director shall develop
21 methods for measuring, in terms of the expected
22 costs of providing benefits under small employer
23 health benefit plans and, in particular, MedAccess
24 plans, the relative health risks of eligible individuals.

25 (2) METHODOLOGY.—The methods—

1 (A) shall rely on diagnosis or other health-
2 related information that is predictive of individ-
3 ual health care needs,

4 (B) may rely upon information routinely
5 collected in the process of making payments
6 under health benefit plans, and

7 (C) may provide for such random, sample
8 audits of records as may be necessary to verify
9 the accuracy of measurements.

10 (c) DEVELOPMENT OF A HEALTH RISK POOLING
11 MODEL.—

12 (1) IN GENERAL.—The Director shall develop a
13 model, based on the methods of measuring risks
14 under subsection (b), for equitably distributing
15 health risks among carriers in the small employer
16 health care coverage market.

17 (2) REDISTRIBUTION OF RISK.—Under such
18 model, carriers with below average health risks
19 would be required to contribute to a common fund
20 for payment to carriers with above average health
21 risks, each in relation to the degree of their favor-
22 able or adverse risk selection.

23 (3) INCENTIVES.—Such model shall include in-
24 centives to encourage continuous coverage of eligible
25 individuals and small employers.

1 (d) CONSULTATION.—The methods and model under
2 this section shall be developed in consultation with the
3 NAIC and the advisory committee established under sec-
4 tion 110(c).

5 (e) REPORT.—By not later than January 1, 1995,
6 the Director shall submit to Congress a report on the
7 methods and model developed under this section (as well
8 as on research and demonstration projects conducted
9 under subsection (a)). The Director shall include in the
10 report such recommendations respecting the application of
11 the model to small employer carriers (and, in particular,
12 to MedAccess plans) under this subtitle as the Director
13 deems appropriate.

14 (f) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section,
16 \$5,000,000 in each of fiscal years 1994 through 1998.

17 **SEC. 112. GENERAL DEFINITIONS.**

18 In this subtitle:

19 (1) The term “carrier” means any entity which
20 provides health insurance or health benefits in a
21 State, and includes a licensed insurance company, a
22 prepaid hospital or medical service plan, a health
23 maintenance organization, the plan sponsor of a
24 multiple employer welfare arrangement or an em-
25 ployee benefit plan (as defined under the Employee

1 Retirement Income Security Act of 1974), or any
2 other entity providing a plan of health insurance
3 subject to State insurance regulation, but such term
4 does not include for purposes of section 103 an en-
5 tity that provides health insurance or health benefits
6 under a multiple employer welfare arrangement.

7 (2) The term “consumer protection standards”
8 means the standards established under section
9 101(a) to carry out the requirements of the follow-
10 ing sections:

11 (A) Section 104 (relating to limitation on
12 pre-existing condition clauses; assurance of con-
13 tinuity of coverage).

14 (B) Section 106 (relating to renewability
15 generally).

16 (C) With respect only to small employer
17 health benefit plans—

18 (i) section 105 (relating to limits on
19 premiums and other requirements for ini-
20 tial writing of plans), and

21 (ii) section 107 (relating to limits on
22 annual premium increases).

23 (3) The term “Director” means the Director of
24 the Office of Private Health Care Coverage estab-
25 lished under section 110(a).

1 (4)(A) Subject to subparagraph (B), the term
2 “employer health benefit plan” means a health bene-
3 fit plan (including an employee welfare benefit plan,
4 as defined in section 3(1) of the Employee Retirement
5 Income Security Act of 1974) which is offered
6 to employees through an employer and for which the
7 employer provides for any contribution to such plan
8 or any premium for such plan are deducted by the
9 employer from compensation to the employee.

10 (B) A State may provide (for a plan in a State)
11 that the term “employer health benefit plan” does
12 not include an association plan (as defined in sub-
13 paragraph (C)) for purposes of some or all of the
14 provisions of this subtitle.

15 (C) For purposes of subparagraph (B), the
16 term “association plan” means a health benefit plan
17 offered by an organization to its members if the or-
18 ganization was formed other than for purposes of
19 purchasing insurance.

20 (5) The term “full-time employee” means, with
21 respect to an employer, an individual who normally
22 is employed for at least 30 hours per week by the
23 employer.

24 (6) The term “health benefit plan” means any
25 hospital or medical expense incurred policy or certifi-

1 cate, hospital or medical service plan contract, or
2 health maintenance subscriber contract, or a mul-
3 tiple employer welfare arrangement or employee ben-
4 efit plan (as defined under the Employee Retirement
5 Income Security Act of 1974) which provides bene-
6 fits with respect to health care services, but does not
7 include—

8 (A) coverage only for accident, dental, vi-
9 sion, disability income, or long-term care insur-
10 ance, or any combination thereof,

11 (B) medicare supplemental health insur-
12 ance,

13 (C) coverage issued as a supplement to li-
14 ability insurance,

15 (D) worker’s compensation or similar in-
16 surance, or

17 (E) automobile medical-payment insurance,
18 or any combination thereof.

19 (7) The term “health maintenance organiza-
20 tion” includes, as defined in standards established
21 under section 101, a carrier that meets specified
22 standards and that offers to provide health services
23 on a prepaid, at-risk basis primarily through a de-
24 fined set of providers.

1 (8) The term “MedAccess standards” means
2 the standards established under section 101(a)(1)(A)
3 relating to the requirements of section 103, and in-
4 cludes the consumer protection standards insofar as
5 such standards apply to MedAccess plans.

6 (9) The term “Secretary” means the Secretary
7 of Health and Human Services.

8 (10) The term “small employer” means an en-
9 tity actively engaged in business which, on at least
10 50 percent of its working days during the preceding
11 year, employed at least 2, but fewer than 36, full-
12 time employees. For purposes of determining if an
13 employer is a small employer, rules similar to the
14 rules of subsection (b) and (c) of section 414 of the
15 Internal Revenue Code of 1986 shall apply.

16 (11) The term “small employer carrier” means
17 a carrier with respect to the issuance of a small em-
18 ployer health benefit plan.

19 (12) The term “small employer health benefit
20 plan” means an employer health benefit plan which
21 provides coverage to one or more full-time employees
22 of a small employer.

23 (13) The term “State” means the 50 States,
24 the District of Columbia, Puerto Rico, the Virgin Is-
25 lands, Guam, and American Samoa.

1 (14) The term “State commissioner of insur-
2 ance” includes a State superintendent of insurance.

3 **Subtitle B—Improved Small**
4 **Employer Purchasing Power of**
5 **Affordable Health Insurance**

6 **SEC. 121. PREEMPTION FROM INSURANCE MANDATES FOR**
7 **QUALIFIED SMALL EMPLOYER PURCHASING**
8 **GROUPS.**

9 (a) QUALIFIED SMALL EMPLOYER PURCHASING
10 GROUP DEFINED.—For purposes of this section, an asso-
11 ciation is a qualified small employer purchasing group if—

12 (1) the association submits an application to
13 the Secretary of Health and Human Services at such
14 time and in such form as the Secretary may require;
15 and

16 (2) on the basis of information contained in the
17 application and any other information the Secretary
18 may require, the Secretary determines that—

19 (A) the association is administered solely
20 under the authority and control of its member
21 employers,

22 (B) the association’s membership consists
23 solely of employers with not more than 100 em-
24 ployees (except that an employer member of the
25 group may retain its membership in the group

1 if, after the Secretary determines that the asso-
2 ciation meets the requirements of this para-
3 graph, the number of employees of the employer
4 member increases to more than 100),

5 (C) with respect to each State in which its
6 members are located, the association consists of
7 not fewer than 100 employers, and

8 (D) at the time the association submits its
9 application, the health benefit plans with re-
10 spect to the employer members of the associa-
11 tion are in compliance with applicable State
12 laws relating to health benefit plans.

13 (b) PREEMPTION FROM INSURANCE MANDATES.—

14 (1) FINDING.—Congress finds that employer
15 purchasing groups organized for the purpose of ob-
16 taining health insurance for employer members af-
17 fect interstate commerce.

18 (2) PREEMPTION OF STATE MANDATES.—In the
19 case of a qualified small employer purchasing group
20 described in subsection (a), no provision of State law
21 shall apply that requires the offering, as part of the
22 health benefit plan with respect to an employer
23 member of such a group, of any services, category
24 of care, or services of any class or type of provider.

1 (3) PREEMPTION OF PROVISIONS PROHIBITING
2 EMPLOYER GROUPS FROM PURCHASING HEALTH IN-
3 SURANCE.—In the case of a qualified small employer
4 purchasing group described in subsection (a), no
5 provision of State or local law shall apply that pro-
6 hibits a group of employers from purchasing health
7 insurance with respect to member employers of the
8 group or their employees.

9 (c) EFFECTIVE DATE.—This section shall take effect
10 60 days after the date of the enactment of this Act.

11 **Subtitle C—Health Deduction**
12 **Fairness**

13 **SEC. 131. PERMANENT EXTENSION AND INCREASE IN**
14 **HEALTH INSURANCE TAX DEDUCTION FOR**
15 **SELF-EMPLOYED INDIVIDUALS.**

16 (a) PERMANENT EXTENSION OF DEDUCTION.—

17 (1) IN GENERAL.—Subsection (l) of section 162
18 of the Internal Revenue Code of 1986 (relating to
19 special rules for health insurance costs of self-em-
20 ployed individuals) is amended by striking paragraph
21 (6).

22 (2) CONFORMING AMENDMENT.—Paragraph (2)
23 of section 110(a) of the Tax Extension Act of 1991
24 is hereby repealed.

1 primary health care services for underserved individuals.

2 Such grants may be used—

3 (1) to promote the provision of off-site services

4 (through means such as mobile medical clinics);

5 (2) to improve birth outcomes in areas with

6 high infant mortality and morbidity;

7 (3) to establish primary care clinics in areas

8 identified as in need of such clinics; and

9 (4) for recruitment and training costs of nec-

10 essary providers and operating costs for unreim-

11 bursed services.

12 (b) CONDITIONS.—(1) Grants under this subsection

13 shall only be made upon application, approved by the Sec-

14 retary.

15 (2) The amount of grants made under this section

16 shall be determined by the Secretary.

17 (c) AUTHORIZATION OF APPROPRIATIONS.—There

18 are authorized to be appropriated—

19 (1) in fiscal year 1994, \$100,000,000,

20 (2) in fiscal year 1995, \$200,000,000,

21 (3) in fiscal year 1996, \$300,000,000,

22 (4) in fiscal year 1997, \$400,000,000, and

23 (5) in fiscal year 1998, \$500,000,000,

24 to carry out this section. Of the amounts appropriated

25 each fiscal year under this section, at least 10 percent

1 shall be used for grants described in subsection (a)(1) and
2 at least 10 percent shall be used for grants described in
3 subsection (a)(2).

4 (d) STUDY AND REPORT.—The Secretary shall con-
5 duct a study of the impact of the grants made under this
6 section to migrant and community health centers on ac-
7 cess to health care, birth outcomes, and the use of emer-
8 gency room services. Not later than 2 years after the date
9 of the enactment of this Act, the Secretary shall submit
10 to Congress a report on such study and on recommenda-
11 tions for changes in the programs under this section in
12 order to promote the appropriate use of cost-effective out-
13 patient services.

14 PART 2—GRANTS FOR PROJECTS FOR COORDINATING
15 DELIVERY OF SERVICES

16 **SEC. 151. PROJECTS FOR COORDINATING DELIVERY OF**
17 **OUTPATIENT PRIMARY HEALTH SERVICES.**

18 Part D of title III of the Public Health Service Act
19 (42 U.S.C. 254b et seq.) is amended by adding at the end
20 the following new subpart:

21 “Subpart VII—Delivery of Services

22 “PROJECTS FOR COORDINATING DELIVERY OF SERVICES

23 “SEC. 340E. (a) AUTHORITY FOR GRANTS.—

24 “(1) IN GENERAL.—The Secretary may make
25 grants to public and nonprofit private entities to

1 carry out demonstration projects for the purpose of
2 increasing access to outpatient primary health serv-
3 ices in geographic areas described in subsection (b)
4 through coordinating the delivery of such services
5 under Federal, State, local, and private programs.

6 “(2) REQUIREMENT REGARDING PLAN.—The
7 Secretary may make a grant under paragraph (1)
8 only if—

9 “(A) the applicant involved has received a
10 grant under subsection (l) and the Secretary
11 has approved the plan developed with such
12 grant; and

13 “(B) the applicant agrees to carry out the
14 project under paragraph (1) in accordance with
15 the plan.

16 “(b) QUALIFIED HEALTH SERVICE AREAS.—

17 “(1) IN GENERAL.—A geographic area de-
18 scribed in this subsection is a geographic area
19 that—

20 “(A) is a rational area for the delivery of
21 health services;

22 “(B) has a population of not more than
23 500,000 individuals; and

1 “(C)(i) has been designated by the Sec-
2 retary as an area with a shortage of personal
3 health services; or

4 “(ii) has a significant number of individ-
5 uals who have low incomes or who have insuffi-
6 cient insurance regarding health care.

7 “(2) AUTHORITY REGARDING MULTIPLE POLIT-
8 ICAL SUBDIVISIONS.—The Secretary shall make a
9 determination of whether a geographic area is a geo-
10 graphic area described in paragraph (1) without re-
11 gard to whether the area is a political subdivision,
12 without regard to whether the area is located in 2
13 or more political subdivisions or States, and without
14 regard to whether the area encompasses 2 or more
15 political subdivisions.

16 “(c) PREFERENCES IN MAKING GRANTS.—In making
17 grants under subsection (a), the Secretary shall give pref-
18 erence to applicants demonstrating that, with respect to
19 the outpatient primary health services that will be the sub-
20 ject of the project conducted by the applicant under such
21 subsection—

22 “(1)(A) the project will result in the reduction
23 of administrative expenses associated with such serv-
24 ices by increasing the efficiency of the administrative
25 processes of the providers participating in the

1 project, and (B) the resulting savings will be ex-
2 pended for the direct provision of such services for
3 the designated population; or

4 “(2) the services that will be the subject of the
5 project will be provided in facilities that are
6 underutilized.

7 “(d) ACTIVITIES OF PROJECT MUST SERVE DES-
8 IGNATED POPULATION.—The Secretary may make a
9 grant under subsection (a) to an applicant only if the ap-
10 plicant demonstrates that carrying out the project under
11 such subsection will increase access to outpatient primary
12 health services for a significant segment of the designated
13 population.

14 “(e) MATCHING FUNDS.—

15 “(1) IN GENERAL.—With respect to the costs of
16 the project to be carried out under subsection (a) by
17 an applicant, the Secretary may make a grant under
18 such subsection only if the applicant agrees to make
19 available (directly or through donations from public
20 or private entities) non-Federal contributions toward
21 such costs in an amount that is not less than 50
22 percent of such costs.

23 “(2) DETERMINATION OF AMOUNT CONTRIB-
24 UTED.—Non-Federal contributions required in para-
25 graph (1) may be in cash or in kind, fairly evalu-

1 ated, including plant, equipment, or services.
2 Amounts provided by the Federal Government, or
3 services assisted or subsidized to any significant ex-
4 tent by the Federal Government, may not be in-
5 cluded in determining the amount of such non-Fed-
6 eral contributions.

7 “(f) CERTAIN LIMITATIONS REGARDING GRANTS.—

8 “(1) PROVISION OF HEALTH SERVICES; CON-
9 STRUCTION OF FACILITIES.—The Secretary may
10 make a grant under subsection (a) only if the appli-
11 cant involved agrees that the grant will not be ex-
12 pended for the direct provision of any health service
13 or for the construction or renovation of facilities.

14 “(2) DURATION AND AMOUNT OF GRANT.—The
15 period during which payments are made for a
16 project under subsection (a) may not exceed 4 years,
17 and the aggregate amount of such payments for the
18 period may not exceed \$200,000. The provision of
19 such payments shall be subject to annual approval
20 by the Secretary of the payments and subject to the
21 availability of appropriations for the fiscal year in-
22 volved to make the payments.

23 “(3) FINANCIAL CAPACITY FOR CONTINUATION
24 OF PROJECT AFTER TERMINATION OF GRANT.—The
25 Secretary may make a grant under subsection (a)

1 only if the Secretary determines that there is a rea-
2 sonable basis for believing that, after termination of
3 payments under such subsection pursuant to para-
4 graph (2), the project under such subsection will
5 have the financial capacity to continue operating.

6 “(g) AGREEMENTS AMONG PARTICIPANTS IN
7 PROJECTS.—

8 “(1) REQUIRED PARTICIPANTS.—The Secretary
9 may make a grant under subsection (a) only if the
10 applicant for the grant has, for purposes of carrying
11 out a project under such subsection, entered into
12 agreements with—

13 “(A) the chief public health officers, and
14 the chief health officers for the elementary and
15 secondary schools, of each of the political sub-
16 divisions of the qualified health service area in
17 which the project under such subsection is to be
18 carried out (or, in the case of a political sub-
19 division that does not have such an official,
20 with another appropriate official of such sub-
21 division);

22 “(B) each hospital in the qualified health
23 service area;

24 “(C) representatives of entities in such
25 area that provide outpatient primary health

1 services under Federal, State, local, or private
2 programs;

3 “(D) representatives of businesses in such
4 area, including small businesses; and

5 “(E) representatives of nonprofit private
6 entities in such area.

7 “(2) OPTIONAL PARTICIPANTS.—With respect
8 to compliance with this section, a grantee under sub-
9 section (a) may, for purposes of carrying out a
10 project under such subsection, enter into such agree-
11 ments with public and private entities in the quali-
12 fied health service area involved (in addition to the
13 entities specified in paragraph (1)) as the grantee
14 may elect.

15 “(h) EXPENDITURES OF GRANT.—With respect to a
16 project under subsection (a), the purposes for which a
17 grant under such subsection may be expended include (but
18 are not limited to) expenditures to increase the efficiency
19 of the administrative processes of providers participating
20 in the project, paying the costs of hiring and compensating
21 staff, obtaining computers and other equipment (including
22 vehicles to transport individuals to programs providing
23 outpatient primary health services), and developing and
24 operating provider networks.

1 “(i) MAINTENANCE OF EFFORT.—In the case of serv-
2 ices and populations that are the subject of a project
3 under subsection (a), the Secretary may make such a
4 grant for a fiscal year only if the applicant involved agrees
5 that the applicant, and each entity making an agreement
6 under subsection (g), will maintain expenditures of non-
7 Federal amounts for such services and populations at a
8 level that is not less than the level of such expenditures
9 maintained by the applicant and the entity, respectively,
10 for the fiscal year preceding the first fiscal year for which
11 the applicant receives such a grant.

12 “(j) REPORTS TO SECRETARY.—The Secretary may
13 make a grant under subsection (a) only if the applicant
14 involved agrees to submit to the Secretary such reports
15 on the project carried out under such subsection as the
16 Secretary may require.

17 “(k) EVALUATIONS AND DISSEMINATION OF INFOR-
18 MATION.—The Secretary shall provide for evaluations of
19 projects carried out under subsection (a), and for the col-
20 lection and dissemination of information developed as a
21 result of such projects and as a result of similar projects.

22 “(l) PLANNING GRANTS.—

23 “(1) IN GENERAL.—The Secretary may make
24 grants to public and nonprofit private entities for
25 the purpose of developing plans to carry out projects

1 under subsection (a). Such a grant may be made
2 only if the applicant involved submits to the Sec-
3 retary information—

4 “(A) providing a detailed statement of the
5 proposal of the applicant for carrying out the
6 project;

7 “(B) identifying the geographic area in
8 which the project is to be carried out; and

9 “(C) demonstrating that the area is a
10 qualified health service area and that the pro-
11 posal otherwise is in accordance with the re-
12 quirements established in this section for the
13 receipt of a grant under subsection (a).

14 “(2) DURATION AND AMOUNT OF GRANT.—The
15 period during which payments are made under para-
16 graph (1) for the development of a plan under such
17 paragraph may not exceed 1 year, and the amount
18 of such payments may not exceed \$100,000.

19 “(m) APPLICATION FOR GRANT.—The Secretary may
20 make a grant under subsection (a) or (l) only if the appli-
21 cant for the grant submits an application to the Secretary
22 that—

23 “(1) contains any agreements, assurances, and
24 information required in this section with respect to
25 the grant; and

1 “(2) is in such form, is made in such manner,
2 and contains such other agreements, assurances, and
3 information as the Secretary determines to be nec-
4 essary to carry out the purpose for which the grant
5 is to be provided.

6 “(n) DEFINITIONS.—For purposes of this section:

7 “(1) The term “designated population” means
8 individuals described in subsection (b)(1)(C)(ii).

9 “(2) The term ‘primary health services’ includes
10 preventive health services.

11 “(3) The term ‘qualified health service area’
12 means a geographic area described in subsection (b).

13 “(o) AUTHORIZATION OF APPROPRIATIONS.—

14 “(1) PLANNING FOR PROJECTS.—For the pur-
15 pose of grants under subsection (l), there is author-
16 ized to be appropriated \$5,000,000 for fiscal year
17 1994, to remain available until expended.

18 “(2) OPERATION OF PROJECTS.—For the pur-
19 pose of grants under subsection (a), there is author-
20 ized to be appropriated an aggregate \$10,000,000
21 for the fiscal years 1995 through 1998.”.

1 **Subtitle E—Improved Access to**
2 **Rural Health Services**

3 PART 1—RURAL EMERGENCY MEDICAL SERVICES

4 AMENDMENTS

5 **SEC. 171. OFFICE OF EMERGENCY MEDICAL SERVICES.**

6 Title XII of the Public Health Service Act (42 U.S.C.
7 300d et seq.) is amended—

8 (1) in the heading for the title, by striking
9 “TRAUMA CARE” and inserting “EMERGENCY
10 MEDICAL SERVICES”;

11 (2) in the heading for part A, by striking
12 “GENERAL” and all that follows and inserting
13 “GENERAL AUTHORITIES AND DUTIES”; and

14 (3) by amending section 1201 to read as fol-
15 lows:

16 **“SEC. 1201. OFFICE OF EMERGENCY MEDICAL SERVICES.**

17 “(a) ESTABLISHMENT.—The Secretary shall estab-
18 lish an office to be known as the Office of Emergency
19 Medical Services, which shall be headed by a director ap-
20 pointed by the Secretary. The Secretary shall carry out
21 this title acting through the Director of such Office.

22 “(b) GENERAL AUTHORITIES AND DUTIES.—With
23 respect to emergency medical services (including trauma
24 care), the Secretary shall—

1 “(1) conduct and support research, training,
2 evaluations, and demonstration projects;

3 “(2) foster the development of appropriate,
4 modern systems of such services through the sharing
5 of information among agencies and individuals in-
6 volved in the study and provision of such services;

7 “(3) sponsor workshops and conferences;

8 “(4) as appropriate, disseminate to public and
9 private entities information obtained in carrying out
10 paragraphs (1) through (3);

11 “(5) provide technical assistance to State and
12 local agencies;

13 “(6) coordinate activities of the Department of
14 Health and Human Services; and

15 “(7) as appropriate, coordinate activities of
16 such Department with activities of other Federal
17 agencies.

18 “(c) CERTAIN REQUIREMENTS.—With respect to
19 emergency medical services (including trauma care), the
20 Secretary shall ensure that activities under subsection (b)
21 are carried out regarding—

22 “(1) maintaining an adequate number of health
23 professionals with expertise in the provision of the
24 services, including hospital-based professionals and
25 prehospital-based professionals;

1 “(2) developing, periodically reviewing, and re-
2 vising as appropriate, in collaboration with appro-
3 priate public and private entities, guidelines for the
4 provision of such services (including, for various typ-
5 ical circumstances, guidelines on the number and va-
6 riety of professionals, on equipment, and on train-
7 ing);

8 “(3) the appropriate use of available tech-
9 nologies, including communications technologies; and

10 “(4) the unique needs of underserved inner-city
11 areas and underserved rural areas.

12 “(d) GRANTS, COOPERATIVE AGREEMENTS, AND
13 CONTRACTS.—In carrying out subsections (b) and (c), the
14 Secretary may make grants and enter into cooperative
15 agreements and contracts.

16 “(e) DEFINITIONS.—For purposes of this part:

17 “(1) The term ‘hospital-based professional’
18 means a health professional (including an allied
19 health professional) who has expertise in providing
20 one or more emergency medical services and who
21 normally provides the services at a medical facility.

