

103^D CONGRESS
1ST SESSION

H. R. 196

To provide improved access to health care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

Mr. HOUGHTON introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, and the Judiciary

A BILL

To provide improved access to health care, 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 This Act may be cited as the “Health Equity and
5 Access Improvement Act of 1992”.

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—TAX INCENTIVES FOR HEALTH CARE ACCESS

- Sec. 101. Refundable health expenses tax credit.
- Sec. 102. Individual tax deduction for health insurance costs.
- Sec. 103. Credit for employers to provide health insurance.
- Sec. 104. Deductibility for self-employed individuals.
- Sec. 105. Revenue incentives for practice in rural areas.

TITLE II—HEALTH CARE REFORM PROVISIONS

Subtitle A—Model Health Care Insurance Benefits Plan

- Sec. 201. Model health care insurance benefits plan.
- Sec. 202. Definitions.

Subtitle B—Managed Care

- Sec. 211. Development of standards for managed care plans.
- Sec. 212. Preemption of provisions relating to managed care.

Subtitle C—Small Employer Purchasing Groups

- Sec. 221. Qualified small employer purchasing groups.
- Sec. 222. Preemption from insurance mandates for small employer purchasing groups.

Subtitle D—Insurance Market Reform

- Sec. 231. Failure to satisfy certain standards for health care insurance provided to small employers.

Subtitle E—Uniform Standards for Reporting Services and Processing Claims

- Sec. 241. Application and establishment of uniform standards.
- Sec. 242. Effective date.

TITLE III—MEDICAL LIABILITY REFORM

Subtitle A—Definitions and Findings

- Sec. 301. Definitions.
- Sec. 302. Effect on interstate commerce.

Subtitle B—Expedited Medical Malpractice Settlements

- Sec. 311. Expedited medical malpractice settlements.

Subtitle C—Alternative Dispute Resolution Procedures

- Sec. 321. Establishment of board of advisors.
- Sec. 322. Development of State voluntary dispute resolution procedures.
- Sec. 323. Application of existing procedures, rebuttable presumption.

Subtitle D—Uniform Standards for Medical Malpractice Cases

- Sec. 331. Application to civil actions.
- Sec. 332. Damages.
- Sec. 333. Joint and several liability for noneconomic damages.
- Sec. 334. Uniform statute of limitations.
- Sec. 335. Special protection for obstetricians and gynecologists.

Subtitle E—Uniform Disciplinary Reforms

- Sec. 341. Requirement of compliance.
- Sec. 342. Funds for State disciplinary activities.
- Sec. 343. Membership of State health care practitioner boards.
- Sec. 344. Immunity for members of State health care practitioner boards.
- Sec. 345. Risk management programs.

Sec. 346. Punitive damages.

Subtitle F—Medical Products

Sec. 351. Limitation on award of punitive damages in product liability actions involving drugs and devices.

Subtitle G—Community Health Centers

Sec. 361. Community and migrant health centers risk retention group.

Subtitle H—Miscellaneous Provisions

Sec. 371. Severability.

Sec. 372. Compliance.

TITLE IV—PUBLIC HEALTH PROVISIONS

Subtitle A—New Basic Health Care Program

Sec. 401. Establishment of BasiCare program.

Sec. 402. GAO study of payments under BasiCare.

Subtitle B—Medicaid Provisions

Sec. 411. Expansion of medicaid waiver authority.

Sec. 412. Establishment of Federal Medical Waiver Demonstration Board.

TITLE V—MEDICALLY UNDERSERVED AREAS

Subtitle A—Public Health Service Act Provisions

Sec. 501. National Health Service Corps.

Sec. 502. Establishment of grant program.

Sec. 503. Establishment of new program to provide funds to allow federally qualified health centers and other entities or organizations to provide expanded services to medically underserved individuals.

Sec. 504. Rural mental health outreach grants.

Sec. 505. Health professions training.

Sec. 506. Area health education centers.

Sec. 507. Rural health extension networks.

Sec. 508. Rural managed care cooperatives.

Subtitle B—Provision Relating to Social Security

Sec. 511. Rural health care transition grant program.

Sec. 512. Essential access community hospital program.

TITLE VI—INCENTIVES TO ENCOURAGE PREVENTIVE SERVICES

Sec. 601. Preventive services tax credit.

Sec. 602. Increase in authorization for childhood immunizations.

TITLE VII—TAX TREATMENT OF LONG-TERM CARE INSURANCE AND PLANS

Subtitle A—Treatment of Long-Term Care Insurance

Sec. 701. Qualified long-term care insurance treated as accident and health insurance for purposes of taxation of life insurance companies.

- Sec. 702. Qualified long-term care insurance treated as accident and health insurance for purposes of exclusion for benefits received under such insurance and for employer contributions for such insurance.
- Sec. 703. Exclusion from gross income for amounts withdrawn from individual retirement plans or 401(k) plans for qualified long-term care insurance.
- Sec. 704. Exchange of life insurance policy for qualified long-term care policy not taxable.

Subtitle B—Employer Funding of Medical Benefits

- Sec. 711. Medical benefits for retired employees and their spouses and dependents.
- Sec. 712. Treatment of health benefits accounts.

Subtitle C—Reverse Mortgage Insurance for Older Americans.

- Sec. 721. Maximum amount insured.

Subtitle D—Income Tax Credits

- Sec. 731. Refundable credit for custodial care of certain dependents in taxpayer's home.
- Sec. 732. Credit for expenses for long-term care services provided to certain independent persons requiring such care.

Subtitle E—Treatment of Accelerated Death Benefits

- Sec. 741. Tax treatment of accelerated death benefits under life insurance contracts.
- Sec. 742. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle F—Federal National Long-Term Care Reinsurance Corporation

- Sec. 751. Authorization for establishment of corporation.
- Sec. 752. Board of directors and officers.
- Sec. 753. Purpose and authority of corporation.
- Sec. 754. Capitalization.
- Sec. 755. Exemption from state regulation and taxation.
- Sec. 756. Audit and annual report.
- Sec. 757. Protection of name.

TITLE VIII—IMPROVEMENTS IN PORTABILITY OF PRIVATE HEALTH INSURANCE

- Sec. 801. Excise tax imposed on failure to provide for preexisting condition.

1 **TITLE I—TAX INCENTIVES FOR**
2 **HEALTH CARE ACCESS**

3 **SEC. 101. REFUNDABLE HEALTH EXPENSES TAX CREDIT.**

4 (a) IN GENERAL.—Subpart C of part IV of sub-
5 chapter A of chapter 1 of the Internal Revenue Code of
6 1986 (relating to refundable personal credits) is amended
7 by inserting after section 34 the following new section:

8 **“SEC. 34A. HEALTH EXPENSES.**

9 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
10 dividual, there shall be allowed as a credit against the tax
11 imposed by this subtitle for the taxable year an amount
12 equal to the qualified health expenses paid by such individ-
13 ual during the taxable year.

14 “(b) QUALIFIED HEALTH EXPENSES.—For purposes
15 of this section—

16 “(1) IN GENERAL.—The term ‘qualified health
17 expenses’ means amounts paid during the taxable
18 year for medical care (within the meaning of section
19 213(d)(1)).

20 “(2) DOLLAR LIMIT ON QUALIFIED HEALTH
21 EXPENSES.—The amount of the qualified health ex-
22 penses paid during any taxable year which may be
23 taken into account under subsection (a) shall not ex-
24 ceed—

1 “(A) \$600, in the case of a taxpayer de-
2 scribed in section 1(c) or 1(d), and

3 “(B) \$1,200, in the case of any other tax-
4 payer.

5 For purposes of this paragraph, the rule of section
6 219(g)(4) shall apply.

7 “(3) PHASEOUT.—In the case of any taxpayer
8 whose adjusted gross income exceeds \$10,000
9 (\$20,000, in the case of a taxpayer described in
10 paragraph (2)(B)), the dollar amounts under para-
11 graph (2) shall be reduced (but not below zero) by
12 an amount equal to 10 percent of such excess.

13 “(4) ELECTION NOT TO TAKE CREDIT.—A tax-
14 payer may elect for any taxable year to have
15 amounts described in paragraph (1) not treated as
16 qualified health expenses.

17 “(c) SPECIAL RULES.—For purposes of this sec-
18 tion—

19 “(1) COORDINATION WITH ADVANCE PAYMENT
20 AND MINIMUM TAX.—Rules similar to the rules of
21 subsections (g) and (h) of section 32 shall apply to
22 any credit to which this section applies.

23 “(2) SUBSIDIZED EXPENSES.—No expense shall
24 be treated as a qualified health expense if—

1 “(b) HEALTH EXPENSES ELIGIBILITY CERTIFI-
2 CATE.—For purposes of this title, a health expenses eligi-
3 bility certificate is a statement furnished by an employee
4 to the employer which—

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

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

12 “(3) states whether or not the employee’s
13 spouse has a health expenses eligibility certificate in
14 effect, and

15 “(4) estimates the amount of qualified health
16 expenses (as defined in section 34A(b)) for the cal-
17 endar year.

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

23 “(c) HEALTH EXPENSES ADVANCE AMOUNT.—

24 “(1) IN GENERAL.—For purposes of this title,
25 the term ‘health expenses advance amount’ means,

1 with respect to any payroll period, the amount deter-
2 mined—

3 “(A) on the basis of the employee’s wages
4 from the employer for such period,

5 “(B) on the basis of the employee’s esti-
6 mated qualified health expenses included in the
7 health expenses eligibility certificate, and

8 “(C) in accordance with tables provided by
9 the Secretary.

10 “(2) ADVANCE AMOUNT TABLES.—The tables
11 referred to in paragraph (1)(C) shall be similar in
12 form to the tables prescribed under section 3402
13 and, to the maximum extent feasible, shall be coordi-
14 nated with such tables and the tables prescribed
15 under section 3507(c).

16 “(d) OTHER RULES.—For purposes of this section,
17 rules similar to the rules of subsections (d) and (e) of sec-
18 tion 3507 shall apply.

19 “(e) REGULATIONS.—The Secretary shall prescribe
20 such regulations as may be necessary to carry out the pur-
21 poses of this section.”.

22 (c) TERMINATION OF HEALTH INSURANCE CRED-
23 IT.—Section 32 of the Internal Revenue Code of 1986 (re-
24 lating to earned income credit) is amended by adding at
25 the end thereof the following new subsection:

1 “(d) TERMINATION OF HEALTH INSURANCE CRED-
2 IT.—In the case of taxable years beginning after Decem-
3 ber 31, 1992, the health insurance credit percentage shall
4 be equal to 0 percent.”.

5 (d) CONFORMING AMENDMENT.—Section 213 of the
6 Internal Revenue Code of 1986 (relating to deduction for
7 medical, dental, etc., expenses) is amended by striking
8 subsections (e) and (f) and by inserting the following new
9 subsection:

10 “(e) COORDINATION WITH HEALTH EXPENSES
11 CREDIT UNDER SECTION 34A.—The amount otherwise
12 taken into account under subsection (a) as expenses paid
13 for medical care shall be reduced by the amount (if any)
14 of the health expenses credit allowable to the taxpayer for
15 the taxable year under section 34A.”.

16 (e) CLERICAL AMENDMENTS.—

17 (1) The table of sections for subpart A of part
18 IV of subchapter A of chapter 1 of the Internal Rev-
19 enue Code of 1986 is amended by inserting after the
20 item relating to section 34 the following new item:

“Sec. 34A. Health expenses.”.

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

“Sec. 3507A. Advance payment of health expenses credit.”.

1 (f) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1992.

4 **SEC. 102. INDIVIDUAL TAX DEDUCTION FOR HEALTH IN-**
5 **SURANCE COSTS.**

6 (a) FULL DEDUCTION ALLOWED.—Subsection (a) of
7 section 213 of the Internal Revenue Code of 1986 (relat-
8 ing to deduction for medical, dental, etc., expenses) is
9 amended to read as follows:

10 “(a) ALLOWANCE OF DEDUCTION.—

11 “(1) IN GENERAL.—Except as provided in para-
12 graph (2), there shall be allowed as a deduction the
13 expenses paid during the taxable year, not com-
14 pensated for by insurance or otherwise, for medical
15 care of the taxpayer, the taxpayer’s spouse, or a de-
16 pendent (as defined in section 152).

17 “(2) SPECIAL DOLLAR LIMITATION.—Expenses
18 for medical care described in subparagraphs (A) and
19 (B) of subsection (d)(1) shall be taken into account
20 under subsection (a) only to the extent that such ex-
21 penses exceed 7.5 percent of the taxpayer’s adjusted
22 gross income for the taxable year.”.

23 (b) DEDUCTION AVAILABLE FOR NONITEMIZERS.—

24 (1) IN GENERAL.—Section 213 of the Internal
25 Revenue Code of 1986, as amended by section

1 101(d), is further amended by adding at the end
2 thereof the following new subsection:

3 “(f) RULE FOR NONITEMIZATION OF DEDUC-
4 TIONS.—In the case of an individual who does not itemize
5 his deductions for the taxable year, the amount allowable
6 under subsection (a) for the taxable year with respect to
7 expenses described in subsection (d)(1)(C) shall be taken
8 into account as a direct health insurance deduction under
9 section 63.”.

10 (2) DEFINITION OF TAXABLE INCOME.—

11 (A) IN GENERAL.—Section 63(b) of such
12 Code (relating to individuals who do not itemize
13 their deductions) is amended—

14 (i) by striking “and” at the end of
15 paragraph (1),

16 (ii) by striking the period at the end
17 of paragraph (2) and inserting “, and”,
18 and

19 (iii) by adding at the end thereof the
20 following new paragraph:

21 “(3) the direct health insurance deduction.”.

22 (B) DIRECT HEALTH INSURANCE DEDUC-
23 TION DEFINED.—Section 63 of such Code (de-
24 fining taxable income) is amended by adding at
25 the end thereof the following new subsection:

1 “(h) DIRECT HEALTH INSURANCE DEDUCTION.—
2 For purposes of this section, the term ‘direct health insur-
3 ance deduction’ means that portion of the amount allow-
4 able under section 213(a) which is taken as a direct health
5 insurance deduction for the taxable year under section
6 213(f).”.

7 (C) CONFORMING AMENDMENT.—Section
8 63(d) of such Code (defining itemized deduc-
9 tions) is amended—

10 (i) by striking “and” at the end of
11 paragraph (1),

12 (ii) by striking the period at the end
13 of paragraph (2) and inserting “, and”,
14 and

15 (iii) by adding at the end thereof the
16 following new paragraph:

17 “(3) the direct health insurance deduction.”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to taxable years beginning after
20 December 31, 1992.

21 **SEC. 103. CREDIT FOR EMPLOYERS TO PROVIDE HEALTH**
22 **INSURANCE.**

23 (a) ALLOWANCE OF CREDIT.—Section 38(b) of the
24 Internal Revenue Code of 1986 (defining general business
25 credit) is amended by striking “plus” at the end of para-

1 graph (6), by striking the period at the end of paragraph
2 (7) and inserting “, plus”, and by adding at the end there-
3 of the following new paragraph:

4 “(8) the employer health insurance credit.”

5 (b) EMPLOYER HEALTH INSURANCE CREDIT.—Sub-
6 part D of part IV of subchapter A of chapter 1 of such
7 Code (relating to business related credits) is amended by
8 adding at the end thereof the following new section:

9 **“SEC. 45. EMPLOYER HEALTH INSURANCE CREDIT.**

10 “(a) GENERAL RULE.—For purposes of section 38,
11 the amount of the employer health insurance credit deter-
12 mined under this section for the taxable year is an amount
13 equal to the sum of—

14 “(1) the small employer basic health insurance
15 credit,

16 “(2) the managed care credit,

17 “(3) the dependent coverage credit, and

18 “(4) the small employer purchasing group
19 health insurance credit.

20 “(b) DEFINITION OF SMALL EMPLOYER BASIC
21 HEALTH INSURANCE CREDIT, MANAGED CARE CREDIT,
22 DEPENDENT COVERAGE CREDIT, AND SMALL EMPLOYER
23 PURCHASING GROUP HEALTH INSURANCE CREDIT.—

24 “(1) SMALL EMPLOYER BASIC HEALTH INSUR-
25 ANCE CREDIT.—The small employer basic health in-

1 surance credit of any eligible employer which is an
2 eligible small employer is 25 percent of the qualified
3 health care costs of such employer beginning with
4 the first full taxable year in which such employer of-
5 fers health-care coverage to employees of such em-
6 ployer, reduced (but not below zero percentage) by
7 5 percentage points for each taxable year thereafter.

8 “(2) MANAGED CARE CREDIT.—The managed
9 care credit of any eligible employer is 25 percent of
10 the approved managed care plan costs of such em-
11 ployer beginning with the first full taxable year in
12 which such employer offers an approved managed
13 care plan (within the meaning of section
14 162(m)(3)(B)) to employees of such employer for
15 the taxable year, reduced (but not below zero per-
16 cent) by 5 percentage points for each taxable year
17 thereafter.

18 “(3) DEPENDENT COVERAGE CREDIT.—The de-
19 pendent coverage credit of any eligible employer is
20 25 percent of the qualified dependent coverage costs
21 of such employer beginning with the first full taxable
22 year in which such employer offers health-care cov-
23 erage to dependents of employees of such employer
24 for the taxable year, reduced (but not below zero

1 percent) by 5 percentage points for each taxable
2 year thereafter.

3 “(4) SMALL EMPLOYER PURCHASING GROUP
4 HEALTH INSURANCE CREDIT.—The small employer
5 purchasing group health insurance credit of any eli-
6 gible small employer which is a member of a quali-
7 fied small employer purchasing group is 20 percent
8 of the qualified health care costs of such employer
9 for the taxable year.

10 “(c) ELIGIBLE EMPLOYER.—An employer is eligible
11 for a small employer basic health insurance credit, man-
12 aged care credit, and dependent coverage credit under this
13 section if such employer (or any predecessor employer) has
14 never provided health-care coverage, an approved managed
15 care plan, or dependent coverage for its employees (as the
16 case may be) at any time before the calendar year in which
17 occurs the first full taxable year described in paragraphs
18 (1), (2), or (3) of subsection (b), respectively.

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

20 “(1) QUALIFIED HEALTH CARE COSTS.—The
21 term ‘qualified health care costs’ means the amounts
22 paid by the employer for health-care coverage of its
23 employees.

24 “(2) APPROVED MANAGED CARE PLAN COSTS.—

1 “(A) IN GENERAL.—The term ‘approved
2 managed care plan costs’ means the amounts
3 paid by the employer for an approved managed
4 care plan for the employees of such employer.

5 “(B) APPROVED MANAGED CARE PLAN.—
6 The term ‘approved managed care plan’ means
7 a managed care plan meeting the requirements
8 of section 202(2) of the Health Equity and Ac-
9 cess Improvement Act of 1992.

10 “(3) QUALIFIED DEPENDENT COVERAGE
11 COSTS.—The term ‘qualified dependent coverage
12 costs’ means the amounts paid by the employer for
13 health-care coverage of the dependents of employees
14 of such employer.

15 “(4) ELIGIBLE SMALL EMPLOYER.—

16 “(A) IN GENERAL.—The term ‘eligible
17 small employer’ means any person—

18 “(i) which, on an average business
19 day during the preceding taxable year, had
20 more than 2 but less than 100 employees,
21 and

22 “(ii) at least 60 percent of the em-
23 ployees of which during the taxable year
24 received health-care coverage described in
25 paragraph (1).

1 “(B) AGGREGATION RULES.—All members
2 of the same controlled group of corporations
3 (within the meaning of section 52(a)) and all
4 persons under common control (within the
5 meaning of section 52(b)) shall be treated as 1
6 person.

7 “(C) EMPLOYEE.—The term ‘employee’
8 shall not include—

9 “(i) a self-employed individual as de-
10 fined in section 401(c)(1), or

11 “(ii) an employee who works less than
12 20 hours per week.

13 “(5) QUALIFIED SMALL EMPLOYER PURCHAS-
14 ING GROUP.—The term ‘qualified small employer
15 purchasing group’ has the meaning given such term
16 by section 221(a) of the Health Equity and Access
17 Improvement Act of 1992.