22 “(2) The term ‘prehospital-based professional’
23 means a health professional (including an allied
24 health professional) who has expertise in providing
25 one or more emergency medical services and who

1 normally provides the services at the site of the med-
2 ical emergency or during transport to a medical fa-
3 cility.”.

4 **SEC. 172. STATE OFFICES OF EMERGENCY MEDICAL**
5 **SERVICES.**

6 (a) TECHNICAL AMENDMENTS TO FACILITATE ES-
7 TABLISHMENT OF PROGRAM.—

8 (1) IN GENERAL.—Title XII of the Public
9 Health Service Act (42 U.S.C. 300d et seq.) is
10 amended—

11 (A) by redesignating section 1232 as sec-
12 tion 1251;

13 (B) by redesignating sections 1231 and
14 1233 as sections 1241 and 1242, respectively;
15 and

16 (C) by redesignating sections 1211 through
17 1222 as sections 1221 through 1232, respec-
18 tively.

19 (2) MODIFICATIONS IN FORMAT OF TITLE
20 XII.—Title XII of the Public Health Service Act, as
21 amended by paragraph (1) of this subsection, is
22 amended—

23 (A) by striking “PART B” and all that fol-
24 lows through “STATE PLANS” and inserting the
25 following:

1 “Subpart II—Formula Grants With Respect to
2 Modifications of State Plans”;

3 (B) by striking “PART C—GENERAL PRO-
4 VISIONS” and inserting the following:

5 “Subpart III—General Provisions”;

6 (C) by redesignating sections 1202 and
7 1203 as sections 1211 and 1212, respectively;
8 and

9 (D) by inserting before section 1211 (as so
10 redesignated) the following:

11 “PART B—TRAUMA CARE

12 “Subpart I—Advisory Council; Clearinghouse”.

13 (b) STATE OFFICES.—Title XII of the Public Health
14 Service Act, as amended by subsection (a) of this section,
15 is amended by inserting after section 1201 the following
16 new section:

17 “**SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL**
18 **SERVICES.**

19 “(a) PROGRAM OF GRANTS.—The Secretary may
20 make grants to States for the purpose of improving the
21 availability and quality of emergency medical services
22 through the operation of State offices of emergency medi-
23 cal services.

24 “(b) REQUIREMENT OF MATCHING FUNDS.—

1 “(1) IN GENERAL.—The Secretary may not
2 make a grant under subsection (a) unless the State
3 involved agrees, with respect to the costs to be in-
4 curred by the State in carrying out the purpose de-
5 scribed in such subsection, to provide non-Federal
6 contributions toward such costs in an amount that—

7 “(A) for the first fiscal year of payments
8 under the grant, is not less than \$1 for each \$3
9 of Federal funds provided in the grant;

10 “(B) for any second fiscal year of such
11 payments, is not less than \$1 for each \$1 of
12 Federal funds provided in the grant; and

13 “(C) for any third fiscal year of such pay-
14 ments, is not less than \$3 for each \$1 of Fed-
15 eral funds provided in the grant.

16 “(2) DETERMINATION OF AMOUNT OF NON-
17 FEDERAL CONTRIBUTION.—

18 “(A) Subject to subparagraph (B), non-
19 Federal contributions required in paragraph (1)
20 may be in cash or in kind, fairly evaluated, in-
21 cluding plant, equipment, or services. Amounts
22 provided by the Federal Government, or serv-
23 ices assisted or subsidized to any significant ex-
24 tent by the Federal Government, may not be in-

1 cluded in determining the amount of such non-
2 Federal contributions.

3 “(B) The Secretary may not make a grant
4 under subsection (a) unless the State involved
5 agrees that—

6 “(i) for the first fiscal year of pay-
7 ments under the grant, 100 percent or less
8 of the non-Federal contributions required
9 in paragraph (1) will be provided in the
10 form of in-kind contributions;

11 “(ii) for any second fiscal year of such
12 payments, not more than 50 percent of
13 such non-Federal contributions will be pro-
14 vided in the form of in-kind contributions;
15 and

16 “(iii) for any third fiscal year of such
17 payments, such non-Federal contributions
18 will be provided solely in the form of cash.

19 “(c) CERTAIN REQUIRED ACTIVITIES.—The Sec-
20 retary may not make a grant under subsection (a) unless
21 the State involved agrees that activities carried out by an
22 office operated pursuant to such subsection will include—

23 “(1) coordinating the activities carried out in
24 the State that relate to emergency medical services;

1 “(2) activities regarding the matters described
2 in paragraphs (1) through (4) section 1201(b); and

3 “(3) identifying Federal and State programs re-
4 garding emergency medical services and providing
5 technical assistance to public and nonprofit private
6 entities regarding participation in such programs.

7 “(d) REQUIREMENT REGARDING ANNUAL BUDGET
8 FOR OFFICE.—The Secretary may not make a grant
9 under subsection (a) unless the State involved agrees that,
10 for any fiscal year for which the State receives such a
11 grant, the office operated pursuant to subsection (a) will
12 be provided with an annual budget of not less than
13 \$50,000.

14 “(e) CERTAIN USES OF FUNDS.—

15 “(1) RESTRICTIONS.—The Secretary may not
16 make a grant under subsection (a) unless the State
17 involved agrees that—

18 “(A) if research with respect to emergency
19 medical services is conducted pursuant to the
20 grant, not more than 10 percent of the grant
21 will be expended for such research; and

22 “(B) the grant will not be expended to pro-
23 vide emergency medical services (including pro-
24 viding cash payments regarding such services).

1 “(2) ESTABLISHMENT OF OFFICE.—Activities
2 for which a State may expend a grant under sub-
3 section (a) include paying the costs of establishing
4 an office of emergency medical services for purposes
5 of such subsection.

6 “(f) REPORTS.—The Secretary may not make a
7 grant under subsection (a) unless the State involved
8 agrees to submit to the Secretary reports containing such
9 information as the Secretary may require regarding activi-
10 ties carried out under this section by the State.

11 “(g) REQUIREMENT OF APPLICATION.—The Sec-
12 retary may not make a grant under subsection (a) unless
13 an application for the grant is submitted to the Secretary
14 and the application is in such form, is made in such man-
15 ner, and contains such agreements, assurances, and infor-
16 mation as the Secretary determines to be necessary to
17 carry out this section.”.

18 **SEC. 173. PROGRAMS FOR RURAL AREAS.**

19 (a) IN GENERAL.—Title XII of the Public Health
20 Service Act, as amended by section 172 of this Act, is
21 amended—

22 (1) by transferring section 1204 to part A;

23 (2) by redesignating such section as section
24 1203;

1 (3) by inserting such section after section 1202;

2 and

3 (4) in section 1203 (as so redesignated)—

4 (A) by redesignating subsection (c) as sub-
5 section (d); and

6 (B) by inserting after subsection (b) the
7 following new subsection:

8 “(c) DEMONSTRATION PROGRAM REGARDING TELE-
9 COMMUNICATIONS.—

10 “(1) LINKAGES FOR RURAL FACILITIES.—

11 Projects under subsection (a)(1) shall include dem-
12 onstration projects to establish telecommunications
13 between rural medical facilities and medical facilities
14 that have expertise or equipment that can be utilized
15 by the rural facilities through the telecommuni-
16 cations.

17 “(2) MODES OF COMMUNICATION.—The Sec-
18 retary shall ensure that the telecommunications
19 technologies demonstrated under paragraph (1) in-
20 clude (interactive) video telecommunications, (static
21 video imaging transmitted through the telephone
22 system), and facsimiles transmitted through such
23 system.”.

24 (b) CONFORMING AMENDMENT.—Section 1203 of the
25 Public Health Service Act, as redesignated by subsection

1 (a)(2) of this section, is amended in the heading for the
2 section by striking “**ESTABLISHMENT**” and all that fol-
3 lows and inserting “**PROGRAMS FOR RURAL AREAS.**”.

4 **SEC. 174. FUNDING.**

5 Title XII of the Public Health Service Act, as amend-
6 ed by the preceding provisions of this part, is amended—

7 (1) by adding at the end the following new part:

8 “PART C—FUNDING”;

9 (2) by transferring section 1251 to part C (as
10 so added); and

11 (3) in such section, by striking subsections (a)
12 and (b) and inserting the following:

13 “(a) EMERGENCY MEDICAL SERVICES GEN-
14 ERALLY.—

15 “(1) IN GENERAL.—For the purpose of carry-
16 ing out section 1201 other than with respect to trau-
17 ma care, there are authorized to be appropriated
18 \$2,000,000 for fiscal year 1994, and such sums as
19 may be necessary for each of the fiscal years 1995
20 and 1996.

21 “(2) STATE OFFICES.—For the purpose of car-
22 rying out section 1202, there are authorized to be
23 appropriated \$3,000,000 for fiscal year 1994, and
24 such sums as may be necessary for each of the fiscal
25 years 1995 and 1996.

1 “(3) CERTAIN TELECOMMUNICATIONS DEM-
2 ONSTRATIONS.—For the purpose of carrying out sec-
3 tion 1203(c), there are authorized to be appro-
4 priated \$10,000,000 for fiscal year 1994, and such
5 sums as may be necessary for each of the fiscal
6 years 1995 and 1996.

7 “(b) TRAUMA CARE AND CERTAIN OTHER ACTIVI-
8 TIES.—

9 “(1) IN GENERAL.—For the purpose of carry-
10 ing out part B, section 1201 with respect to trauma
11 care, and section 1203 (other than subsection (c) of
12 such section), there are authorized to be appro-
13 priated \$60,000,000 for fiscal year 1994, and such
14 sums as may be necessary for each of the fiscal
15 years 1995 and 1996.

16 “(2) ALLOCATION OF FUNDS BY SECRETARY.—

17 “(A) For the purpose of carrying out sub-
18 part I of part B, section 1201 with respect to
19 trauma care, and section 1203 (other than sub-
20 section (c) of such section), the Secretary shall
21 make available 10 percent of the amounts ap-
22 propriated for a fiscal year under paragraph
23 (1).

24 “(B) For the purpose of carrying out sec-
25 tion 1203 (other than subsection (c) of such

1 section), the Secretary shall make available 10
2 percent of the amounts appropriated for a fiscal
3 year under paragraph (1).

4 “(C)(i) For the purpose of making allot-
5 ments under section 1221(a), the Secretary
6 shall, subject to subsection (c), make available
7 80 percent of the amounts appropriated for a
8 fiscal year under paragraph (1).

9 “(ii) Amounts paid to a State under sec-
10 tion 1221(a) for a fiscal year shall, for the pur-
11 poses for which the amounts were paid, remain
12 available for obligation until the end of the fis-
13 cal year immediately following the fiscal year
14 for which the amounts were paid.”.

15 **SEC. 175. CONFORMING AMENDMENTS.**

16 Title XII of the Public Health Service Act, as amend-
17 ed by the preceding provisions of this part, is amended—

18 (1) in section 1203(b), by striking “1214(c)(1)”
19 and inserting “1224(c)(1)”;

20 (2) in section 1211(b)(3), by striking “1213(c)”
21 and inserting “1223(c)”;

22 (3) in section 1221—

23 (A) in subsection (a)—

24 (i) by striking “1218” and inserting
25 “1228”; and

1 (ii) by striking “1217” and inserting
2 “1227”; and

3 (B) in subsection (b)—

4 (i) by striking “1233” and inserting
5 “1242”; and

6 (ii) by striking “1213” and inserting
7 “1223”;

8 (4) in section 1222—

9 (A) in subsection (a)—

10 (i) in paragraph (1), by striking
11 “1211(a)” and inserting “1221(a)”; and

12 (ii) in paragraph (2)(A), by striking
13 “1211(c)” and inserting “1221(c)”; and

14 (B) in subsection (b), by striking
15 “1211(a)” and inserting “1221(a)”; and

16 (5) in section 1223—

17 (A) in subsection (a), by striking
18 “1211(b)” and inserting “1221(b)”; and

19 (B) in subsection (b)—

20 (i) in paragraph (1), by striking
21 “1211(a)” and inserting “1221(a)”; and

22 (ii) in paragraph (3), by striking
23 “1211(a)” and inserting “1221(a)”; and

24 (C) in subsection (d), by striking
25 “1211(a)” and inserting “1221(a)”; and

1 (6) in section 1224—

2 (A) in each of subsections (a) through (c),
3 by striking “1211(a)” and inserting “1221(a)”;
4 and

5 (B) in subsection (b), by striking
6 “1213(a)(7)” and inserting “1223(a)(7)”;

7 (7) in section 1225—

8 (A) in subsection (a)—

9 (i) by striking “1211(a)” and insert-
10 ing “1221(a)”;

11 (ii) by striking “1233” and inserting
12 “1242”;

13 (B) in subsection (b), by striking
14 “1211(b)” and inserting “1221(b)”;

15 (8) in section 1226, in each of subsections (a)
16 through (c), by striking “1211(a)” and inserting
17 “1221(a)”;

18 (9) in section 1227—

19 (A) by striking “1211(a)” and inserting
20 “1221(a)”;

21 (B) by striking “1214” and inserting
22 “1224”;

23 (10) in section 1228—

1 (A) in each of subsections (a) through (c),
2 by striking “1211(a)” each place such term ap-
3 pears and inserting “1221(a)”;

4 (B) in subsection (b), in each of para-
5 graphs (2)(A) and (3)(A), by striking
6 “1232(a)” and inserting “1251(a)”;

7 (C) in subsection (c)(2)—

8 (i) by striking “1232(b)(3)” and in-
9 serting “1251(b)(3)”;

10 (ii) by striking “1217” and inserting
11 “1227”;

12 (11) in section 1229(a), by striking “1211(a)”
13 each place such term appears and inserting
14 “1221(a)”;

15 (12) in section 1230(a), by striking “1211(a)”
16 each place such term appears and inserting
17 “1221(a)”;

18 (13) in section 1231—

19 (A) in each of subsections (a) and (b), by
20 striking “1211(a)” each place such term ap-
21 pears and inserting “1221(a)”;

22 (B) in each of subsections (a) and (b), by
23 striking “1211(b)” and inserting “1221(b)”;

24 (14) in section 1232, by striking “1211” and
25 inserting “1221”;

1 (15) in section 1241—

2 (A) in the matter preceding paragraph (1),
3 by striking “this title” and inserting “this
4 part”; and

5 (B) in paragraph (1), by striking “1213”
6 and inserting “1223”;

7 (16) in section 1242—

8 (A) in each of subsections (a) and (b), by
9 striking “1211” each place such term appears
10 and inserting “1221”;

11 (B) in subsection (b)—

12 (i) by striking “part B” and inserting
13 “subpart II”; and

14 (ii) by striking “1214(c)(1)” and in-
15 serting “1224(c)(1)”;

16 (C) in subsection (c), by striking “1213”
17 and inserting “1223”; and

18 (17) in section 1251(c)(1)—

19 (A) by striking “1211(a)” and inserting
20 “1221(a)”;

21 (B) by striking “1218(a)(2)” and inserting
22 “1228(a)(2)”;

23 (C) by striking “part B” and inserting
24 “subpart II”.

1 **SEC. 176. EFFECTIVE DATE.**

2 The amendments made by this part shall take effect
3 October 1, 1993, or upon the date of the enactment of
4 this Act, whichever occurs later.

5 PART 2—AIR TRANSPORT FOR RURAL VICTIMS OF
6 MEDICAL EMERGENCIES

7 **SEC. 181. GRANTS TO STATES REGARDING AIRCRAFT FOR**
8 **TRANSPORTING RURAL VICTIMS OF MEDICAL**
9 **EMERGENCIES.**

10 Title XII of the Public Health Service Act (42 U.S.C.
11 300d et seq.), as amended by part 1, is amended by adding
12 at the end thereof the following new part:

13 “PART D—MISCELLANEOUS GRANT PROGRAMS AND
14 REQUIREMENTS

15 “**SEC. 1261. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**
16 **VICTIMS OF MEDICAL EMERGENCIES.**

17 “(a) IN GENERAL.—The Secretary shall make grants
18 to States to assist such States in the creation or enhance-
19 ment of air medical transport systems that provide victims
20 of medical emergencies in rural areas with access to treat-
21 ments for the injuries or other conditions resulting from
22 such emergencies.

23 “(b) APPLICATION AND PLAN.—

24 “(1) APPLICATION.—To be eligible to receive a
25 grant under subsection (a), a State shall prepare
26 and submit to the Secretary an application in such

1 form, made in such manner, and containing such
2 agreements, assurances, and information, including
3 a State plan as required in paragraph (2), as the
4 Secretary determines to be necessary to carry out
5 this section.

6 “(2) STATE PLAN.—An application submitted
7 under paragraph (1) shall contain a State plan that
8 shall—

9 “(A) describe the intended uses of the
10 grant proceeds and the geographic areas to be
11 served;

12 “(B) demonstrates that the geographic
13 areas to be served, as described under subpara-
14 graph (A), are rural in nature;

15 “(C) demonstrate that there is a lack of
16 facilities available and equipped to deliver ad-
17 vanced levels of medical care in the geographic
18 areas to be served;

19 “(D) demonstrate that in utilizing the
20 grant proceeds for the establishment or en-
21 hancement of air medical services the State
22 would be making a cost-effective improvement
23 to existing ground-based or air emergency medi-
24 cal service systems;

1 “(E) demonstrate that the State will not
2 utilize the grant proceeds to duplicate the capa-
3 bilities of existing air medical systems that are
4 effectively meeting the emergency medical needs
5 of the populations they serve;

6 “(F) demonstrate that in utilizing the
7 grant proceeds the State is likely to achieve a
8 reduction in the morbidity and mortality rates
9 of the areas to be served, as determined by the
10 Secretary;

11 “(G) demonstrate that the State, in utiliz-
12 ing the grant proceeds, will—

13 “(i) maintain the expenditures of the
14 State for air and ground medical transport
15 systems at a level equal to not less than
16 the level of such expenditures maintained
17 by the State for the fiscal year preceding
18 the fiscal year for which the grant is re-
19 ceived; and

20 “(ii) ensure that recipients of direct
21 financial assistance from the State under
22 such grant will maintain expenditures of
23 such recipients for such systems at a level
24 at least equal to the level of such expendi-
25 tures maintained by such recipients for the

1 fiscal year preceding the fiscal year for
2 which the financial assistance is received;

3 “(H) demonstrate that persons experienced
4 in the field of air medical service delivery were
5 consulted in the preparation of the State plan;
6 and

7 “(I) contain such other information as the
8 Secretary may determine appropriate.

9 “(c) CONSIDERATIONS IN AWARDING GRANTS.—In
10 determining whether to award a grant to a State under
11 this section, the Secretary shall—

12 “(1) consider the rural nature of the areas to
13 be served with the grant proceeds and the services
14 to be provided with such proceeds, as identified in
15 the State plan submitted under subsection (b); and

16 “(2) give preference to States with State plans
17 that demonstrate an effective integration of the pro-
18 posed air medical transport systems into a com-
19 prehensive network or plan for regional or statewide
20 emergency medical service delivery.

21 “(d) STATE ADMINISTRATION AND USE OF
22 GRANT.—

23 “(1) IN GENERAL.—The Secretary may not
24 make a grant to a State under subsection (a) unless
25 the State agrees that such grant will be adminis-

1 tered by the State agency with principal responsibil-
2 ity for carrying out programs regarding the provi-
3 sion of medical services to victims of medical emer-
4 gencies or trauma.

5 “(2) PERMITTED USES.—A State may use
6 amounts received under a grant awarded under this
7 section to award subgrants to public and private en-
8 tities operating within the State.

9 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—
10 The Secretary may not make a grant to a State
11 under subsection (a) unless that State agrees that,
12 in developing and carrying out the State plan under
13 subsection (b)(2), the State will provide public notice
14 with respect to the plan (including any revisions
15 thereto) and facilitate comments from interested
16 persons.

17 “(e) NUMBER OF GRANTS.—The Secretary shall
18 award grants under this section to not less than 7 States.

19 “(f) REPORTS.—

20 “(1) REQUIREMENT.—A State that receives a
21 grant under this section shall annually (during each
22 year in which the grant proceeds are used) prepare
23 and submit to the Secretary a report that shall con-
24 tain—

1 “(A) a description of the manner in which
2 the grant proceeds were utilized;

3 “(B) a description of the effectiveness of
4 the air medical transport programs assisted
5 with grant proceeds; and

6 “(C) such other information as the Sec-
7 retary may require.

8 “(2) TERMINATION OF FUNDING.—In reviewing
9 reports submitted under paragraph (1), if the Sec-
10 retary determines that a State is not using amounts
11 provided under a grant awarded under this section
12 in accordance with the State plan submitted by the
13 State under subsection (b), the Secretary may termi-
14 nate the payment of amounts under such grant to
15 the State until such time as the Secretary deter-
16 mines that the State comes into compliance with
17 such plan.

18 “(g) DEFINITION.—As used in this section, the term
19 ‘rural areas’ means geographic areas that are located out-
20 side of standard metropolitan statistical areas, as identi-
21 fied by the Secretary.

22 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to make grants under
24 this section, \$15,000,000 for fiscal year 1994, and such

1 sums as may be necessary for each of the fiscal years 1995
2 and 1996.”.

3 PART 3—EXTENSION OF SPECIAL TREATMENT RULES
4 FOR MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS
5 **SEC. 191. EXTENSION OF SPECIAL TREATMENT RULES FOR**
6 **MEDICARE-DEPENDENT, SMALL RURAL HOS-**
7 **PITALS.**

8 (a) IN GENERAL.—

9 (1) DETERMINATION OF PAYMENT AMOUNT.—
10 Section 1886(b)(3)(D) of the Social Security Act (42
11 U.S.C. 1395ww(b)(3)(D)) is amended by striking
12 “March 31, 1993,” and inserting “March 31,
13 1994,”.

14 (2) ELIGIBILITY FOR DESIGNATION.—Section
15 1886(d)(5)(G)(i) of such Act (42 U.S.C.
16 1395ww(d)(5)(G)(i)) is amended by striking “March
17 31, 1993,” and inserting “March 31, 1994,”.

18 (b) EFFECTIVE DATE.—The amendments made by
19 subsection (a) shall take effect as if included in the enact-
20 ment of section 6003(f) of the Omnibus Budget Reconcili-
21 ation Act of 1989.

1 **TITLE II—HEALTH CARE COST**
2 **CONTAINMENT AND QUALITY**
3 **ENHANCEMENT**

4 **Subtitle A—Medical Malpractice**
5 **Liability Reform**

6 PART 1—GENERAL PROVISIONS

7 **SEC. 201. FEDERAL REFORM OF MEDICAL MALPRACTICE**
8 **LIABILITY ACTIONS.**

9 (a) CONGRESSIONAL FINDINGS.—

10 (1) EFFECT ON INTERSTATE COMMERCE.—

11 Congress finds that the health care and insurance
12 industries are industries affecting interstate com-
13 merce and the medical malpractice litigation systems
14 existing throughout the United States affect inter-
15 state commerce by contributing to the high cost of
16 health care and premiums for malpractice insurance
17 purchased by health care providers.

18 (2) EFFECT ON FEDERAL SPENDING.—Con-
19 gress finds that the medical malpractice litigation
20 systems existing throughout the United States have
21 a significant effect on the amount, distribution, and
22 use of Federal funds because of—

23 (A) the large number of individuals who
24 receive health care benefits under programs op-
25 erated or financed by the Federal Government;

1 (B) the large number of individuals who
2 benefit because of the exclusion from Federal
3 taxes of the amounts spent by their employers
4 to provide them with health insurance benefits;

5 (C) the large number of health care provid-
6 ers and health care professionals who provide
7 items or services for which the Federal Govern-
8 ment makes payments; and

9 (D) the large number of such providers
10 and professionals who have received direct or
11 indirect financial assistance from the Federal
12 Government because of their status as such
13 professionals or providers.

14 (b) APPLICABILITY.—This subtitle shall apply with
15 respect to any medical malpractice liability claim and to
16 any medical malpractice liability action brought in any
17 State or Federal court, except that this subtitle shall not
18 apply to—

19 (1) a claim or action for damages arising from
20 a vaccine-related injury or death to the extent that
21 title XXI of the Public Health Service Act applies to
22 the action; or

23 (2) a claim or action in which the plaintiff's
24 sole allegation is an allegation of an injury arising
25 from the use of a medical product.

1 (c) PREEMPTION OF STATE LAW.—Subject to section
2 221, this subtitle supersedes State law only to the extent
3 that State law differs from any provision of law estab-
4 lished by or under this subtitle. Any issue that is not gov-
5 erned by any provision of law established by or under this
6 subtitle shall be governed by otherwise applicable State or
7 Federal law.

8 (d) FEDERAL COURT JURISDICTION NOT ESTAB-
9 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
10 this subtitle shall be construed to establish any jurisdiction
11 in the district courts of the United States over medical
12 malpractice liability actions on the basis of sections 1331
13 or 1337 of title 28, United States Code.

14 **SEC. 202. DEFINITIONS.**

15 As used in this subtitle:

16 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
17 TEM; ADR.—The term “alternative dispute resolu-
18 tion system” or “ADR” means a system established
19 by a State that provides for the resolution of medical
20 malpractice liability claims in a manner other than
21 through medical malpractice liability actions.

22 (2) CLAIMANT.—The term “claimant” means
23 any person who alleges a medical malpractice liabil-
24 ity claim, or, in the case of an individual who is de-

1 ceased, incompetent, or a minor, the person on
2 whose behalf such a claim is alleged.

3 (3) ECONOMIC DAMAGES.—The term “economic
4 damages” means damages paid to compensate an in-
5 dividual for losses for hospital and other medical ex-
6 penses, lost wages, lost employment, and other pecu-
7 niary losses.

8 (4) HEALTH CARE PROFESSIONAL.—The term
9 “health care professional” means any individual who
10 provides health care services in a State and who is
11 required by State law or regulation to be licensed or
12 certified by the State to provide such services in the
13 State.

14 (5) HEALTH CARE PROVIDER.—The term
15 “health care provider” means any organization or
16 institution that is engaged in the delivery of health
17 care services in a State and that is required by State
18 law or regulation to be licensed or certified by the
19 State to engage in the delivery of such services in
20 the State.

21 (6) INJURY.—The term “injury” means any ill-
22 ness, disease, or other harm that is the subject of
23 a medical malpractice liability action or claim.

24 (7) MEDICAL MALPRACTICE LIABILITY AC-
25 TION.—The term “medical malpractice liability ac-

1 tion” means a civil action (other than an action in
2 which the plaintiff’s sole allegation is an allegation
3 of an intentional tort) brought in a State or Federal
4 court against a health care provider or health care
5 professional (regardless of the theory of liability on
6 which the action is based) in which the plaintiff al-
7 leges a medical malpractice liability claim.

8 (8) MEDICAL MALPRACTICE LIABILITY
9 CLAIM.—The term “medical malpractice liability
10 claim” means a claim in which the claimant alleges
11 that injury was caused by the provision of (or the
12 failure to provide) health care services.

13 (9) MEDICAL PRODUCT.—The term “medical
14 product” means a device (as defined in section
15 201(h) of the Federal Food, Drug, and Cosmetic
16 Act) or a drug (as defined in section 201(g)(1) of
17 the Federal Food, Drug, and Cosmetic Act).

18 (10) NONECONOMIC DAMAGES.—The term
19 “noneconomic damages” means damages paid to
20 compensate an individual for losses for physical and
21 emotional pain, suffering, inconvenience, physical
22 impairment, mental anguish, disfigurement, loss of
23 enjoyment of life, loss of consortium, and other
24 nonpecuniary losses, but does not include punitive
25 damages.

1 (11) SECRETARY.—The term “Secretary”
2 means the Secretary of Health and Human Services.

3 (12) STATE.—The term “State” means each of
4 the several States, the District of Columbia, the
5 Commonwealth of Puerto Rico, the Virgin Islands,
6 Guam, and American Samoa.

7 **SEC. 203. EFFECTIVE DATE.**

8 (a) IN GENERAL.—Except as provided in subsection
9 (b) and sections 219, 242, and 243, this subtitle shall
10 apply with respect to claims accruing or actions brought
11 on or after the expiration of the 3-year period that begins
12 on the date of the enactment of this Act.

13 (b) EXCEPTION FOR STATES REQUESTING EARLIER
14 IMPLEMENTATION OF REFORMS.—

15 (1) APPLICATION.—A State may submit an ap-
16 plication to the Secretary requesting the early imple-
17 mentation of this subtitle with respect to claims or
18 actions brought in the State.

19 (2) DECISION BY SECRETARY.—The Secretary
20 shall issue a response to a State’s application under
21 paragraph (1) not later than 90 days after receiving
22 the application. If the Secretary determines that the
23 State meets the requirements of this subtitle at the
24 time of submitting its application, the Secretary
25 shall approve the State’s application, and this sub-

1 title shall apply with respect to actions brought in
2 the State on or after the expiration of the 90-day
3 period that begins on the date the Secretary issues
4 the response. If the Secretary denies the State's ap-
5 plication, the Secretary shall provide the State with
6 a written explanation of the grounds for the deci-
7 sion.

8 PART 2—UNIFORM STANDARDS FOR MEDICAL
9 MALPRACTICE LIABILITY ACTIONS

10 **SEC. 211. STATUTE OF LIMITATIONS.**

11 (a) IN GENERAL.—No medical malpractice liability
12 claim may be brought after the expiration of the 2-year
13 period that begins on the date the alleged injury that is
14 the subject of the action should reasonably have been dis-
15 covered, but in no event after the expiration of the 4-year
16 period that begins on the date the alleged injury occurred.

17 (b) EXCEPTION FOR MINORS.—In the case of an al-
18 leged injury suffered by a minor who has not attained 6
19 years of age, no medical malpractice liability claim may
20 be brought after the expiration of the 2-year period that
21 begins on the date the alleged injury that is the subject
22 of the action should reasonably have been discovered, but
23 in no event after the date on which the minor attains 10
24 years of age.

1 **SEC. 212. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**
2 **TION THROUGH ALTERNATIVE DISPUTE RES-**
3 **OLUTION.**

4 (a) IN GENERAL.—No medical malpractice liability
5 action may be brought in any State court during a cal-
6 endar year unless the medical malpractice liability claim
7 that is the subject of the action has been initially resolved
8 under an alternative dispute resolution system certified for
9 the year by the Secretary under section 232(a), or, in the
10 case of a State in which such a system is not in effect
11 for the year, under the alternative Federal system estab-
12 lished under section 232(b).

13 (b) INITIAL RESOLUTION OF CLAIMS UNDER
14 ADR.—For purposes of subsection (a), an action is “ini-
15 tially resolved” under an alternative dispute resolution
16 system if—

17 (1) the ADR reaches a decision on whether the
18 defendant is liable to the plaintiff for damages; and

19 (2) if the ADR determines that the defendant
20 is liable, the ADR reaches a decision on the amount
21 of damages assessed against the defendant.

22 (c) PROCEDURES FOR FILING ACTIONS.—

23 (1) NOTICE OF INTENT TO CONTEST DECI-
24 SION.—Not later than 60 days after a decision is is-
25 sued with respect to a medical malpractice liability
26 claim under an alternative dispute resolution system,

1 each party affected by the decision shall submit a
2 sealed statement to a court of competent jurisdiction
3 indicating whether or not the party intends to con-
4 test the decision.

5 (2) DEADLINE FOR FILING ACTION.—No medi-
6 cal malpractice liability action may be brought un-
7 less the action is filed in a court of competent juris-
8 diction not later than 90 days after the decision re-
9 solving the medical malpractice liability claim that is
10 the subject of the action is issued under the applica-
11 ble alternative dispute resolution system.

12 (3) COURT OF COMPETENT JURISDICTION.—
13 For purposes of this subsection, the term “court of
14 competent jurisdiction” means—

15 (A) with respect to actions filed in a State
16 court, the appropriate State trial court; and

17 (B) with respect to actions filed in a Fed-
18 eral court, the appropriate United States dis-
19 trict court.

20 (d) EFFECT OF ADR DECISION ON BURDEN OF
21 PROOF IN SUBSEQUENT ACTION.—In any medical mal-
22 practice liability action, the trier of fact shall uphold the
23 decision made under the previous alternative dispute reso-
24 lution system with respect to the claim that is the subject
25 of the action unless the party contesting the decision

1 proves by a preponderance of the evidence that the deci-
2 sion was incorrect.

3 (e) LEGAL EFFECT OF UNCONTESTED ADR DECI-
4 SION.—The decision reached under an alternative dispute
5 resolution system shall, for purposes of enforcement by a
6 court of competent jurisdiction, have the same status in
7 the court as the verdict of a medical malpractice liability
8 action adjudicated in a State or Federal trial court. The
9 previous sentence shall not apply to a decision that is con-
10 tested by a party affected by the decision pursuant to sub-
11 section (c)(1).

12 **SEC. 213. ESTABLISHMENT OF PROCESS FOR RESOLUTION**
13 **OF CLAIMS AGAINST UNITED STATES.**

14 The Attorney General shall establish an alternative
15 dispute resolution process for the resolution of tort claims
16 consisting of medical malpractice liability claims brought
17 against the United States under the Federal Tort Claims
18 Act. Under such process, the resolution of the claim shall
19 occur after the completion of the administrative claim
20 process applicable to the claim under section 2675 of title
21 28, United States Code.

22 **SEC. 214. MANDATORY PRE-TRIAL SETTLEMENT CON-**
23 **FERENCE.**

24 (a) IN GENERAL.—Before the beginning of the trial
25 phase of any medical malpractice liability action, the par-

1 ties shall attend a conference called by the court for pur-
2 poses of determining whether grounds exist upon which
3 the parties may negotiate a settlement for the action.

4 (b) REQUIRING PARTIES TO SUBMIT SETTLEMENT
5 OFFERS.—At the conference called pursuant to subsection
6 (a), each party to a medical malpractice liability action
7 shall present an offer of settlement for the action.

8 **SEC. 215. CALCULATION AND PAYMENT OF DAMAGES.**

9 (a) LIMITATION ON NONECONOMIC DAMAGES.—The
10 total amount of noneconomic damages that may be award-
11 ed to a plaintiff and the members of the plaintiff's family
12 for losses resulting from the injury which is the subject
13 of a medical malpractice liability action may not exceed
14 \$250,000, regardless of the number of parties against
15 whom the action is brought or the number of actions
16 brought with respect to the injury.

17 (b) TREATMENT OF PUNITIVE DAMAGES.—

18 (1) LIMITATION ON AMOUNT.—The total
19 amount of punitive damages that may be imposed
20 under a medical malpractice liability action may not
21 exceed twice the total of the damages awarded to the
22 plaintiff and the members of the plaintiff's family.

23 (2) PAYMENTS TO STATE FOR MEDICAL QUAL-
24 ITY ASSURANCE ACTIVITIES.—

1 (A) IN GENERAL.—Any punitive damages
2 imposed under a medical malpractice liability
3 action shall be paid to the State in which the
4 action is brought.

5 (B) ACTIVITIES DESCRIBED.—A State
6 shall use amount paid pursuant to subpara-
7 graph (A) to carry out activities to assure the
8 safety and quality of health care services pro-
9 vided in the State, including (but not limited
10 to)—

11 (i) licensing or certifying health care
12 professionals and health care providers in
13 the State;

14 (ii) operating alternative dispute reso-
15 lution systems;

16 (iii) carrying out public education pro-
17 grams relating to medical malpractice and
18 the availability of alternative dispute reso-
19 lution systems in the State; and

20 (iv) carrying out programs to reduce
21 malpractice-related costs for retired provid-
22 ers or other providers volunteering to pro-
23 vide services in medically underserved
24 areas.

1 (C) MAINTENANCE OF EFFORT.—A State
2 shall use any amounts paid pursuant to sub-
3 paragraph (A) to supplement and not to replace
4 amounts spent by the State for the activities
5 described in subparagraph (B).

6 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—If
7 more than \$100,000 in damages for expenses to be in-
8 curred in the future is awarded to the plaintiff in a medi-
9 cal malpractice liability action, the defendant shall provide
10 for payment for such damages on a periodic basis deter-
11 mined appropriate by the court (based upon projections
12 of when such expenses are likely to be incurred), unless
13 the court determines that it is not in the plaintiff's best
14 interest to receive payments for such damages on such a
15 periodic basis.

16 (d) MANDATORY OFFSETS FOR DAMAGES PAID BY
17 A COLLATERAL SOURCE.—

18 (1) IN GENERAL.—The total amount of dam-
19 ages received by a plaintiff in a medical malpractice
20 liability action shall be reduced (in accordance with
21 paragraph (2)) by any other payment that has been
22 or will be made to the individual to compensate the
23 plaintiff for the injury that was the subject of the
24 action, including payment under—

1 (A) Federal or State disability or sickness
2 programs;

3 (B) Federal, State, or private health insur-
4 ance programs;

5 (C) private disability insurance programs;

6 (D) employer wage continuation programs;

7 and

8 (E) any other source of payment intended
9 to compensate the plaintiff for such injury.

10 (2) AMOUNT OF REDUCTION.—The amount by
11 which an award of damages to a plaintiff shall be re-
12 duced under paragraph (1) shall be—

13 (A) the total amount of any payments
14 (other than such award) that have been made
15 or that will be made to the plaintiff to com-
16 pensate the plaintiff for the injury that was the
17 subject of the action; minus

18 (B) the amount paid by the plaintiff (or by
19 the spouse, parent, or legal guardian of the
20 plaintiff) to secure the payments described in
21 subparagraph (A).

22 **SEC. 216. TREATMENT OF ATTORNEY'S FEES AND OTHER**
23 **COSTS.**

24 (a) LIMITATION ON ATTORNEY'S FEES.—If the
25 plaintiff in a medical malpractice liability action has en-

1 tered into an agreement with the plaintiff's attorney to
2 pay the attorney's fees on a contingency basis, the attor-
3 ney's fees for the action may not exceed—

4 (1) 25 percent of the first \$150,000 of any
5 award or settlement paid to the plaintiff; or

6 (2) 15 percent of any additional amounts paid
7 to the plaintiff.

8 (b) REQUIRING PARTY CONTESTING ADR RULING
9 TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

10 (1) IN GENERAL.—The court in a medical mal-
11 practice liability action shall require the party that
12 (pursuant to section 212(c)(1)) contested the ruling
13 of the alternative dispute resolution system with re-
14 spect to the medical malpractice liability claim that
15 is the subject of the action to pay to the opposing
16 party the costs incurred by the opposing party under
17 the action, including attorney's fees, fees paid to ex-
18 pert witnesses, and other litigation expenses (but not
19 including court costs, filing fees, or other expenses
20 paid directly by the party to the court, or any fees
21 or costs associated with the resolution of the claim
22 under the alternative dispute resolution system), but
23 only if—

24 (A) in the case of an action in which the
25 party that contested the ruling is the plaintiff,

1 the amount of damages awarded to the party
2 under the action does not exceed the amount of
3 damages awarded to the party under the ADR
4 system by at least 10 percent; and

5 (B) in the case of an action in which the
6 party that contested the ruling is the defendant,
7 the amount of damages assessed against the
8 party under the action is not at least 10 per-
9 cent less than the amount of damages assessed
10 under the ADR system.

11 (2) EXCEPTIONS.—Paragraph (1) shall not
12 apply if—

13 (A) the party contesting the ruling made
14 under the previous alternative dispute resolu-
15 tion system shows that—

16 (i) the ruling was procured by corrup-
17 tion, fraud, or undue means,

18 (ii) there was partiality or corruption
19 under the system,

20 (iii) there was other misconduct under
21 the system that materially prejudiced the
22 party's rights, or

23 (iv) the ruling was based on an error
24 of law;

1 (B) the party contesting the ruling made
2 under the previous alternative dispute resolu-
3 tion system presents new evidence before the
4 trier of fact that was not available for presen-
5 tation under the ADR system;

6 (C) the medical malpractice liability action
7 raised a novel issue of law; or

8 (D) the court finds that the application of
9 such paragraph to a party would constitute an
10 undue hardship, and issues an order waiving or
11 modifying the application of such paragraph
12 that specifies the grounds for the court's deci-
13 sion.

14 **SEC. 217. JOINT AND SEVERAL LIABILITY.**

15 The liability of each defendant in a medical mal-
16 practice liability action shall be several only and shall not
17 be joint, and each defendant shall be liable only for the
18 amount of damages allocated to the defendant in direct
19 proportion to the defendant's percentage of responsibility
20 (as determined by the trier of fact).

21 **SEC. 218. UNIFORM STANDARD FOR DETERMINING NEG-**
22 **LIGENCE.**

23 Except as provided in subsection (b), a defendant in
24 a medical malpractice liability action may not be found
25 to have acted negligently unless the defendant's conduct

1 at the time of providing the health care services that are
2 the subject of the action was not reasonable.

3 **SEC. 219. APPLICATION OF MEDICAL PRACTICE GUIDE-**
4 **LINES IN MALPRACTICE LIABILITY ACTIONS.**

5 (a) USE OF GUIDELINES AS AFFIRMATIVE DE-
6 FENSE.—In any medical malpractice liability action, it
7 shall be a complete defense to any allegation that the de-
8 fendant was negligent that, in the provision of (or the fail-
9 ure to provide) the services that are the subject of the
10 action, the defendant followed the appropriate practice
11 guideline.

12 (b) RESTRICTION ON GUIDELINES CONSIDERED AP-
13 PROPRIATE.—

14 (1) GUIDELINES SANCTIONED BY SEC-
15 RETARY.—For purposes of subsection (a), a practice
16 guideline may not be considered appropriate with re-
17 spect to actions brought during a year unless the
18 Secretary has sanctioned the use of the guideline for
19 purposes of an affirmative defense to medical mal-
20 practice liability actions brought during the year in
21 accordance with paragraph (2) or (3).

22 (2) PROCESS FOR SANCTIONING GUIDELINES.—
23 Not less frequently than October 1 of each year (be-
24 ginning with 1994), the Secretary shall review the
25 practice guidelines and standards developed by the

1 Administrator for Health Care Policy and Research
2 pursuant to section 1142 of the Social Security Act,
3 and shall sanction those guidelines which the Sec-
4 retary considers appropriate for purposes of an af-
5 firmative defense to medical malpractice liability ac-
6 tions brought during the next calendar year as ap-
7 propriate practice guidelines for purposes of sub-
8 section (a).

9 (3) USE OF STATE GUIDELINES.—Upon the ap-
10 plication of a State, the Secretary may sanction
11 practice guidelines selected by the State for purposes
12 of an affirmative defense to medical malpractice li-
13 ability actions brought in the State as appropriate
14 practice guidelines for purposes of subsection (a) if
15 the guidelines meet such requirements as the Sec-
16 retary may impose.

17 (c) PROHIBITING APPLICATION OF FAILURE TO FOL-
18 LOW GUIDELINES AS PRIMA FACIE EVIDENCE OF NEG-
19 LIGENCE.—No plaintiff in a medical malpractice liability
20 action may be deemed to have presented prima facie evi-
21 dence that a defendant was negligent solely by showing
22 that the defendant failed to follow the appropriate practice
23 guideline.

1 **SEC. 220. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**
2 **SERVICES.**

3 (a) IMPOSITION OF HIGHER STANDARD OF PROOF.—

4 (1) IN GENERAL.—In the case of a medical
5 malpractice liability action relating to services pro-
6 vided during labor or the delivery of a baby, if the
7 defendant health care professional did not previously
8 treat the plaintiff for the pregnancy, the trier of fact
9 may not find that the defendant committed mal-
10 practice and may not assess damages against the de-
11 fendant unless the malpractice is proven by clear
12 and convincing evidence.

13 (2) APPLICABILITY TO GROUP PRACTICES OR
14 AGREEMENTS AMONG PROVIDERS.—For purposes of
15 paragraph (1), a health care professional shall be
16 considered to have previously treated an individual
17 for a pregnancy if the professional is a member of
18 a group practice whose members previously treated
19 the individual for the pregnancy or is providing serv-
20 ices to the individual during labor or the delivery of
21 a baby pursuant to an agreement with another pro-
22 fessional.

23 (b) CLEAR AND CONVINCING EVIDENCE DEFINED.—

24 In subsection (a), the term “clear and convincing evi-
25 dence” is that measure or degree of proof that will
26 produce in the mind of the trier of fact a firm belief or

1 conviction as to the truth of the allegations sought to be
2 established, except that such measure or degree of proof
3 is more than that required under preponderance of the evi-
4 dence, but less than that required for proof beyond a rea-
5 sonable doubt.

6 (c) EFFECTIVE DATE.—This section shall apply to
7 claims accruing or actions brought on or after the expira-
8 tion of the 2-year period that begins on the date of the
9 enactment of this Act.

10 **SEC. 221. PREEMPTION.**

11 (a) IN GENERAL.—This part supersedes any State
12 law only to the extent that State law—

13 (1) permits the recovery of a greater amount of
14 damages by a plaintiff;

15 (2) permits the collection of a greater amount
16 of attorneys' fees by a plaintiff's attorney;

17 (3) establishes a longer period during which a
18 medical malpractice liability claim may be initiated;
19 or

20 (4) establishes a stricter standard for determin-
21 ing whether a defendant was negligent or for deter-
22 mining the liability of defendants described in sec-
23 tion 220(a) in actions described in such section.

1 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
2 OF LAW OR VENUE.—Nothing in subsection (a) shall be
3 construed to—

4 (1) waive or affect any defense of sovereign im-
5 munity asserted by any State under any provision of
6 law;

7 (2) waive or affect any defense of sovereign im-
8 munity asserted by the United States;

9 (3) affect the applicability of any provision of
10 the Foreign Sovereign Immunities Act of 1976;

11 (4) preempt State choice-of-law rules with re-
12 spect to claims brought by a foreign nation or a citi-
13 zen of a foreign nation; or

14 (5) affect the right of any court to transfer
15 venue or to apply the law of a foreign nation or to
16 dismiss a claim of a foreign nation or of a citizen
17 of a foreign nation on the ground of inconvenient
18 forum.

19 PART 3—REQUIREMENTS FOR ALTERNATIVE DISPUTE
20 RESOLUTION SYSTEMS (ADR)

21 **SEC. 231. BASIC REQUIREMENTS.**

22 (a) IN GENERAL.—A State’s alternative dispute reso-
23 lution system meets the requirements of this section if the
24 system—

1 (1) applies to all medical malpractice liability
2 claims under the jurisdiction of the State courts;

3 (2) requires that a written opinion resolving the
4 dispute be issued not later than 6 months after the
5 date by which each party against whom the claim is
6 filed has received notice of the claim (other than in
7 exceptional cases for which a longer period is re-
8 quired for the issuance of such an opinion), and that
9 the opinion contain—

10 (A) findings of fact relating to the dispute,
11 and

12 (B) a description of the costs incurred in
13 resolving the dispute under the system (includ-
14 ing any fees paid to the individuals hearing and
15 resolving the claim), together with an appro-
16 priate assessment of the costs against any of
17 the parties;

18 (3) requires individuals who hear and resolve
19 claims under the system to meet such qualifications
20 as the State may require (in accordance with regula-
21 tions of the Secretary);

22 (4) is approved by the State or by local govern-
23 ments in the State;

24 (5) with respect to a State system that consists
25 of multiple dispute resolution procedures—

1 (A) permits the parties to a dispute to se-
2 lect the procedure to be used for the resolution
3 of the dispute under the system, and

4 (B) if the parties do not agree on the pro-
5 cedure to be used for the resolution of the dis-
6 pute, assigns a particular procedure to the par-
7 ties;

8 (6) provides for the transmittal to the State
9 agency responsible for monitoring or disciplining
10 health care professionals and health care providers
11 of any findings made under the system that such a
12 professional or provider committed malpractice, un-
13 less, during the 90-day period beginning on the date
14 the system resolves the claim against the profes-
15 sional or provider, the professional or provider
16 brings a medical malpractice liability action contest-
17 ing the decision made under the system; and

18 (7) provides for the regular transmittal to the
19 Administrator for Health Care Policy and Research
20 of information on disputes resolved under the sys-
21 tem, in a manner that assures that the identity of
22 the parties to a dispute shall not be revealed.

23 (b) APPLICATION OF MALPRACTICE LIABILITY
24 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—
25 The provisions of part 2 shall apply with respect to claims

1 brought under a State alternative dispute resolution sys-
2 tem or the alternative Federal system in the same manner
3 as such provisions apply with respect to medical mal-
4 practice liability actions brought in the State.