18 “(e) COORDINATION WITH DEDUCTION.—No deduc-
19 tion shall be allowable under this chapter for any qualified
20 health care costs taken into account in computing the
21 amount of the credit under section 38.”.

22 (c) CONFORMING AMENDMENT.—Section 39(d) of
23 such Code is amended by adding at the end thereof the
24 following new paragraph:

1 (1) by striking “health insurance credit” and
2 inserting “health expenses credit and employer
3 health insurance credit”,

4 (2) by striking “section 32” and inserting “sec-
5 tion 34A with respect to such insurance and section
6 38, respectively”, and

7 (3) by striking “CREDIT” in the heading thereof
8 and inserting “CREDITS”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 December 31, 1992.

12 **SEC. 105. REVENUE INCENTIVES FOR PRACTICE IN RURAL**
13 **AREAS.**

14 (a) NONREFUNDABLE CREDIT FOR CERTAIN PRI-
15 MARY HEALTH SERVICES PROVIDERS.—

16 (1) IN GENERAL.—Subpart A of part IV of sub-
17 chapter A of chapter 1 of the Internal Revenue Code
18 of 1986 (relating to nonrefundable personal credits)
19 is amended by inserting after section 25 the follow-
20 ing new section:

21 **“SEC. 25A. PRIMARY HEALTH SERVICES PROVIDERS.**

22 “(a) ALLOWANCE OF CREDIT.—In the case of a
23 qualified primary health services provider, there is allowed
24 as a credit against the tax imposed by this chapter for

1 any taxable year in a mandatory service period an amount
2 equal to the product of—

3 “(1) the lesser of—

4 “(A) the number of months of such period
5 occurring in such taxable year, or

6 “(B) 36 months, reduced by the number of
7 months taken into account under this para-
8 graph with respect to such provider for all pre-
9 ceding taxable years (whether or not in the
10 same mandatory service period), multiplied by

11 “(2) \$1,000 (\$500 in the case of a qualified
12 health services provider who is a physician assistant
13 or a nurse practitioner).

14 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-
15 VIDER.—For purposes of this section, the term ‘qualified
16 primary health services provider’ means any physician,
17 physician assistant, or nurse practitioner who for any
18 month during a mandatory service period is certified by
19 the Bureau to be a primary health services provider who—

20 “(1) is providing primary health services—

21 “(A) full time, and

22 “(B) to individuals at least 80 percent of
23 whom reside in a rural health professional
24 shortage area,

1 “(2) is not receiving during such year a scholar-
2 ship under the National Health Service Corps Schol-
3 arship Program or a loan repayment under the Na-
4 tional Health Service Corps Loan Repayment Pro-
5 gram,

6 “(3) is not fulfilling service obligations under
7 such Programs, and

8 “(4) has not defaulted on such obligations.

9 “(c) MANDATORY SERVICE PERIOD.—For purposes
10 of this section, the term ‘mandatory service period’ means
11 the period of 60 consecutive calendar months beginning
12 with the first month the taxpayer is a qualified primary
13 health services provider.

14 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
15 poses of this section—

16 “(1) BUREAU.—The term ‘Bureau’ means the
17 Bureau of Health Care Delivery and Assistance,
18 Health Resources and Services Administration of the
19 United States Public Health Service.

20 “(2) PHYSICIAN.—The term ‘physician’ has the
21 meaning given to such term by section 1861(r) of
22 the Social Security Act.

23 “(3) PHYSICIAN ASSISTANT; NURSE PRACTI-
24 TIONER.—The terms ‘physician assistant’ and ‘nurse

1 practitioner' have the meanings given to such terms
2 by section 1861(aa)(3) of the Social Security Act.

3 “(4) PRIMARY HEALTH SERVICES PROVIDER.—
4 The term ‘primary health services provider’ means a
5 provider of primary health services (as defined in
6 section 330(b)(1) of the Public Health Service Act).

7 “(5) RURAL HEALTH PROFESSIONAL SHORTAGE
8 AREA.—The term ‘rural health professional shortage
9 area’ means—

10 “(A) a class 1 or class 2 health profes-
11 sional shortage area (as defined in section
12 332(a)(1)(A) of the Public Health Service Act)
13 in a rural area (as determined under section
14 1886(d)(2)(D) of the Social Security Act), or

15 “(B) an area which is determined by the
16 Secretary of Health and Human Services as
17 equivalent to an area described in subparagraph
18 (A) and which is designated by the Bureau of
19 the Census as not urbanized.

20 “(e) RECAPTURE OF CREDIT.—

21 “(1) IN GENERAL.—If, during any taxable year,
22 there is a recapture event, then the tax of the tax-
23 payer under this chapter for such taxable year shall
24 be increased by an amount equal to the product of—

25 “(A) the applicable percentage, and

1 “(B) the aggregate unrecaptured credits
 2 allowed to such taxpayer under this section for
 3 all prior taxable years.

4 “(2) APPLICABLE RECAPTURE PERCENTAGE.—

5 “(A) IN GENERAL.—For purposes of this
 6 subsection, the applicable recapture percentage
 7 shall be determined from the following table:

“If the recapture event occurs during:	The applicable recap- ture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Months 61 and thereafter	0.

8 “(B) TIMING.—For purposes of subpara-
 9 graph (A), month 1 shall begin on the first day
 10 of the mandatory service period.

11 “(3) RECAPTURE EVENT DEFINED.—

12 “(A) IN GENERAL.—For purposes of this
 13 subsection, the term ‘recapture event’ means
 14 the failure of the taxpayer to be a qualified pri-
 15 mary health services provider for any month
 16 during any mandatory service period.

17 “(B) CESSATION OF DESIGNATION.—The
 18 cessation of the designation of any area as a
 19 rural health professional shortage area after the
 20 beginning of the mandatory service period for
 21 any taxpayer shall not constitute a recapture
 22 event.

1 “(C) SECRETARIAL WAIVER.—The Sec-
2 retary may waive any recapture event caused by
3 extraordinary circumstances.

4 “(4) NO CREDITS AGAINST TAX.—Any increase
5 in tax under this subsection shall not be treated as
6 a tax imposed by this chapter for purposes of deter-
7 mining the amount of any credit under subpart A,
8 B, or D of this part.”.

9 (2) CLERICAL AMENDMENT.—The table of sec-
10 tions for subpart A of part IV of subchapter A of
11 chapter 1 of such Code is amended by inserting
12 after the item relating to section 25 the following
13 new item:

 “Sec. 25A. Primary health services providers.”.

14 (3) EFFECTIVE DATE.—The amendments made
15 by this subsection shall apply to taxable years begin-
16 ning after December 31, 1992.

17 (b) NATIONAL HEALTH SERVICE CORPS LOAN RE-
18 PAYMENTS EXCLUDED FROM GROSS INCOME.—

19 (1) IN GENERAL.—Part III of subchapter B of
20 chapter 1 of the Internal Revenue Code of 1986 (re-
21 lating to items specifically excluded from gross in-
22 come) is amended by redesignating section 136 as
23 section 137 and by inserting after section 135 the
24 following new section:

1 **“SEC. 136. NATIONAL HEALTH SERVICE CORPS LOAN RE-**
2 **PAYMENTS.**

3 “(a) GENERAL RULE.—Gross income shall not in-
4 clude any qualified loan repayment.

5 “(b) QUALIFIED LOAN REPAYMENT.—For purposes
6 of this section, the term ‘qualified loan repayment’ means
7 any payment made on behalf of the taxpayer by the Na-
8 tional Health Service Corps Loan Repayment Program
9 under section 338B(g) of the Public Health Service Act.”.

10 (2) CONFORMING AMENDMENT.—Paragraph (3)
11 of section 338B(g) of the Public Health Service Act
12 is amended by striking “Federal, State, or local”
13 and inserting “State or local”.

14 (3) CLERICAL AMENDMENT.—The table of sec-
15 tions for part III of subchapter B of chapter 1 of
16 the Internal Revenue Code of 1986 is amended by
17 striking the item relating to section 136 and insert-
18 ing the following:

“Sec. 136. National Health Service Corps loan repayments.
“Sec. 137. Cross references to other Acts.”.

19 (4) EFFECTIVE DATE.—The amendments made
20 by this subsection shall apply to payments made
21 under section 338B(g) of the Public Health Service
22 Act after the date of the enactment of this Act.

23 (c) EXPENSING OF MEDICAL EQUIPMENT.—

1 (1) IN GENERAL.—Section 179 of the Internal
2 Revenue Code of 1986 (relating to election to ex-
3 pense of certain depreciable business assets) is
4 amended—

5 (A) by striking paragraph (1) of subsection
6 (b) and inserting the following:

7 “(1) DOLLAR LIMITATION.—

8 “(A) GENERAL RULE.—The aggregate cost
9 which may be taken into account under sub-
10 section (a) for any taxable year shall not exceed
11 \$10,000.

12 “(B) RURAL HEALTH CARE PROPERTY.—

13 In the case of rural health care property, the
14 aggregate cost which may be taken into account
15 under subsection (a) for any taxable year shall
16 not exceed \$25,000, reduced by the amount
17 otherwise taken into account under subsection
18 (a) for such year.”; and

19 (B) by adding at the end of subsection (d)
20 the following new paragraph:

21 “(11) RURAL HEALTH CARE PROPERTY.—For
22 purposes of this section, the term ‘rural health care
23 property’ means section 179 property used by a phy-
24 sician (as defined in section 1861(r) of the Social
25 Security Act) in the active conduct of such physi-

1 cian’s full-time trade or business of providing pri-
2 mary health services (as defined in section 330(b)(1)
3 of the Public Health Service Act) in a rural health
4 professional shortage area (as defined in section
5 25A(d)(5)).”.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to property placed in
8 service after December 31, 1992, in taxable years
9 ending after such date.

10 (d) DEDUCTION FOR STUDENT LOAN PAYMENTS BY
11 MEDICAL PROFESSIONALS PRACTICING IN RURAL
12 AREAS.—

13 (1) INTEREST ON STUDENT LOANS NOT TREAT-
14 ED AS PERSONAL INTEREST.—Section 163(h)(2) of
15 the Internal Revenue Code of 1986 (defining per-
16 sonal interest) is amended by striking “and” at the
17 end of subparagraph (D), by striking the period at
18 the end of subparagraph (E) and inserting “, and”,
19 and by adding at the end thereof the following new
20 subparagraph:

21 “(F) any qualified medical education interest
22 (within the meaning of subsection (k)).”.

23 (2) QUALIFIED MEDICAL EDUCATION INTEREST
24 DEFINED.—Section 163 of such Code (relating to in-
25 terest expenses) is amended by redesignating sub-

1 section (k) as subsection (l) and by inserting after
2 subsection (j) the following new subsection:

3 “(k) QUALIFIED MEDICAL EDUCATION INTEREST OF
4 MEDICAL PROFESSIONALS PRACTICING IN RURAL
5 AREAS.—

6 “(1) IN GENERAL.—For purposes of subsection
7 (h)(2)(F), the term ‘qualified medical education in-
8 terest’ means an amount which bears the same ratio
9 to the interest paid on qualified educational loans
10 during the taxable year by an individual performing
11 services under a qualified rural medical practice
12 agreement as—

13 “(A) the number of months during the tax-
14 able year during which such services were per-
15 formed, bears to

16 “(B) the number of months in the taxable
17 year.

18 “(2) DOLLAR LIMITATION.—The aggregate
19 amount which may be treated as qualified medical
20 education interest for any taxable year with respect
21 to any individual shall not exceed \$5,000.

22 “(3) QUALIFIED RURAL MEDICAL PRACTICE
23 AGREEMENT.—For purposes of this subsection—

24 “(A) IN GENERAL.—The term ‘qualified
25 rural medical practice agreement’ means a writ-

1 ten agreement between an individual and an ap-
2 plicable rural community under which the indi-
3 vidual agrees—

4 “(i) in the case of a medical doctor,
5 upon completion of the individual’s resi-
6 dency (or internship if no residency is re-
7 quired), or

8 “(ii) in the case of a registered nurse,
9 nurse practitioner, or physician’s assistant,
10 upon completion of the education to which
11 the qualified education loan relates,

12 to perform full-time services as such a medical
13 professional in the applicable rural community
14 for a period of 24 consecutive months. An indi-
15 vidual and an applicable rural community may
16 elect to have the agreement apply for 36 con-
17 secutive months rather than 24 months.

18 “(B) SPECIAL RULE FOR COMPUTING PE-
19 RIODS.—An individual shall be treated as meet-
20 ing the 24 or 36 consecutive month requirement
21 under subparagraph (A) if, during each 12-con-
22 secutive month period within either such period,
23 the individual performs full-time services as a
24 medical doctor, registered nurse, nurse practi-
25 tioner, or physician’s assistant, whichever ap-

1 plies, in the applicable rural community during
2 9 of the months in such 12-consecutive month
3 period. For purposes of this subsection, an indi-
4 vidual meeting the requirements of the preced-
5 ing sentence shall be treated as performing
6 services during the entire 12-month period.

7 “(C) APPLICABLE RURAL COMMUNITY.—
8 The term ‘applicable rural community’ means—

9 “(i) any political subdivision of a
10 State which—

11 “(I) has a population of 5,000 or
12 less, and

13 “(II) has a per capita income of
14 \$15,000 or less, or

15 “(ii) an Indian reservation which has
16 a per capita income of \$15,000 or less.

17 “(4) QUALIFIED EDUCATIONAL LOAN.—The
18 term ‘qualified educational loan’ means any indebt-
19 edness to pay qualified tuition and related expenses
20 (within the meaning of section 117(b)) and reason-
21 able living expenses—

22 “(A) which are paid or incurred—

23 “(i) as a candidate for a degree as a
24 medical doctor at an educational institu-

1 tion described in section 170(b)(1)(A)(ii),
2 or

3 “(ii) in connection with courses of in-
4 struction at such an institution necessary
5 for certification as a registered nurse,
6 nurse practitioner, or physician’s assistant,
7 and

8 “(B) which are paid or incurred within a
9 reasonable time before or after such indebted-
10 ness is incurred.

11 “(5) RECAPTURE.—If an individual fails to
12 carry out a qualified rural medical practice agree-
13 ment during any taxable year, then—

14 “(A) no deduction with respect to such
15 agreement shall be allowable by reason of sub-
16 section (h)(2)(F) for such taxable year and any
17 subsequent taxable year, and

18 “(B) there shall be included in gross in-
19 come for such taxable year the aggregate
20 amount of the deductions allowable under this
21 section (by reason of subsection (h)(2)(F)) for
22 all preceding taxable years.

23 “(6) DEFINITIONS.—For purposes of this sub-
24 section, the terms ‘registered nurse’, ‘nurse practi-
25 tioner’, and ‘physician’s assistant’ have the meaning

1 given such terms by section 1861 of the Social Secu-
2 rity Act.”.

3 (3) DEDUCTION ALLOWED IN COMPUTING AD-
4 JUSTED GROSS INCOME.—Section 62(a) of such
5 Code is amended by inserting after paragraph (13)
6 the following new paragraph:

7 “(14) INTEREST ON STUDENT LOANS OF RURAL
8 HEALTH PROFESSIONALS.—The deduction allowable
9 by reason of section 163(h)(2)(F) (relating to stu-
10 dent loan payments of medical professionals practic-
11 ing in rural areas).”.

12 (4) EFFECTIVE DATE.—The amendments made
13 by this subsection shall apply to taxable years begin-
14 ning after December 31, 1991.

15 **TITLE II—HEALTH CARE**
16 **REFORM PROVISIONS**
17 **Subtitle A—Model Health Care**
18 **Insurance Benefits Plan**

19 **SEC. 201. MODEL HEALTH CARE INSURANCE BENEFITS**
20 **PLAN.**

21 (a) IN GENERAL.—The Secretary shall request that
22 the NAIC—

23 (1) develop a model health care insurance bene-
24 fits plan that shall contain standards that entities
25 offering health care insurance policies should meet

1 with respect to the benefits and coverage provided
2 under such policies, and

3 (2) report to the Secretary on such standards,
4 not later than 1 year after the date of enactment of
5 this Act.

6 If the NAIC develops such a plan by such date and the
7 Secretary finds that such plan implements the require-
8 ments of subsection (c), such plan shall be the model
9 health care insurance benefits plan under this Act.

10 (b) ROLE OF THE SECRETARY IN ABSENCE OF NAIC
11 PLAN.—If the NAIC fails to develop and report a model
12 health care insurance benefits plan by the date specified
13 in subsection (a) or the Secretary finds that such plan
14 does not implement the requirements of subsection (c), the
15 Secretary shall develop and publish such a plan, by not
16 later than eighteen months after the date of enactment
17 of this Act. Such plan shall then be the plan under this
18 Act.

19 (c) CONTENTS.—The standards under the model ben-
20 efits plan should require—

21 (1) that coverage be provided under health care
22 insurance policies for basic hospital, medical and
23 surgical services, including preventative care services
24 determined appropriate by the Secretary;

1 (2) reasonable cost sharing by the beneficiaries
2 under such policies; and

3 (3) appropriate copayments and deductibles.

4 **SEC. 202. DEFINITIONS.**

5 As used in this title:

6 (1) HEALTH CARE INSURANCE.—The term
7 “health care insurance” means any hospital or medi-
8 cal expense incurred policy or certificate, hospital or
9 medical service plan contract, health maintenance
10 subscriber contract, multiple employer welfare ar-
11 rangement, other employee welfare plan (as defined
12 in the Employee Retirement Income Security Act of
13 1974), or any other health insurance arrangement,
14 and includes an employment-related reinsurance
15 plan, but does not include—

16 (A) a self-insured health care insurance
17 plan; or

18 (B) any of the following offered by an in-
19 surer—

20 (i) accident only, dental only, or dis-
21 ability income only insurance,

22 (ii) coverage issued as a supplement
23 to liability insurance,

24 (iii) worker’s compensation or similar
25 insurance, or

1 (iv) automobile medical-payment in-
2 surance.

3 (2) MANAGED CARE PLAN.—The term “man-
4 aged care plan” means a health care insurance plan
5 in which the insurer offering such plan utilizes the
6 standards recommended under section 211 concern-
7 ing the benefits and coverage under such plan.

8 (3) MODEL BENEFITS PLAN.—The term “model
9 benefits plan” means the model health care insur-
10 ance benefits plan developed under section 201(a).

11 (4) NAIC.—The term “NAIC” means the Na-
12 tional Association of Insurance Commissioners.

13 (5) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services.

15 (6) SMALL EMPLOYER.—

16 (A) IN GENERAL.—The term “small em-
17 ployer” means any employer which, on an aver-
18 age business day during the preceding taxable
19 year, had more than 2 but less than 100 em-
20 ployees.

21 (B) EMPLOYEE.—The term “employee”
22 shall not include—

23 (i) a self-employed individual as de-
24 fined in section 401(c)(1) of the Internal
25 Revenue Code of 1986, or

- 1 (ii) an employee who works less than
2 20 hours per week.

3 **Subtitle B—Managed Care**

4 **SEC. 211. DEVELOPMENT OF STANDARDS FOR MANAGED**
5 **CARE PLANS.**

6 (a) IN GENERAL.—Not later than 1 year after the
7 date of enactment of this Act, the Secretary, taking into
8 account recommendations of the Managed Care Advisory
9 Committee, shall develop recommended standards that in-
10 surers offering managed care plans should meet with re-
11 spect to the benefits, coverage, and delivery systems pro-
12 vided under such plans. Such standards shall encompass
13 the standards by which managed care entities operate.

14 (b) MANAGED CARE ADVISORY COMMITTEE.—

15 (1) ESTABLISHMENT.—There shall be estab-
16 lished a Managed Care Advisory Committee (herein-
17 after referred to as the “Committee”).

18 (2) MEMBERSHIP.—The Committee shall be
19 composed of 5 members appointed by the Secretary,
20 each member representing 1 of the following areas:

21 (A) Health care professionals.

22 (B) Managed care industry.