5 **SEC. 232. CERTIFICATION OF STATE SYSTEMS; APPLICABIL-**
6 **ITY OF ALTERNATIVE FEDERAL SYSTEM.**

7 (a) CERTIFICATION.—

8 (1) IN GENERAL.—Not later than October 1 of
9 each year (beginning with 1994), the Secretary, in
10 consultation with the Attorney General, shall deter-
11 mine whether a State's alternative dispute resolution
12 system meets the requirements of this part for the
13 following calendar year.

14 (2) BASIS FOR CERTIFICATION.—The Secretary
15 shall certify a State's alternative dispute resolution
16 system under this subsection for a calendar year if
17 the Secretary determines under paragraph (1) that
18 the system meets the requirements of section 231.

19 (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-
20 TEM.—

21 (1) ESTABLISHMENT AND APPLICABILITY.—
22 Not later than October 1, 1994, the Secretary, in
23 consultation with the Attorney General, shall estab-
24 lish by rule an alternative Federal ADR system for
25 the resolution of medical malpractice liability claims

1 during a calendar year in States that do not have
2 in effect an alternative dispute resolution system
3 certified under subsection (a) for the year.

4 (2) REQUIREMENTS FOR SYSTEM.—Under the
5 alternative Federal ADR system established under
6 paragraph (1)—

7 (A) paragraphs (1), (2), (6), and (7) of
8 section 231(a) shall apply to claims brought
9 under the system;

10 (B) claims brought under the system shall
11 be heard and resolved by arbitrators appointed
12 by the Secretary in consultation with the Attor-
13 ney General; and

14 (C) with respect to a State in which the
15 system is in effect, the Secretary may (at the
16 State's request) modify the system to take into
17 account the existence of dispute resolution pro-
18 cedures in the State that affect the resolution
19 of medical malpractice liability claims.

20 **SEC. 233. REPORTS ON IMPLEMENTATION AND EFFECTIVE-**
21 **NESS OF ALTERNATIVE DISPUTE RESOLU-**
22 **TION SYSTEMS.**

23 (a) IN GENERAL.—Not later than 5 years after the
24 date of the enactment of this Act, the Secretary shall pre-
25 pare and submit to Congress a report describing and eval-

1 uating State alternative dispute resolution systems oper-
2 ated pursuant to this part and the alternative Federal sys-
3 tem established under section 232(b).

4 (b) CONTENTS OF REPORT.—The Secretary shall in-
5 clude in the report prepared and submitted under sub-
6 section (a)—

7 (1) information on—

8 (A) the effect of such systems on the cost
9 of health care within each State,

10 (B) the impact of such systems on the ac-
11 cess of individuals to health care within the
12 State, and

13 (C) the effect of such systems on the qual-
14 ity of health care provided within the State; and

15 (2) to the extent that such report does not pro-
16 vide information on no-fault systems operated by
17 States as alternative dispute resolution systems pur-
18 suant to this part, an analysis of the feasibility and
19 desirability of establishing a system under which
20 medical malpractice liability claims shall be resolved
21 on a no-fault basis.

1 PART 4—OTHER REQUIREMENTS AND PROGRAMS

2 **SEC. 241. FACILITATING DEVELOPMENT AND USE OF**
3 **MEDICAL PRACTICE GUIDELINES.**

4 (a) INCREASE IN AUTHORIZATION OF APPROPRIA-
5 TIONS.—Section 1142(i)(1) of the Social Security Act (42
6 U.S.C. 1320b–12(i)(1)) is amended by striking “and” at
7 the end of subparagraph (D) and by striking subpara-
8 graph (E) and inserting the following:

9 “(E) \$195,000,000 for fiscal year 1994 (of
10 which \$10,000,000 shall be used for sanction-
11 ing practice guidelines for purposes of an af-
12 firmative defense in medical malpractice liabil-
13 ity actions); and

14 “(F) \$20,000,000 for each of fiscal year
15 1995 and 1996, to be used for sanctioning
16 practice guidelines for purposes of an affirma-
17 tive defense in medical malpractice liability ac-
18 tions.”.

19 (b) CONSIDERATION OF MALPRACTICE LIABILITY
20 DATA IN DEVELOPING AND UPDATING GUIDELINES.—
21 Section 1142(c)(5) of such Act (42 U.S.C. 1320b–
22 12(c)(5)) is amended by striking “claims data” and all
23 that follows through “patients” and inserting the follow-
24 ing: “claims data, data on clinical and functional status

1 of patients, and data on medical malpractice liability ac-
2 tions”.

3 (c) DEVELOPMENT OF REPORTING FORMS FOR
4 STATE ADR SYSTEMS.—The Secretary, in consultation
5 with the Administrator for Health Care Policy and Re-
6 search, shall develop a standard reporting form to be used
7 by State alternative dispute resolution systems in trans-
8 mitting information to the Administrator pursuant to sec-
9 tion 231(a)(6) on disputes resolved under such systems.

10 (d) STUDY OF EFFECT OF GUIDELINES ON MEDICAL
11 MALPRACTICE.—

12 (1) STUDY.—The Secretary shall conduct a
13 study of the effect of the use of the medical practice
14 guidelines developed by the Administrator for Health
15 Care Policy and Research on the incidence of and
16 the costs associated with medical malpractice.

17 (2) REPORTS.—(A) Not later than 1 year after
18 the date of the enactment of this Act, the Secretary
19 shall submit an interim report to Congress describ-
20 ing the availability and use of medical practice
21 guidelines and the aggregate costs associated with
22 medical malpractice.

23 (B) Not later than 5 years after the date of the
24 enactment of this Act, the Secretary shall submit a
25 report to Congress on the study conducted under

1 paragraph (1), together with recommendations re-
2 garding expanding the use of medical practice guide-
3 lines for determining the liability of health care pro-
4 fessionals and health care providers for medical mal-
5 practice.

6 **SEC. 242. PERMITTING STATE PROFESSIONAL SOCIETIES**
7 **TO PARTICIPATE IN DISCIPLINARY ACTIVI-**
8 **TIES.**

9 (a) **ROLE OF PROFESSIONAL SOCIETIES.**—Notwith-
10 standing any other provision of State or Federal law, a
11 State agency responsible for the conduct of disciplinary
12 actions for a type of health care practitioner may enter
13 into agreements with State or county professional societies
14 of such type of health care practitioner to permit such so-
15 cieties to participate in the licensing of such health care
16 practitioner, and to review any health care malpractice ac-
17 tion, health care malpractice claim or allegation, or other
18 information concerning the practice patterns of any such
19 health care practitioner. Any such agreement shall comply
20 with subsection (b).

21 (b) **REQUIREMENTS OF AGREEMENTS.**—Any agree-
22 ment entered into under subsection (a) for licensing activi-
23 ties or the review of any health care malpractice action,
24 health care malpractice claim or allegation, or other infor-

1 mation concerning the practice patterns of a health care
2 practitioner shall provide that—

3 (1) the health care professional society conducts
4 such activities or review as expeditiously as possible;

5 (2) after the completion of such review, such so-
6 ciety shall report its findings to the State agency
7 with which it entered into such agreement;

8 (3) the conduct of such activities or review and
9 the reporting of such findings be conducted in a
10 manner which assures the preservation of confiden-
11 tiality of health care information and of the review
12 process; and

13 (4) no individual affiliated with such society is
14 liable for any damages or injury directly caused by
15 the individual's actions in conducting such activities
16 or review.

17 (c) AGREEMENTS NOT MANDATORY.—Nothing in
18 this section may be construed to require a State to enter
19 into agreements with societies described in subsection (a)
20 to conduct the activities described in such subsection.

21 (d) EFFECTIVE DATE.—This section shall take effect
22 2 years after the date of the enactment of this Act.

1 **SEC. 243. REQUIREMENTS FOR RISK MANAGEMENT PRO-**
2 **GRAMS.**

3 (a) REQUIREMENTS FOR PROVIDERS.—Each State
4 shall require each health care professional and health care
5 provider providing services in the State to participate in
6 a risk management program to prevent and provide early
7 warning of practices which may result in injuries to pa-
8 tients or which otherwise may endanger patient safety.

9 (b) REQUIREMENTS FOR INSURERS.—Each State
10 shall require each entity which provides health care profes-
11 sional or provider liability insurance to health care profes-
12 sionals and health care providers in the State to—

13 (1) establish risk management programs based
14 on data available to such entity or sanction pro-
15 grams of risk management for health care profes-
16 sionals and health care providers provided by other
17 entities; and

18 (2) require each such professional or provider,
19 as a condition of maintaining insurance, to partici-
20 pate in one program described in paragraph (1) at
21 least once in each 3-year period.

22 (c) EFFECTIVE DATE.—This section shall take effect
23 2 years after the date of the enactment of this Act.

24 **SEC. 244. GRANTS FOR MEDICAL SAFETY PROMOTION.**

25 (a) RESEARCH ON MEDICAL INJURY PREVENTION
26 AND COMPENSATION.—

1 (1) IN GENERAL.—The Secretary shall make
2 grants for the conduct of basic research in the pre-
3 vention of and compensation for injuries resulting
4 from health care professional or health care provider
5 malpractice, and research of the outcomes of health
6 care procedures.

7 (2) PREFERENCE FOR RESEARCH ON CERTAIN
8 ACTIVITIES.—In making grants under paragraph
9 (1), the Secretary shall give preference to applica-
10 tions for grants to conduct research on the behavior
11 of health care providers and health care profes-
12 sionals in carrying out their professional duties and
13 of other participants in systems for compensating in-
14 dividuals injured by medical malpractice, the effects
15 of financial and other incentives on such behavior,
16 the determinants of compensation system outcomes,
17 and the costs and benefits of alternative compensa-
18 tion policy options.

19 (3) APPLICATION.—The Secretary may not
20 make a grant under paragraph (1) unless an appli-
21 cant submits an application to the Secretary at such
22 time, in such form, in such manner, and containing
23 such information as the Secretary may require.

24 (b) GRANTS FOR LICENSING AND DISCIPLINARY AC-
25 TIVITIES.—

1 (1) IN GENERAL.—The Secretary shall make
2 grants to States to assist States in improving the
3 States' ability to license and discipline health care
4 professionals.

5 (2) USES FOR GRANTS.—A State may use a
6 grant awarded under subsection (a) to develop and
7 implement improved mechanisms for monitoring the
8 practices of health care professionals or for conduct-
9 ing disciplinary activities.

10 (3) TECHNICAL ASSISTANCE.—The Secretary
11 shall provide technical assistance to States receiving
12 grants under paragraph (1) to assist them in evalu-
13 ating their medical practice acts and procedures and
14 to encourage the use of efficient and effective early
15 warning systems and other mechanisms for detecting
16 practices which endanger patient safety and for dis-
17 ciplining health care professionals.

18 (4) APPLICATIONS.—The Secretary may not
19 make a grant under paragraph (1) unless the appli-
20 cant submits an application to the Secretary at such
21 time, in such form, in such manner, and containing
22 such information as the Secretary shall require.

23 (c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

24 (1) IN GENERAL.—The Secretary shall make
25 grants to States and to local governments, private

1 nonprofit organizations, and health professional
2 schools (as defined in paragraph (3)) for—

3 (A) educating the general public about the
4 appropriate use of health care and realistic ex-
5 pectations of medical intervention;

6 (B) educating the public about the re-
7 sources and role of health care professional li-
8 censing and disciplinary boards in investigating
9 claims of incompetence or health care mal-
10 practice; and

11 (C) developing programs of faculty train-
12 ing and curricula for educating health care pro-
13 fessionals in quality assurance, risk manage-
14 ment, and medical injury prevention.

15 (2) APPLICATIONS.—The Secretary may not
16 make a grant under paragraph (1) unless the appli-
17 cant submits an application to the Secretary at such
18 time, in such form, in such manner, and containing
19 such information as the Secretary shall require.

20 (3) HEALTH PROFESSIONAL SCHOOL DE-
21 FINED.—In paragraph (1), the term “health profes-
22 sional school” means a school of nursing (as defined
23 in section 853(2) of the Public Health Service Act)
24 or an institution described in section 701(4) of such
25 Act.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated not more than
3 \$15,000,000 for each of the first 5 fiscal years beginning
4 on or after the date of the enactment of this Act for grants
5 under this section.

6 **SEC. 245. STUDY OF BARRIERS TO VOLUNTARY SERVICE BY**
7 **PHYSICIANS.**

8 (a) STUDY.—The Secretary shall conduct a study to
9 determine the factors preventing or discouraging physi-
10 cians (whether practicing or retired) from volunteering to
11 provide health care services in medically underserved
12 areas.

13 (b) REPORTS.—(1) Not later than 1 year after the
14 date of the enactment of this Act, the Secretary shall sub-
15 mit an interim report to Congress on the study conducted
16 under subsection (a), together with the Secretary's rec-
17 ommendations for actions to increase the number of physi-
18 cians volunteering to provide health care services in medi-
19 cally underserved areas.

20 (2) Not later than 5 years after the date of the enact-
21 ment of this Act, the Secretary shall submit a final report
22 to Congress on the study conducted under subsection (a)
23 (taking into account the effects of this subtitle on the inci-
24 dence and costs of medical malpractice), together with the
25 Secretary's recommendations for actions to increase the

1 number of physicians volunteering to provide health care
2 services in medically underserved areas.

3 **Subtitle B—Administrative Cost**
4 **Savings**

5 PART 1—STANDARDIZATION OF CLAIMS PROCESSING

6 **SEC. 251. ADOPTION OF DATA ELEMENTS, UNIFORM**
7 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**
8 **MISSION STANDARDS.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services (in this subtitle referred to as the “Sec-
11 retary”) shall adopt standards relating to each of the fol-
12 lowing:

13 (1) Data elements for use in paper and elec-
14 tronic claims processing under health benefit plans,
15 as well as for use in utilization review and manage-
16 ment of care (including data fields, formats, and
17 medical nomenclature, and including plan benefit
18 and insurance information).

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

23 (3) Uniform electronic transmission of the data
24 elements (for purposes of billing and utilization re-
25 view).

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

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

12 (1) the Secretary shall take into account the
13 recommendations of current taskforces, including at
14 least the Workgroup on Electronic Data Inter-
15 change, National Uniform Billing Committee, the
16 Uniform Claim Task Force, and the Computer-based
17 Patient Record Institute;

18 (2) the Secretary shall consult with the Na-
19 tional Association of Insurance Commissioners (and,
20 with respect to standards under subsection (a)(3),
21 the American National Standards Institute); and

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

1 (c) DEADLINES FOR PROMULGATION.—The Sec-
2 retary shall promulgate the standards under—

3 (1) subsection (a)(1) relating to claims process-
4 ing data, by not later than 12 months after the date
5 of the enactment of this Act;

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

9 (3)(A) subsection (a)(3) relating to trans-
10 mission of information concerning hospital and phy-
11 sicians services, by not later than 24 months after
12 the date of the enactment of this Act, and

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

16 (d) REPORT TO CONGRESS.—Not later than 3 years
17 after the date of the enactment of this Act, the Secretary
18 shall report to Congress recommendations regarding re-
19 structuring the medicare peer review quality assurance
20 program given the availability of hospital data in elec-
21 tronic form.

22 **SEC. 252. APPLICATION OF STANDARDS.**

23 (a) IN GENERAL.—If the Secretary determines, at
24 the end of the 2-year period beginning on the date that
25 standards are adopted under section 251 with respect to

1 classes of services, that a significant number of claims for
2 benefits for such services under health benefit plans are
3 not being submitted in accordance with such standards,
4 the Secretary may require, after notice in the Federal
5 Register of not less than 6 months, that all providers of
6 such services must submit claims to health benefit plans
7 in accordance with such standards. The Secretary may
8 waive the application of such a requirement in such cases
9 as the Secretary finds that the imposition of the require-
10 ment would not be economically practicable.

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

18 (c) APPLICATION OF REQUIREMENT.—

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

21 (A) in the case of a requirement that imposes
22 the standards relating to electronic trans-
23 mission of claims for a class of services, each
24 health care provider that furnishes such services
25 for which benefits are payable under a health

1 benefit plan shall transmit electronically and di-
2 rectly to the plan on behalf of the beneficiary
3 involved a claim for such services in accordance
4 with such standards;

5 (B) any health benefit plan may reject any
6 claim subject to the standards adopted under
7 section 251 but which is not submitted in ac-
8 cordance with such standards;

9 (C) it is unlawful for a health benefit plan
10 (i) to reject any such claim on the basis of the
11 form in which it is submitted if it is submitted
12 in accordance with such standards or (ii) to re-
13 quire, for the purpose of utilization review or as
14 a condition of providing benefits under the plan,
15 a provider to transmit medical data elements
16 that are inconsistent with the standards estab-
17 lished under section 251(a)(1); and

18 (D) the Secretary may impose a civil
19 money penalty on any provider that knowingly
20 and repeatedly submits claims in violation of
21 such standards or on any health benefit plan
22 (other than a health benefit plan described in
23 paragraph (2)) that knowingly and repeatedly
24 rejects claims in violation of subparagraph (B),

1 in an amount not to exceed \$100 for each such
2 claim.

3 The provisions of section 1128A of the Social Secu-
4 rity Act (other than the first sentence of subsection
5 (a) and other than subsection (b)) shall apply to a
6 civil money penalty under subparagraph (D) in the
7 same manner as such provisions apply to a penalty
8 or proceeding under section 1128A(a) of such Act.

9 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
10 ULATION.—A plan described in this paragraph is a
11 health benefit plan—

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

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

16 (i) the State provides for application
17 of the standards established under section
18 251, and

19 (ii) the State regulatory program pro-
20 vides for the appropriate and effective en-
21 forcement of such standards.

22 (d) TREATMENT OF REJECTIONS.—If a plan rejects
23 a claim pursuant to subsection (c)(1), the plan shall per-
24 mit the person submitting the claim a reasonable oppor-
25 tunity to resubmit the claim on a form or in an electronic

1 manner that meets the requirements for acceptance of the
2 claim under such subsection.

3 **SEC. 253. PERIODIC REVIEW AND REVISION OF**
4 **STANDARDS.**

5 (a) IN GENERAL.—The Secretary shall—

6 (1) provide for the ongoing receipt and review
7 of comments and suggestions for changes in the
8 standards adopted and promulgated under section
9 251;

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

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

15 (b) APPLICATION OF REVISED STANDARDS.—If the
16 Secretary under subsection (a) revises the standards de-
17 scribed in 251, then, in the case of any claim for benefits
18 submitted under a health benefit plan more than the mini-
19 mum period (of not less than 6 months specified by the
20 Secretary) after the date the revision is promulgated
21 under subsection (a)(3), such standards shall apply under
22 section 252 instead of the standards previously promul-
23 gated.

1 **SEC. 254. HEALTH BENEFIT PLAN DEFINED.**

2 In this subtitle, the term “health benefit plan” has
3 the meaning given such term in section 112(6) and in-
4 cludes—

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

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

10 **PART 2—ELECTRONIC MEDICAL DATA STANDARDS**

11 **SEC. 261. MEDICAL DATA STANDARDS FOR HOSPITALS AND**
12 **OTHER PROVIDERS.**

13 (a) **PROMULGATION OF HOSPITAL DATA STAND-**
14 **ARDS.—**

15 (1) **IN GENERAL.—**Between July 1, 1994, and
16 January 1, 1995, the Secretary shall promulgate
17 standards described in subsection (b) for hospitals
18 concerning electronic medical data.

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

22 (b) **CONTENTS OF DATA STANDARDS.—**The stand-
23 ards promulgated under subsection (a) shall include at
24 least the following:

1 (1) A definition of a standard set of data ele-
2 ments for use by utilization and quality control peer
3 review organizations.

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

8 (3) Standards for an electronic patient care in-
9 formation system with data obtained at the point of
10 care, including standards to protect against the un-
11 authorized use and disclosure of information.

12 (4) A specification of, and manner of presen-
13 tation of, the individual data elements of the sets
14 and system under this subsection.

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

17 (6) Standards relating to confidentiality of pa-
18 tient-specific information.

19 The standards under this section shall be consistent with
20 standards for data elements established under section 251.

21 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-
22 VIDERS.—

23 (1) IN GENERAL.—The Secretary may promul-
24 gate standards described in paragraph (2) concern-
25 ing electronic medical data for providers that are not

1 hospitals. The Secretary may from time to time re-
2 vise the standards promulgated under this sub-
3 section.

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

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

11 (1) consult with the American National Stand-
12 ards Institute, hospitals, with the advisory commis-
13 sion established under section 265, and with other
14 affected providers, health benefit plans, and other
15 interested parties, and

16 (2) take into consideration, in developing stand-
17 ards under subsection (b)(1), the data set used by
18 the utilization and quality control peer review pro-
19 gram under part B of title XI of the Social Security
20 Act.

21 **SEC. 262. APPLICATION OF ELECTRONIC DATA STANDARDS**
22 **TO CERTAIN HOSPITALS.**

23 (a) MEDICARE REQUIREMENT FOR SHARING OF
24 HOSPITAL INFORMATION.—As of January 1, 1996, sub-
25 ject to paragraph (2), each hospital, as a requirement of

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

3 (1) maintain clinical data included in the set of
4 comprehensive data elements under section
5 261(b)(2) in electronic form on all inpatients,

6 (2) upon request of the Secretary or of a utili-
7 zation and quality control peer review organization
8 (with which the Secretary has entered into a con-
9 tract under part B of title XI of such Act), transmit
10 electronically the data set, and

11 (3) upon request of the Secretary, or of a fiscal
12 intermediary or carrier, transmit electronically any
13 data (with respect to a claim) from such data set,
14 in accordance with the standards promulgated under sec-
15 tion 261(a).

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

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

22 (2) The Secretary may waive the application of
23 the requirements of subsection (a) for a hospital
24 that is in the process of developing a system to pro-
25 vide the required data set and executes agreements

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

5 (3) The Secretary may waive the application of
6 the requirement of subsection (a)(1) for a hospital
7 that agrees to obtain from its records the data ele-
8 ments that are needed to meet the requirements of
9 paragraphs (2) and (3) of subsection (a) and agrees
10 to subject its data transfer process to a quality as-
11 surance program specified by the Secretary.

12 (c) APPLICATION TO HOSPITALS OF THE DEPART-
13 MENT OF VETERANS AFFAIRS.—

14 (1) IN GENERAL.—The Secretary of Veterans
15 Affairs shall provide that each hospital of the De-
16 partment of Veterans Affairs shall comply with the
17 requirements of subsection (a) in the same manner
18 as such requirements would apply to the hospital if
19 it were participating in the Medicare program.

20 (2) WAIVER.—Such Secretary may waive the
21 application of such requirements to a hospital in the
22 same manner as the Secretary of Health and
23 Human Services may waive under subsection (b) the
24 application of the requirements of subsection (a).

1 **SEC. 263. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**
2 **CIES.**

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

11 (b) PRESENTATION OR TRANSMISSION STANDARD
12 DEFINED.—In subsection (a), the term “presentation or
13 transmission standard” means a standard, promulgated
14 under subsection (b) or (c) of section 261, described in
15 paragraph (4) or (5) of section 261(b).

16 **SEC. 264. LIMITATION ON DATA REQUIREMENTS WHERE**
17 **STANDARDS IN EFFECT.**

18 (a) IN GENERAL.—If standards with respect to data
19 elements are promulgated under section 261 with respect
20 to a class of provider, a health benefit plan may not re-
21 quire, for the purpose of utilization review or as a condi-
22 tion of providing benefits under the plan, that a provider
23 in the class—

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

1 (2) transmit or present any such data element
2 in a manner inconsistent with the applicable stand-
3 ards for such transmission or presentation.

4 (b) COMPLIANCE.—

5 (1) IN GENERAL.—The Secretary may impose a
6 civil money penalty on any health benefit plan (other
7 than a health benefit plan described in paragraph
8 (2)) that fails to comply with subsection (a) in an
9 amount not to exceed \$100 for each such failure.
10 The provisions of section 1128A of the Social Secu-
11 rity Act (other than the first sentence of subsection
12 (a) and other than subsection (b)) shall apply to a
13 civil money penalty under this paragraph in the
14 same manner as such provisions apply to a penalty
15 or proceeding under section 1128A(a) of such Act.