23 (C) Academia (with specific expertise in
24 managed care plans).

25 (D) Business management.

1 (E) Organized labor.

2 (3) COMPENSATION.—

3 (A) IN GENERAL.—Members of the Com-
4 mittee shall serve without compensation.

5 (B) EXPENSES, ETC., REIMBURSED.—
6 While away from their homes or regular places
7 of business on the business of the Committee,
8 the members may be allowed travel expenses,
9 including per diem in lieu of subsistence, as au-
10 thorized by section 5703 of title 5, United
11 States Code, for persons employed intermit-
12 tently in Government service.

13 (C) APPLICATION OF ACT.—The provisions
14 of the Federal Advisory Committee Act (5
15 U.S.C. App.) shall not apply with respect to the
16 Committee.

17 (D) SUPPORT.—The Secretary shall supply
18 such necessary office facilities, office supplies,
19 support services, and related expenses as nec-
20 essary to carry out the functions of the Com-
21 mittee.

22 **SEC. 212. PREEMPTION OF PROVISIONS RELATING TO MAN-**
23 **AGED CARE.**

24 In the case of a managed care plan meeting the rec-
25 ommended standards under section 211 that is offered by

1 an insurer, the following provisions of State law are pre-
2 empted and may not be enforced against the managed care
3 plan with respect to an insurer offering such plan:

4 (1) RESTRICTIONS ON REIMBURSEMENT RATES
5 OR SELECTIVE CONTRACTING.—Any law that re-
6 stricts the ability of the insurer to negotiate reim-
7 bursement rates with health care providers or to
8 contract selectively with one provider or a limited
9 number of providers.

10 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
11 CIAL INCENTIVES.—Any law that limits the financial
12 incentives that the managed care plan may require
13 a beneficiary to pay when a non-plan provider is
14 used on a non-emergency basis.

15 (3) RESTRICTIONS ON UTILIZATION REVIEW
16 METHODS.—

17 (A) IN GENERAL.—Any law that—

18 (i) prohibits utilization review of any
19 or all treatments and conditions;

20 (ii) requires that such review be made
21 by a resident of the State in which the
22 treatment is to be offered or by an individ-
23 ual licensed in such State, or by a physi-
24 cian in any particular specialty or with any
25 board certified specialty of the same medi-

1 cal specialty as the provider whose services
2 are being rendered;

3 (iii) requires the use of specified
4 standards of health care practice in such
5 review or requires the disclosure of the
6 specific criteria used in such review;

7 (iv) requires payments to providers for
8 the expenses of responding to utilization
9 review requests; or

10 (v) imposes liability for delays in per-
11 forming such review.

12 (B) CONSTRUCTION.—Nothing in subpara-
13 graph (A)(ii) shall be construed as prohibiting
14 a State from requiring that utilization review be
15 conducted by a licensed health care profes-
16 sional, or requiring that any appeal from such
17 a review be made by a licensed physician or by
18 a licensed physician in any particular specialty
19 or with any board certified specialty of the
20 same medical specialty as the provider whose
21 services are being rendered.

22 (4) RESTRICTIONS ON BENEFITS.—Any law
23 that mandates benefits under the managed care plan
24 that are greater than the benefits recommended
25 under the standards developed under section 211.

1 **Subtitle C—Small Employer**
2 **Purchasing Groups**

3 **SEC. 221. QUALIFIED SMALL EMPLOYER PURCHASING**
4 **GROUPS.**

5 (a) **DEFINED.**—For purposes of this title, an entity
6 is a qualified small employer purchasing group if—

7 (1) the entity submits an application to the Sec-
8 retary at such time, in such form and containing
9 such information as the Secretary may require; and

10 (2) on the basis of information contained in the
11 application and any other information the Secretary
12 may require, the Secretary determines that—

13 (A) the entity is administered solely under
14 the authority and control of its member employ-
15 ers;

16 (B) the membership of the entity consists
17 solely of small employers (except that an em-
18 ployer member of the group may retain its
19 membership in the group if, after the Secretary
20 determines that the entity meets the require-
21 ments of this subsection, the number of employ-
22 ees of the employer member increases to more
23 than 100);

1 (C) with respect to each State in which its
2 members are located, the entity consists of not
3 fewer than 100 employers;

4 (D) at the time the entity submits its ap-
5 plication, the health care insurance plans with
6 respect to the employer members of the entity
7 are in compliance with applicable State laws
8 and the model benefits plan relating to such
9 plans;

10 (E) the health care insurance plans of the
11 entity and the employer members of the entity
12 are not self-insured plans;

13 (F) each enrollee in the program of the en-
14 tity may enroll with any participating carrier
15 that offers health care insurance coverage in
16 the geographic area in which the enrollee re-
17 sides; and

18 (G) such entity will be a nonprofit entity;
19 and

20 (3) such entity has a board of directors as de-
21 scribed in subsection (b) with authority to act as de-
22 scribed in subsection (c).

23 (b) OPERATIONS.—A small employer purchasing
24 group shall be administered by a board of directors. The
25 members of such board shall be elected by the employers

1 that are members of the group, and such board members
2 shall serve at the pleasure of the majority of such employ-
3 ers.

4 (c) DUTIES OF BOARD.—

5 (1) IN GENERAL.—The board shall have the au-
6 thority to—

7 (A) enter into contracts with carriers to
8 provide health care insurance coverage to eligi-
9 ble employees and their dependents;

10 (B) enter into other contracts as are nec-
11 essary or proper to carry out the provisions of
12 this subtitle;

13 (C) employ necessary staff;

14 (D) appoint committees as necessary to
15 provide technical assistance in the operation of
16 the entity's program;

17 (E) assess participating employers a rea-
18 sonable fee for necessary costs in connection
19 with the program;

20 (F) undertake activities necessary to ad-
21 minister the program including marketing and
22 publicizing the program and assuring carrier,
23 employer, and enrollee compliance with program
24 requirements;

1 (G) issue rules and regulations necessary
2 to carry out the purpose of this subtitle; and

3 (H) accept and expend funds received
4 through fees, grants, appropriations, or other
5 appropriate and lawful means.

6 (2) PROGRAM MANAGEMENT.—

7 (A) GEOGRAPHIC AREAS OF COVERAGE.—

8 The board shall establish geographic areas
9 within which participating carriers may offer
10 health care insurance coverage to eligible em-
11 ployees and dependents. The board shall con-
12 tract with sufficient numbers and types of car-
13 riers in an area to assure that employees have
14 a choice from among a reasonable number and
15 type of competing health care insurance car-
16 riers.

17 (B) CONTRACT REQUIREMENTS.—

18 (i) IN GENERAL.—The board shall
19 enter into contracts with qualified carriers
20 for the purpose of providing health care in-
21 surance coverage to eligible employees and
22 dependents, and shall pay qualified carriers
23 on at least a monthly basis at the con-
24 tracted rates.

1 (ii) GENERAL QUALIFICATIONS OF
2 CARRIERS.—Participating carriers shall be
3 qualified if such carriers have—

4 (I) adequate administrative man-
5 agement,

6 (II) financial solvency, and

7 (III) the ability to assume the
8 risk of providing and paying for cov-
9 ered services.

10 A participating carrier may utilize reinsur-
11 ance, provider risk sharing, and other ap-
12 propriate mechanisms to share a portion of
13 the risk described in subclause (III). The
14 board may establish risk adjustment mech-
15 anisms that can be utilized to address cir-
16 cumstances where a participating carrier
17 has a significantly disproportionate share
18 of high risk or low risk enrollees based
19 upon valid data provided by carrier. Any
20 such risk adjustment mechanism may be
21 developed and applied only after consulta-
22 tion with the participating carriers.

23 (C) PROGRAM STANDARDS.—The board
24 shall require that participating carriers that
25 contract with or employ health care providers

1 shall have mechanisms to accomplish at least
2 the following, satisfactory to the program:

3 (i) Review the quality of care covered.

4 (ii) Review the appropriateness of care
5 covered.

6 (iii) Provide accessible health services.

7 (D) UNIFORMITY OF BENEFITS.—The
8 board shall assure that participating carriers—

9 (i) shall offer substantially similar
10 benefits to enrollees in the program, except
11 that enrollees cost sharing required by par-
12 ticipating carriers may vary according to
13 the basic method of operation of the car-
14 rier, and

15 (ii) shall not vary rates to small em-
16 ployers or enrollees in the program on ac-
17 count of claim experience, health status or
18 duration from issue.

19 (E) PAYMENT MECHANISM.—The board
20 shall establish a mechanism to collect premiums
21 from small employers, including remittance of
22 the enrollee's share of the premium.

23 (3) NOTIFICATION OF PROGRAM BENEFITS.—

24 The board shall use appropriate and efficient means
25 to notify employers of the availability of sponsored

1 health care insurance coverage from the program.
2 The board shall make available marketing materials
3 which accurately summarize the carriers' insurance
4 plans and rates which are offered through the pro-
5 gram. A participating carrier may contract with an
6 agent or broker to provide marketing, advertising, or
7 presentation proposals or otherwise disseminate in-
8 formation regarding coverage or services or rates of-
9 fered in connection with the program.

10 (4) CONDITIONS OF PARTICIPATION.—

11 (A) IN GENERAL.—The board shall estab-
12 lish conditions of participation for small em-
13 ployers and enrollees that—

14 (i) assure that the entity is a valid
15 small employer purchasing group and is
16 not formed for the purpose of securing
17 health care insurance coverage;

18 (ii) assure that individuals in the
19 group are not added for the purpose of se-
20 curing such coverage;

21 (iii) require that a specified percent-
22 age of employees and dependents obtain
23 health care insurance coverage;

24 (iv) require minimum employer con-
25 tributions; and

1 (v) require prepayment of premiums
2 or other mechanisms to assure that pay-
3 ment will be made for coverage.

4 (B) MINIMUM PARTICIPATION.—The board
5 may require participating employers to agree to
6 participate in the program for a specified mini-
7 mum period of time and may include in any
8 participation agreements with employers a re-
9 quirement for a financial deposit or provision
10 for a financial penalty, which would be invoked
11 in the event the employer violates the participa-
12 tion agreement.

13 (d) GRANTS.—

14 (1) AUTHORITY.—The Secretary may award
15 grants to qualified small employer purchasing
16 groups to assist such groups in paying the expendi-
17 tures associated with the formation and initial oper-
18 ations of such groups.

19 (2) APPLICATION.—To be eligible to receive a
20 grant under this subsection, a qualified small em-
21 ployer purchasing group shall request such a grant
22 as part of the application submitted by such group
23 under subsection (a)(1).

1 “(2) the specific contractual requirements of
2 section 850B.

3 “(b) LIMITATION.—

4 “(1) SECTION NOT TO APPLY WHERE FAILURE
5 NOT DISCOVERED EXERCISING REASONABLE DILI-
6 GENCE.—Subsection (a) shall not apply with respect
7 to any failure for which it is established to the satis-
8 faction of the Secretary that the person described in
9 such subsection did not know, or exercising reason-
10 able diligence would not have known, that such fail-
11 ure existed.

12 “(2) SECTION NOT TO APPLY WHERE FAILURES
13 CORRECTED WITHIN 30 DAYS.—Subsection (a) shall
14 not apply with respect to any failure if—

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

17 “(B) such failure is corrected during the
18 30-day period beginning on the 1st date any of
19 the persons described in such subsection knew,
20 or exercising reasonable diligence would have
21 known, that such failure existed.

22 “(3) WAIVER BY SECRETARY.—In the case of a
23 failure which is due to reasonable cause and not to
24 willful neglect, the Secretary may waive the applica-
25 tion of subsection (a).

1 **“SEC. 850A. GENERAL ISSUANCE REQUIREMENTS.**

2 “(a) GENERAL RULE.—The requirements of this sec-
3 tion are met if a person meets—

4 “(1) the mandatory policy requirements of sub-
5 section (b),

6 “(2) the guaranteed issue requirements of sub-
7 section (c), and

8 “(3) the mandatory registration and disclosure
9 requirements of subsection (d).

10 **“(b) MANDATORY POLICY REQUIREMENTS.—**

11 “(1) IN GENERAL.—The requirements of this
12 subsection are met if any person issuing a health
13 care insurance contract to any eligible small em-
14 ployer makes available to such employer a health
15 care insurance contract which—

16 “(A) provides benefits and coverage con-
17 sistent with the model health care insurance
18 benefits plan developed under section 201 of the
19 Health Equity and Access Improvement Act of
20 1992, and

21 “(B) is for a term of not less than 12
22 months.

23 “(2) PRICING AND MARKETING REQUIRE-
24 MENTS.—The requirements of paragraph (1) are not
25 met unless—

1 “(A) the price at which the contract de-
2 scribed in paragraph (1) is made available is
3 not greater than the price for such contract de-
4 termined on the same basis as prices for other
5 health care insurance contracts within the same
6 class of business made available by the person
7 to eligible small employers, and

8 “(B) such contract is made available to eli-
9 gible small employers using at least the market-
10 ing methods and other sales practices which are
11 used in selling such other contracts.

12 “(c) GUARANTEED ISSUE.—

13 “(1) IN GENERAL.—The requirements of this
14 subsection are met if the person offering health care
15 insurance contracts to eligible small employers issues
16 such a contract to any eligible small employer seek-
17 ing to enter into such a contract.

18 “(2) FINANCIAL CAPACITY EXCEPTION.—Para-
19 graph (1) shall not require any person to issue a
20 health care insurance contract to the extent that the
21 issuance of such contract would result in such per-
22 son violating the financial solvency standards (if
23 any) established by the State in which such contract
24 is to be issued.

1 “(3) DELIVERY CAPACITY EXCEPTION.—Para-
2 graph (1) shall not require any person to issue a
3 health care insurance contract to the extent that the
4 issuance of such contract would result, upon dem-
5 onstration to the Secretary, in such person exceeding
6 its administrative capacity to serve previously en-
7 rolled groups and individuals (and additional individ-
8 uals who will be expected to enroll because of affili-
9 ation with such previously enrolled groups).

10 “(4) EXCEPTION FOR CERTAIN EMPLOYERS.—
11 Paragraph (1) shall not apply to a failure to issue
12 a health care insurance contract to an eligible small
13 employer if—

14 “(A) such employer is unable to pay the
15 premium for such contract, or

16 “(B) in the case of an eligible small em-
17 ployer with fewer than 15 employees, such em-
18 ployer fails to enroll a minimum percentage of
19 the employer’s eligible employees for coverage
20 under such contract, so long as such percentage
21 is enforced uniformly for all eligible small em-
22 ployers of comparable size.

23 “(5) EXCEPTION FOR ALTERNATIVE STATE
24 PROGRAMS.—

1 “(A) IN GENERAL.—Paragraph (1) shall
2 not apply if the State in which the health care
3 insurance contract is issued—

4 “(i) has a program which—

5 “(I) assures the availability of
6 health care insurance contracts to eli-
7 gible small employers through the eq-
8 uitable distribution of high risk
9 groups among all persons offering
10 such contracts to such employers, and

11 “(II) is consistent with a model
12 program developed by the NAIC;

13 “(ii) has a qualified State-run reinsur-
14 ance program, or

15 “(iii) has a program which the Sec-
16 retary of Health and Human Services has
17 determined assures all eligible small em-
18 ployers in the State an opportunity to pur-
19 chase a health care insurance contract
20 without regard to any risk characteristic.

21 “(B) REINSURANCE PROGRAM.—

22 “(i) PROGRAM REQUIREMENTS.—For
23 purposes of subparagraph (A)(ii), a State-
24 run reinsurance program is qualified if
25 such program is one of the NAIC reinsur-

1 ance program models developed under
2 clause (ii) or is a variation of one of such
3 models, as approved by the Secretary of
4 Health and Human Services.

5 “(ii) MODELS.—Not later than the
6 120 days after the date of the enactment
7 of the Health Equity and Access Improve-
8 ment Act of 1992, the NAIC shall develop
9 several models for a reinsurance program,
10 including options for program funding.

11 “(d) MANDATORY REGISTRATION AND DISCLOSURE
12 REQUIREMENTS.—The requirements of this subsection
13 are met if the person offering health care insurance con-
14 tracts to eligible small employers in any State—

15 “(1) registers with the State commissioner or
16 superintendent of insurance or other State authority
17 responsible for regulation of health insurance,

18 “(2) fully discloses the rating practices for
19 small employer health care insurance contracts at
20 the time such person offers a health care insurance
21 contract to an eligible small employer, and

22 “(3) fully discloses the terms for renewal of the
23 contract at the time of the offering of such contract
24 and at least 90 days before the expiration of such
25 contract.

1 **“SEC. 850B. SPECIFIC CONTRACTUAL REQUIREMENTS.**

2 “(a) GENERAL RULE.—The requirements of this sec-
3 tion are met if the following requirements are met:

4 “(1) The coverage requirements of subsection
5 (b).

6 “(2) The rating requirements of subsection (c).

7 “(b) COVERAGE REQUIREMENTS.—

8 “(1) IN GENERAL.—The requirements of this
9 subsection are met with respect to any health care
10 insurance contract if, under the terms and operation
11 of the contract, the following requirements are met:

12 “(A) GUARANTEED ELIGIBILITY.—No eli-
13 gible employee (and the spouse or any depend-
14 ent child of the employee eligible for coverage)
15 may be excluded from coverage under the con-
16 tract.

17 “(B) LIMITATIONS ON COVERAGE OF PRE-
18 EXISTING CONDITIONS.—Any limitation under
19 the contract on any preexisting condition—

20 “(i) may not extend beyond the 6-
21 month period beginning with the date an
22 insured is first covered by the contract,
23 and

24 “(ii) may only apply to preexisting
25 conditions which manifested themselves, or
26 for which medical care or advice was

1 sought or recommended, during the 3-
2 month period preceding the date an in-
3 sured is first covered by the contract.

4 “(C) GUARANTEED RENEWABILITY.—

5 “(i) IN GENERAL.—The contract must
6 be renewed at the election of the eligible
7 small employer unless the contract is ter-
8 minated for cause.

9 “(ii) CAUSE.—For purposes of this
10 subparagraph, the term ‘cause’ means—

11 “(I) nonpayment of the required
12 premiums;

13 “(II) fraud or misrepresentation
14 of the employer or, with respect to
15 coverage of individual insureds, the
16 insureds or their representatives;

17 “(III) noncompliance with the
18 contract’s minimum participation re-
19 quirements;

20 “(IV) noncompliance with the
21 contract’s employer contribution re-
22 quirements; or

23 “(V) repeated misuse of a pro-
24 vider network provision in the con-
25 tract.

1 “(2) WAITING PERIODS.—Paragraph (1)(A)
2 shall not apply to any period an employee is ex-
3 cluded from coverage under the contract solely by
4 reason of a requirement applicable to all employees
5 that a minimum period of service with the employer
6 is required before the employee is eligible for such
7 coverage.

8 “(3) DETERMINATION OF PERIODS FOR RULES
9 RELATING TO PREEXISTING CONDITIONS.—For pur-
10 poses of paragraph (1)(B), the date on which an in-
11 sured is first covered by a contract shall be the ear-
12 lier of—

13 “(A) the date on which coverage under
14 such contract begins, or

15 “(B) the first day of any continuous pe-
16 riod—

17 “(i) during which the insured was cov-
18 ered under 1 or more other health insur-
19 ance arrangements, and

20 “(ii) which does not end more than
21 120 days before the date employment with
22 the employer begins.

23 “(4) CESSATION OF SMALL EMPLOYER HEALTH
24 INSURANCE BUSINESS.—

1 “(A) IN GENERAL.—Except as otherwise
2 provided in this paragraph, a person shall not
3 be treated as failing to meet the requirements
4 of paragraph (1)(C) if such person terminates
5 the class of business which includes the health
6 care insurance contract.

7 “(B) NOTICE REQUIREMENT.—Subpara-
8 graph (A) shall apply only if the person gives
9 notice of the decision to terminate at least 90
10 days before the expiration of the contract.