16 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
17 ULATION.—A plan described in this paragraph is a
18 health benefit plan that is subject to regulation by
19 a State, if the Secretary finds that—

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

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

1 **SEC. 265. ADVISORY COMMISSION.**

2 (a) IN GENERAL.—The Secretary shall establish an
3 advisory commission including hospital executives, hospital
4 data base managers, physicians, health services research-
5 ers, and technical experts in collection and use of data
6 and operation of data systems. Such commission shall in-
7 clude, as ex officio members, a representative of the Direc-
8 tor of the National Institutes of Health, the Administrator
9 for Health Care Policy and Research, the Secretary of
10 Veterans Affairs, and the Director of the Centers for Dis-
11 ease Control.

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

14 (1) the standards established under this part,
15 and

16 (2) operational concerns about the implementa-
17 tion of such standards under this part.

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

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated \$2,000,000 for each of
24 fiscal years 1994 through 1999 to carry out this section.

1 PART 3—DEVELOPMENT AND DISTRIBUTION OF
2 COMPARATIVE VALUE INFORMATION

3 **SEC. 271. STATE COMPARATIVE VALUE INFORMATION PRO-**
4 **GRAMS FOR HEALTH CARE PURCHASING.**

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

11 (b) CRITERIA AND SCHEDULE FOR STATE PRO-
12 GRAMS.—The criteria and schedule for a State health care
13 value information program in this subsection shall be spec-
14 ified by the Secretary as follows:

15 (1) The State begins promptly after enactment
16 of this Act to develop (directly or through contrac-
17 tual or other arrangements with one or more States,
18 coalitions of health insurance purchasers, other enti-
19 ties, or any combination of such arrangements) in-
20 formation systems regarding comparative health val-
21 ues.

22 (2) The information contained in such systems
23 covers at least the average prices of common health
24 care services (as defined in subsection (d)) and
25 health insurance plans, and, where available, meas-

1 ures of the variability of these prices within a State
2 or other market areas.

3 (3) The information described in paragraph (2)
4 is made available within the State beginning not
5 later than one year after the date of the enactment
6 of this Act, and is revised as frequently as reason-
7 ably necessary, but at intervals of no greater than
8 one year.

9 (4) Not later than 6 years after the date of the
10 enactment of this Act the State has developed infor-
11 mation systems that provide comparative costs, qual-
12 ity, and outcomes data with respect to health insur-
13 ance plans and hospitals and made the information
14 broadly available within the relevant market areas.

15 Nothing in this section shall preclude a State from provid-
16 ing additional information, such as information on prices
17 and benefits of different health benefit plans, available.

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

20 (1) GRANT AUTHORITY.—The Secretary may
21 make grants to each State to enable such State to
22 plan the development of its health care value infor-
23 mation program and, if necessary, to initiate the im-
24 plementation of such program. Each State seeking
25 such a grant shall submit an application therefore,

1 containing such information as the Secretary finds
2 necessary to assure that the State is likely to de-
3 velop and implement a program in accordance with
4 the criteria and schedule in subsection (b).

5 (2) OFFSET AUTHORITY.—If, at any time with-
6 in the 3-year period following the receipt by a State
7 of a grant under this subsection, the Secretary is re-
8 quired by section 272 to implement a health care in-
9 formation program in the State, the Secretary may
10 recover the amount of the grant under this sub-
11 section by offset against any other amount payable
12 to the State under the Social Security Act. The
13 amount of the offset shall be made available (from
14 the appropriation account with respect to which the
15 offset was taken) to the Secretary to carry out such
16 section.

17 (3) AUTHORIZATION OF APPROPRIATIONS.—
18 There are authorized to be appropriated such sums
19 as are necessary to make grants under this sub-
20 section, to remain available until expended.

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

1 (e) STATE DEFINED.—In this subtitle, the term
2 “State” includes the District of Columbia, Puerto Rico,
3 the Virgin Islands, Guam, and American Samoa.

4 **SEC. 272. FEDERAL IMPLEMENTATION.**

5 (a) IN GENERAL.—If the Secretary finds, at any
6 time, that a State has failed to develop or to continue to
7 implement a health care value information program in ac-
8 cordance with the criteria and schedule in section 271(b),
9 the Secretary shall take the actions necessary, directly or
10 through grants or contract, to implement a comparable
11 program in the State.

12 (b) FEES.—Fees may be charged by the Secretary
13 for the information materials provided pursuant to a pro-
14 gram under this section. Any amounts so collected shall
15 be deposited in the appropriation account from which the
16 Secretary’s costs of providing such materials were met,
17 and shall remain available for such purposes until ex-
18 pended.

19 **SEC. 273. COMPARATIVE VALUE INFORMATION CONCERN-**
20 **ING FEDERAL PROGRAMS.**

21 (a) DEVELOPMENT.—The head of each Federal agen-
22 cy with responsibility for the provision of health insurance
23 or of health care services to individuals shall promptly de-
24 velop health care value information relating to each pro-
25 gram that such head administers and covering the same

1 types of data that a State program meeting the criteria
2 of section 271(b) would provide.

3 (b) DISSEMINATION OF INFORMATION.—Such infor-
4 mation shall be made generally available to States and to
5 providers and consumers of health care services.

6 **SEC. 274. DEVELOPMENT OF MODEL SYSTEMS.**

7 (a) IN GENERAL.—The Secretary shall, directly or
8 through grant or contract, develop model systems to facili-
9 tate—

10 (1) the gathering of data on health care cost,
11 quality, and outcome described in section 271(b)(4),
12 and

13 (2) analyzing such data in a manner that will
14 permit the valid comparison of such data among
15 providers and among health plans.

16 (b) EXPERIMENTATION.—The Secretary shall sup-
17 port experimentation with different approaches to achieve
18 the objectives of subsection (a) in the most cost effective
19 manner (relative to the accuracy and timeliness of the
20 data secured) and shall evaluate the various methods to
21 determine their relative success.

22 (c) STANDARDS.—When the Secretary considers it
23 appropriate, the Secretary may establish standards for the
24 collection and reporting of data on health care cost, qual-

1 ity and outcomes in order to facilitate analysis and com-
 2 parisons among States and nationally.

3 (e) REPORT.—By not later than 3 years after the
 4 date of the enactment of this Act, the Secretary shall re-
 5 port to the Congress and the States on the models devel-
 6 oped, and experiments conducted, under this section.

7 (e) AUTHORIZATION OF APPROPRIATIONS.—There
 8 are authorized to be appropriated such sums as are nec-
 9 essary for each fiscal year beginning with fiscal year 1993
 10 to enable the Secretary to carry out this section, including
 11 evaluation of the different approaches tested under sub-
 12 section (b) and their relative cost effectiveness.

13 PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS;
 14 RESEARCH AND DEMONSTRATIONS

15 **SEC. 281. STANDARDS RELATING TO USE OF MEDICARE**
 16 **AND MEDICAID MAGNETIZED HEALTH BENE-**
 17 **FIT CARDS; SECONDARY PAYOR DATA BANK.**

18 (a) MAGNETIZED IDENTIFICATION CARDS UNDER
 19 MEDICARE PROGRAM.—The Secretary shall adopt stand-
 20 ards relating to the design and use of magnetized medi-
 21 care identification cards in order to assist health care pro-
 22 viders providing medicare covered services to individuals—

23 (1) in determining whether individuals are eligi-
 24 ble for benefits under the medicare program, and

1 (2) in billing the medicare program for such
2 services provided to eligible individuals.

3 Such cards shall be designed to be compatible with ma-
4 chines currently employed to transmit information on
5 credit cards. Such cards also shall be designed to be able
6 to be used with respect to the provision of benefits under
7 medicare supplemental policies.

8 (b) ADOPTION UNDER MEDICAID PLANS.—

9 (1) IN GENERAL.—The Secretary shall take
10 such steps as may be necessary to encourage and as-
11 sist States to design and use magnetized medicaid
12 identification cards that meet such standards, for
13 use under their medicaid plans.

14 (2) LIMITATION ON MMIS FUNDS.—In applying
15 section 1903(a)(3) of the Social Security Act, the
16 Secretary may determine that Federal financial par-
17 ticipation is not available under that section to a
18 State which has provided for a magnetized card sys-
19 tem that is inconsistent with the standards adopted
20 under subsection (a).

21 (c) MEDICARE AND MEDICAID SECONDARY PAYOR
22 DATA BANK.—The Secretary shall establish a medicare
23 and medicaid information system which is designed to pro-
24 vide information on those group health plans and other
25 health benefit plans that are primary payors to the medi-

1 care program and medicaid program under section
2 1862(b) or section 1905(a)(25) of the Social Security Act.

3 (d) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated, in equal proportions
5 from the Federal Hospital Insurance Trust Fund and
6 from the Federal Supplementary Medical Insurance Trust
7 Fund, a total of \$25,000,000 to carry out subsections (a)
8 and (c), including the issuance of magnetized cards to
9 medicare beneficiaries.

10 **SEC. 282. PREEMPTION OF STATE QUILL PEN LAWS.**

11 (a) IN GENERAL.—Effective January 1, 1994, no ef-
12 fect shall be given to any provision of State law that re-
13 quires medical or health insurance records (including bill-
14 ing information) to be maintained in written, rather than
15 electronic form.

16 (b) SECRETARIAL AUTHORITY.—The Secretary of
17 Health and Human Services may issue regulations to
18 carry out subsection (a). Such regulations may provide for
19 such exceptions to subsection (a) as the Secretary deter-
20 mines to be necessary to prevent fraud and abuse, with
21 respect to controlled substances, and in such other cases
22 as the Secretary deems appropriate.

23 **SEC. 283. USE OF STANDARD IDENTIFICATION NUMBERS.**

24 (a) IN GENERAL.—Effective January 1, 1994, each
25 health benefit plan shall—

1 (1) for each of its beneficiaries that has a social
2 security account number, use that number as the
3 personal identifier for claims processing and related
4 purposes, and

5 (2) for each provider that has a unique identi-
6 fier for purposes of title XVIII of the Social Security
7 Act and that furnishes health care items or services
8 to a beneficiary under the plan, use that identifier
9 as the identifier of that provider for claims process-
10 ing and related purposes.

11 (b) COMPLIANCE.—

12 (1) IN GENERAL.—The Secretary may impose a
13 civil money penalty on any health benefit plan (other
14 than a health benefit plan described in paragraph
15 (2)) that fails to comply with standards established
16 under subsection (a) in an amount not to exceed
17 \$100 for each such failure. The provisions of section
18 1128A of the Social Security Act (other than the
19 first sentence of subsection (a) and other than sub-
20 section (b)) shall apply to a civil money penalty
21 under this paragraph in the same manner as such
22 provisions apply to a penalty or proceeding under
23 section 1128A(a) of such Act.

24 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
25 ULATION.—A plan described in this paragraph is a

1 health benefit plan that is subject to regulation by
2 a State, if the Secretary finds that—

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

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

8 **SEC. 284. COORDINATION OF BENEFIT STANDARDS.**

9 (a) REVIEW OF COORDINATION OF BENEFIT PROB-
10 LEMS.—Between July 1, 1994, and January 1, 1995, the
11 Secretary shall determine whether problems relating to—

12 (1) the rules for determining the liability of
13 health benefit plans when benefits are payable under
14 two or more such plans, or

15 (2) the availability of information among such
16 health benefit plans when benefits are so payable,
17 cause significant administrative costs.

18 (b) CONTINGENT PROMULGATION OF STANDARDS.—

19 (1) IN GENERAL.—If the Secretary determines
20 that such problems do cause significant administra-
21 tive costs that could be significantly reduced through
22 the implementation of standards, the Secretary shall
23 promulgate standards concerning—

1 (A) the liability of health benefit plans
2 when benefits are payable under two or more
3 such plans, and

4 (B) the transfer among health benefit
5 plans of appropriate information (which may in-
6 clude standards for the use of unique identifi-
7 ers, and for the listing of all individuals covered
8 under a health benefit plan) in determining li-
9 ability in cases when benefits are payable under
10 two or more such plans.

11 (2) EFFECTIVE DATE.—The standards promul-
12 gated under paragraph (1) shall become effective on
13 a date specified by the Secretary, which date shall
14 be not earlier than one year after the date of pro-
15 mulgation of the standards.

16 (c) COMPLIANCE.—

17 (1) IN GENERAL.—The Secretary may impose a
18 civil money penalty on any health benefit plan (other
19 than a health benefit plan described in paragraph
20 (2)) that fails to comply with standards promulgated
21 under subsection (b) in an amount not to exceed
22 \$100 for each such failure. The provisions of section
23 1128A of the Social Security Act (other than the
24 first sentence of subsection (a) and other than sub-
25 section (b)) shall apply to a civil money penalty

1 under this paragraph in the same manner as such
2 provisions apply to a penalty or proceeding under
3 section 1128A(a) of such Act.

4 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
5 ULATION.—A plan described in this paragraph is a
6 health benefit plan that is subject to regulation by
7 a State, if the Secretary finds that—

8 (A) the State provides for application of
9 the standards established under subsection (b),
10 and

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

14 (d) REVISION OF STANDARDS.—If the Secretary es-
15 tablishes standards under subsection (b), the Secretary
16 may revise such standards from time to time and such
17 revised standards shall be applied under subsection (c) on
18 or after such date (not earlier than 6 months after the
19 date the revision is promulgated) as the Secretary shall
20 specify.

21 **SEC. 285. RESEARCH AND DEMONSTRATIONS.**

22 (a) DEMONSTRATIONS AND RESEARCH ON MONITOR-
23 ING AND IMPROVING PATIENT CARE.—

24 (1) The Secretary shall provide grants to quali-
25 fied entities to demonstrate (and conduct research

1 concerning) the application of comprehensive infor-
2 mation systems—

3 (A) in continuously monitoring patient
4 care, and

5 (B) in improving patient care.

6 (2) To make grants under this subsection, there
7 are authorized to be appropriated from the Federal
8 Hospital Insurance Trust Fund \$10,000,000 for
9 each fiscal year (beginning with fiscal year 1994 and
10 ending with fiscal year 1998).

11 (b) COMMUNICATION LINKS.—

12 (1) The Secretary may make grants to at least
13 two, but not more than five, community organiza-
14 tions, or coalitions of health care providers, health
15 benefit plans, and purchasers, to establish and docu-
16 ment the efficacy of communication links between
17 the information systems of health benefit plans and
18 of health care providers.

19 (2) To make grants under this subsection, there
20 are authorized to be appropriated such sums as may
21 be necessary for fiscal year 1994, to remain avail-
22 able until expended.

23 (c) REGIONAL OR COMMUNITY BASED CLINICAL IN-
24 FORMATION SYSTEMS.—

1 (1) The Secretary may make grants to at least
2 two, but not more than five, public or private non-
3 profit entities for the development of regional or
4 community-based clinical information systems.

5 (2) To make grants under this subsection, there
6 are authorized to be appropriated such sums as may
7 be necessary for fiscal year 1994, to remain avail-
8 able until expended.

9 (d) AMBULATORY CARE DATA SETS.—

10 (1) The Secretary may make grants to public or
11 private non-profit entities to develop and test, for
12 electronic medical data generated by physicians and
13 other entities (other than hospitals) that provide
14 health care services—

15 (A) the definition of a comprehensive set of
16 data elements, and

17 (B) the specification of, and manner of
18 presentation of, the individual data elements of
19 the set under subparagraph (A).

20 (2) To make grants under this subsection, there
21 are authorized to be appropriated such sums as may
22 be necessary for fiscal year 1994, to remain avail-
23 able until expended.

1 **Subtitle C—Medical Savings**
2 **Accounts (Medisave)**

3 **SEC. 291. MEDICAL SAVINGS ACCOUNTS.**

4 (a) IN GENERAL.—Part III of subchapter B of chap-
5 ter 1 of the Internal Revenue Code of 1986 (relating to
6 items specifically excluded from gross income) is amended
7 by redesignating section 136 as section 137 and by insert-
8 ing after section 135 the following new section:

9 **“SEC. 136. MEDICAL SAVINGS ACCOUNTS.**

10 “(a) EXCLUSION.—Gross income of an employee
11 shall not include any amount contributed during the tax-
12 able year by the employer to a medical savings account
13 of such employee pursuant to a qualified medical savings
14 account plan.

15 “(b) LIMITATION.—The amount contributed by an
16 employer which may be excluded under subsection (a) by
17 any employee for any taxable year shall not exceed the
18 excess (if any) of—

19 “(1) the applicable limit for such taxable year
20 with respect to such employer, over

21 “(2) the employer health plan contributions as
22 defined in subsection (e), if any, by such employer
23 with respect to such employee for such taxable year.

24 “(c) APPLICABLE LIMIT.—For purposes of this sec-
25 tion—

1 “(1) EMPLOYERS MAKING HEALTH PLAN CON-
2 TRIBUTIONS FOR PRIOR PERIOD.—

3 “(A) IN GENERAL.—In the case of an em-
4 ployer to whom this paragraph applies, the ap-
5 plicable limit for any taxable year is the least
6 of—

7 “(i) the adjusted base year employer
8 health plan contributions with respect to
9 the employee,

10 “(ii) the amount equal to the 70th
11 percentile of the per employee health plan
12 expenditures (for the calendar year in
13 which such taxable year begins) for the
14 type of coverage applicable to such em-
15 ployee estimated by the Secretary of
16 Health and Human Services based on a
17 broad, representative survey, or

18 “(iii) the participation adjusted con-
19 tribution limit (as defined in subparagraph
20 (E)).

21 “(B) EMPLOYERS TO WHOM PARAGRAPH
22 APPLIES.—This paragraph shall apply to an
23 employer if—

1 “(i) for a period of consecutive cal-
2 endar years (but not less than 3) during
3 each of which—

4 “(I) the employer made employer
5 health plan contributions for any em-
6 ployee for coverage throughout the
7 calendar year, and

8 “(II) no employee of the em-
9 ployer participated in any medical
10 savings account plan of the employer,
11 and

12 “(ii) there has not been a period of 3
13 consecutive calendar years after the close
14 of such period during each of which the re-
15 quirements of both subclauses (I) and (II)
16 of clause (i) were not met.

17 “(C) ADJUSTED BASE YEAR EMPLOYER
18 HEALTH PLAN CONTRIBUTIONS.—For purposes
19 of subparagraph (A), the adjusted base year
20 employer health plan contributions with respect
21 to an employee are, with respect to the taxable
22 year, the sum of—

23 “(i) the employer health plan con-
24 tributions with respect to a similarly situ-
25 ated employee for the base year, plus

1 “(ii) the product of such amount and
2 the cost-of-living adjustment for the cal-
3 endar year in which such taxable year be-
4 gins, determined under section 1(f)(3) by
5 substituting the calendar year in which the
6 base year begins for the calendar year
7 specified in section 1(f)(3)(B) (and, in the
8 case of a taxable year which is not a cal-
9 endar year, by substituting the last day of
10 the 8th month of such taxable year for
11 ‘August 31’).

12 “(D) BASE YEAR.—For purposes of this
13 section, the term ‘base year’ means the last cal-
14 endar year of the period described in subpara-
15 graph (B)(i) (or, if later, the last calendar year
16 ending before the date of the enactment of this
17 section).

18 “(E) PARTICIPATION ADJUSTED CON-
19 TRIBUTION LIMIT.—

20 “(i) IN GENERAL.—For purposes of
21 subparagraph (A), the participation ad-
22 justed contribution limit is the adjusted
23 base year employer health plan contribu-
24 tions (as defined in subparagraph (C))
25 multiplied by the ratio of—

1 “(I) the participation rate for the
2 base year, to

3 “(II) the participation rate for
4 the taxable year for which the deter-
5 mination under subsection (a) is being
6 made.

7 “(ii) PARTICIPATION RATE.—For pur-
8 poses of clause (i), the participation rate
9 for a year is—

10 “(I) the average number of em-
11 ployees receiving employer-provided
12 health plan coverage (including cov-
13 erage provided under a cafeteria plan,
14 as defined in section 125) for the
15 year, divided by

16 “(II) the average total number of
17 employees for the year.

18 “(2) OTHER EMPLOYERS.—In the case of an
19 employer to whom paragraph (1) does not apply—

20 “(A) IN GENERAL.—Except as provided in
21 subparagraph (B), the applicable limit is the
22 amount described in paragraph (1)(A)(ii), de-
23 termined by substituting ‘50th percentile’ for
24 ‘70th percentile’.

1 “(B) EMPLOYEES OF NEW EMPLOYERS,
2 ETC. INELIGIBLE FOR 3 YEARS.—The applica-
3 ble limit shall be zero for any taxable year be-
4 fore the later of—

5 “(i) the 4th calendar year beginning
6 after the date of the enactment of this sec-
7 tion, or

8 “(ii) the 4th calendar year of the ear-
9 liest 4-year period throughout which the
10 employer is actively engaged in a trade or
11 business.

12 “(d) QUALIFIED MEDICAL SAVINGS ACCOUNT
13 PLAN.—

14 “(1) IN GENERAL.—For purposes of this sec-
15 tion, a qualified medical savings account plan is a
16 separate written plan of the employer for the exclu-
17 sive benefit of his employees and their beneficiaries
18 to provide contributions to medical savings accounts
19 of such employees, but only if such plan meets the
20 requirements of paragraphs (2) through (4).

21 “(2) ELIGIBILITY.—

22 “(A) IN GENERAL.—A plan meets the re-
23 quirements of this paragraph only if—

24 “(i) all employees who participate in
25 the plan are also participants in a health

1 insurance plan maintained by the em-
2 ployer, and

3 “(ii) the employer does not offer to
4 any employee who is eligible to participate
5 in a qualified medical savings account plan
6 any health insurance plan that does not in-
7 volve medical savings accounts.

8 “(B) COLLECTIVE BARGAINING UNITS.—
9 The requirements of this paragraph shall be ap-
10 plied separately to—

11 “(i) employees covered by an agree-
12 ment which the Secretary of Labor finds to
13 be a collective bargaining agreement be-
14 tween employee representatives and one or
15 more employers, and

16 “(ii) other employees.

17 “(3) ALTERNATIVES MUST HAVE SAME ACTUAR-
18 IAL VALUE.—If an employer offers more than 1
19 health plan, a plan of such employer meets the re-
20 quirements of this paragraph only if—

21 “(A) the value of the employer-provided
22 coverage (not including contributions to medical
23 savings accounts) under all such plans is the
24 same for all employees electing the same type of
25 coverage under such plans, and

1 “(B) the value of the employer-provided
2 coverage (including contributions to medical
3 savings accounts) under all such plans is the
4 same for all employees electing the same type of
5 coverage under such plans.

6 “(4) NOTIFICATION OF EMPLOYEES.—A plan
7 meets the requirements of this paragraph if reason-
8 able notification of the availability and terms of the
9 plan is provided to eligible employees.

10 “(5) TREATMENT UNDER ERISA.—A qualified
11 medical savings account plan shall be treated as an
12 employee welfare benefit plan and not as an em-
13 ployee pension benefit plan for purposes of the Em-
14 ployee Retirement Income Security Act of 1974.

15 “(e) EMPLOYER HEALTH PLAN CONTRIBUTIONS.—
16 For purposes of this section—

17 “(1) BASE YEAR.—

18 “(A) IN GENERAL.—The term ‘employer
19 health plan contributions’ means, with respect
20 to any employee for the base year, the average
21 cost per covered employee of employer-provided
22 health plan coverage (including coverage pro-
23 vided under a cafeteria plan (as defined in sec-
24 tion 125)).

1 “(B) SPECIAL RULE FOR SMALL EMPLOY-
2 ERS.—If fewer than 100 individuals were em-
3 ployed by the employer at any time during the
4 base year, subparagraph (A) shall be applied by
5 substituting for the amount described therein
6 such amount as is determined by the Secretary
7 of Health and Human Services to reflect actu-
8 arially determined values of costs of similar em-
9 ployer health plans for employers who employ
10 fewer than 100 individuals.

11 “(2) CURRENT YEAR.—The term ‘employer
12 health plan contributions’ means, with respect to an
13 employee for the taxable year for which the deter-
14 mination under subsection (a) is being made, the
15 sum of—

16 “(A) the average cost per covered employee
17 of employer-provided health plan coverage
18 (other than coverage provided under a cafeteria
19 plan (as defined in section 125)) for such year
20 under each health plan for such employer’s em-
21 ployees, their spouses, and dependents (as de-
22 fined in section 152), plus

23 “(B) the cost of employer-provided health
24 plan coverage for such employee for such year

1 provided under a cafeteria plan (within the
2 meaning of section 125).

3 “(3) SEPARATE DETERMINATIONS FOR CAT-
4 EGORIES OF EMPLOYEES AND SEPARATE LINES OF
5 BUSINESS.—Employer health plan contributions
6 shall be separately determined (both for the base
7 year and the current taxable year) on the basis of:

8 “(A) Types of coverage.

9 “(B) Averages for employees described in
10 each of the following clauses:

11 “(i) Reasonable classifications of em-
12 ployees based on normal work hours per
13 week.

14 “(ii) Retired employees.

15 “(iii) Former employees, other than
16 retired employees.

17 “(iv) Employees covered by an agree-
18 ment which the Secretary of Labor finds to
19 be a collective bargaining agreement be-
20 tween employee representatives and one or
21 more employers, if there is evidence that
22 medical savings account benefits were the
23 subject of good faith bargaining between
24 such employee representatives and such
25 employer or employers. Employees de-

1 scribed in this clause shall be treated as
2 not described in any other clause of this
3 subparagraph.

4 “(C) Employees in separate lines of busi-
5 ness (within the meaning of section 414(r)).

6 “(4) PREDECESSORS.—An employer shall be
7 treated as making the health plan contributions
8 made by any predecessor of such employer (deter-
9 mined under rules similar to the rules applicable
10 under section 414(a)).

11 “(f) OTHER DEFINITIONS.—For purposes of this sec-
12 tion—

13 “(1) EMPLOYER.—The term ‘employer’ includes
14 persons treated as an employer under section
15 401(c)(4).

16 “(2) EMPLOYEE.—The term ‘employee’ in-
17 cludes—

18 “(A) an individual who is an employee
19 within the meaning of section 401(c)(1), and

20 “(B) former employees.

21 “(3) TYPE OF COVERAGE.—The types of cov-
22 erage are—

23 “(A) self-only coverage, and

24 “(B) coverage other than self-only cov-
25 erage.

1 “(4) HEALTH INSURANCE PLAN.—The term
2 ‘health insurance plan’ means any contract or ar-
3 rangement under which an insurer bears all or part
4 of the cost or risk of providing health care items and
5 services, including a hospital or medical expense in-
6 curred policy or certificate, hospital or medical serv-
7 ice plan contract, or health maintenance subscriber
8 contract (including any self-insured health insurance
9 plan), but does not include—

10 “(A) coverage only for accident, dental, vi-
11 sion, disability, or long term care, medicare
12 supplemental health insurance, or any combina-
13 tion thereof,

14 “(B) coverage issued as a supplement to li-
15 ability insurance,

16 “(C) workers’ compensation or similar in-
17 surance, or

18 “(D) automobile medical-payment insur-
19 ance.

20 “(g) DEFINITIONS AND SPECIAL RULES RELATING
21 TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this
22 section—

23 “(1) MEDICAL SAVINGS ACCOUNT.—The term
24 ‘medical savings account’ means a trust created or
25 organized in the United States exclusively for the

1 purpose of paying the medical expenses (as defined
2 in paragraph (2)) with respect to the individual for
3 whose benefit the trust is established, but only if the
4 written governing instrument creating the trust
5 meets the following requirements:

6 “(A) Except in the case of a rollover con-
7 tribution described in subsection (h)(5), no con-
8 tribution will be accepted unless it is in cash
9 and unless it is made by an employer of such
10 individual pursuant to a qualified medical sav-
11 ings account plan of such employer.

12 “(B) The trustee is a bank (as defined in
13 section 408(n)) or another person who dem-
14 onstrates to the satisfaction of the Secretary
15 that the manner in which such person will ad-
16 minister the trust will be consistent with the re-
17 quirements of this section.

18 “(C) No part of the trust assets will be in-
19 vested in life insurance contracts.

20 “(D) The assets of the trust will not be
21 commingled with other property except in a
22 common trust fund or common investment
23 fund.

24 “(E) The interest of an individual in the
25 balance in his account is nonforfeitable.

1 “(2) MEDICAL EXPENSES.—The term ‘medical
2 expenses’ means, with respect to an individual,
3 amounts paid or incurred by the individual for
4 whose benefit the account was established for medi-
5 cal care (as defined in section 213), or long-term
6 care (as defined in paragraph (3)), of such individ-
7 ual, the spouse of such individual, and any depend-
8 ent (as defined in section 152) of such individual,
9 but only to the extent such amounts are not com-
10 pensated for by insurance or otherwise.

11 “(3) LONG-TERM CARE.—

12 “(A) IN GENERAL.—The term ‘long-term
13 care’ means diagnostic, preventive, therapeutic,
14 rehabilitative, maintenance, or personal care
15 services which are required by, and provided to,
16 a chronically ill individual, which have as their
17 primary purpose the direct provision of needed
18 assistance with 1 or more activities of daily liv-
19 ing (or the alleviation of the conditions neces-
20 sitating such assistance) that the individual is
21 certified under subparagraph (B) as being un-
22 able to perform, and which are provided in a
23 setting other than an acute care unit of a hos-
24 pital pursuant to a continuing plan of care pre-
25 scribed by a physician or registered professional

1 nurse. Such term does not include food or lodg-
2 ing provided in an institutional or other setting,
3 or basic living services associated with the
4 maintenance of a household or participation in
5 community life, such as case management,
6 transportation or legal services, or the perform-
7 ance of home maintenance or household chores.

8 “(B) CHRONICALLY ILL INDIVIDUAL.—The
9 term ‘chronically ill individual’ means an indi-
10 vidual who is certified by a physician or reg-
11 istered professional nurse as being unable to
12 perform at least 3 activities of daily living with-
13 out substantial assistance from another individ-
14 ual. For purposes of this paragraph, the term
15 ‘activities of daily living’ means bathing, dress-
16 ing, eating, toileting, transferring, and walking.

17 “(4) TIME WHEN CONTRIBUTIONS DEEMED
18 MADE.—A contribution shall be deemed to be made
19 on the last day of the preceding taxable year if the
20 contribution is made on account of such taxable year
21 and is made not later than the time prescribed by
22 law for filing the return for such taxable year (not
23 including extensions thereof).

24 “(h) TAX TREATMENT OF DISTRIBUTIONS.—

1 “(1) IN GENERAL.—Any amount paid or dis-
2 tributed out of a medical savings account shall be in-
3 cluded in the gross income of the individual for
4 whose benefit such account was established unless—

5 “(A) such amount is used exclusively to
6 pay the medical expenses with respect to such
7 individual, or

8 “(B) such amount is treated as a payment
9 or distribution of amounts which are, or have
10 been, includible in the gross income of the indi-
11 vidual under subsection (i).

12 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
13 FORE DUE DATE OF RETURN.—Paragraph (1) shall
14 not apply to the distribution of any contribution paid
15 during a taxable year to a medical savings account
16 to the extent that such contribution exceeds the
17 amount excludable under subsection (a) if—

18 “(A) such distribution is received by the
19 individual on or before the last day prescribed
20 by law (including extensions of time) for filing
21 such individual’s return for such taxable year,
22 and

23 “(B) such distribution is accompanied by
24 the amount of net income attributable to such
25 excess contribution.

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

4 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
5 FOR MEDICAL EXPENSES.—The tax imposed by this
6 chapter for any taxable year in which there is a pay-
7 ment or distribution from a medical savings account
8 which is not used to pay the medical expenses with
9 respect to the individual for whose benefit the ac-
10 count was established shall be increased by 10 per-
11 cent of the amount of such payment or distribution
12 which is includible in gross income under paragraph
13 (1).

14 “(4) ORDERING RULE.—

15 “(A) DISTRIBUTIONS FOR MEDICAL EX-
16 PENSES.—Any payment or distribution from a
17 medical savings account which is used exclu-
18 sively to pay the medical expenses with respect
19 to the individual for whose benefit such account
20 was established shall be treated as first attrib-
21 utable to untaxed amounts and then to pre-
22 viously taxed amounts.

23 “(B) DISTRIBUTIONS NOT FOR MEDICAL
24 EXPENSES.—Any payment or distribution from
25 a medical savings account which is not used ex-

1 clusively to pay the medical expenses with re-
2 spect to the individual for whose benefit such
3 account was established shall be treated as first
4 attributable to previously taxed amounts and
5 then to untaxed amounts.

6 “(C) DEFINITIONS.—For purposes of this
7 paragraph—

8 “(i) the term ‘previously taxed
9 amount’ means any amount which is or
10 was includible under subsection (i) in the
11 gross income of the individual for whose
12 benefit such account was established, and

13 “(ii) the term ‘untaxed amount’
14 means any amount which is not a pre-
15 viously taxed amount.

16 “(5) ROLLOVERS.—Paragraph (1) shall not
17 apply to any amount paid or distributed out of a
18 medical savings account to the individual for whose
19 benefit the account is maintained if the entire
20 amount received (including money and any other
21 property) is paid into another medical savings ac-
22 count for the benefit of such individual not later
23 than the 60th day after the day on which he received
24 the payment or distribution.

25 “(i) TAX TREATMENT OF ACCOUNTS.—

1 “(1) ACCOUNT TAXED AS GRANTOR TRUST.—
2 The individual for whose benefit a medical savings
3 account is established shall be treated for purposes
4 of this title as the owner thereof and shall be subject
5 to tax thereon in accordance with subpart E of part
6 I of subchapter J of this chapter (relating to
7 grantors and others treated as substantial owners).

8 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-
9 GAGES IN PROHIBITED TRANSACTION.—

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

17 “(B) ACCOUNT TREATED AS DISTRIBUTING
18 ALL ITS ASSETS.—In any case in which any ac-
19 count ceases to be a medical savings account by
20 reason of subparagraph (A) on the first day of
21 any taxable year, paragraph (1) of subsection
22 (h) shall be applied as if there were a distribu-
23 tion on such first day in an amount equal to
24 the fair market value (on such first day) of all
25 assets in the account (on such first day) and no

1 portion of such distribution were used to pay
2 medical expenses.

3 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
4 RITY.—If, during any taxable year, the individual for
5 whose benefit a medical savings account was estab-
6 lished uses the account or any portion thereof as se-
7 curity for a loan, the portion so used is treated as
8 distributed to that individual and not used to pay
9 medical expenses.

10 “(j) CUSTODIAL ACCOUNTS.—For purposes of this
11 section, a custodial account shall be treated as a trust if—

12 “(1) the assets of such account are held by a
13 bank (as defined in section 408(n)) or another per-
14 son who demonstrates to the satisfaction of the Sec-
15 retary that the manner in which he will administer
16 the account will be consistent with the requirements
17 of this section, and

18 “(2) the custodial account would, except for the
19 fact that it is not a trust, constitute a medical sav-
20 ings account described in subsection (g).

21 For purposes of this title, in the case of a custodial ac-
22 count treated as a trust by reason of the preceding sen-
23 tence, the custodian of such account shall be treated as
24 the trustee thereof.

1 “(k) REPORTS.—The trustee of a medical savings ac-
2 count shall make such reports regarding such account to
3 the Secretary and to the individual for whose benefit the
4 account is maintained with respect to contributions, dis-
5 tributions, and such other matters as the Secretary may
6 require under regulations. The reports required by this
7 subsection shall be filed at such time and in such manner
8 and furnished to such individuals at such time and in such
9 manner as may be required by those regulations.”

10 (b) EXCLUSION APPLIES FOR EMPLOYMENT TAX
11 PURPOSES.—

12 (1) SOCIAL SECURITY TAXES.—

13 (A) Paragraph (20) of section 3121(a) of
14 such Code is amended by striking “or 132” and
15 inserting “132, or 136”.

16 (B) Paragraph (17) of section 209(a) of
17 the Social Security Act is amended by striking
18 “or 132” and inserting “132, or 136”.

19 (2) RAILROAD RETIREMENT TAX.—Paragraph
20 (5) of section 3231(e) of such Code is amended by
21 striking “or 132” and inserting “132, or 136”.

22 (3) UNEMPLOYMENT TAX.—Paragraph (16) of
23 section 3306(b) of such Code is amended by striking
24 “or 132” and inserting “132, or 136”.

1 (4) WITHHOLDING TAX.—Paragraph (19) of
2 section 3401(a) of such Code is amended by striking
3 “or 132” and inserting “, 132, or 136”.

4 (c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
5 of such Code (relating to tax on excess contributions to
6 individual retirement accounts, certain section 403(b) con-
7 tracts, and certain individual retirement annuities) is
8 amended—

9 (1) by inserting “**MEDICAL SAVINGS AC-**
10 **ACCOUNTS,**” after “**ACCOUNTS,**” in the heading of
11 such section,

12 (2) by redesignating paragraph (2) of sub-
13 section (a) as paragraph (3) and by inserting after
14 paragraph (1) the following:

15 “(2) a medical savings account (within the
16 meaning of section 136(g)),”,

17 (3) by striking “or” at the end of paragraph
18 (1) of subsection (a), and

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

21 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
22 ACCOUNTS.—For purposes of this section, in the case of
23 a medical savings account (within the meaning of section
24 136(g)), the term ‘excess contributions’ means the amount
25 by which the amount contributed for the taxable year to

1 the account exceeds the amount excludable from gross in-
2 come under section 136 for such taxable year. For pur-
3 poses of this subsection, any contribution which is distrib-
4 uted out of the medical savings account in a distribution
5 to which section 136(h)(2) applies shall be treated as an
6 amount not contributed.”

7 (d) TAX ON PROHIBITED TRANSACTIONS.—Section
8 4975 of such Code (relating to prohibited transactions)
9 is amended—

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

12 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
13 COUNTS.—An individual for whose benefit a medical
14 savings account (within the meaning of section
15 136(g)) is established shall be exempt from the tax
16 imposed by this section with respect to any trans-
17 action concerning such account (which would other-
18 wise be taxable under this section) if, with respect
19 to such transaction, the account ceases to be a medi-
20 cal savings account by reason of the application of
21 section 136(h)(2)(A) to such account.”, and

22 (2) by inserting “or a medical savings account
23 described in section 136(g)” in subsection (e)(1)
24 after “described in section 408(a)”.

1 (e) FAILURE TO PROVIDE REPORTS ON MEDICAL
2 SAVINGS ACCOUNTS.—Section 6693 of such Code (relat-
3 ing to failure to provide reports on individual retirement
4 account or annuities) is amended—

5 (1) by inserting “**OR ON MEDICAL SAVINGS**
6 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
7 such section, and

8 (2) by adding at the end of subsection (a) the
9 following: “The person required by section 136(k) to
10 file a report regarding a medical savings account at
11 the time and in the manner required by such section
12 shall pay a penalty of \$50 for each failure unless it
13 is shown that such failure is due to reasonable
14 cause.”

15 (f) MEDICAL SAVINGS ACCOUNTS NOT TREATED AS
16 WELFARE BENEFIT FUNDS.—Paragraph (3)(B) of sec-
17 tion 419(e) of such Code (defining a fund) is amended
18 by inserting “other than a medical savings account within
19 the meaning of section 136” after “this chapter”.

20 (g) CLERICAL AMENDMENTS.—

21 (1) The table of sections for part III of sub-
22 chapter B of chapter 1 of such Code is amended by
23 striking the last item and inserting the following:

“Sec. 136. Medical savings accounts.

“Sec. 137. Cross references to other Acts.”

1 “(A) GENERAL RULE.—No payment shall
2 be made under this title to a State with respect
3 to expenditures incurred by it for payment to a
4 risk contracting entity or primary care case
5 management entity (as defined in subparagraph
6 (B)), or with respect to an undertaking de-
7 scribed in paragraph (6), unless the State and
8 the entity or undertaking meet the applicable
9 requirements of this subsection. For purposes
10 of determining whether payment may be made
11 under this section, the Secretary may reject a
12 State’s determination of compliance with any
13 provision of this subsection.

14 “(B) GENERAL DEFINITIONS.—For pur-
15 poses of this title—

16 “(i) RISK CONTRACTING ENTITY.—
17 The term ‘risk contracting entity’ means
18 an entity that has a contract with the
19 State agency under which the entity—

20 “(I) provides or arranges for the
21 provision of health care items or serv-
22 ices to individuals eligible for medical
23 assistance under the State plan under
24 this title, and

1 “(II) is at risk (as defined in
2 clause (iv)) for part or all of the cost
3 of such items or services furnished to
4 such individuals.

5 “(ii) PRIMARY CARE CASE MANAGE-
6 MENT PROGRAM.—The term ‘primary care
7 case management program’ means a State
8 program under which individuals eligible
9 for medical assistance under the State plan
10 under this title are enrolled with primary
11 care case management entities, and are en-
12 titled to receive specified health care items
13 and services covered under such plan only
14 as arranged for and approved by such enti-
15 ties.

16 “(iii) AT RISK.—An entity is ‘at risk’,
17 for purposes of this subparagraph, if it has
18 a contract with the State agency under
19 which it is paid a fixed amount for provid-
20 ing or arranging for the provision of speci-
21 fied health care items or services to an in-
22 dividual eligible for medical assistance and
23 enrolled with the entity, regardless of
24 whether such items or services are fur-
25 nished to such individual, and is liable for

1 all or part of the cost of furnishing such
2 items or services, regardless of whether or
3 the extent to which such cost exceeds such
4 fixed payment.

5 “(iv) PRIMARY CARE CASE MANAGE-
6 MENT ENTITY.—The term ‘primary care
7 case management entity’ means a health
8 care provider (whether an individual or an
9 entity) that, under a State primary care
10 case management program meeting the re-
11 quirements of paragraph (7), has a con-
12 tract with the State agency under which
13 the entity arranges for or authorizes the
14 provision of health care items and services
15 to individuals eligible for medical assist-
16 ance under the State plan under this title,
17 but is not at risk (as defined in clause (iv))
18 for the cost of such items or services pro-
19 vided to such individuals.

20 “(2) GENERAL REQUIREMENTS FOR RISK CON-
21 TRACTING ENTITIES.—

22 “(A) FEDERAL OR STATE QUALIFICA-
23 TION.—Subject to paragraph (3), a risk con-
24 tracting entity meets the requirements of this
25 subsection only if it either—

1 “(i) is a qualified health maintenance
2 organization as defined in section 1310(d)
3 of the Public Health Service Act, as deter-
4 mined by the Secretary pursuant to section
5 1312 of that Act, or

6 “(ii) is an entity which the State
7 agency has determined—

8 “(I) affords, to individuals eligi-
9 ble for medical assistance under the
10 State plan and enrolled with the en-
11 tity, access to health care items and
12 services furnished by the entity, with-
13 in the area served by the entity, at
14 least equivalent to the access such in-
15 dividuals would have to such health
16 care items and services in such area if
17 not enrolled with the entity, and

18 “(II) has made adequate provi-
19 sion against the risk of insolvency,
20 and assures that individuals eligible
21 for medical assistance under this title
22 are not held liable for the entity’s
23 debts in case of the entity’s insol-
24 vency.

1 “(B) INTERNAL QUALITY ASSURANCE.—
2 Subject to paragraph (3), a risk contracting en-
3 tity meets the requirements of this subsection
4 only if it has in effect an internal quality assur-
5 ance program that meets the requirements of
6 paragraph (9).

7 “(C) CONTRACT WITH STATE AGENCY.—
8 Subject to paragraph (3), a risk contracting en-
9 tity meets the requirements of this subsection
10 only if the entity has a written contract with
11 the State agency that provides—

12 “(i) that the entity will comply with
13 all applicable provisions of this subsection;

14 “(ii) for a payment methodology based
15 on experience rating or another actuarially
16 sound methodology approved by the Sec-
17 retary, which guarantees (as demonstrated
18 by such models or formulas as the Sec-
19 retary may approve) that payments to the
20 entity under the contract shall not exceed
21 100 percent of expenditures that would
22 have been made by the State agency in the
23 absence of the contract;

24 “(iii) that the Secretary and the State
25 (or any person or organization designated

1 by either) shall have the right to audit and
2 inspect any books and records of the entity
3 (and of any subcontractor) that pertain—

4 “(I) to the ability of the entity to
5 bear the risk of potential financial
6 losses, or

7 “(II) to services performed or de-
8 terminations of amounts payable
9 under the contract;

10 “(iv) that in the entity’s enrollment,
11 reenrollment, or disenrollment of individ-
12 uals eligible for medical assistance under
13 this title and eligible to enroll, reenroll, or
14 disenroll with the entity pursuant to the
15 contract, the entity will not discriminate
16 among such individuals on the basis of
17 their health status or requirements for
18 health care services;

19 “(v)(I) that individuals eligible for
20 medical assistance under the State plan
21 who have enrolled with the entity are per-
22 mitted to terminate such enrollment with-
23 out cause as of the beginning of the first
24 calendar month following a full calendar
25 month after the request is made for such

1 termination (or at such times as required
2 pursuant to paragraph (8)), and

3 “(II) for notification of each such in-
4 dividual, at the time of the individual’s en-
5 rollment, of the right to terminate enroll-
6 ment;

7 “(vi) for reimbursement, either by the
8 entity or by the State agency, for medically
9 necessary services provided—

10 “(I) to an individual eligible for
11 medical assistance under the State
12 plan and enrolled with the entity, and

13 “(II) other than through the en-
14 tity because the services were imme-
15 diately required due to an unforeseen
16 illness, injury, or condition;

17 “(vii) for disclosure of information in
18 accordance with paragraph (4) and section
19 1124;

20 “(viii) in the case of an entity that
21 has entered into a contract with a Feder-
22 ally-qualified health center for the provi-
23 sion of services of such center—

24 “(I) that rates of prepayment
25 from the State are adjusted to reflect

1 fully the rates of payment specified in
2 section 1902(a)(13)(E), and

3 “(II) that, at the election of such
4 center, payments made by the entity
5 to such center for services described
6 in section 1905(a)(2)(C) are made at
7 the rates of payment specified in sec-
8 tion 1902(a)(13)(E);

9 “(ix) that any physician incentive plan
10 that the entity operates meets the require-
11 ments of section 1876(i)(8);

12 “(x) for maintenance of sufficient pa-
13 tient encounter data to identify the physi-
14 cian who delivers services to patients; and

15 “(xi) that the entity complies with the
16 requirement of section 1902(w) with re-
17 spect to each enrollee.

18 “(3) EXCEPTIONS TO REQUIREMENTS FOR RISK
19 CONTRACTING ENTITIES.—The requirements of
20 paragraph (2) (other than subparagraph (C)(viii))
21 do not apply to an entity that—

22 “(A)(i) received a grant of at least
23 \$100,000 in the fiscal year ending June 30,
24 1976, under section 329(d)(1)(A) or 330(d)(1)
25 of the Public Health Service Act, and for the

1 period beginning July 1, 1976, and ending on
2 the expiration of the period for which payments
3 are to be made under this title, has been the re-
4 cipient of a grant under either such section;
5 and

6 “(ii) provides to its enrollees, on a prepaid
7 capitation or other risk basis, all of the services
8 described in paragraphs (1), (2), (3), (4)(C),
9 and (5) of section 1905(a) and, to the extent
10 required by section 1902(a)(10)(D) to be pro-
11 vided under the State plan, the services de-
12 scribed in section 1905(a)(7);

13 “(B) is a nonprofit primary health care en-
14 tity located in a rural area (as defined by the
15 Appalachian Regional Commission)—

16 “(i) which received in the fiscal year
17 ending June 30, 1976, at least \$100,000
18 (by grant, subgrant, or subcontract) under
19 the Appalachian Regional Development Act
20 of 1965), and

21 “(ii) for the period beginning July 1,
22 1976, and ending on the expiration of the
23 period for which payments are to be made
24 under this title either has been the recipi-
25 ent of a grant, subgrant, or subcontract

1 under such Act or has provided services
2 under a contract (initially entered into dur-
3 ing a year in which the entity was the re-
4 cipient of such a grant, subgrant, or sub-
5 contract) with a State agency under this
6 title on a prepaid capitation or other risk
7 basis; or

8 “(C) which has contracted with the State
9 agency for the provision of services (but not in-
10 cluding inpatient hospital services) to persons
11 eligible for medical assistance under this title
12 on a prepaid risk basis prior to 1970.”; and

13 (2) by adding after paragraph (6) the following
14 new paragraphs:

15 “(7) GENERAL REQUIREMENTS FOR PRIMARY
16 CARE CASE MANAGEMENT.—A State that elects in
17 its State plan under this title to implement a pri-
18 mary care case management program under this
19 subsection shall include in the plan methods for the
20 selection and monitoring of participating primary
21 care case management entities to ensure that—

22 “(A) the numbers, geographic locations,
23 hours of operation, and other relevant charac-
24 teristics of such entities are sufficient to afford
25 individuals eligible for medical assistance rea-

1 sonable access to and choice among such enti-
2 ties;

3 “(B) such entities and their professional
4 personnel are qualified to provide health care
5 case management services, through methods in-
6 cluding ongoing monitoring of compliance with
7 applicable requirements for licensing of health
8 care providers, providing training and certifi-
9 cation of primary care case managers, and pro-
10 viding information and technical assistance; and

11 “(C) such entities are making timely and
12 appropriate decisions with respect to enrollees’
13 need for health care items and services, and are
14 giving timely approval and referral to providers
15 of adequate quality where such items and serv-
16 ices are determined to be medically necessary.