11 “(C) 5-YEAR MORATORIUM.—If, within 5
12 years of the year in which a person terminates
13 a class of business under subparagraph (A),
14 such person establishes a new class of business,
15 the issuance of such contracts in that year shall
16 be treated as a failure to which this section ap-
17 plies.

18 “(D) TRANSFERS.—If, upon a failure to
19 renew a contract to which subparagraph (A)
20 applies, a person offers to transfer such con-
21 tract to another class of business, such transfer
22 must be made without regard to risk character-
23 istics.

24 “(c) RATING REQUIREMENTS.—

1 “(1) IN GENERAL.—The requirements of this
2 subsection are met if—

3 “(A) the requirements of paragraphs (2)
4 and (3) are met, and

5 “(B) any increase in any premium rate
6 under the renewal contract over the correspond-
7 ing rate under the health care insurance con-
8 tract being renewed does not exceed the appli-
9 cable annual adjusted increase.

10 “(2) LIMIT ON VARIATION OF PREMIUMS BE-
11 TWEEN CLASSES OF BUSINESS.—

12 “(A) IN GENERAL.—The requirements of
13 this paragraph are met if the index rate for a
14 rating period for any class of business of the in-
15 surer does not exceed the index rate for any
16 other class of business by more than 20 per-
17 cent.

18 “(B) EXCEPTIONS.—Subparagraph (A)
19 shall not apply to a class of business if—

20 “(i) the class is one for which the in-
21 surer does not reject, and never has re-
22 jected, eligible small employers included
23 within the class of business or otherwise el-
24 igible employees and dependents who enroll

1 on a timely basis, based upon risk charac-
2 teristics,

3 “(ii) the insurer does not transfer,
4 and never has transferred, a health care
5 insurance contract involuntarily into or out
6 of the class of business, and

7 “(iii) the class of business is currently
8 available for purchase.

9 “(3) LIMIT ON VARIATION IN PREMIUM RATES
10 WITHIN A CLASS OF BUSINESS.—The requirements
11 of this paragraph are met if the premium rates
12 charged during a rating period to eligible small em-
13 ployers with similar case characteristics (other than
14 risk characteristics) for the same or similar cov-
15 erage, or the rates which could be charged to such
16 employers under the rating system for that class of
17 business, do not vary from the index rate by more
18 than 20 percent of the index rate.

19 “(4) APPLICABLE ANNUAL ADJUSTED IN-
20 CREASE.—For purposes of paragraph (1)(B)—

21 “(A) IN GENERAL.—The applicable annual
22 adjusted increase is an amount equal to the
23 sum of—

1 “(i) the applicable percentage of the
2 premium rate under the health care insur-
3 ance contract being renewed, plus

4 “(ii) any increase in the rate under
5 the renewal contract due to any change in
6 coverage or to any change of case charac-
7 teristics (other than risk characteristics),
8 plus

9 “(iii) 5 percentage points.

10 “(B) APPLICABLE PERCENTAGE.—

11 “(i) IN GENERAL.—For purposes of
12 subparagraph (A), the applicable percent-
13 age is the percentage (if any) by which—

14 “(I) the premium rate for newly
15 issued contracts for substantially simi-
16 lar coverage for an employer with
17 similar case characteristics (other
18 than risk characteristics) as the em-
19 ployer under the health care insurance
20 contract (determined on the 1st day
21 of the rating period applicable to such
22 contracts), exceeds

23 “(II) such rate on the 1st day of
24 the rating period applicable to the
25 contract being renewed.

1 “(ii) CASES WHERE NO NEW BUSI-
2 NESS.—If no new contracts are being is-
3 sued for a class of business during any rat-
4 ing period, the applicable percentage shall
5 be the percentage (if any) by which the
6 base premium rate determined under para-
7 graph (5)(B) with respect to the renewal
8 contract exceeds such rate for the contract
9 to be renewed.

10 “(5) DEFINITIONS.—For purposes of this sub-
11 section—

12 “(A) INDEX RATE.—The term ‘index rate’
13 means, with respect to a class of business, the
14 arithmetic average of the applicable base pre-
15 mium rate and the corresponding highest pre-
16 mium rate for that class.

17 “(B) BASE PREMIUM RATE.—The term
18 ‘base premium rate’ means, for each class of
19 business for each rating period, the lowest pre-
20 mium rate which could have been charged
21 under a rating system for that class of business
22 by the insurer to eligible small employers with
23 similar case characteristics (other than risk
24 characteristics) for health care insurance con-
25 tracts with the same or similar coverage.

1 **“SEC. 850C. STATE COMPLIANCE AGREEMENTS.**

2 “(a) AGREEMENTS.—The Secretary of Health and
3 Human Services may enter into an agreement with any
4 State—

5 “(1) to apply the standards set by the NAIC
6 for health care insurance contracts in lieu of the re-
7 quirements of this subchapter, and

8 “(2) to provide for the State to make the initial
9 determination as to whether a person is in compli-
10 ance with such standards for purposes of applying
11 the sanctions under section 850.

12 “(b) STANDARDS.—An agreement may be entered
13 into under subsection (a)(1) only if—

14 “(1) the chief executive officer of the State re-
15 quests such agreement be entered into,

16 “(2) the Secretary of Health and Human Serv-
17 ices determines that the NAIC standards to be ap-
18 plied under the agreement will carry out the pur-
19 poses of this subchapter, and

20 “(3) the Secretary determines that the NAIC
21 standards to be applied under the agreement will
22 apply to substantially all health care insurance con-
23 tracts issued in such State to eligible small employ-
24 ers.

25 “(c) TERMINATION.—The Secretary of Health and
26 Human Services shall terminate any agreement if the Sec-

1 reary determines that the application of NAIC standards
2 by the State ceases to carry out the purposes of this sub-
3 chapter.

4 “(d) NAIC STANDARDS.—Not later than the 270
5 days after the date of the enactment of the Health Equity
6 and Access Improvement Act of 1992, the NAIC shall de-
7 velop standards which provide for requirements substan-
8 tially similar to the requirements of this subchapter.

9 **“SEC. 850D. DEFINITIONS AND OTHER RULES.**

10 For purposes of this part—

11 “(1) HEALTH CARE INSURANCE.—The term
12 ‘health care insurance’ means any hospital or medi-
13 cal expense incurred policy or certificate, hospital or
14 medical service plan contract, health maintenance
15 subscriber contract, multiple employer welfare ar-
16 rangement, other employee welfare plan (as defined
17 in the Employee Retirement Income Security Act of
18 1974), or any other health insurance arrangement,
19 and includes an employment-related reinsurance
20 plan, but does not include—

21 “(A) a self-insured health care insurance
22 plan; or

23 “(B) any of the following offered by an in-
24 surer—

1 “(i) accident only, dental only, or dis-
2 ability income only insurance,

3 “(ii) coverage issued as a supplement
4 to liability insurance,

5 “(iii) worker’s compensation or simi-
6 lar insurance, or

7 “(iv) automobile medical-payment in-
8 surance.

9 “(2) CLASS OF BUSINESS.—

10 “(A) IN GENERAL.—Except as provided in
11 subparagraph (B), the term ‘class of business’
12 means, with respect to health care insurance
13 provided to eligible small employers, all health
14 care insurance provided to such employers.

15 “(B) ESTABLISHMENT OF GROUPINGS.—

16 “(i) IN GENERAL.—An issuer may es-
17 tablish separate classes of business with re-
18 spect to health care insurance provided to
19 eligible small employers but only if such
20 classes are based on 1 or more of the fol-
21 lowing:

22 “(I) Business marketed and sold
23 through persons not participating in
24 the marketing and sale of such insur-
25 ance to other eligible small employers.

1 “(II) Business acquired from
2 other insurers as a distinct grouping.

3 “(III) Business provided through
4 an association of not less than 20 eli-
5 gible small employers which was es-
6 tablished for purposes other than ob-
7 taining insurance.

8 “(IV) Business related to man-
9 aged care plans (as defined in section
10 202(2) of the Health Equity and Ac-
11 cess Improvement Act of 1992).

12 “(V) Any other business which
13 the Secretary of Health and Human
14 Services determines needs to be sepa-
15 rately grouped to prevent a substan-
16 tial threat to the solvency of the in-
17 surer.

18 “(ii) EXCEPTION ALLOWED.—Except
19 as provided in subparagraph (C), an in-
20 surer may not establish more than one dis-
21 tinct group of eligible small employers for
22 each category specified in clause (i).

23 “(C) SPECIAL RULE.—An insurer may es-
24 tablish up to 2 groups under each category in
25 subparagraph (A) or (B) to account for dif-

1 ferences in characteristics (other than dif-
2 ferences in plan benefits) of health insurance
3 plans that are expected to produce substantial
4 variation in health care costs.

5 “(2) CHARACTERISTICS.—

6 “(A) IN GENERAL.—The term ‘characteris-
7 tics’ means, with respect to any insurance rat-
8 ing system, the factors used in determining
9 rates.

10 “(B) RISK CHARACTERISTICS.—The term
11 ‘risk characteristics’ means factors related to
12 the health risks of individuals, including health
13 status, prior claims experience, the duration
14 since the date of issue of a health insurance
15 plan or arrangement, industry, and occupation.

16 “(C) GEOGRAPHIC FACTORS.—

17 “(i) IN GENERAL.—In applying geo-
18 graphic location as a characteristic, an in-
19 surer may not use for purposes of this sub-
20 chapter areas smaller than 3-digit postal
21 zip code areas.

22 “(ii) STUDY AND REPORT.—Not later
23 than 120 days after the date of the enact-
24 ment of the Health Equity and Access Im-
25 provement Act of 1992, the Comptroller

1 General of the United States shall study
2 and report to the Congress concerning—

3 “(I) insurance industry practices
4 in determining the geographic bound-
5 aries of communities used for setting
6 rates,

7 “(II) the feasibility and desirabil-
8 ity of establishing standardized geo-
9 graphic communities for setting rates,
10 and

11 “(III) the effect such standard-
12 ized geographic communities would
13 have on rates charged small employ-
14 ers.

15 “(3) ELIGIBLE SMALL EMPLOYER.—

16 “(A) IN GENERAL.—The term ‘eligible
17 small employer’ means any person which, on an
18 average business day during the preceding tax-
19 able year, had more than 2 but less than 50
20 employees.

21 “(B) AGGREGATION RULES.—All members
22 of the same controlled group of corporations
23 (within the meaning of section 52(a)) and all
24 persons under common control (within the

1 meaning of section 52(b)) shall be treated as 1
2 person.

3 “(C) EMPLOYEE.—The term ‘employee’
4 shall not include—

5 “(i) a self-employed individual as de-
6 fined in section 401(c)(1), or

7 “(ii) an employee who works less than
8 20 hours per week.

9 “(4) NAIC.—The term ‘NAIC’ means the Na-
10 tional Association of Insurance Commissioners.”

11 (b) CONFORMING AMENDMENT.—Subchapter L of
12 chapter 1 of the Internal Revenue Code of 1986 is amend-
13 ed by adding at the end thereof the following new item:

“Part IV. Health care insurance provided to small employers.”

14 (c) EFFECTIVE DATES.—

15 (1) IN GENERAL.—The amendments made by
16 this section shall apply to contracts issued, or re-
17 newed, after the date of the enactment of this Act.

18 (2) GUARANTEED ISSUE.—The provisions of
19 section 850A(c) of the Internal Revenue Code of
20 1986, as added by this section, shall apply to con-
21 tracts which are issued, or renewed, after the date
22 which is 18 months after the date of the enactment
23 of this Act.

24 (3) PREMIUM RANGE.—In the case of any con-
25 tract in effect on the date of the enactment of this

1 Act, the provisions of section 850B(c)(1)(A) of such
2 Code, as added by this section, shall not apply to the
3 premiums under such contract or any renewal con-
4 tract for benefits provided during the period begin-
5 ning on such date and ending on the last day of the
6 2nd plan year beginning after such date.

7 **Subtitle E—Uniform Standards for**
8 **Reporting Services and Process-**
9 **ing Claims**

10 **SEC. 241. APPLICATION AND ESTABLISHMENT OF UNIFORM**
11 **STANDARDS.**

12 (a) IN GENERAL.—Each entity providing medical or
13 other health care services shall comply with the uniform
14 standards for reporting health care services and process-
15 ing claims established by the National Association of In-
16 surance Commissioners (hereafter in this section referred
17 to as “NAIC”) under subsection (b)(1) (or, if applicable,
18 by the Secretary of Health and Human Services under
19 subsection (b)(2)).

20 (b) ESTABLISHMENT OF STANDARDS.—

21 (1) ROLE OF NAIC.—Not later than 18 months
22 after the date of the enactment of this Act, the
23 NAIC shall establish and submit to the Secretary of
24 Health and Human Services (hereafter in this sec-
25 tion referred to as the “Secretary”) uniform stand-

1 ards for processing claims for medical or other
2 health services and for reporting the delivery of such
3 services to a national data collection entity.

4 (2) ESTABLISHMENT BY SECRETARY.—If the
5 NAIC fails to establish standards under paragraph
6 (1), or if the Secretary finds that the standards es-
7 tablished by the NAIC fail to promote efficiency and
8 cost-effectiveness in the delivery and reporting of
9 medically appropriate health care services, the Sec-
10 retary shall establish the uniform standards de-
11 scribed under paragraph (1).

12 (3) REVIEW AND UPDATING OF STANDARDS.—
13 The Secretary shall periodically review the standards
14 established under this subsection, and may revise the
15 standards to ensure that the standards continue to
16 promote efficiency and cost-effectiveness in the deliv-
17 ery and reporting of medically appropriate health
18 care services.

19 **SEC. 242. EFFECTIVE DATE.**

20 Section 241 shall apply with respect to medical or
21 other health care services provided on or after the expira-
22 tion of the 2-year period that begins on the date of the
23 enactment of this Act.

1 **TITLE III—MEDICAL LIABILITY**
2 **REFORM**
3 **Subtitle A—Definitions and**
4 **Findings**

5 **SEC. 301. DEFINITIONS.**

6 As used in this title:

7 (1) BOARD OF ADVISORS.—The term “Board of
8 Advisors” means the Alternative Dispute Resolution
9 Board of Advisors established under section 321.

10 (2) CLAIMANT.—The term “claimant” means
11 any person who brings a civil action that is subject
12 to the requirements of this Act, and any person on
13 whose behalf such an action is brought. If such an
14 action is brought through or on behalf of an estate,
15 such term includes the claimant’s decedent, or if
16 such an action is brought through or on behalf of a
17 minor or incompetent, such term includes the claim-
18 ant’s parent or guardian.

19 (3) CLEAR AND CONVINCING EVIDENCE.—The
20 term “clear and convincing evidence” is that meas-
21 ure or degree of proof that will produce in the mind
22 of the trier of fact a firm belief or conviction as to
23 the truth of the allegations sought to be established.
24 The level of proof required to satisfy such standard
25 is more than that required under preponderance of

1 the evidence, but less than that required for proof
2 beyond a reasonable doubt.

3 (4) MEDICAL MALPRACTICE ACTION.—The term
4 “medical malpractice action” includes any action in-
5 volving a claim, third-party claim, cross-claim, coun-
6 terclaim, or contribution claim in a civil action in
7 which a health care provider is alleged to be liable
8 for harm caused by such health care provider.

9 (5) NONECONOMIC DAMAGES.—The term “non-
10 economic damages” means subjective, nonmonetary
11 losses including, pain, suffering, inconvenience, men-
12 tal suffering, emotional distress, loss of society and
13 companionship, loss of consortium, and injury to
14 reputation and humiliation. Such term does not in-
15 clude objectively verifiable monetary losses including
16 medical expenses, loss of earnings, burial costs, loss
17 of use of property, costs of obtaining substitute do-
18 mestic services, rehabilitation and training expenses,
19 loss of employment, or loss of business or employ-
20 ment opportunities.

21 (6) SECRETARY.—The term “Secretary” means
22 the Secretary of Health and Human Services.

23 (7) STATE.—The term “State” means each of
24 the several States, the District of Columbia, the
25 Commonwealth of Puerto Rico, the Commonwealth

1 of the Northern Mariana Islands, the Virgin Islands,
2 Guam, American Samoa, and any other territory or
3 possession of the United States, or any political sub-
4 division thereof.

5 **SEC. 302. EFFECT ON INTERSTATE COMMERCE.**

6 Congress finds that the health care and insurance in-
7 dustries are industries affecting interstate commerce and
8 the medical malpractice litigation systems existing
9 throughout the United States impact on interstate com-
10 merce by contributing to the high cost of health care and
11 premiums for malpractice insurance purchased by health
12 care providers.

13 **Subtitle B—Expedited Medical**
14 **Malpractice Settlements**

15 **SEC. 311. EXPEDITED MEDICAL MALPRACTICE SETTLE-**
16 **MENTS.**

17 (a) RIGHT TO BRING ACTION.—Any claimant may
18 bring a civil action for damages against a person for harm
19 caused during the provision of medical care pursuant to
20 applicable State law, except to the extent that such law
21 is superseded by this subtitle.

22 (b) SETTLEMENT OFFERS.—

23 (1) BY CLAIMANT.—Any claimant may, in addi-
24 tion to any claim for relief made in accordance with
25 State law as provided for in subsection (a), include

1 in the complaint filed by such complainant an offer
2 of settlement for a specific dollar amount.

3 (2) BY DEFENDANT.—Within 60 days after
4 service of the complaint of a claimant of the type re-
5 ferred to in paragraph (1), or within the time per-
6 mitted pursuant to State law for a responsive plead-
7 ing, whichever is longer, the defendant may make an
8 offer of settlement for a specific dollar amount, ex-
9 cept that if such pleading includes a motion to dis-
10 miss in accordance with applicable State law, the de-
11 fendant may tender such relief to the claimant with-
12 in 10 days after the determination of the court re-
13 garding such motion.

14 (c) EXTENSION OF TIME.—

15 (1) AUTHORITY.—In any case in which an offer
16 of settlement is made pursuant to subsection (b), the
17 court may, upon motion made prior to the expiration
18 of the applicable period for response, enter an order
19 extending such period.

20 (2) CONTENTS OF EXTENSION ORDER.—Any
21 order extending the period for response under para-
22 graph (1) shall contain a schedule for discovery of
23 evidence material to the issue of the appropriate
24 amount of relief, and shall not extend such period
25 for more than 60 days. Any such motion shall be ac-

1 accompanied by a supporting affidavit of the moving
2 party setting forth the reasons why such extension
3 is necessary to promote the interests of justice and
4 stating that the information likely to be discovered
5 is material, and is not, after reasonable inquiry, oth-
6 erwise available to the moving party.

7 (d) REJECTION OF OFFER BY DEFENDANT
8 OFFEREE.—If the defendant, as offeree, does not accept
9 the offer of settlement made by a claimant in accordance
10 with subsection (b)(1) within the time permitted pursuant
11 to State law for a responsive pleading or, if such pleading
12 includes a motion to dismiss in accordance with applicable
13 law, within 30 days after the court’s determination regard-
14 ing such motion, and a verdict is entered in such action
15 equal to or greater than the specific dollar amount of such
16 offer of settlement, the court shall enter judgment against
17 the defendant and shall include in such judgment an
18 amount for the claimant’s reasonable attorney’s fees and
19 costs. Such fees shall be offset against any fees owed by
20 the claimant to the claimant’s attorney by reason of the
21 verdict.

22 (e) REJECTION OF OFFER BY CLAIMANT
23 OFFEREE.—If the claimant, as offeree, does not accept
24 the offer of settlement made by a defendant in accordance
25 with subsection (b)(2) within 30 days after the date on

1 which such offer is made and a verdict is entered in such
2 action equal to or less than the specific dollar amount of
3 such offer of settlement, the court shall reduce the amount
4 of the verdict in such action by an amount equal to the
5 reasonable attorney's fees and costs owed by the defendant
6 to the defendant's attorney by reason of the verdict, except
7 that the amount of such reduction shall not exceed that
8 portion of the verdict which is allocable to noneconomic
9 loss and economic loss for which the claimant has received
10 or will receive collateral benefits.