17 “(8) STATE OPTIONS WITH RESPECT TO EN-
18 ROLLMENT AND DISENROLLMENT.—

19 “(A) MANDATORY ENROLLMENT OP-
20 TION.—A State plan may require an individual
21 eligible for medical assistance under the State
22 plan (other than a medicare qualified bene-
23 ficiary) to enroll with a risk contracting entity
24 or primary care case management entity, with-
25 out regard to the requirement of section

1 1902(a)(1) (concerning Statewideness), the re-
2 quirements of section 1902(a)(10)(B) (concern-
3 ing comparability of benefits), or the require-
4 ments of section 1902(a)(23) (concerning free-
5 dom of choice of provider), if the individual is
6 permitted a choice—

7 “(i) between or among two or more
8 risk contracting entities,

9 “(ii) between a risk contracting entity
10 and a primary care case management en-
11 tity, or

12 “(iii) between or among two or more
13 primary care case management entities.

14 “(B)(i) RESTRICTIONS ON
15 DISENROLLMENT WITHOUT CAUSE.—A State
16 plan may restrict the period in which individ-
17 uals enrolled with a qualifying risk contracting
18 entity (as defined in clause (ii)) may terminate
19 such enrollment without cause to the first
20 month of each period of enrollment (as defined
21 in clause (iii)), but only if the State provides
22 notification, at least once during each such en-
23 rollment period, to individuals enrolled with
24 such entity of the right to terminate such en-
25 rollment and the restriction on the exercise of

1 this right. Such restriction shall not apply to
2 requests for termination of enrollment for
3 cause.

4 “(ii) For purposes of this subparagraph,
5 the term ‘qualifying risk contracting entity’
6 means a risk contracting entity that is—

7 “(I) a qualified health maintenance
8 organization as defined in section 1310(d)
9 of the Public Health Service Act;

10 “(II) an eligible organization with a
11 contract under section 1876;

12 “(III) an entity that is receiving (and
13 has received during the previous 2 years)
14 a grant of at least \$100,000 under section
15 329(d)(1)(A) or 330(d)(1) of the Public
16 Health Service Act;

17 “(IV) an entity that is receiving (and
18 has received during the previous 2 years)
19 at least \$100,000 (by grant, subgrant, or
20 subcontract) under the Appalachian Re-
21 gional Development Act of 1965;

22 “(V) a program pursuant to an under-
23 taking described in paragraph (6) in which
24 at least 25 percent of the membership en-
25 rolled on a prepaid basis are individuals

1 who (I) are not insured for benefits under
2 part B of title XVIII or eligible for medical
3 assistance under this title, and (II) (in the
4 case of such individuals whose prepay-
5 ments are made in whole or in part by any
6 government entity) had the opportunity at
7 the time of enrollment in the program to
8 elect other coverage of health care costs
9 that would have been paid in whole or in
10 part by any governmental entity; or

11 “(VI) an entity that, on the date of
12 enactment of this provision, had a contract
13 with the State agency under a waiver
14 under section 1115 or 1915(b) and was
15 not subject to a requirement under this
16 subsection to permit disenrollment without
17 cause.

18 “(iii) For purposes of this subparagraph,
19 the term ‘period of enrollment’ means—

20 “(I) a period not to exceed 6 months
21 in duration, or

22 “(II) a period not to exceed one year
23 in duration, in the case of a State that, on
24 the effective date of this subparagraph,
25 had in effect a waiver under section 1115

1 of requirements under this title under
2 which the State could establish a 1-year
3 minimum period of enrollment with risk
4 contracting entities.

5 “(C) REENROLLMENT OF INDIVIDUALS
6 WHO REGAIN ELIGIBILITY.—In the case of an
7 individual who—

8 “(i) in a month is eligible for medical
9 assistance under the State plan and en-
10 rolled with a risk contracting entity with a
11 contract under this subsection,

12 “(ii) in the next month (or next 2
13 months) is not eligible for such medical as-
14 sistance, but

15 “(iii) in the succeeding month is again
16 eligible for such benefits,

17 the State plan may enroll the individual for
18 that succeeding month with such entity, if the
19 entity continues to have a contract with the
20 State agency under this subsection.

21 “(9) REQUIREMENTS FOR INTERNAL QUALITY
22 ASSURANCE PROGRAMS.—The requirements for an
23 internal quality assurance program of a risk con-
24 tracting entity are that program is written and the
25 program—

1 “(A) specifies a systematic process includ-
2 ing ongoing monitoring, corrective action, and
3 other appropriate activities to achieve specified
4 and measurable goals and objectives for quality
5 of care, and including annual evaluation of the
6 program;

7 “(B) identifies the organizational units re-
8 sponsible for performing specific quality assur-
9 ance functions, and ensure that they are ac-
10 countable to the governing body of the entity
11 and that they have adequate supervision, staff,
12 and other necessary resources to perform these
13 functions effectively;

14 “(C) if any quality assistance functions are
15 delegated to other entities, ensures that the risk
16 contracting entity remains accountable for all
17 quality assurance functions, and has mecha-
18 nisms to ensure that all quality assurance ac-
19 tivities are carried out;

20 “(D) includes methods to ensure that phy-
21 sicians and other health care professionals
22 under contract with the entity are qualified to
23 perform the services they provide, and that
24 these qualifications are ensured through appro-

1 appropriate credentialing and recredentialing proce-
2 dures;

3 “(E) includes policies addressing enrollee
4 rights and responsibilities, including grievance
5 mechanisms and mechanisms to inform enroll-
6 ees about access to and use of services provided
7 by the entity;

8 “(F) provides for continuous monitoring of
9 the delivery of health care, including—

10 “(i) identification of clinical areas to
11 be monitored,

12 “(ii) use of quality indicators and
13 standards for assessing care delivered, in-
14 cluding availability and accessibility of
15 care,

16 “(iii) monitoring, through use of epi-
17 demiological data or chart review, the care
18 of individuals, as appropriate, and patterns
19 of care overall, and

20 “(iv) implementation of corrective ac-
21 tions; and

22 “(G) meets any other requirements pre-
23 scribed by the Secretary after consultation with
24 States.

1 “(10) INDEPENDENT REVIEW AND QUALITY AS-
2 SURANCE.—

3 “(A) STATE GRIEVANCE PROCEDURE.—A
4 State contracting with a risk contracting entity
5 or primary care case management entity under
6 this subsection shall provide for a grievance
7 procedure for enrollees of such entity with at
8 least the following elements:

9 “(i) A toll-free telephone number for
10 enrollee questions and grievances.

11 “(ii) A State-operated enrollee griev-
12 ance procedure.

13 “(iii) Periodic notification of enrollees
14 of their rights with respect to such entity
15 or program.

16 “(iv) Periodic sample reviews of griev-
17 ances registered with such entity or pro-
18 gram or with the State.

19 “(v) Periodic survey and analysis of
20 enrollee satisfaction with such entity or
21 program.

22 “(B) STATE MONITORING OF RISK CON-
23 TRACTING ENTITIES’ QUALITY ASSURANCE PRO-
24 GRAMS.—A State contracting with a risk con-
25 tracting entity under this subsection shall peri-

1 odically review such entity’s quality assurance
2 program to ensure that it meets the require-
3 ments of paragraph (9).

4 “(C) EXTERNAL INDEPENDENT REVIEW
5 OF INTERNAL QUALITY ASSURANCE.—A State
6 contracting with a risk contracting entity under
7 this subsection shall provide for annual external
8 independent review (by a utilization control and
9 peer review organization with a contract under
10 section 1153, or another organization unaffili-
11 ated with the State government approved by the
12 Secretary) of such entity’s internal quality as-
13 surance activities. Such independent review
14 shall include—

15 “(i) review of the entity’s medical
16 care, through sampling of medical records
17 or other appropriate methods, for indica-
18 tions of inappropriate utilization and treat-
19 ment,

20 “(ii) review of enrollee inpatient and
21 ambulatory data, through sampling of
22 medical records or other appropriate meth-
23 ods, to determine quality trends,

24 “(iii) review of the entity’s internal
25 quality assurance activities, and

1 “(iv) notification of the entity and the
2 State, and appropriate followup activities,
3 when the review under this subparagraph
4 indicates inappropriate care or treat-
5 ment.”.

6 (b) STATE OPTION TO GUARANTEE MEDICAID ELIGI-
7 BILITY.—Section 1902(e)(2) of such Act (42 U.S.C.
8 1396a(e)(2)) is amended—

9 (A) in subparagraph (A), by striking all
10 that precedes “(but for this paragraph)” and
11 inserting “In the case of an individual who is
12 enrolled—

13 “(i) with a risk contracting entity (as
14 defined in section 1903(m)(1)(B)(i)) re-
15 sponsible for the provision of inpatient hos-
16 pital services and any other service de-
17 scribed in paragraphs (2), (3), (4), (5),
18 and (7) of section 1905(a),

19 “(ii) with any risk contracting entity
20 (as so defined) in a State that, on the ef-
21 fective date of this provision, had in effect
22 a waiver under section 1115 of require-
23 ments under this title under which the
24 State could extend eligibility for medical
25 assistance for enrollees of such entity, or

1 “(iii) with an eligible organization
2 with a contract under section 1876 and
3 who would”, and

4 (B) in subparagraph (B), by striking “or-
5 ganization or” each place it appears.

6 (c) CONFORMING AMENDMENTS.—

7 (1) Section 1128(b)(6)(C)(i) of such Act (42
8 U.S.C. 1320a-7(b)(6)(C)(i)) is amended by striking
9 “health maintenance organization” and inserting
10 “risk contracting entity”.

11 (2) Section 1902(a)(30)(C) of such Act (42
12 U.S.C. 1396a(a)(30)(C)) is amended by striking all
13 that precedes “with the results” and inserting “pro-
14 vide for independent review and quality assurance of
15 entities with contracts under section 1903(m), in ac-
16 cordance with paragraph (10) of such section,”.

17 (3) Section 1902(a)(57) of such Act (42 U.S.C.
18 1396a(a)(57)) is amended by striking “or health
19 maintenance organization” and inserting “or risk
20 contracting entity”.

21 (4) Section 1902(a) of such Act (42 U.S.C.
22 1396a(a)) is amended—

23 (A) by striking “and” at the end of para-
24 graph (54);

1 (B) in the paragraph (55) inserted by sec-
2 tion 4602(a)(3) of Public Law 101-508, by
3 striking the period at the end and inserting a
4 semicolon;

5 (C) by redesignating the paragraph (55)
6 inserted by section 4604(b)(3) of Public Law
7 101-508 as paragraph (56), by transferring
8 and inserting it after the paragraph (55) in-
9 serted by section 4602(a)(3) of such Act, and
10 by striking the period at the end and inserting
11 a semicolon;

12 (D) by placing paragraphs (57) and (58),
13 inserted by section 4751(a)(1)(C) of Public
14 Law 101-508, immediately after paragraph
15 (56), as redesignated by paragraph (3);

16 (E) in the paragraph (58) inserted by sec-
17 tion 4751(a)(1)(C) of Public Law 101-508, by
18 striking the period at the end and inserting a
19 semicolon;

20 (F) by redesignating the paragraph (58)
21 inserted by section 4752(c)(1)(C) of Public Law
22 101-508 as paragraph (59), by transferring
23 and inserting it after the paragraph (58) in-
24 serted by section 4751(a)(1)(C) of such Act,

1 and by striking the period at the end and in-
2 serting “; and”; and

3 (G) by inserting after such paragraph (59)
4 the following new paragraph:

5 “(60) at State option, provide for a primary
6 care case management program in accordance with
7 section 1903(m)(7).”.

8 (5) Section 1902(p)(2) of such Act (42 U.S.C.
9 1396a(p)(2)) is amended by striking “health mainte-
10 nance organization” and inserting “risk contracting
11 entity”.

12 (6) Section 1902(w) of such Act (42 U.S.C.
13 1396a(w)) is amended—

14 (A) in paragraph (1), by striking “section
15 1903(m)(1)(A)” and inserting “section
16 1903(m)(2)(C)(xi)”, and

17 (B) in paragraph (2)(E), by striking
18 “health maintenance organization” and “the or-
19 ganization” and inserting “risk contracting en-
20 tity” and “the entity”, respectively.

21 (7) Section 1903(k) of such Act (42 U.S.C.
22 1396b(k)) is amended by striking “health mainte-
23 nance organization” and inserting “risk contracting
24 entity”.

1 (8) Section 1903(m)(4)(A) of such Act (42
2 U.S.C. 1396b(m)(4)(A)) is amended—

3 (A) in the first sentence, by striking “Each
4 health maintenance organization” and inserting
5 “Each risk contracting entity”,

6 (B) in the first sentence, by striking “the
7 organization” each place it appears and insert-
8 ing “the entity”, and

9 (C) in the second sentence, by striking “an
10 organization” and “the organization” and in-
11 sserting “a risk contracting entity” and “the
12 risk contracting entity”, respectively.

13 (9) Section 1903(m)(4)(B) of such Act (42
14 U.S.C. 1396b(m)(4)(B)) is amended by striking “or-
15 ganization” and inserting “risk contracting entity”.

16 (10) Section 1903(m)(5) of such Act (42
17 U.S.C. 1396b(m)(5)) is amended in paragraphs
18 (A)(iii) and (B)(ii) by striking “organization” and
19 inserting “entity”.

20 (11) Section 1903(w)(7)(A)(viii) of such Act
21 (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by
22 striking “health maintenance organizations (and
23 other organizations with contracts under section
24 1903(m))” and inserting “risk contracting entities
25 with contracts under section 1903(m)”.

1 (12) Section 1905(a) of such Act (42 U.S.C.
2 1396d(a)) is amended, in the matter preceding
3 clause (i), by inserting “(which may be on a prepaid
4 capitation or other risk basis)” after “payment” the
5 first place it appears.

6 (13) Section 1916(b)(2)(D) of such Act (42
7 U.S.C. 1396o(b)(2)(D)) is amended by striking
8 “health maintenance organization” and inserting
9 “risk contracting entity”.

10 (14) Section 1925(b)(4)(D)(iv) of such Act (42
11 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended—

12 (A) in the heading, by striking “HMO” and
13 inserting “RISK CONTRACTING ENTITY”,

14 (B) by striking “health maintenance orga-
15 nization” and inserting “risk contracting en-
16 tity” each place it appears, and

17 (C) by striking “section 1903(m)(1)(A)”
18 and inserting “section 1903(m)(1)(B)(i)”.

19 (15) Paragraphs (1) and (2) of section 1926(a)
20 of such Act (42 U.S.C. 1396r-7(a)) are each amend-
21 ed by striking “health maintenance organizations”
22 and inserting “risk contracting entities”.

23 (16) Section 1927(j)(1) of such Act (42 U.S.C.
24 1396s(j)(1)) is amended by striking “*** Health

1 Maintenance Organizations, including those organi-
2 zations” and inserting “risk contracting entities”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 this section shall become effective with respect to calendar
5 quarters beginning on or after January 1, 1994.

6 **SEC. 302. PERIOD OF CERTAIN WAIVERS.**

7 (a) IN GENERAL.—Section 1915(h) of the Social Se-
8 curity Act (42 U.S.C. 1396n(h)) is amended by striking
9 “No waiver” and all that follows through “unless the Sec-
10 retary” and inserting “A waiver under this section (other
11 than under subsection (c), (d), or (e)) shall be for an ini-
12 tial term of 3 years and, upon the request of a State, shall
13 be extended for additional 5 year periods unless the Sec-
14 retary”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to waivers pursuant to applica-
17 tions which are approved, and with respect to continu-
18 ations of waivers for which requests are made, later than
19 30 days after the date of the enactment of this Act.

20 **Subtitle E—Limitations on**
21 **Physician Self-Referrals**

22 **SEC. 311. EXTENSION OF PHYSICIAN SELF-REFERRAL**
23 **LIMITATIONS TO ALL PAYORS.**

24 Section 1877 of the Social Security Act (42 U.S.C.
25 1395nn) is amended—

1 (1) in subsection (a)—

2 (A) in paragraph (1)(A), by striking “for
3 which payment otherwise may be made under
4 this title” and inserting “for which a charge is
5 imposed”, and

6 (B) in paragraph (1)(B), by striking
7 “under this title”;

8 (2) by amending paragraph (1) of subsection
9 (g) to read as follows:

10 “(1) DENIAL OF PAYMENT.—No payment may
11 be made under this title, under another Federal
12 health care program, or under a State health care
13 program (as defined in section 1128(h)) for a des-
14 ignated health service for which a claim is presented
15 in violation of subsection (a)(1)(B). No individual,
16 third party payor, or other entity is liable for pay-
17 ment for designated health services for which a
18 claim is presented in violation of such subsection.”;
19 and

20 (3) in subsection (g)(3), by striking “for which
21 payment may not be made under paragraph (1)”
22 and inserting “for which such a claim may not be
23 presented under subsection (a)(1)”.

1 **SEC. 312. EXTENSION OF PHYSICIAN SELF-REFERRAL**
2 **LIMITATIONS TO CERTAIN ADDITIONAL**
3 **SERVICES.**

4 (a) IN GENERAL.—Section 1877 of the Social Secu-
5 rity Act is further amended—

6 (1) by striking “clinical laboratory services”
7 and “CLINICAL LABORATORY SERVICES” and insert-
8 ing “designated health services” and “DESIGNATED
9 HEALTH SERVICES”, respectively, each place either
10 appears in subsections (a)(1), (b)(2)(A)(ii)(I),
11 (b)(4), (d)(1), (d)(2), and (d)(3), and

12 (2) by adding at the end the following new sub-
13 section:

14 “(i) DESIGNATED HEALTH SERVICES DEFINED.—In
15 this section, the term ‘designated health services’ means—

16 “(1) clinical laboratory services,

17 “(2) physical therapy services,

18 “(3) radiology and diagnostic imaging services,

19 “(4) radiation therapy services, and

20 “(5) the furnishing of durable medical equip-
21 ment.”.

22 (b) CONFORMING AMENDMENTS.—Section 1877 of
23 such Act is further amended—

24 (1) in subsection (d)(2), by striking “labora-
25 tory” and inserting “entity”,

1 (2) in subsection (g)(1), by striking “clinical
2 laboratory service” and inserting “designated health
3 service”, and

4 (3) in subsection (h)(7)(B), by striking “clinical
5 laboratory service” and inserting “designated health
6 service”.

7 **SEC. 313. CHANGES IN EXCEPTIONS.**

8 (a) HEALTH MAINTENANCE ORGANIZATIONS AND
9 MANAGED CARE PLANS.—Paragraph (3) of section
10 1877(b) of the Social Security Act is amended to read as
11 follows:

12 “(3) HEALTH MAINTENANCE ORGANIZATIONS
13 AND MANAGED CARE PLANS.—

14 “(A) HEALTH MAINTENANCE ORGANIZA-
15 TIONS.—In the case of services furnished by a
16 health maintenance organization to an individ-
17 ual enrolled with the health maintenance orga-
18 nization, including services furnished by—

19 “(i) an eligible organization (as de-
20 fined in section 1876(b));

21 “(ii) an organization described in sec-
22 tion 1833(a)(1)(A);

23 “(iii) an organization receiving pay-
24 ments on a prepaid basis under a dem-
25 onstration project under section 402(a) of

1 the Social Security Amendments of 1967
2 or under section 222(a) of the Social Secu-
3 rity Amendments of 1972; and

4 “(iv) any other entity designated by
5 the Secretary as a health maintenance or-
6 ganization for purposes of this subpara-
7 graph.

8 “(B) CERTAIN MANAGED CARE PLANS.—In
9 the case of services furnished by a managed
10 care plan (as defined by the Secretary) to an
11 individual enrolled under the plan if—

12 “(i) the plan selectively contracts with
13 physicians and with providers of des-
14 ignated health services; and

15 “(ii) under the plan physicians bear a
16 significant financial risk for the cost of
17 designated health services furnished upon
18 referral.”.

19 (b) EXCEPTION FOR SHARED FACILITY SERVICES.—
20 Section 1877 of such Act is amended—

21 (1) in subsection (b), by redesignating para-
22 graphs (3), (4), and (5) as paragraphs (4), (6), and
23 (7), respectively, and by inserting after paragraph
24 (2) the following new paragraph:

25 “(3) SHARED FACILITY SERVICES.—

1 “(A) IN GENERAL.—In the case of shared
2 facility services of a shared facility—

3 “(i) that are furnished—

4 “(I) personally by the referring
5 physician who is a shared facility phy-
6 sician or personally by an individual
7 supervised by such a physician or by
8 another shared facility physician and
9 employed under the shared facility ar-
10 rangement,

11 “(II) by a shared facility in a
12 building in which the referring physi-
13 cian furnishes physician’s services un-
14 related to the furnishing of shared fa-
15 cility services, and

16 “(III) to a patient of a shared fa-
17 cility physician;

18 “(ii) that are billed by the referring
19 physician or by an entity that is wholly
20 owned by such physician; and

21 “(iii) with respect to the referral for
22 which the disclosure requirements of sub-
23 paragraph (B) are met.

24 “(B) CONFLICT OF INTEREST DISCLOSURE
25 REQUIREMENTS.—A shared facility meets the

1 disclosure requirements of this subparagraph,
2 with respect to a referral of an individual for
3 the furnishing of shared facility services, if at
4 the time of the referral (and before the provi-
5 sion of shared facility services under the refer-
6 ral) and in a form and manner specified by the
7 Secretary—

8 “(i) the individual (I) is given infor-
9 mation on the financial relationship be-
10 tween the referring physician and the
11 shared facility, and (II) is informed that a
12 list of alternative providers (if any) that
13 are available to provide such services will
14 be given upon request,

15 “(ii) the individual is given, upon re-
16 quest, a list of alternative providers (if
17 any) that are available to provide such
18 services, and

19 “(iii) the individual is informed that
20 (I) the individual has the option to use any
21 of the alternative providers and (II) the re-
22 ferring physician will not treat the individ-
23 ual differently if an alternative provider is
24 selected to provide the designated health
25 services.

1 “(C) CONSTRUCTION.—Nothing in sub-
2 paragraph (B) shall be construed to limit the
3 information that a shared facility or shared fa-
4 cility physician may provide to an individual.”;
5 and

6 (2) in subsection (h), by adding at the end the
7 following new paragraph:

8 “(8) SHARED FACILITY RELATED DEFINI-
9 TIONS.—

10 “(A) SHARED FACILITY SERVICES.—The
11 term ‘shared facility services’ means, with re-
12 spect to a shared facility, a type of designated
13 health services which is furnished by the facility
14 to patients of shared facility physicians.

15 “(B) SHARED FACILITY.—The term
16 ‘shared facility’ means an entity that furnishes
17 shared facility services under a shared facility
18 arrangement.

19 “(C) SHARED FACILITY PHYSICIAN.—The
20 term ‘shared facility physician’ means, with re-
21 spect to a shared facility, a physician who has
22 a financial relationship under a shared facility
23 arrangement with the facility.

24 “(D) SHARED FACILITY ARRANGEMENT.—
25 The term ‘shared facility arrangement’ means,

1 with respect to the provision of a type of des-
2 ignated health services by a shared facility in a
3 building, a financial arrangement—

4 “(i) which is only between physicians
5 who are providing services (unrelated to
6 shared facility services) in the same build-
7 ing,

8 “(ii) which makes one or more of the
9 shared facility physicians responsible for
10 the provision of shared facility services by
11 the facility,

12 “(iii) in which the overhead expenses
13 of the facility are shared, in accordance
14 with methods previously determined by the
15 physicians in the arrangement, among the
16 physicians in the arrangement, and

17 “(iv) which, in the case of a corpora-
18 tion, is wholly owned and controlled by
19 shared facility physicians.”.