11 (f) CALCULATION OF ATTORNEY'S FEES.—For pur-
12 poses of this section, attorney's fees shall be calculated
13 on the basis of an hourly rate that should not exceed that
14 which is considered acceptable in the community in which
15 the attorney practices, considering the attorney's quali-
16 fications and experience and the complexity of the case.

17 **Subtitle C—Alternative Dispute**
18 **Resolution Procedures**

19 **SEC. 321. ESTABLISHMENT OF BOARD OF ADVISORS.**

20 (a) IN GENERAL.—The Secretary shall establish an
21 Alternative Dispute Resolution Board of Advisors to make
22 recommendations to the Secretary concerning the estab-
23 lishment of a model voluntary alternative dispute resolu-
24 tion program.

1 (b) COMPOSITION.—The Board of Advisors shall be
2 composed of members to be appointed by the Secretary.

3 Such members shall include representatives of—

4 (1) patient advocacy groups;

5 (2) State governments;

6 (3) physicians groups;

7 (4) hospitals;

8 (5) health and medical malpractice insurers;

9 (6) medical product manufacturers; and

10 (7) other professions or industries determined

11 appropriate by the Secretary.

12 (c) DUTIES OF BOARD.—The Board of Advisors
13 shall—

14 (1) provide advice and assistance to representa-
15 tives from State governments concerning the estab-
16 lishment of alternative dispute resolution systems;
17 and

18 (2) not later than 1 year after the date of en-
19 actment of this Act, submit a recommendation to the
20 Secretary for the implementation of a model vol-
21 untary alternative dispute resolution system.

22 (d) APPROVAL BY SECRETARY.—The Secretary shall
23 approve the model system submitted under subsection
24 (c)(2) with any modifications that the Secretary deter-
25 mines appropriate.

1 **SEC. 322. DEVELOPMENT OF STATE VOLUNTARY DISPUTE**
2 **RESOLUTION PROCEDURES.**

3 (a) PROGRAM TO ENCOURAGE ADOPTION.—The Sec-
4 retary shall develop and implement a program to encour-
5 age States to develop and implement voluntary alternative
6 dispute resolution procedures that meet the requirements
7 of this title.

8 (b) FAILURE TO ADOPT PROCEDURES.—With respect
9 to a State that has not adopted alternative dispute resolu-
10 tion procedures that meet the requirements of this title
11 by the date that occurs 2 years after the date of enactment
12 of this Act, such State shall be required to adopt the model
13 voluntary dispute resolution procedure system approved by
14 the Secretary under section 321(d).

15 **SEC. 323. APPLICATION OF EXISTING PROCEDURES, RE-**
16 **BUTTABLE PRESUMPTION.**

17 (a) OFFER TO PROCEED.—With respect to a State
18 that has an alternative dispute resolution system in effect
19 that meets the requirements of this title, in lieu of or in
20 addition to making an offer of settlement under section
21 311, a claimant or defendant may, within the time per-
22 mitted for the making of such an offer under section 311,
23 offer to proceed pursuant to any voluntary alternative dis-
24 pute resolution procedure established or recognized under
25 the law of the State in which the civil action for damages
26 for harm caused through a medical procedure is brought

1 or under the rules of the court in which such action is
2 maintained.

3 (b) REFUSAL TO PROCEED.—If the recipient of an
4 offer to proceed under subsection (a) refuses to proceed
5 pursuant to an alternative dispute resolution procedure
6 and the court determines that such refusal was unreason-
7 able or not in good faith, the court shall assess reasonable
8 attorney’s fees and costs against the offeree.

9 (c) REBUTTABLE PRESUMPTION.—For the purposes
10 of this section, there shall be created a rebuttable pre-
11 sumption that a refusal by an offeree under subsection
12 (b) to proceed pursuant to an alternative dispute resolu-
13 tion procedure was unreasonable or not in good faith, if
14 a verdict is rendered in favor of the offeror.

15 **Subtitle D—Uniform Standards for** 16 **Medical Malpractice Cases**

17 **SEC. 331. APPLICATION TO CIVIL ACTIONS.**

18 This subtitle shall apply to any medical malpractice
19 action brought in any Federal or State court and any med-
20 ical malpractice claim resolved through an alternative dis-
21 pute resolution system.

22 **SEC. 332. DAMAGES.**

23 (a) PAYMENTS.—With respect to a civil action or
24 claim of the type referred to in section 331, no person
25 may be required to pay more than \$100,000 in a single

1 payment for future losses, but such person shall be per-
2 mitted to make such payments on a periodic basis. The
3 periods for such payments shall be determined by the
4 court, based upon projections of such future losses. This
5 subsection shall apply to awards of plaintiff's damages.

6 (b) LIMITATION ON NONECONOMIC DAMAGES.—With
7 respect to a civil action or claim of the type referred to
8 in section 331, the total amount of damages that may be
9 awarded to an individual and the family members of such
10 individual for noneconomic losses resulting from an injury
11 alleged under such action or claim may not exceed
12 \$250,000, regardless of the number of health care profes-
13 sionals and health care providers against whom the claim
14 is brought or the number of claims brought with respect
15 to the injury.

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

18 (1) IN GENERAL.—With respect to a civil action
19 or claim of the type referred to in section 331, the
20 total amount of damages received by an individual
21 under such action or claim shall be reduced, in ac-
22 cordance with paragraph (2), by any other payment
23 that has been, or will be, made to an individual to
24 compensate such individual for the injury that was
25 the subject of such action or claim.

1 (2) AMOUNT OF REDUCTION.—The amount by
2 which an award of damages to an individual for an
3 injury shall be reduced under paragraph (1) shall
4 be—

5 (A) the total amount of any payments
6 (other than such award) that have been made
7 or that will be made to such individual to com-
8 pensate such individual for the injury that was
9 the subject of the action or claim; minus

10 (B) the amount paid by such individual (or
11 by the spouse, parent, or legal guardian of such
12 individual) to secure the payments described in
13 subparagraph (A).

14 (d) ATTORNEYS' FEES.—With respect to a civil ac-
15 tion or claim of the type referred to in section 331, attor-
16 neys' fees may not exceed—

17 (1) 25 percent of the first \$150,000 of any
18 award or settlement under such action or claim; and

19 (2) 15 percent of any additional amounts in ex-
20 cess of \$150,000.

21 **SEC. 333. JOINT AND SEVERAL LIABILITY FOR NON-**
22 **ECONOMIC DAMAGES.**

23 (a) IN GENERAL.—With respect to a civil action or
24 claim of the type referred to in section 331, the liability
25 of each defendant for noneconomic damages shall be sev-

1 eral only and shall not be joint. Each defendant shall be
2 liable only for the amount of noneconomic damages allo-
3 cated to such defendant in direct proportion to such de-
4 fendant's percentage of responsibility as determined under
5 subsection (b).

6 (b) PROPORTION OF RESPONSIBILITY.—For pur-
7 poses of this section, the trier of fact shall determine the
8 proportion of responsibility of each party for the claim-
9 ant's harm.

10 **SEC. 334. UNIFORM STATUTE OF LIMITATIONS.**

11 (a) IN GENERAL.—Except as provided in subsection
12 (b), no medical malpractice civil action may be initiated
13 after the expiration of the 2-year period that begins on
14 the date on which the alleged injury should reasonably
15 have been discovered, but in no event later than 4 years
16 after the date of the alleged occurrence of the injury.

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 claim may be initi-
20 ated after the expiration of the 2-year period that begins
21 on the date on which the alleged injury should reasonably
22 have been discovered, but in no event later than 4 years
23 after the date of the alleged occurrence of the injury or
24 the date on which the minor attains 8 years of age, which-
25 ever is later.

1 **SEC. 335. PROVISION FOR DROP IN DELIVERIES**

2 With respect to a civil action of the type referred to
3 in section 331, for alleged medical malpractice related to
4 services provided during the delivery of a baby, a court
5 shall only find in favor of the claimant if such malpractice
6 on the part of the defendant health care professional is
7 proven by clear and convincing evidence, except that such
8 evidentiary standard shall only apply if a defendant did
9 not previously provide prenatal care to the claimant for
10 this pregnancy, was not part of group practice that pre-
11 viously treated the claimant during the pregnancy result-
12 ing in this delivery, or was not providing coverage pursu-
13 ant to an agreement with another health care professional
14 for this delivery.

15 **Subtitle E—Uniform Disciplinary**
16 **Reforms**

17 **SEC. 341. REQUIREMENT OF COMPLIANCE.**

18 Not later than 2 years after the date of enactment
19 of this Act, a State shall comply with the requirements
20 of this subtitle.

21 **SEC. 342. FUNDS FOR STATE DISCIPLINARY ACTIVITIES.**

22 Each State shall allocate the total amount of fees
23 paid to the State in each year for the licensing or certifi-
24 cation of each type of health care practitioner, or an
25 amount of State funds equal to such total amount, to the
26 State agency or agencies responsible for the conduct of

1 licensing and disciplinary actions with respect to such type
2 of health care practitioner.

3 **SEC. 343. MEMBERSHIP OF STATE HEALTH CARE PRACTI-**
4 **TIONER BOARDS.**

5 Each State shall permit the general public to be rep-
6 resented on State health care practitioner disciplinary
7 boards. Not less than 25 percent of the membership of
8 each such health care practitioner disciplinary board shall
9 be appointed from among the general public.

10 **SEC. 344. IMMUNITY FOR MEMBERS OF STATE HEALTH**
11 **CARE PRACTITIONER BOARDS.**

12 There shall be no monetary liability on the part of,
13 and no cause of action for damages shall arise against,
14 any current or former member, officer, administrator,
15 staff member, committee member, examiner, representa-
16 tive, agent, employee, consultant, witness, or any other in-
17 dividual serving or having served on a State health care
18 practitioner disciplinary board, either as a part of the
19 board's operation or as an individual, as a result of any
20 act, omission, proceeding, conduct or decision related to
21 the duties of such individual undertaken or performed in
22 good faith and within the scope of the function of the
23 board.

1 **SEC. 345. RISK MANAGEMENT PROGRAMS.**

2 Not later than 2 years after the date of enactment
3 of this Act, each State shall have in effect a Statewide
4 risk management program, to reduce the incidence of med-
5 ical malpractice that meets any regulations promulgated
6 by the Secretary for the establishment of such program.

7 **SEC. 346. PUNITIVE DAMAGES.**

8 (a) TRUST FUND.—Each State shall establish a
9 health care disciplinary trust fund consisting of such
10 amounts as are transferred to the trust fund under sub-
11 section (b).

12 (b) TRANSFER OF AMOUNTS.—Each State shall re-
13 quire that all awards of punitive damages resulting from
14 all medical malpractice and medical products civil actions
15 in that State be transferred to the trust fund established
16 under subsection (a) in the State.

17 (c) OBLIGATIONS FROM TRUST FUND.—The chief
18 executive officer of a State shall obligate such sums as
19 are available in the trust fund established in that State
20 under subsection (a) to provide additional resources to
21 State health care practitioner disciplinary boards for the
22 disciplining of health care practitioners and to provide ad-
23 ditional resources for consumer protection activities of the
24 State.

1 **Subtitle F—Medical Products**

2 **SEC. 351. LIMITATION ON AWARD OF PUNITIVE DAMAGES** 3 **IN PRODUCT LIABILITY ACTIONS INVOLVING** 4 **DRUGS AND DEVICES.**

5 (a) DEFINITIONS.—As used in this section:

6 (1) DEVICE.—The term “device” has the mean-
7 ing given the term in section 201(h) of the Federal
8 Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

9 (2) DRUG.—The term “drug” has the meaning
10 given the term in section 201(g)(1) of the Federal
11 Food, Drug, and Cosmetic Act (21 U.S.C.
12 321(g)(1)).

13 (3) HEALTH CARE PRODUCER.—The term
14 “health care producer” means any firm or business
15 enterprise that designs, manufactures, produces, or
16 sells a drug or device that is the subject of a liability
17 action.

18 (b) LIMITATION.—

19 (1) IN GENERAL.—Punitive damages otherwise
20 permitted by applicable law shall not be awarded in
21 an action under this Act against a health care pro-
22 ducer of a drug or device that caused the harm com-
23 plained of by the claimant if—

24 (A) the drug or device—

1 (i) was subject to approval under sec-
2 tion 505 (21 U.S.C. 355) or premarket ap-
3 proval under section 515 (21 U.S.C. 360e),
4 respectively, of the Federal Food, Drug,
5 and Cosmetic Act, by the Food and Drug
6 Administration, with respect to—

7 (I) the safety of the formulation
8 or performance of the aspect of the
9 drug or device that caused the harm;
10 or

11 (II) the adequacy of the packag-
12 ing or labeling of the drug or device;
13 and

14 (ii) was approved by the Food and
15 Drug Administration; or

16 (B) the drug or device is generally recog-
17 nized as safe and effective pursuant to condi-
18 tions established by the Food and Drug Admin-
19 istration and applicable regulations, including
20 packaging and labeling regulations.

21 (2) WITHHELD INFORMATION; MISREPRESENTATION;
22 ILLEGAL PAYMENT.—The provisions of
23 paragraph (1) shall not apply in any case in which
24 the defendant—

1 (A) withheld from or misrepresented to the
2 Food and Drug Administration or any other
3 agency or official of the Federal Government in-
4 formation that is material and relevant to the
5 performance of the drug or device; or

6 (B) made an illegal payment to an official
7 of the Food and Drug Administration for the
8 purpose of securing approval of the drug or de-
9 vice.

10 (c) SEPARATE PROCEEDING.—

11 (1) CONSIDERATIONS.—At the request of the
12 health care producer in an action described in sub-
13 section (b), the trier of fact shall consider in a sepa-
14 rate proceeding—

15 (A) whether punitive damages are to be
16 awarded and the amount of the award; or

17 (B) the amount of punitive damages fol-
18 lowing a determination of punitive liability.

19 (2) EVIDENCE.—If a separate proceeding is re-
20 quested in accordance with paragraph (1), evidence
21 relevant only to the claim of punitive damages, as
22 determined by applicable State law, shall be inadmis-
23 sible in any proceeding to determine whether com-
24 pensatory damages are to be awarded.

1 (d) AMOUNT OF PUNITIVE DAMAGES.—In determin-
2 ing the amount of punitive damages in an action described
3 in subsection (b) or (c), the trier of fact shall consider
4 all relevant evidence, including—

5 (1) the financial condition of the health care
6 producer;

7 (2) the severity of the harm caused by the con-
8 duct of the health care producer;

9 (3) the duration of the conduct or any conceal-
10 ment of the conduct by the health care producer;

11 (4) the profitability of the conduct to the health
12 care producer;

13 (5) the number of products sold by the health
14 care producer of the kind causing the harm com-
15 plained of by the claimant;

16 (6) awards of punitive or exemplary damages to
17 persons similarly situated to the claimant;

18 (7) prospective awards of compensatory dam-
19 ages to persons similarly situated to the claimant;

20 (8) any criminal penalties imposed on the
21 health care producer as a result of the conduct com-
22 plained of by the claimant; and

23 (9) the amount of any civil fines assessed
24 against the defendant as a result of the conduct
25 complained of by the claimant.

1 (e) STRICT LIABILITY DEFENSE.—In a civil action
2 brought by a claimant in a Federal or State court under
3 which the claimant alleges that a health care producer of
4 a drug or device is strictly liable to such claimant for inju-
5 ries sustained from the use of such drug or device, a show-
6 ing by the defendant that such drug or devices was subject
7 to approval and was approved by the Food and Drug Ad-
8 ministration as described in subsection (b)(1)(A) shall be
9 an absolute defense to such strict liability claims.

10 **Subtitle G—Community Health** 11 **Centers**

12 **SEC. 361. COMMUNITY AND MIGRANT HEALTH CENTERS** 13 **RISK RETENTION GROUP.**

14 (a) IN GENERAL.—Subpart I of part D of title III
15 of the Public Health Service Act (42 U.S.C. 254b et seq.)
16 is amended by adding at the end thereof the following new
17 section:

18 **“SEC. 330A. RISK RETENTION GROUP.**

19 “(a) GRANT.—The Secretary shall make a grant to
20 an entity that represents recipients of assistance under
21 section 329 and 330 to enable such entity to develop a
22 business plan as described in subsection (b)(2) and estab-
23 lish a nationwide risk retention group as provided for in
24 Liability Risk Retention Act of 1986 (15 U.S.C. 3901 et
25 seq.), and that meets the requirements of this section.

1 “(b) BUSINESS PLAN AND FORMATION.—

2 “(1) DEVELOPMENT AND ESTABLISHMENT.—

3 “(A) IN GENERAL.—Not later than Sep-
4 tember 30, 1993, the grantee shall develop a
5 business plan as described in paragraph (2) and
6 have established a risk retention group that
7 meets the requirements of section 2(4) of the
8 Product Liability Risk Retention Act of 1981
9 (15 U.S.C. 3901(2)(4)).

10 “(B) ESTABLISHMENT.—In establishing
11 the risk retention group under subparagraph
12 (A), the grantee shall take all steps, in accord-
13 ance with this subsection, necessary to enable
14 such group to be prepared to issue insurance
15 policies under this section.

16 “(2) BUSINESS PLAN.—The grantee shall de-
17 velop a plan for the operation of the risk retention
18 group that shall include all actuarial reports and
19 studies conducted with respect to the formation, cap-
20 italization, and operation of the group.

21 “(3) STRUCTURE, RIGHTS, AND DUTIES OF THE
22 RISK RETENTION GROUP.—

23 “(A) BOARD OF DIRECTORS.—

24 “(i) APPOINTMENT.—The board of di-
25 rectors of the risk retention group shall

1 consist of 12 members to be appointed by
2 the recipient of the grant under subsection
3 (a), and approved as provided in clause
4 (ii).

5 “(ii) APPROVAL.—The initial mem-
6 bers appointed under clause (i) shall be ap-
7 proved by the Secretary, and shall serve
8 for a term as provided in clause (iii). All
9 subsequent members shall be subject to the
10 approval of the members of the risk reten-
11 tion group.

12 “(iii) TERMS.—The recipient of the
13 grant under subsection (a) shall appoint
14 the members of the board under clause (i)
15 as follows:

16 “(I) Four members shall be ap-
17 pointed for an initial term of 1 year.

18 “(II) Four members shall be ap-
19 pointed for an initial term of 2 years.

20 “(III) Four members shall be ap-
21 pointed for an initial term of 3 years.

22 Members serving terms other than initial
23 terms shall serve for 3 years. Members
24 may serve successive terms.

1 “(iv) EXECUTIVE DIRECTOR.—The
2 Executive Director of the board shall be
3 elected by the members of the board, and
4 shall serve at the pleasure of such mem-
5 bers.

6 “(v) VACANCIES.—Vacancies on the
7 board shall be filled through a vote of the
8 remaining members of the board, subject
9 to the approval of the members of the risk
10 retention group.

11 “(B) BYLAWS.—The board shall develop
12 the bylaws of the risk retention group that shall
13 be subject to the disapproval of the Secretary.
14 Any changes that the board desires to make in
15 such bylaws shall also be subject to the dis-
16 approval of the Secretary. The Secretary shall
17 provide the board with 90 days notice of the
18 Secretary’s intent to disapprove a bylaw.

19 “(C) ADMINISTRATION.—The risk reten-
20 tion group may negotiate with other entities for
21 the purposes of managing and administering
22 the risk retention group, and for purposes of
23 obtaining reinsurance.

24 “(D) PROVISION OF INSURANCE.—The
25 risk retention group shall provide professional

1 liability insurance, and other types of profitable
2 insurance approved for issuance by the Sec-
3 retary, to migrant and community health cen-
4 ters that receive assistance under sections 329
5 and 330 and that meet the requirements of
6 subparagraph (E).

7 “(E) PARTICIPANTS.—

8 “(i) IN GENERAL.—Except as pro-
9 vided in clause (ii), all community and mi-
10 grant health centers that receive assistance
11 under section 329 and 330 shall become
12 members in the risk retention group estab-
13 lished under this section and shall pur-
14 chase the professional liability insurance
15 that is offered by such group for such cen-
16 ters and any health care staff or personnel
17 employed by such centers or under con-
18 tract with such centers. All professional
19 staff members of such centers shall be eli-
20 gible to obtain the insurance offered by
21 such group.

22 “(ii) EXCEPTIONS.—

23 “(I) GOOD CAUSE.—The Sec-
24 retary may, on a showing of good
25 cause by the center, exempt such cen-

1 ter from the requirements of clause
2 (i).

3 “(II) FAILURE TO MEET CONDI-
4 TIONS.—If the risk retention group
5 determines that a center is not com-
6 plying with the established underwrit-
7 ing standards, such group may decline
8 to provide insurance to such center.
9 The risk retention group shall provide
10 a center with 60 days notice of a deci-
11 sion by the group not to provide in-
12 surance to such center.

13 “(III) HEARING.—Prior to the
14 Secretary granting an exemption or
15 severance as requested in an applica-
16 tion submitted under subclause (I),
17 the Secretary shall require that the
18 applicant provide evidence concerning
19 its application and shall afford the
20 risk retention group an opportunity to
21 address the allegations contained in
22 such application. The Secretary may
23 grant the center temporary relief
24 under this subparagraph without a
25 hearing in emergency situations.

1 “(F) APPLICABILITY OF INSURANCE TO
2 CLAIMS.—Insurance provided by the risk reten-
3 tion group under this section shall apply to all
4 claims filed against a covered community or mi-
5 grant health center after the initiation of insur-
6 ance coverage by the risk retention group, in-
7 cluding acts that occur prior to coverage under
8 this section that are not covered by other insur-
9 ance.

10 “(c) SUBMISSION OF BUSINESS PLAN TO OUTSIDE
11 EXPERTS.—After the development of the business plan
12 and the establishment of the risk retention group as re-
13 quired under subsection (b), the risk retention group shall
14 enter into a contract with individuals or entities who are
15 insurance, financing, and business experts to require such
16 individuals or entities to analyze and audit the group.
17 Such individuals and entities shall provide the group with
18 an evaluation of such plan and group.

19 “(d) SUBMISSION OF PLAN AND EVALUATION.—

20 “(1) IN GENERAL.—The risk retention group
21 shall submit to the Secretary the business plan re-
22 quired under subsection (b) and the evaluation com-
23 pleted under subsection (c) to the Secretary.

24 “(2) DETERMINATION BY SECRETARY.—Not
25 later than September 30, 1993, the Secretary shall

1 make a determination, based on the plan and evalua-
2 tion submitted under paragraph (1), of whether the
3 operation of the risk retention group results in an
4 increase in the amount of funds available for use by
5 community and migrant health centers and other en-
6 tities that receive assistance under sections 329 and
7 330 in the 2-year period ending on September 30,
8 1995.

9 “(3) IMPLEMENTATION.—If the Secretary
10 makes an affirmative determination under para-
11 graph (1), the Secretary shall permit the implemen-
12 tation of the plan and the operation of the risk re-
13 tention group as provided for in this section, and
14 shall capitalize such group as provided for in sub-
15 section (e)(2).

16 “(e) FUNDING.—

17 “(1) CAPITALIZATION.—There are authorized
18 to be appropriated to carry out this section,
19 \$40,000,000 for each of the fiscal years 1993 and
20 1994. Amounts appropriated under this paragraph
21 may only be made available if the Secretary makes
22 an affirmative determination under subsection
23 (d)(2).

24 “(2) REMAINING ASSETS.—All assets of the
25 risk retention group that remain after the dissolu-

1 tion of such group shall become the property of the
2 Secretary who shall use such assets to pay the re-
3 maining expenses of the group.

4 “(3) SAVINGS.—Any amount saved by the
5 grantees under sections 329 and 330 as a result of
6 the establishment of the risk retention group shall
7 be utilized—

8 “(A) to provide additional services of the
9 type permitted under section 329 or 330, as ap-
10 propriate; and

11 “(B) to defend against medical malpractice
12 claims arising from services provided by such
13 grantees.”.

14 (b) CONFORMING AMENDMENTS.—

15 (1) Section 329(h)(1)(A) of the Public Health
16 Service Act (42 U.S.C. 254b(h)(1)(A)) is amended
17 by striking “1991” and inserting “1994”.

18 (2) Section 330(g)(2)(A) of such Act (42
19 U.S.C. 254b(h)(1)(A)) is amended by inserting “,
20 and such sums as may be necessary for fiscal year
21 1993” after “1991”.

1 **Subtitle H—Miscellaneous**
2 **Provisions**

3 **SEC. 371. SEVERABILITY.**

4 If any provision of this title, or an amendment made
5 by this title, or the application of such provision to any
6 person or circumstance is held to be unconstitutional, the
7 remainder of this title and the amendments made by this
8 title, and the application of the provisions of such to any
9 person or circumstance shall not be affected thereby.

10 **SEC. 372. COMPLIANCE.**

11 Except as otherwise specifically provided, not later
12 than 2 years after the date of enactment of this Act, a
13 State shall enact, adopt, or otherwise comply with the pro-
14 visions of this title.

15 **TITLE IV—PUBLIC HEALTH**
16 **PROVISIONS**

17 **Subtitle A—New Basic Health Care**
18 **Program**

19 **SEC. 401. ESTABLISHMENT OF BASICARE PROGRAM.**

20 (a) IN GENERAL.—The Social Security Act (42
21 U.S.C. 301 et seq.) is amended by adding at the end there-
22 of the following new title:

23 “TITLE XXI—BASICARE

24 “TABLE OF CONTENTS OF TITLE

“Sec. 2101. Appropriation.

“Sec. 2102. State plans for BasiCare assistance.

“Sec. 2103. Payment to States.

“Sec. 2104. Quality assurance.

“Sec. 2105. Definitions.

1 “APPROPRIATION

2 “SEC. 2101. For the purpose of providing basic
3 health care benefits to low-income uninsured individuals
4 not eligible for coverage under title XIX of this Act, there
5 is hereby authorized to be appropriated for each fiscal year
6 a sum sufficient to carry out the purposes of this title.
7 The sums made available under this section shall be used
8 for making payments to States which have submitted, and
9 had approved by the Secretary, State plans for BasiCare
10 assistance.

11 “STATE PLANS FOR BASICARE ASSISTANCE

12 “SEC. 2102. (a) IN GENERAL.—A State plan for
13 BasiCare assistance must—

14 “(1) provide either for the establishment or des-
15 ignation of a single State agency to administer or
16 supervise the administration of the program estab-
17 lished under this title;

18 “(2) provide for financial participation by the
19 State equal to the non-Federal share of the expendi-
20 tures under the plan with respect to which payments
21 under section 2103 are authorized by this title;

22 “(3) provide health assistance to all eligible in-
23 dividuals described in subsection (b), and at the op-

1 tion of the State, subsets of basic medical and social
2 benefits to subgroups of such eligible individuals;

3 “(4) meet the quality assurance requirements of
4 section 2104;

5 “(5) provide that the State will not modify its
6 State plan under title XIX of this Act so as to result
7 in individuals eligible under the State’s plan under
8 such title becoming eligible for enrollment under
9 BasiCare;

10 “(6) meet the requirements of paragraphs (4),
11 (6), (7), (19), (45), (46), (48), and (49) of section
12 1902(a); and

13 “(7) meet such further requirements as the
14 Secretary may specify.

15 “(b) ELIGIBILITY FOR BASICARE.—An individual is
16 eligible to receive benefits under this title if such individ-
17 ual—

18 “(1) has a family income below 200 percent of
19 the income official poverty line (as defined by the
20 Office of Management and Budget and revised an-
21 nually in accordance with section 673(2) of the Om-
22 nibus Budget Reconciliation Act of 1981);

23 “(2) is not otherwise eligible for medical assist-
24 ance under a State plan under title XIX of this Act;
25 and

1 “(3) is not otherwise covered under a health
2 plan offered by the individual’s employer.

3 “PAYMENT TO STATES

4 “SEC. 2103. (a) IN GENERAL.—From the sums ap-
5 propriated therefor (subject to the expenditure limitation
6 described in subsection (b)), the Secretary shall pay to
7 each State which has a plan approved under this title, for
8 each quarter, beginning with the quarter commencing
9 January 1, 1993—

10 “(1) an amount equal to the Federal health as-
11 sistance percentage (as defined in section 2105(b));
12 plus

13 “(2) an amount equal to 3 percent of the aver-
14 age per person expenditures under the plan for each
15 individual under the plan enrolled in a managed care
16 setting (including health maintenance organizations,
17 community health centers and such other types of
18 providers as designated by the Secretary).

19 “(b) LIMIT ON FEDERAL EXPENDITURES AS
20 HEALTH ASSISTANCE.—Payments under this section to a
21 State may not exceed an average of \$10,000 per year, per
22 enrolled individual.

23 “(c) COST-SHARING.—(1) With respect to individuals
24 eligible for health assistance under this title whose income
25 is between 100 and 200 percent of the income official pov-
26 erty line (as defined by the Office of Management and

1 Budget and revised annually in accordance with section
2 673(2) of the Omnibus Budget Reconciliation Act of
3 1981), the State may impose such deductibles, copayments
4 or premiums with respect to such individual's coverage
5 under this title as the State may deem appropriate, sub-
6 ject to the limitation in paragraph (2).

7 “(2) A State may not impose a deductible, copayment
8 or premium with respect to an individual described in
9 paragraph (1) that is in excess of 5 percent of such indi-
10 vidual's gross income during a calendar year.

11 “QUALITY ASSURANCE

12 “SEC. 2104. The Secretary shall establish a program
13 to assure the quality of services provided under this title.
14 In establishing such program, the Secretary shall provide
15 that Federal employees and contractors are utilized in en-
16 suring compliance with the quality assurance provisions
17 of this title and provide for criteria to disallow payment
18 under section 2103 for services found not to meet the
19 quality assurance provisions of this title established by the
20 Secretary.

21 “DEFINITIONS

22 “SEC. 2105. (a) HEALTH ASSISTANCE.—For pur-
23 poses of this title, the term ‘health assistance’ means a
24 set of basic medical and social benefits as defined by the
25 State, including services provided in skilled nursing facili-

1 ties or in other long-term care settings for a period not
2 to exceed 45 days in a calendar year.

3 “(b) FEDERAL HEALTH ASSISTANCE PERCENT-
4 AGE.—For purposes of this title, the term ‘Federal health
5 assistance percentage’ means the Federal medical assist-
6 ance percentage as defined in section 1905(b).”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall become effective with respect to pay-
9 ments for health assistance beginning on or after January
10 1, 1993.

11 **SEC. 402. GAO STUDY OF PAYMENTS UNDER BASICARE.**

12 The Comptroller General of the Government Account-
13 ing Office shall study and report to Congress by no later
14 than January 1, 1995, on payments to providers of serv-
15 ices under title XXI of the Social Security Act and shall
16 include in such report recommendations on whether or not
17 payments under such title to managed care programs need
18 to be increased in order to encourage greater participation
19 of such entities under such title.

20 **SEC. 411. EXPANSION OF MEDICAID WAIVER AUTHORITY.**

21 (a) IN GENERAL.—Section 1115 of the Social Secu-
22 rity Act (42 U.S.C. 1315) is amended by adding at the
23 end the following new subsection:

24 “(e)(1) Notwithstanding any other provision of this
25 title, with respect to any waiver granted by the Secretary

1 under title XIX (except waivers under section 1915(c))
2 after such a waiver has been in effect for over a period
3 of 3 years, the Secretary shall not require a State operat-
4 ing under such a waiver to conduct an independent assess-
5 ment of such waiver unless the State proposes a substan-
6 tial (as determined by the Secretary) amendment to the
7 waiver agreement.

8 “(2) Any waiver granted under title XIX which has
9 been in effect for over a period of 3 years shall be consid-
10 ered, at the option of a State, to be a permanent amend-
11 ment to the State’s plan for medical assistance in effect
12 under section 1902.”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 subsection (a) shall become effective with respect to waiv-
15 ers granted under title XIX of the Social Security Act be-
16 ginning before, on or after January 1, 1993.

17 **SEC. 412. ESTABLISHMENT OF FEDERAL MEDICAL WAIVER**
18 **DEMONSTRATION BOARD.**

19 (a) ESTABLISHMENT.—There is established a board
20 to be known as the Federal Medical Waiver Demonstra-
21 tion Board (hereinafter referred to as the “Board”).

22 (b) MEMBERSHIP.—The Board shall be composed
23 of—

24 (1) the Secretary of Health and Human Serv-
25 ices;

1 (2) the Secretary of Labor; and

2 (3) the Secretary of Veterans Affairs.

3 (c) DUTIES AND POWERS OF THE BOARD.—

4 (1) REVIEW OF STATE APPLICATIONS.—The
5 Board shall review applications submitted by States
6 to conduct health care related demonstration
7 projects in the State and shall approve within 3
8 months of receiving such applications those applica-
9 tions which meet the requirements of this section.
10 The Board in reviewing and approving the applica-
11 tion of a State shall make a determination whether
12 such application provides for a demonstration
13 project which—

14 (A) would provide that at least 95 percent
15 of the residents of the State would have access
16 to basic health care services (as defined by the
17 Board);

18 (B) would improve the delivery of and in-
19 crease access to health care services for a sig-
20 nificant number of individuals in the State; and

21 (C) would assure the quality of care of
22 health care services provided under such
23 project.

24 (2) DEVELOPMENT OF MODEL STATE PLANS.—

25 The Board shall develop and publish in the Federal

1 Register, no later than 6 months after the date of
2 enactment of this Act, at least 3 different model
3 health care delivery plans that provide for new ap-
4 proaches that may be adopted by States in providing
5 and furnishing health care services to residents of
6 the State.

7 (3) WAIVER OF CERTAIN FEDERAL HEALTH RE-
8 LATED PROVISIONS.—The Board upon approving the
9 application of a State to conduct a demonstration
10 project under this section shall waive to the extent
11 necessary to allow the State to conduct such a dem-
12 onstration project the following provisions of Federal
13 law:

14 (A) The Public Health Service Act.

15 (B) Subject to paragraph (4), title XVIII
16 of the Social Security Act.

17 (C) Titles XIX and XXI of the Social Se-
18 curity Act.

19 (D) All health care programs operated
20 under laws administered by the Secretary of
21 Veterans Affairs.

22 (E) The Employee Retirement Income Se-
23 curity Act of 1974.

24 (4) LIMITED WAIVER OF MEDICARE.—The
25 Board may waive the provisions of title XVIII of the

1 Social Security Act only if a State provides that all
2 individuals residing in the State receiving benefits
3 under the medicare program under such title are eli-
4 gible for health care benefits under the program op-
5 erated by the State under a waiver granted under
6 this section and that such health care benefits pro-
7 vided to such individuals are equal in amount, dura-
8 tion, and scope to the benefits provided under such
9 title.

10 (d) 3-YEAR RENEWAL OF WAIVER.—A waiver ap-
11 proved by the Board for a State shall be in effect in the
12 State for a 36-month period commencing from the date
13 of such approval. At the end of the 36-month period such
14 waiver shall be renewed unless the Board determines that
15 the State is not substantially in compliance with the re-
16 quirements described in subparagraphs (A) through (C)
17 of subsection (c)(1).

18 (e) BUDGET NEUTRALITY.—The Board in carrying
19 out its duties under this section shall provide that total
20 Federal expenditures under the programs for which waiv-
21 ers are granted under this section are no greater than
22 what such expenditures would have been but for the waiv-
23 ers granted under this section.

1 **TITLE V—MEDICALLY**
2 **UNDERSERVED AREAS**
3 **Subtitle A—Public Health Service**
4 **Act Provisions**

5 **SEC. 501. NATIONAL HEALTH SERVICE CORPS.**

6 Section 338H(b) of the Public Health Service Act (42
7 U.S.C. 254q(b)) is amended—

8 (1) in paragraph (1), by striking “and such
9 sums” and all that follows through the end thereof
10 and inserting “\$118,900,000 for each of the fiscal
11 years 1993 through 1997.”; and

12 (2) in paragraph (2)—

13 (A) by redesignating subparagraphs (A)
14 and (B) as subparagraphs (B) and (C), respec-
15 tively; and

16 (B) by inserting before subparagraph (B)
17 (as so redesignated) the following new subpara-
18 graph:

19 “(A) IN GENERAL.—Of the amount appro-
20 priated under paragraph (1) for each fiscal
21 year, the Secretary shall utilize 25 percent of
22 such amount to carry out section 338A and 75
23 percent of such amount to carry out section
24 338B.”.

1 **SEC. 502. ESTABLISHMENT OF GRANT PROGRAM.**

2 Subpart I of part D of title III of the Public Health
3 Service Act (42 U.S.C. 254b et seq.) is amended by adding
4 at the end thereof the following new section:

5 **“SEC. 330A. COMMUNITY BASED PRIMARY HEALTH CARE**
6 **GRANT PROGRAM.**

7 “(a) ESTABLISHMENT.—The Secretary shall estab-
8 lish and administer a program to provide allotments to
9 States to enable such States to provide grants for the cre-
10 ation or enhancement of community based primary health
11 care entities that provide services to pregnant women and
12 children up to age three.

13 “(b) ALLOTMENTS TO STATES.—

14 “(1) IN GENERAL.—From the amounts avail-
15 able for allotment under subsection (h) for a fiscal
16 year, the Secretary shall allot to each State an
17 amount equal to the product of the grant share of
18 the State (as determined under paragraph (2)) mul-
19 tiplied by the amount available for allotment for
20 such fiscal year.

21 “(2) GRANT SHARE.—

22 “(A) IN GENERAL.—For purposes of para-
23 graph (1), the grant share of a State shall be
24 the product of the need-adjusted population of
25 the State (as determined under subparagraph
26 (B)) multiplied by the Federal matching per-

1 centage of the State (as determined under sub-
2 paragraph (C)), expressed as a percentage of
3 the sum of the products of such factors for all
4 States.

5 “(B) NEED-ADJUSTED POPULATION.—

6 “(i) IN GENERAL.—For purposes of
7 subparagraph (A), the need-adjusted popu-
8 lation of a State shall be the product of
9 the total population of the State (as esti-
10 mated by the Secretary of Commerce) mul-
11 tiplied by the need index of the State (as
12 determined under clause (ii)).

13 “(ii) NEED INDEX.—For purposes of
14 clause (i), the need index of a State shall
15 be the ratio of—

16 “(I) the weighted sum of the geo-
17 graphic percentage of the State (as
18 determined under clause (iii)), the
19 poverty percentage of the State (as
20 determined under clause (iv)), and the
21 multiple grant percentage of the State
22 (as determined under clause (v)); to

23 “(II) the general population per-
24 centage of the State (as determined
25 under clause (vi)).

1 “(iii) GEOGRAPHIC PERCENTAGE.—

2 “(I) IN GENERAL.—For purposes
3 of clause (ii)(I), the geographic per-
4 centage of the State shall be the esti-
5 mated population of the State that is
6 residing in nonurbanized areas (as de-
7 termined under subclause (II)) ex-
8 pressed as a percentage of the total
9 nonurbanized population of all States.

10 “(II) NONURBANIZED POPU-
11 LATION.—For purposes of subclause
12 (I), the estimated population of the
13 State that is residing in non-urban-
14 ized areas shall be one minus the ur-
15 banized population of the State (as
16 determined using the most recent de-
17 cennial census), expressed as a per-
18 centage of the total population of the
19 State (as determined using the most
20 recent decennial census), multiplied by
21 the current estimated population of
22 the State.

23 “(iv) POVERTY PERCENTAGE.—For
24 purposes of clause (ii)(I), the poverty per-
25 centage of the State shall be the estimated

1 number of people residing in the State
2 with incomes below 200 percent of the in-
3 come official poverty line (as determined
4 by the Office of Management and Budget)
5 expressed as a percentage of the total
6 number of such people residing in all
7 States.