20 (c) EXCEPTION FOR VALUABLE COMMUNITY SERV-
21 ICES.—Section 1877(b) of such Act is further amended
22 by inserting after paragraph (4), as redesignated by sub-
23 section (b)(1), the following new paragraph:

24 “(5) VALUABLE COMMUNITY SERVICES.—

1 “(A) IN GENERAL.—In the case of services
2 furnished by an entity to individuals in a com-
3 munity if the Secretary determines that—

4 “(i) individuals in the community will
5 be deprived of adequate health care serv-
6 ices without an exception under this para-
7 graph for the entity and the services, and

8 “(ii) the requirements of subpara-
9 graph (B) are met.

10 “(B) REQUIREMENTS.—The requirements
11 of this subparagraph for an exception under
12 subparagraph (A), for the furnishing of des-
13 igned health services by an entity, are as fol-
14 lows:

15 “(i) EQUAL INVESTMENT OPPOR-
16 TUNITY.—(I) Individuals who are not re-
17 ferring physicians must be given a bona
18 fide opportunity to invest in the entity on
19 the same terms that are offered to refer-
20 ring physicians.

21 “(II) The terms on which investment
22 interests are offered to physicians must not
23 be related to the past or expected volume
24 of referrals or other business from the phy-
25 sicians.

1 “(III) The return on investment for
2 interested investors must be tied to the in-
3 vestor’s equity in the entity and not be re-
4 lated to the volume of referrals attributable
5 to the investor.

6 “(IV) There is no requirement that
7 any interested or other investor make re-
8 ferrals to the entity or otherwise generate
9 business as a condition for remaining an
10 investor.

11 “(V) The entity must not loan funds
12 or guarantee a loan for interested investors
13 or physicians in a position to refer to the
14 entity.

15 “(VI) The entity must not market or
16 furnish its items or services to interested
17 investors differently from other investors.

18 “(ii) PROHIBITION OF
19 NONCOMPETITION CLAUSES.—Investment
20 contracts must not include a
21 ‘noncompetition clause’ that prevents phy-
22 sicians or interested investors from invest-
23 ing in other entities furnishing such serv-
24 ices.

1 “(iii) DISCLOSURE REQUIREMENTS.—

2 (I) The disclosure requirements of para-
3 graph (3)(B) must be met.

4 “(II) The financial relationship with
5 the referring physician must be disclosed,
6 when required, to any third-party payor.

7 “(iv) INTERNAL UTILIZATION RE-
8 VIEW.—There must be in operation an in-
9 ternal utilization review program to ensure
10 that physicians who are interested inves-
11 tors do not exploit their patients in any
12 way through inappropriate utilization or
13 otherwise.

14 “(C) REVIEW.—In the case of any excep-
15 tion provided an entity under this paragraph,
16 the Secretary shall periodically review the entity
17 to determine if the requirements of subpara-
18 graph (B) continue to be met.

19 “(D) TERMINATION OF EXCEPTION.—The
20 Secretary shall, after notice and opportunity for
21 a hearing, terminate an exception granted an
22 entity under this paragraph if the Secretary de-
23 termines that—

1 “(i) there was a misrepresentation of
2 material fact in the application for the ex-
3 ception; or

4 “(ii) the entity has failed to comply
5 substantially with the requirements of sub-
6 paragraph (B).

7 “(E) COMMUNITY DEFINED.—In this para-
8 graph, the term ‘community’ means—

9 “(i) part or all of a metropolitan sta-
10 tistical area (or equivalent area), or

11 “(ii) a county (or equivalent area)
12 outside such a metropolitan statistical area
13 (or equivalent area).”.

14 (d) EXCEPTION FOR HOSPITALS.—Subparagraph (A)
15 of subsection (d)(3) of such section is amended to read
16 as follows:

17 “(A) at the time the services are furnished,
18 the hospital has a participation agreement in
19 effect under section 1866, and”.

20 **SEC. 314. STUDY AND REPORT ON CHANGES IN COSTS.**

21 The Secretary of Health and Human Services shall
22 conduct a study in order to estimate the changes in aggre-
23 gate costs for designated health services, under the medi-
24 care program and other health plans, which will result
25 from the implementation of the amendments made by this

1 subtitle. Not later than 2 years after the date of the enact-
2 ment of this Act the Secretary shall submit to Congress
3 a report on such study.

4 **SEC. 315. EFFECTIVE DATE.**

5 (a) IN GENERAL.—Subject to subsection (b), the
6 amendments made by this subtitle shall apply with respect
7 to a referral by a physician for designated health services
8 (as described in section 1877(i) of the Social Security Act)
9 made on or after the first day of the first month beginning
10 6 months after the date of the enactment of this Act.

11 (b) TIME-LIMITED EXCEPTION FOR CURRENT FI-
12 NANCIAL RELATIONSHIPS.—

13 (1) IN GENERAL.—Subject to paragraph (3),
14 the amendments made by this subtitle shall not
15 apply in the case of a patient referral with respect
16 to which a prohibited financial relationship (de-
17 scribed in paragraph (3)) existed as of the date of
18 the enactment of this Act if, at the time of the refer-
19 ral (and before the receipt of services under the re-
20 ferral), the patient is provided information on the
21 prohibited financial relationship. Such information
22 shall be disclosed in the same manner information
23 must be disclosed under section 1877(b)(3)(B) of
24 the Social Security Act (as amended by this sub-
25 title). If such information is not so provided, the re-

1 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
2 CIAL INCENTIVES.—Any law that limits the financial
3 incentives that a health benefit plan may require a
4 beneficiary to pay when a non-plan provider is used
5 on a non-emergency basis.

6 (3) RESTRICTIONS ON UTILIZATION REVIEW
7 METHODS.—Any law that—

8 (A) prohibits utilization review of any or
9 all treatments and conditions,

10 (B) requires that such review be made (i)
11 by a resident of the State in which the treat-
12 ment is to be offered or by an individual li-
13 censed in such State, or (ii) by a physician in
14 any particular specialty or with any board cer-
15 tified specialty of the same medical specialty as
16 the provider whose services are being reviewed,

17 (C) requires the use of specified standards
18 of health care practice in such reviews or re-
19 quires the disclosure of the specific criteria used
20 in such reviews,

21 (D) requires payments to providers for the
22 expenses of responding to utilization review re-
23 quests, or

24 (E) imposes liability for delays in perform-
25 ing such review.

1 Nothing in subparagraph (B) shall be construed as
2 prohibiting a State from (i) requiring that utilization
3 review be conducted by a licensed health care profes-
4 sional or (ii) requiring that any appeal from such a
5 review be made by a licensed physician or by a li-
6 censed physician in any particular specialty or with
7 any board certified specialty of the same medical
8 specialty as the provider whose services are being re-
9 viewed.

10 (b) GAO STUDY.—

11 (1) IN GENERAL.—The Comptroller General
12 shall conduct a study of the benefits and cost effec-
13 tiveness of the use of managed care in the delivery
14 of health services.

15 (2) REPORT.—By not later than 4 years after
16 the date of the enactment of this Act, the Comptrol-
17 ler General shall submit a report to Congress on the
18 study conducted under paragraph (1) and shall in-
19 clude in the report such recommendations (including
20 whether the provisions of subsection (a) should be
21 extended) as may be appropriate.

22 (c) SUNSET.—Unless otherwise provided, subsection
23 (a) shall not apply 5 years after the date of the enactment
24 of this Act.

1 **Subtitle G—Medicare Payment**
2 **Changes**

3 **SEC. 331. REVISIONS TO METHODOLOGY FOR DETERMIN-**
4 **ING UPDATES TO MEDICARE HOSPITAL PAY-**
5 **MENTS.**

6 (a) UPDATES FOR PPS HOSPITALS ON CALENDAR
7 YEAR BASIS.—

8 (1) IN GENERAL.—Section 1886(b)(3)(B)(i) of
9 the Social Security Act (42 U.S.C.
10 1395ww(b)(3)(B)(i)) is amended—

11 (A) in the matter preceding subclause (i),
12 by striking “fiscal year” and inserting “particu-
13 lar time period”;

14 (B) in subclause (VIII), by striking
15 “1993,” and inserting “1993 and the first 3
16 months of fiscal year 1994”; and

17 (C) in subclause (XI) through (X), by
18 striking “fiscal year” each place it appears and
19 inserting “calendar year”.

20 (2) UPDATES TO STANDARDIZED AMOUNTS.—
21 Section 1886(d)(3)(A) of such Act (42 U.S.C.
22 1395ww(d)(3)(A)) is amended—

23 (A) in clause (ii)—

24 (i) by striking “1994,” and inserting
25 the following: “1992, a 15-month period

1 beginning October 1, 1992, and calendar
2 year 1994”, and

3 (ii) by striking “fiscal year” the sec-
4 ond and third place it appears and insert-
5 ing “fiscal year, particular time period, or
6 calendar year”;

7 (B) in clause (iii), by striking “the fiscal
8 year beginning on October 1, 1994,” and in-
9 serting “calendar year 1995,”; and

10 (C) in clause (iv)—

11 (i) by striking “a fiscal year beginning
12 on or after October 1, 1995,” and insert-
13 ing “a calendar year beginning on or after
14 January 1, 1996,”; and

15 (ii) by striking “fiscal year” each
16 place it appears and inserting “calendar
17 year”.

18 (3) CONFORMING AMENDMENTS.—Section
19 1886(b)(3)(B)(iii) of such Act (42 U.S.C.
20 1395ww(b)(3)(B)(iii)) is amended—

21 (A) by striking “fiscal year” the first place
22 it appears and inserting “particular time pe-
23 riod”,

1 (B) by striking “period or fiscal year” the
2 first place it appears and inserting “cost report-
3 ing period or particular time period”, and

4 (C) by striking “for the period or fiscal
5 year” and inserting “for the cost reporting pe-
6 riod or fiscal year ending in the particular time
7 period”.

8 (b) REDUCTION IN UPDATES FOR NON-PPS HOS-
9 PITALS.—Section 1886(b)(3)(B)(ii) of such Act (42
10 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

11 (1) by redesignating subclause (IV) and
12 subclause (VI); and

13 (2) by striking “and” at the end of subclause
14 (III) and by inserting after subclause (III) the fol-
15 lowing:

16 “(IV) fiscal years 1989, 1990, 1991, 1992, and
17 1993, the market basket percentage increase,

18 “(V) fiscal year 1994, 75 percent of the market
19 basket percentage increase, and”.

20 **SEC. 332. REDUCTION IN MEDICARE PAYMENT FOR CLINI-**
21 **CAL DIAGNOSTIC LABORATORY TESTS.**

22 (a) LOWERING CAP ON PAYMENT AMOUNT.—Section
23 1833(h)(4)(B) of the Social Security Act (42 U.S.C.
24 1395l(h)(4)(B)) is amended—

25 (1) by striking “and” at the end of clause (iii);

1 (2) in clause (iv), by inserting “and before Oc-
2 tober 1, 1993,” after “1990,”;

3 (3) by striking the period at the end of clause
4 (iv) and inserting “, and”; and

5 (4) by adding at the end the following:

6 “(v) after September 30, 1993, is equal to 76
7 percent of the median of all the fee schedules estab-
8 lished for that test for that laboratory setting under
9 paragraph (1).”.

10 (b) REPEAL OF ANNUAL UPDATE IN PAYMENTS FOR
11 CLINICAL DIAGNOSTIC LABORATORY TESTS.—Section
12 1833(h)(2)(A)(ii) of such Act (42 U.S.C.
13 1395l(h)(2)(A)(ii)) is amended—

14 (1) by striking “and” at the end of subclause
15 (II);

16 (2) in subclause (III), by striking the period at
17 the end and inserting a semicolon; and

18 (3) by adding at the end the following:

19 “(IV) no annual adjustment in the fee sched-
20 ules shall be made under clause (i) for any of the
21 years 1994 through 1998.”.

1 **Subtitle H—Limitation of Antitrust**
2 **Recovery for Certain Hospital**
3 **Joint Ventures**

4 **SEC. 341. PURPOSE.**

5 The purpose of this subtitle is to encourage coopera-
6 tion among hospitals in order to contain costs and achieve
7 a more efficient health care delivery system through the
8 elimination of unnecessary duplication and proliferation of
9 expensive high technology equipment, medical services, or
10 ancillary services.

11 **SEC. 342. DEFINITIONS.**

12 For the purposes of this subtitle:

13 (1) The term “antitrust laws” has the meaning
14 given it in subsection (a) of the first section of the
15 Clayton Act (15 U.S.C. 12(a)), except that such
16 term includes—

17 (A) section 5 of the Federal Trade Com-
18 mission Act (15 U.S.C. 45) to the extent such
19 section applies to unfair methods of competi-
20 tion, and

21 (B) any State law similar to the antitrust
22 laws.

23 (2) The term “high technology equipment”
24 means equipment and devices utilized in medical

1 care, and the technical support systems for them,
2 that—

3 (A) have acquisition costs greater than
4 \$1,000,000 or annual operating costs greater
5 than \$500,000, and

6 (B) use technologies with respect to which
7 there is a reasonable expectation that shared
8 ownership will avoid a significant degree of ac-
9 tual or anticipated excess capacity of service in
10 the geographical area to be served.

11 (3) The term “medical services” means services
12 that are involved in providing medical care to pa-
13 tients and that—

14 (A) have annual operating costs greater
15 than \$1,000,000, and

16 (B) with respect to which there is a rea-
17 sonable expectation that shared ownership will
18 avoid a significant degree of the actual or an-
19 ticipated excess capacity of such services in the
20 geographical area to be served,

21 and may include mobile services.

22 (4) The term “ancillary services” means sup-
23 port functions associated with operating a hospital
24 (laundry, billing, patient transportation, data proc-
25 essing, and other similar services) the predominant

1 function of which does not involve the provision of
2 medical treatment to patients.

3 (5) The term “hospital” means a hospital
4 that—

5 (A) has entered into, and has in effect a
6 participation agreement under section 1866(a)
7 of the Social Security Act (42 U.S.C.
8 1395cc(a)), or

9 (B) has in effect a participation agreement
10 under title XIX of such Act (42 U.S.C. 1396 et
11 seq.) with the State in which the hospital is lo-
12 cated.

13 (6) The term “hospital joint venture” means an
14 agreement between 2 or more hospitals that is en-
15 tered into solely for the purpose of sharing in the
16 purchase or operation of high technology equipment,
17 medical services, or ancillary services, and that in-
18 volves substantial integration or financial risk-shar-
19 ing between the parties. The term excludes—

20 (A) exchanging information among com-
21 petitors relating to costs, sales, profitability,
22 prices, marketing, or distribution of any prod-
23 uct, process, or service that is not reasonably
24 required to carry out such agreement,

1 (B) entering into any arrangement or en-
2 gaging in any other conduct to restrict, require,
3 or otherwise involve the marketing by any party
4 to such agreement of any product, process, or
5 service that is not reasonably required to carry
6 out such agreement, and

7 (C) entering into any arrangement or en-
8 gaging in any other conduct to restrict or re-
9 quire the participation by any party to such
10 agreement in conduct that is not reasonably re-
11 quired to carry out such agreement.

12 (7) The term “Attorney General” means the
13 Attorney General of the United States.

14 (8) The term “Secretary” means the Secretary
15 of Health and Human Services.

16 (9) The term “Commission” means the Federal
17 Trade Commission.

18 **SEC. 343. LIMITATION ON DAMAGES FOR ANTITRUST VIO-**
19 **LATIONS.**

20 Monetary recovery on a claim in any action brought
21 under the antitrust laws against a hospital that is a party
22 to a hospital joint venture shall be limited to actual dam-
23 ages if—

24 (1) the hospitals forming such venture meet the
25 notification requirements specified in section 344,

1 (2) the claim results from conduct that is with-
2 in the scope of the notification filed under section
3 344, and

4 (3) the action is filed after such notification be-
5 comes effective pursuant to section 344(c).

6 **SEC. 344. DISCLOSURE OF HOSPITAL JOINT VENTURE.**

7 (a) WRITTEN NOTIFICATIONS; FILING.—Any hos-
8 pital that is a party to a hospital joint venture, acting on
9 the venture’s behalf, not later than 90 days after entering
10 into a written agreement to form the venture, or not later
11 than 90 days after, the date of the enactment of this Act,
12 whichever is later, may file simultaneously with the Attor-
13 ney General, the Secretary, and the Commission, a written
14 notification disclosing—

15 (1) the identities of the parties to the venture,
16 and

17 (2) the nature, objectives, and planned activity
18 of the venture.

19 Any hospital that is a party to a hospital joint venture,
20 acting on the venture’s behalf, may file additional disclo-
21 sure notifications pursuant to this section as are appro-
22 priate to extend the protections of section 343. In order
23 to maintain the protections of section 343, the venture,
24 not later than 90 days after a change in its membership
25 or its planned activity, shall file simultaneously with the

1 Attorney General, the Secretary, and the Commission a
2 written notification disclosing such change.

3 (b) PUBLICATION; FEDERAL REGISTER; NOTICE.—

4 Not later than 30 days after receiving a notification filed
5 under subsection (a), the Secretary, after consultation
6 with the Attorney General and the Commission, shall pub-
7 lish in the Federal Register a notice with respect to the
8 hospital joint venture that identifies the parties to the ven-
9 ture and that describes the planned activity of the venture.
10 Prior to its publication, the contents of such notice shall
11 be made available to the parties to the venture.

12 (c) EFFECT OF THE NOTICE.—If with respect to a
13 notification filed under subsection (a) of this section, no-
14 tice is published in the Federal Register, then such notifi-
15 cation shall operate to convey the protections of section
16 343 as of the earlier of—

17 (1) the date of the publication of notice under
18 subsection (b), or

19 (2) if such notice is not so published within the
20 time required by subsection (b) of this section, after
21 the expiration of the 30-day period beginning on the
22 date that the Attorney General, the Secretary, or the
23 Commission receives the applicable information de-
24 scribed in subsection (a).

1 (d) EXEMPTION; DISCLOSURE; INFORMATION.—Ex-
2 cept with respect to the information published pursuant
3 to subsection (b)—

4 (1) all information and documentary material
5 submitted as part of a notification filed pursuant to
6 this section, and

7 (2) all other information obtained by the Attor-
8 ney General, the Secretary, or the Commission in
9 the course of any investigation, administrative pro-
10 ceeding, or case, with respect to a potential violation
11 of the antitrust laws by the joint venture with re-
12 spect to which such notification was filed,

13 shall be exempt from disclosure under section 552 of title
14 5, United States Code, and shall not be made publicly
15 available by any agency of the United States to which such
16 section applies, except as relevant to a law enforcement
17 investigation or in a judicial or administrative proceeding
18 in which such information and material is subject to any
19 protective order.

20 (e) WITHDRAWAL OF NOTIFICATION.—Any party
21 that files a notification pursuant to this section may with-
22 draw such notification before notice of the hospital joint
23 venture involved is published under subsection (b) of this
24 section. Any notification so withdrawn shall not be subject

1 to subsection (b) and shall not confer the protections of
2 section 343.

3 (f) JUDICIAL REVIEW: INAPPLICABLE WITH RE-
4 SPECT TO NOTIFICATIONS.—Any action taken or not
5 taken by the Attorney General, the Secretary, or the Com-
6 mission with respect to notifications filed pursuant to this
7 section shall not be subject to judicial review.

8 (g) ADMISSIBILITY INTO EVIDENCE: DISCLOSURE OF
9 CONDUCT; PUBLICATION OF NOTICE; SUPPORTING OR
10 ANSWERING CLAIMS UNDER ANTITRUST LAWS.—

11 (1) Except as provided in paragraph (2), the
12 fact of disclosure of conduct under subsection (a)
13 and the fact of publication of a notice under sub-
14 section (b) shall be admissible into evidence in any
15 judicial or administrative proceeding for the sole
16 purpose of establishing that a person is entitled to
17 the protections of section 343.

18 (2) No action by the Attorney General, the Sec-
19 retary, or the Commission taken pursuant to this
20 section shall be admissible into evidence in any pro-
21 ceeding for the purpose of supporting or answering
22 any claim under the antitrust laws.

1 **SEC. 345. INTERAGENCY COMMITTEE ON COMPETITION,**
2 **ANTITRUST POLICY, AND HEALTH CARE.**

3 (a) ESTABLISHMENT.—There is hereby established
4 the Interagency Committee on Competition, Antitrust Pol-
5 icy, and Health Care (hereinafter in this section referred
6 to as the “Committee”). The Committee shall be composed
7 of—

8 (1) the Secretary of Health and Human Serv-
9 ices (or the designee of the Secretary),

10 (2) the Attorney General (or the designee of the
11 Attorney General)

12 (3) the Director of the Office of Management
13 and Budget (or the designee of the Director), and

14 (4) a representative of the Federal Trade Com-
15 mission.

16 (b) DUTIES.—The Duties of the Committee are—

17 (1) to discuss and evaluate competition and
18 antitrust policy, and their implications with respect
19 to the performance of health care markets, and

20 (2) to make such recommendations to the Con-
21 gress not later than 1 year after the date of the en-
22 actment of this Act, and thereafter as the Commit-
23 tee considers to be appropriate, regarding achieving
24 both health-care cost containment and greater access
25 to quality health care through cooperation among
26 health care providers.

1 **Subtitle I—Encouraging Enforcement**
2 **Activities of Medical Self-Regulatory Entities**

3 PART 1—APPLICATION OF THE CLAYTON ACT TO
4 MEDICAL SELF-REGULATORY ENTITIES

5 **SEC. 351. ANTITRUST EXEMPTION FOR MEDICAL SELF-REG-**
6 **ULATORY ENTITIES.**

7 (a) IN GENERAL.—(1) Except as provided in para-
8 graph (2), no damages, interest on damages, cost of suit,
9 or attorney’s fee may be recovered under section 4, 4A,
10 or 4C of the Clayton Act (15 U.S.C. 15, 15a, 15c), or
11 under any State law similar to such section, from any
12 medical self-regulatory entity (including its members, offi-
13 cers, employees, consultants, and volunteers or committees
14 thereof) as a result of engaging in standard setting or en-
15 forcement activities that are—

16 (A) designed to promote the quality of health
17 care provided to patients, and

18 (B) not conducted for purposes of financial
19 gain.

20 (2) Paragraph (1) shall not prohibit the recovery of
21 actual damages, interest on damages, the cost of suit, or
22 a reasonable attorney’s fee under section 4 or 4A of the
23 Clayton Act (15 U.S.C. 15, 15a), or under any State law
24 similar to such section, by a State or the United States
25 from a medical self-regulatory entity (including its mem-

1 bers, officers, employees, consultants, and volunteers or
2 committees thereof) for injury sustained as a result of en-
3 gaging in the conduct described in such paragraph.

4 (b) FEES.—In any action under section 4, 4C, or 16
5 of the Clayton Act (15 U.S.C. 15, 15c, 26), or under a
6 similar State law, brought against any medical self-regu-
7 latory entity (including its members, officers, employees,
8 consultants, and volunteers or committees thereof) as a
9 result of engaging in conduct described in subsection
10 (a)(1), the court shall award the cost of suit, including
11 a reasonable attorney’s fee, to a substantially prevailing
12 defendant.

13 **SEC. 352. DEFINITIONS.**

14 For purposes of this subtitle:

15 (1) The term “medical self-regulatory entity”
16 means a medical society or association, a specialty
17 board, a recognized accrediting agency, or a hospital
18 medical staff.

19 (2) The term “standard setting and enforce-
20 ment activities” means—

21 (A) accreditation of health care practition-
22 ers, health care providers, medical education in-
23 stitutions, or medical education programs,

24 (B) technology assessment and risk man-
25 agement activities,

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

3 (D) official peer review proceedings under-
4 taken by a hospital medical staff (or committee
5 thereof) for purposes of evaluating the quality
6 of health care provided by a medical profes-
7 sional.

8 PART 2—CONSULTATION BY FEDERAL AGENCIES

9 **SEC. 357. CONSULTATION WITH MEDICAL SELF-REGU-**
10 **LATORY ENTITIES RESPECTING MEDICAL**
11 **PROFESSIONAL GUIDELINES AND STAND-**
12 **ARDS.**

13 Any Federal agency engaged in the establishment of
14 medical professional standards shall consult with appro-
15 priate medical societies or associations, specialty boards,
16 or recognized accrediting agencies, if available, in carrying
17 out medical professional standard setting and guidelines
18 or standards relating to the practice of medicine.

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