8 “(v) MULTIPLE GRANT PERCENT-
9 AGE.—For purposes of clause (ii)(I), the
10 multiple grant percentage of the State
11 shall be the amount of Federal funding re-
12 ceived by the State under grants awarded
13 under sections 329, 330 and 340, ex-
14 pressed as a percentage of the total
15 amounts received under such grants by all
16 States. With respect to a State, such
17 amount shall not exceed twice the general
18 population percentage of the State under
19 clause (vi) or be less than one half of the
20 States general population percentage.

21 “(vi) GENERAL POPULATION PER-
22 CENTAGE.—For purposes of clause (ii)(II),
23 the general population percentage of the
24 State shall be the total population of the
25 State (as determined by the Secretary of

1 Commerce) expressed as a percentage of
2 the total population of all States.

3 “(C) FEDERAL MATCHING PERCENTAGE.—

4 “(i) IN GENERAL.—For purposes of
5 subparagraph (A), the Federal matching
6 percentage of the State shall be equal to
7 one less the State matching percentage (as
8 determined under clause (ii)).

9 “(ii) STATE MATCHING PERCENT-
10 AGE.—For purposes of clause (ii), the
11 State matching percentage of the State
12 shall be 0.25 multiplied by the ratio of the
13 total taxable resource percentage (as deter-
14 mined under clause (iii)) to the need-ad-
15 justed population of the State (as deter-
16 mined under subparagraph (B)).

17 “(iii) TOTAL TAXABLE RESOURCE
18 PERCENTAGE.—For purposes of clause (ii),
19 the total taxable resources percentage of
20 the State shall be the total taxable re-
21 sources of a State (as determined by the
22 Secretary of the Treasury) expressed as a
23 percentage of the sum of the total taxable
24 resources of all States.

25 “(3) ANNUAL ESTIMATES.—

1 “(A) IN GENERAL.—If the Secretary of
2 Commerce does not produce the annual esti-
3 mates required under paragraph (2)(B)(iv),
4 such estimates shall be determined by multiply-
5 ing the percentage of the population of the
6 State that is below 200 percent of the income
7 official poverty line as determined using the
8 most recent decennial census by the most recent
9 estimate of the total population of the State.
10 Except as provided in subparagraph (B), the
11 calculations required under this subparagraph
12 shall be made based on the most recent 3 year
13 average of the total taxable resources of individ-
14 uals within the State.

15 “(B) DISTRICT OF COLUMBIA.—Notwith-
16 standing subparagraph (A), the calculations re-
17 quired under such subparagraph with respect to
18 the District of Columbia shall be based on the
19 most recent 3 year average of the personal in-
20 come of individuals residing within the District
21 as a percentage of the personal income for all
22 individuals residing within the District, as de-
23 termined by the Secretary of Commerce.

24 “(4) MATCHING REQUIREMENT.—A State that
25 receives an allotment under this section shall make

1 available State resources (either directly or indi-
2 rectly) to carry out this section in an amount that
3 shall equal the State matching percentage for the
4 State (as determined under paragraph (2)(C)(II))
5 divided by the Federal matching percentage (as de-
6 termined under paragraph (2)(C)).

7 “(c) APPLICATION.—

8 “(1) IN GENERAL.—To be eligible to receive an
9 allotment under this section, a State shall prepare
10 and submit an application to the Secretary at such
11 time, in such manner, and containing such informa-
12 tion as the Secretary may by regulation require.

13 “(2) ASSURANCES.—A State application sub-
14 mitted under paragraph (1) shall contain an assur-
15 ance that—

16 “(A) the State will use amounts received
17 under it’s allotment consistent with the require-
18 ments of this section; and

19 “(B) the State will provide, from non-Fed-
20 eral sources, the amounts required under sub-
21 section (b)(4).

22 “(d) USE OF FUNDS.—

23 “(1) IN GENERAL.—The State shall use
24 amounts received under this section to award grants
25 to eligible public and nonprofit private entities, or

1 consortia of such entities, within the State to enable
2 such entities or consortia to provide services of the
3 type described in paragraph (2) of section 329(h) to
4 pregnant women and children up to age three.

5 “(2) ELIGIBILITY.—To be eligible to receive a
6 grant under paragraph (1), an entity or consortium
7 shall—

8 “(A) prepare and submit to the admin-
9 istering entity of the State, an application at
10 such time, in such manner and containing such
11 information as such administering entity may
12 require, including a plan for the provision of
13 services;

14 “(B) provide assurances that services will
15 be provided under the grant at fee rates estab-
16 lished or determined in accordance with section
17 330(e)(3)(F); and

18 “(C) provide assurances that in the case of
19 services provided to individuals with health in-
20 surance, such insurance shall be used as the
21 primary source of payment for such services.

22 “(3) TARGET POPULATIONS.—Entities or con-
23 sortia receiving grants under paragraph (1) shall, in
24 providing the services described in paragraph (3),

1 substantially target populations of pregnant women
2 and children within the State who—

3 “(A) lack the health care coverage, or abil-
4 ity to pay, for primary or supplemental health
5 care services; or

6 “(B) reside in medically underserved or
7 health professional shortage areas, areas cer-
8 tified as underserved under the rural health
9 clinic program, or other areas determined ap-
10 propriate by the State, within the State.

11 “(4) PRIORITY.—In awarding grants under
12 paragraph (1), the State shall—

13 “(A) give priority to entities or consortia
14 that can demonstrate through the plan submit-
15 ted under paragraph (2) that—

16 “(i) the services provided under the
17 grant will expand the availability of pri-
18 mary care services to the maximum num-
19 ber of pregnant women and children who
20 have no access to such care on the date of
21 the grant award; and

22 “(ii) the delivery of services under the
23 grant will be cost-effective; and

1 “(B) ensure that an equitable distribution
2 of funds is achieved among urban and rural en-
3 tities or consortia.

4 “(e) REPORTS AND AUDITS.—Each State shall pre-
5 pare and submit to the Secretary annual reports concern-
6 ing the State’s activities under this section which shall be
7 in such form and contain such information as the Sec-
8 retary determines appropriate. Each such State shall es-
9 tablish fiscal control and fund accounting procedures as
10 may be necessary to assure that amounts received under
11 this section are being disbursed properly and are ac-
12 counted for, and include the results of audits conducted
13 under such procedures in the reports submitted under this
14 subsection.

15 “(f) PAYMENTS.—

16 “(1) ENTITLEMENT.—Each State for which an
17 application has been approved by the Secretary
18 under this section shall be entitled to payments
19 under this section for each fiscal year in an amount
20 not to exceed the State’s allotment under subsection
21 (b) to be expended by the State in accordance with
22 the terms of the application for the fiscal year for
23 which the allotment is to be made.

24 “(2) METHOD OF PAYMENTS.—The Secretary
25 may make payments to a State in installments, and

1 in advance or, by way of reimbursement, with nec-
2 essary adjustments on account of overpayments or
3 underpayments, as the Secretary may determine.

4 “(3) STATE SPENDING OF PAYMENTS.—Pay-
5 ments to a State from the allotment under sub-
6 section (b) for any fiscal year must be expended by
7 the State in that fiscal year or in the succeeding fis-
8 cal year.

9 “(g) DEFINITION.—As used in this section, the term
10 ‘administering entity of the State’ means the agency or
11 official designated by the chief executive officer of the
12 State to administer the amounts provided to the State
13 under this section.

14 “(h) FUNDING.—Notwithstanding any other provi-
15 sion of law, the Secretary shall use 50 percent of the
16 amounts that the Secretary is required to utilize under
17 section 330B(h) in each fiscal year to carry out this sec-
18 tion.”.

1 **SEC. 503. ESTABLISHMENT OF NEW PROGRAM TO PROVIDE**
2 **FUNDS TO ALLOW FEDERALLY QUALIFIED**
3 **HEALTH CENTERS AND OTHER ENTITIES OR**
4 **ORGANIZATIONS TO PROVIDE EXPANDED**
5 **SERVICES TO MEDICALLY UNDERSERVED IN-**
6 **DIVIDUALS.**

7 (a) IN GENERAL.—Subpart I of part D of title III
8 of the Public Health Service Act (42 U.S.C. 254b et seq.)
9 (as amended by section 502) is further amended by adding
10 at the end thereof the following new section:

11 **“SEC. 330B. ESTABLISHMENT OF NEW PROGRAM TO PRO-**
12 **VIDE FUNDS TO ALLOW FEDERALLY QUALI-**
13 **FIED HEALTH CENTERS AND OTHER ENTI-**
14 **TIES OR ORGANIZATIONS TO PROVIDE EX-**
15 **PANDED SERVICES TO MEDICALLY UNDER-**
16 **SERVED INDIVIDUALS.**

17 “(a) ESTABLISHMENT OF HEALTH SERVICES AC-
18 CESS PROGRAM.—From amounts appropriated under this
19 section, the Secretary shall, acting through the Bureau of
20 Health Care Delivery Assistance, award grants under this
21 section to federally qualified health centers (hereinafter re-
22 ferred to in this section as ‘FQHC’s’) and other entities
23 and organizations submitting applications under this sec-
24 tion (as described in subsection (c)) for the purpose of
25 providing access to services for medically underserved pop-
26 ulations (as defined in section 330(b)(3)) or in high im-

1 pact areas (as defined in section 329(a)(5)) not currently
2 being served by a FQHC.

3 “(b) ELIGIBILITY FOR GRANTS.—

4 “(1) IN GENERAL.—The Secretary shall award
5 grants under this section to entities or organizations
6 described in this paragraph and paragraph (2) which
7 have submitted a proposal to the Secretary to ex-
8 pand such entities or organizations operations (in-
9 cluding expansions to new sites (as determined nec-
10 essary by the Secretary)) to serve medically under-
11 served populations or high impact areas not cur-
12 rently served by a FQHC and which—

13 “(A) have as of January 1, 1992, been cer-
14 tified by the Secretary as a FQHC under sec-
15 tion 1905(l)(2)(B) of the Social Security Act;

16 “(B) have submitted applications to the
17 Secretary to qualify as FQHC’s under such sec-
18 tion 1905(l)(2)(B); or

19 “(C) have submitted a plan to the Sec-
20 retary which provides that the entity will meet
21 the requirements to qualify as a FQHC when
22 operational.

23 “(2) NON FQHC ENTITIES.—

24 “(A) ELIGIBILITY.—The Secretary shall
25 also make grants under this section to public or

1 private nonprofit agencies, health care entities
2 or organizations which meet the requirements
3 necessary to qualify as a FQHC except, the re-
4 quirement that such entity have a consumer
5 majority governing board and which have sub-
6 mitted a proposal to the Secretary to provide
7 those services provided by a FQHC as defined
8 in section 1905(l)(2)(B) of the Social Security
9 Act and which are designed to promote access
10 to primary care services or to reduce reliance on
11 hospital emergency rooms or other high cost
12 providers of primary health care services, pro-
13 vided such proposal is developed by the entity
14 or organizations (or such entities or organiza-
15 tions acting in a consortium in a community)
16 with the review and approval of the Governor of
17 the State in which such entity or organization
18 is located.

19 “(B) LIMITATION.—The Secretary shall
20 provide in making grants to entities or organi-
21 zations described in this paragraph that no
22 more than 10 percent of the funds provided for
23 grants under this section shall be made avail-
24 able for grants to such entities or organizations.

25 “(c) APPLICATION REQUIREMENTS.—

1 “(1) IN GENERAL.—In order to be eligible to
2 receive a grant under this section, a FQHC or other
3 entity or organization must submit an application in
4 such form and at such time as the Secretary shall
5 prescribe and which meets the requirements of this
6 subsection.

7 “(2) REQUIREMENTS.—An application submit-
8 ted under this section must provide—

9 “(A)(i) for a schedule of fees or payments
10 for the provision of the services provided by the
11 entity designed to cover its reasonable costs of
12 operations; and

13 “(ii) for a corresponding schedule of dis-
14 counts to be applied to such fees or payments,
15 based upon the patient’s ability to pay (deter-
16 mined by using a sliding scale formula based on
17 the income of the patient);

18 “(B) assurances that the entity or organi-
19 zation provides services to persons who are eli-
20 gible for benefits under title XVIII of the Social
21 Security Act, for medical assistance under title
22 XIX of such Act or for assistance for medical
23 expenses under any other public assistance pro-
24 gram or private health insurance program; and

1 “(C) assurances that the entity or organi-
2 zation has made and will continue to make
3 every reasonable effort to collect reimbursement
4 for services—

5 “(i) from persons eligible for assist-
6 ance under any of the programs described
7 in subparagraph (B); and

8 “(ii) from patients not entitled to ben-
9 efits under any such programs.

10 “(d) LIMITATIONS ON USE OF FUNDS.—

11 “(1) IN GENERAL.—From the amounts award-
12 ed to an entity or organization under this section,
13 funds may be used for purposes of planning but may
14 only be expended for the costs of—

15 “(A) assessing the needs of the populations
16 or proposed areas to be served;

17 “(B) preparing a description of how the
18 needs identified will be met;

19 “(C) development of an implementation
20 plan that addresses—

21 “(i) recruitment and training of per-
22 sonnel; and

23 “(ii) activities necessary to achieve
24 operational status in order to meet FQHC

1 requirements under 1905(l)(2)(B) of the
2 Social Security Act.

3 “(2) RECRUITING, TRAINING AND COMPENSA-
4 TION OF STAFF.—From the amounts awarded to an
5 entity or organization under this section, funds may
6 be used for the purposes of paying for the costs of
7 recruiting, training and compensating staff (clinical
8 and associated administrative personnel (to the ex-
9 tent such costs are not already reimbursed under
10 title XIX of the Social Security Act or any other
11 State or Federal program)) to the extent necessary
12 to allow the entity to operate at new or expanded ex-
13 isting sites.

14 “(3) FACILITIES AND EQUIPMENT.—From the
15 amounts awarded to an entity or organization under
16 this section, funds may be expended for the purposes
17 of acquiring facilities and equipment but only for the
18 costs of—

19 “(A) construction of new buildings (to the
20 extent that new construction is found to be the
21 most cost-efficient approach by the Secretary);

22 “(B) acquiring, expanding, or modernizing
23 of existing facilities;

24 “(C) purchasing essential (as determined
25 by the Secretary) equipment; and

1 “(D) amortization of principal and pay-
2 ment of interest on loans obtained for purposes
3 of site construction, acquisition, modernization,
4 or expansion, as well as necessary equipment.

5 “(4) SERVICES.—From the amounts awarded
6 to an entity or organization under this section, funds
7 may be expended for the payment of services but
8 only for the costs of—

9 “(A) providing or arranging for the provi-
10 sion of all services through the entity necessary
11 to qualify such entity as a FQHC under section
12 1905(l)(2)(B) of the Social Security Act;

13 “(B) providing or arranging for any other
14 service that a FQHC may provide and be reim-
15 bursed for under title XIX of such Act; and

16 “(C) providing any unreimbursed costs of
17 providing services as described in section 330(a)
18 to patients.

19 “(e) PRIORITIES IN THE AWARDING OF GRANTS.—

20 “(1) CERTIFIED FQHC’S.—The Secretary shall
21 give priority in awarding grants under this section
22 to entities which have, as of January 1, 1992, been
23 certified as a FQHC under section 1905(l)(2)(B) of
24 the Social Security Act and which have submitted a
25 proposal to the Secretary to expand their operations

1 (including expansion to new sites) to serve medically
2 underserved populations for high impact areas not
3 currently served by a FQHC. The Secretary shall
4 give first priority in awarding grants under this sec-
5 tion to those FQHCs or other entities which propose
6 to serve populations with the highest degree of
7 unmet need, and which can demonstrate the ability
8 to expand their operations in the most efficient man-
9 ner.

10 “(2) QUALIFIED FQHC’S.—The Secretary shall
11 give second priority in awarding grants to entities
12 which have submitted applications to the Secretary
13 which demonstrate that the entity will qualify as a
14 FQHC under section 1905(l)(2)(B) of the Social Se-
15 curity Act before it provides or arranges for the pro-
16 vision of services supported by funds awarded under
17 this section, and which are serving or proposing to
18 serve medically underserved populations or high im-
19 pact areas which are not currently served (or pro-
20 posed to be served) by a FQHC.

21 “(3) EXPANDED SERVICES AND PROJECTS.—
22 The Secretary shall give third priority in awarding
23 grants in subsequent years to those FQHCs or other
24 entities which have provided for expanded services
25 and project and are able to demonstrate that such

1 entity will incur significant unreimbursed costs in
2 providing such expanded services.

3 “(f) RETURN OF FUNDS TO SECRETARY FOR COSTS
4 REIMBURSED FROM OTHER SOURCES.—To the extent
5 that an entity or organization receiving funds under this
6 section is reimbursed from another source for the provi-
7 sion of services to an individual, and does not use such
8 increased reimbursement to expand services furnished,
9 areas served, to compensate for costs of unreimbursed
10 services provided to patients, or to promote recruitment,
11 training, or retention of personnel, such excess revenues
12 shall be returned to the Secretary.

13 “(g) TERMINATION OF GRANTS.—

14 “(1) FAILURE TO MEET FQHC REQUIRE-
15 MENTS.—

16 “(A) IN GENERAL.—With respect to any
17 entity that is receiving funds awarded under
18 this section and which subsequently fails to
19 meet the requirements to qualify as a FQHC
20 under section 1905(l)(2)(B) or is an entity that
21 is not required to meet the requirements to
22 qualify as a FQHC under section 1905(l)(2)(B)
23 of the Social Security Act but fails to meet the
24 requirements of this section, the Secretary shall

1 terminate the award of funds under this section
2 to such entity.

3 “(B) NOTICE.—Prior to any termination
4 of funds under this section to an entity, the en-
5 tities shall be entitled to 60 days prior notice of
6 termination and, as provided by the Secretary
7 in regulations, an opportunity to correct any de-
8 ficiencies in order to allow the entity to con-
9 tinue to receive funds under this section.

10 “(2) REQUIREMENTS.—Upon any termination
11 of funding under this section, the Secretary may (to
12 the extent practicable)—

13 “(A) sell any property (including equip-
14 ment) acquired or constructed by the entity
15 using funds made available under this section
16 or transfer such property to another FQHC,
17 provided, that the Secretary shall reimburse
18 any costs which were incurred by the entity in
19 acquiring or constructing such property (includ-
20 ing equipment) which were not supported by
21 grants under this section; and

22 “(B) recoup any funds provided to an en-
23 tity terminated under this section.

24 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section,

1 \$400,000,000 for fiscal year 1993, \$800,000,000 for fis-
2 cal year 1994, \$1,200,000,000 for fiscal year 1995,
3 \$1,600,000,000 for fiscal year 1996, and \$1,600,000,000
4 for fiscal year 1997.”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 subsection (a) shall become effective with respect to serv-
7 ices furnished by a federally qualified health center or
8 other qualifying entity described in this section beginning
9 on or after October 1, 1992.

10 (c) STUDY AND REPORT ON SERVICES PROVIDED BY
11 COMMUNITY HEALTH CENTERS AND HOSPITALS.—

12 (1) IN GENERAL.—The Secretary of Health and
13 Human Services (hereinafter referred to in this sub-
14 section as the “Secretary”) shall provide for a study
15 to examine the relationship and interaction between
16 community health centers and hospitals in providing
17 services to individuals residing in medically under-
18 served areas. The Secretary shall ensure that the
19 National Rural Research Centers participate in such
20 study.

21 (2) REPORT.—The Secretary shall provide to
22 the appropriate committees of Congress a report
23 summarizing the findings of the study within 90
24 days of the end of each project year and shall in-
25 clude in such report recommendations on methods to

1 improve the coordination of and provision of services
2 in medically underserved areas by community health
3 centers and hospitals.

4 (3) AUTHORIZATION.—There are authorized to
5 be appropriated to carry out the study provided for
6 in this subsection \$150,000 for each of fiscal years
7 1993 and 1994.

8 **SEC. 504. RURAL MENTAL HEALTH OUTREACH GRANTS.**

9 Subpart 3 of part B of title V of the Public Health
10 Service Act (42 U.S.C. 290cc–11 et seq.) is amended by
11 adding at the end thereof the following new section:

12 **“SEC. 520A. RURAL MENTAL HEALTH OUTREACH GRANTS.**

13 “(a) IN GENERAL.—The Secretary may award com-
14 petitive grants to eligible entities to enable such entities
15 to develop and implement a plan for mental health out-
16 reach programs in rural areas.

17 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
18 a grant under subsection (a) an entity shall—

19 “(1) prepare and submit to the Secretary an
20 application at such time, in such form and contain-
21 ing such information as the Secretary may require,
22 including a description of the activities that the en-
23 tity intends to undertake using grant funds; and

24 “(2) meet such other requirements as the Sec-
25 retary determines appropriate.

1 “(c) PRIORITY.—In awarding grants under sub-
2 section (a), the Secretary shall give priority to applications
3 that place emphasis on mental health services for the el-
4 derly or children. Priority shall also be given to applica-
5 tions that involve relationships between the applicant and
6 rural managed care cooperatives.

7 “(d) MATCHING REQUIREMENT.—An entity that re-
8 ceives a grant under subsection (a) shall make available
9 (directly or through donations from public or private enti-
10 ties), non-Federal contributions toward the costs of the
11 operations of the network in an amount equal to the
12 amount of the grant.

13 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section,
15 \$5,000,000 for each of the fiscal years 1993 through
16 1997.”.

17 **SEC. 505. HEALTH PROFESSIONS TRAINING.**

18 (a) MEDICALLY UNDERSERVED AREA TRAINING IN-
19 CENTIVES.—Part A of title VII of the Public Health Serv-
20 ice Act (42 U.S.C. 292 et seq.) is amended by adding at
21 the end thereof the following new section:

22 **“SEC. 711. PRIORITIES IN AWARDING OF GRANTS.**

23 “(a) ALLOCATION OF COMPETITIVE GRANT
24 FUNDS.—In awarding competitive grants under this title
25 or title VIII, the Secretary shall, among applicants that

1 meet the eligibility requirements under such titles, give
2 priority to entities submitting applications that—

3 “(1) can demonstrate that such entities—

4 “(A) have a high permanent rate for plac-
5 ing graduates in practice settings which serve
6 residents of medically underserved communities;
7 and

8 “(B) have a curriculum that includes—

9 “(i) the rotation of medical students
10 and residents to clinical settings the focus
11 of which is to serve medically underserved
12 communities;

13 “(ii) the appointment of health profes-
14 sionals whose practices serve medically un-
15 derserved communities to act as preceptors
16 to supervise training in such settings;

17 “(iii) classroom instruction on practice
18 opportunities involving medically under-
19 served communities;

20 “(iv) service contingent scholarship or
21 loan repayment programs for students and
22 residents to encourage practice in or serv-
23 ice to underserved communities;

24 “(v) the recruitment of students who
25 are most likely to elect to practice in or

1 provide service to medically underserved
2 communities;

3 “(vi) other training methodologies
4 that demonstrate a significant commitment
5 to the expansion of the proportion of grad-
6 uates that elect to practice in or serve the
7 needs of medically underserved commu-
8 nities; or

9 “(2) contain an organized plan for the expedi-
10 tious development of the placement rate and curricu-
11 lum described in paragraph (1).

12 “(b) SERVICE IN MEDICALLY UNDERSERVED COM-
13 MUNITIES.—Not less than 50 percent of the amounts ap-
14 propriated for fiscal year 1996, and for each subsequent
15 fiscal year, for competitive grants under this title or title
16 VIII, shall be used to award grants to institutions that
17 are otherwise eligible for grants under such titles, and that
18 can demonstrate that—

19 “(1) not less than 15 percent of the graduates
20 of such institutions during the preceding 2-year pe-
21 riod are engaged in full-time practice serving the
22 needs of medically underserved communities; or

23 “(2) the number of the graduates of such insti-
24 tutions that are practicing in a medically under-
25 served community has increased by not less than 50

1 percent over that proportion of such graduates for
2 the previous 2-year period.

3 “(c) WAIVERS.—A health professions school may pe-
4 tition the Secretary for a temporary waiver of the prior-
5 ities of this section. Such waiver shall be approved if the
6 health professions school demonstrates that the State in
7 which such school is located is not suffering from a short-
8 age of primary care providers, as determined by the Sec-
9 retary. Such waiver shall not be for a period in excess of
10 2 years.

11 “(d) DEFINITIONS.—As used in this section:

12 “(1) GRADUATE.—The term ‘graduate’ means,
13 unless otherwise specified, an individual who has
14 successfully completed all training and residency re-
15 quirements necessary for full certification in the
16 health professions discipline that such individual has
17 selected.

18 “(2) MEDICALLY UNDERSERVED COMMUNITY.—
19 The term ‘medically underserved community’
20 means—

21 “(A) an area designated under section 332
22 as a health professional shortage area;

23 “(B) an area designated as a medically un-
24 derserved area under this Act;

1 “(C) populations served by migrant health
2 centers under section 329, community health
3 centers under section 330, or Federally quali-
4 fied health centers under section 1905(l)(2)(B)
5 of the Social Security Act;

6 “(D) a community that is certified as un-
7 derserved by the Secretary for purposes of par-
8 ticipation in the rural health clinic program
9 under title XVIII of the Social Security Act; or

10 “(E) a community that meets the criteria
11 for the designation described in subparagraph
12 (A) or (B) but that has not been so des-
13 ignated.”.

14 (b) **MEDICALLY UNDERSERVED AREA TRAINING**
15 **GRANTS.**—Part F of title VII (42 U.S.C. 295g et seq.)
16 of such Act is amended by adding at the end thereof the
17 following new section:

18 **“SEC. 790B. MEDICALLY UNDERSERVED AREA TRAINING**
19 **GRANT PROGRAM.**

20 “(a) **GRANTS.**—The Secretary shall award grants to
21 health professions institutions to expand training pro-
22 grams that are targeted at those individuals desiring to
23 practice in or serve the needs of medically underserved
24 communities.

1 “(b) PLAN.—As part of an application submitted for
2 a grant under this section, the applicant shall prepare and
3 submit a plan that describes the proposed use of funds
4 that may be provided to the applicant under the grant.

5 “(c) PRIORITY.—In awarding grants under this sec-
6 tion, the Secretary shall give priority to applicants that
7 demonstrate the greatest likelihood of expanding the pro-
8 portion of graduates who choose to practice in or serve
9 the needs of medically underserved areas.

10 “(d) USE OF FUNDS.—An institution that receives
11 a grant under this section shall use amounts received
12 under such grant to establish or enhance procedures or
13 efforts to—

14 “(1) rotate health professions students from
15 such institution to clinical settings the focus of
16 which is to serve the residents of medically under-
17 served communities;

18 “(2) appoint health professionals whose prac-
19 tices serve medically underserved areas to serve as
20 preceptors to supervise training in such settings;

21 “(3) provide classroom instruction on practice
22 opportunities involving medically underserved com-
23 munities;

24 “(4) provide service contingent scholarship or
25 loan repayment programs for students and residents

1 to encourage practice in or service to underserved
2 communities;

3 “(5) recruit students who are most likely to
4 elect to practice in or provide service to medically
5 underserved communities; or

6 “(6) provide other training methodologies that
7 demonstrate a significant commitment to the expan-
8 sion of the proportion of graduates that elect to
9 practice in or serve the needs of medically under-
10 served communities.

11 “(e) ADMINISTRATION.—

12 “(1) REQUIRED CONTRIBUTION.—An institu-
13 tion that receives a grant under this section shall
14 contribute, from non-Federal sources, either in cash
15 or in-kind, an amount equal to the amount of the
16 grant to the activities to be undertaken with the
17 grant funds.

18 “(2) LIMITATION.—An institution that receives
19 a grant under this section, shall use amounts re-
20 ceived under such grant to supplement, not sup-
21 plant, amounts made available by such institution
22 for activities of the type described in subsection (d)
23 in the fiscal year preceding the year for which the
24 grant is received.

25 “(f) DEFINITIONS.—As used in this section:

1 “(1) GRADUATE.—The term ‘graduate’ means,
2 unless otherwise specified, an individual who has
3 successfully completed all training and residency re-
4 quirements necessary for full certification in the
5 health professions discipline that such individual has
6 selected.

7 “(2) MEDICALLY UNDERSERVED COMMUNITY.—
8 The term ‘medically underserved community’
9 means—

10 “(A) an area designated under section 332
11 as a health professional shortage area;

12 “(B) an area designated as a medically un-
13 derserved area under this Act;

14 “(C) populations served by migrant health
15 centers under section 329, community health
16 centers under section 330, or Federally quali-
17 fied health centers under section 1905(l)(2)(B)
18 of the Social Security Act;

19 “(D) a community that is certified as un-
20 derserved by the Secretary for purposes of par-
21 ticipation in the rural health clinic program
22 under title XVIII of the Social Security Act; or

23 “(E) a community that meets the criteria
24 for the designation described in subparagraph
25 (A) or (B) but that has not been so designated.

1 “(2) PLAN.—As part of the application submit-
2 ted by a consortium under paragraph (1)(B), the
3 consortium shall prepare and submit a plan that de-
4 scribes the proposed use of funds that may be pro-
5 vided to the consortium under the grant.

6 “(c) USE OF FUNDS.—A consortium that receives a
7 grant under this section shall use amounts received under
8 such grant to establish or enhance—

9 “(1) strategies for better clinical cooperation
10 among different types of health professionals;

11 “(2) classroom instruction on integrated prac-
12 tice opportunities, particularly targeted toward rural
13 areas;

14 “(3) integrated clinical clerkship programs that
15 make use of students in differing health professions
16 schools; or

17 “(4) other training methodologies that dem-
18 onstrate a significant commitment to the expansion
19 of clinical cooperation among different types of
20 health professionals, particularly in underserved
21 rural areas.

22 “(d) LIMITATION.—A consortium that receives a
23 grant under this section, shall use amounts received under
24 such grant to supplement, not supplant, amounts made
25 available by such institution for activities of the type de-

1 scribed in subsection (c) in the fiscal year preceding the
2 year for which the grant is received.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section,
5 \$7,000,000 for each of the fiscal years 1993 and 1994,
6 and such sums as may be necessary for each of the fiscal
7 years 1995 through 1997.”.

8 **SEC. 506. AREA HEALTH EDUCATION CENTERS.**

9 (a) STIPENDS FOR PERSONNEL.—Section 781(a) of
10 the Public Health Service Act (42 U.S.C. 295g-1(a)) is
11 amended by adding at the end thereof the following new
12 paragraph:

13 “(3)(A) The Secretary may award grants under this
14 section to rural communities to enable such communities
15 to provide stipends to physicians, nurses or other health
16 professional trainees to encourage such individuals to con-
17 tinue to provide health care services in such rural commu-
18 nities.

19 “(B) A community that receives a grant under sub-
20 paragraph (A) shall make available (directly or through
21 donations from public or private entities), non-Federal
22 contributions towards the costs of the operations of the
23 network in an amount equal to the amount of the grant.”.

24 (b) REAUTHORIZATION.—Section 781(h) of such Act
25 (42 U.S.C. 295g-1(h)) is amended to read as follows:

1 “(h)(1) For purposes of carrying out this section,
2 other than subsection (f), there are authorized to be ap-
3 propriated \$40,000,000 for each of the fiscal years 1993
4 through 1997.

5 “(2) For purposes of carrying out subsection (f),
6 there are authorized to be appropriated \$12,000,000 for
7 each of the fiscal years 1993 through 1997.

8 “(3) A contract entered into under this section after
9 the date of enactment of this subsection shall require that
10 the entity awarded such contract make available (directly
11 or through donations from public or private entities), dur-
12 ing the fourth and remaining years of the contract, non-
13 Federal contributions equal to—

14 “(A) for the fourth year for which such con-
15 tract is in effect, \$3 for every \$7 of Federal funds
16 provided under the contract in such year;

17 “(B) for the fifth year for which such contract
18 is in effect, \$4 for every \$6 of Federal funds pro-
19 vided under the contract in such year; and

20 “(C) for the sixth and subsequent years for
21 which such contract is in effect, \$1 for every \$1 of
22 Federal funds provided under the contract in such
23 year.”.

1 **SEC. 507. RURAL HEALTH EXTENSION NETWORKS.**

2 Title XVII of the Public Health Service Act (42
3 U.S.C. 300u et seq.) is amended by adding at the end
4 thereof the following new section:

5 **“SEC. 1707. RURAL HEALTH EXTENSION NETWORKS.**

6 “(a) GRANTS.—The Secretary, acting through the
7 Health Resources and Services Administration, may
8 award competitive grants to eligible entities to enable such
9 entities to facilitate the development of networks among
10 rural and urban health care providers to preserve and
11 share health care resources and enhance the quality and
12 availability of health care in rural areas. Such networks
13 may be statewide or regionalized in focus.

14 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
15 a grant under subsection (a) an entity shall—

16 “(1) be a rural health extension network that
17 meets the requirements of subsection (c);

18 “(2) prepare and submit to the Secretary an
19 application at such time, in such form and contain-
20 ing such information as the Secretary may require;
21 and

22 “(3) meets such other requirements as the Sec-
23 retary determines appropriate.

24 “(c) NETWORKS.—For purposes of subsection (b)(1),
25 a rural health extension network shall be an association
26 or consortium of three or more rural health care providers,

1 and may include one or more urban health care providers,
2 for the purpose of applying for a grant under this section
3 and using amounts received under such grant to provide
4 the services described in subsection (d).

5 “(d) SERVICES.—

6 “(1) IN GENERAL.—An entity that receives a
7 grant under subsection (a) shall use amounts re-
8 ceived under such grant to—

9 “(A) provide education and community de-
10 cision-making support for health care providers
11 in the rural areas served by the network;

12 “(B) utilize existing health care provider
13 education programs, including but not limited
14 to, the program for area health education cen-
15 ters under section 781, to provide educational
16 services to health care providers in the areas
17 served by the network;

18 “(C) make appropriately trained
19 facilitators available to health care providers lo-
20 cated in the areas served by the network to as-
21 sist such providers in developing cooperative ap-
22 proaches to health care in such area;

23 “(D) facilitate linkage building through the
24 organization of discussion and planning groups
25 and the dissemination of information concern-

1 ing the health care resources where available,
2 within the area served by the network;

3 “(E) support telecommunications and con-
4 sultative projects to link rural hospitals and
5 other health care providers, and urban or ter-
6 tiary hospitals in the areas served by the net-
7 work; or

8 “(F) carry out any other activity deter-
9 mined appropriate by the Secretary.

10 “(2) EDUCATION.—In carrying out activities
11 under paragraph (1)(B), an entity shall support the
12 development of an information and resource sharing
13 system, including elements targeted towards high
14 risk populations and focusing on health promotion,
15 to facilitate the ability of rural health care providers
16 to have access to needed health care information.
17 Such activities may include the provision of training
18 to enable individuals to serve as coordinators of
19 health education programs in rural areas.

20 “(3) COLLECTION AND DISSEMINATION OF
21 DATA.—The chief executive officer of a State shall
22 designate a State agency that shall be responsible
23 for collecting and regularly disseminating informa-
24 tion concerning the activities of the rural health ex-
25 tension networks in that State.

1 “(e) MATCHING REQUIREMENT.—An entity that re-
2 ceives a grant under subsection (a) shall make available
3 (directly or through donations from public or private enti-
4 ties), non-Federal contributions towards the costs of the
5 operations of the network in an amount equal to the
6 amount of the grant.

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to carry out this section,
9 \$10,000,000 for each of the fiscal years 1993 through
10 1997.

11 “(g) DEFINITION.—As used in this section and sec-
12 tion 1708, the term ‘rural health care providers’ means
13 health care professionals and hospitals located in rural
14 areas. The Secretary shall ensure that for purposes of this
15 definition, rural areas shall include any area that meets
16 any applicable Federal or State definition of rural area.”.

17 **SEC. 508. RURAL MANAGED CARE COOPERATIVES.**

18 Title XVII of the Public Health Service Act (42
19 U.S.C. 300u et seq.) as amended by section 507 is further
20 amended by adding at the end thereof the following new
21 section:

22 **“SEC. 1708. RURAL MANAGED CARE COOPERATIVES.**

23 “(a) GRANTS.—The Secretary, acting through the
24 Health Resources and Services Administration, may
25 award competitive grants to eligible entities to enable such

1 entities to develop and administer cooperatives in rural
2 areas that will establish an effective case management and
3 reimbursement system designed to support the economic
4 viability of essential public or private health services, fa-
5 cilities, health care systems and health care resources in
6 such rural areas.

7 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
8 a grant under subsection (a) an entity shall—

9 “(1) prepare and submit to the Secretary an
10 application at such time, in such form and contain-
11 ing such information as the Secretary may require,
12 including a description of the cooperative that the
13 entity intends to develop and operate using grant
14 funds; and

15 “(2) meet such other requirements as the Sec-
16 retary determines appropriate.

17 “(c) COOPERATIVES.—

18 “(1) IN GENERAL.—Amounts provided under a
19 grant awarded under subsection (a) shall be used to
20 establish and operate a cooperative made up of all
21 types of health care providers, hospitals, primary ac-
22 cess hospitals, other alternate rural health care fa-
23 cilities, physicians, rural health clinics, rural nurse
24 practitioners and physician assistant practitioners,
25 public health departments and others located in, but

1 not restricted to, the rural areas to be served by the
2 cooperative.

3 “(2) BOARD OF DIRECTORS.—A cooperative es-
4 tablished under paragraph (1) shall be administered
5 by a board of directors elected by the members of
6 the cooperative, a majority of whom shall represent
7 rural providers from the local community and in-
8 clude representatives from the local community.
9 Such directors shall serve at the pleasure of such
10 members.

11 “(3) EXECUTIVE DIRECTOR.—The members of
12 a cooperative established under paragraph (1) shall
13 elect an executive director who shall serve as the
14 chief operating officer of the cooperative. The execu-
15 tive director shall be responsible for conducting the
16 day to day operation of the cooperative including—

17 “(A) maintaining an accounting system for
18 the cooperative;

19 “(B) maintaining the business records of
20 the cooperative;

21 “(C) negotiating contracts with provider
22 members of the cooperative; and

23 “(D) coordinating the membership and
24 programs of the cooperative.

25 “(4) REIMBURSEMENTS.—

1 “(A) NEGOTIATIONS.—A cooperative es-
2 tablished under paragraph (1) shall facilitate
3 negotiations among member health care provid-
4 ers and third party payers concerning the rates
5 at which such providers will be reimbursed for
6 services provided to individuals for which such
7 payers may be liable.

8 “(B) AGREEMENTS.—Agreements reached
9 under subparagraph (A) shall be binding on the
10 members of the cooperative.

11 “(C) EMPLOYERS.—Employer entities may
12 become members of a cooperative established
13 under paragraph (a) in order to provide,
14 through a member third party payer, health in-
15 surance coverage for employees of such entities.
16 Deductibles shall only be charged to employees
17 covered under such insurance if such employees
18 receive health care services from a provider that
19 is not a member of the cooperative if similar
20 services would have been available from a mem-
21 ber provider.

22 “(D) MALPRACTICE INSURANCE.—A coop-
23 erative established under subsection (a) shall be
24 responsible for identifying and implementing a
25 malpractice insurance program that shall in-

1 clude a requirement that such cooperative as-
2 sume responsibility for the payment of a por-
3 tion of the malpractice insurance premium of
4 providers members.

5 “(5) MANAGED CARE AND PRACTICE STAND-
6 ARDS.—A cooperative established under paragraph
7 (1) shall establish joint case management and pa-
8 tient care practice standards programs that health
9 care providers that are members of such cooperative
10 must meet to be eligible to participate in agreements
11 entered into under paragraph (4). Such standards
12 shall be developed by such provider members and
13 shall be subject to the approval of a majority of the
14 board of directors. Such programs shall include cost
15 and quality of care guidelines including a require-
16 ment that such providers make available
17 preadmission screening, selective case management
18 services, joint patient care practice standards devel-
19 opment and compliance and joint utilization review.

20 “(6) CONFIDENTIALITY.—Patients records,
21 records of peer review, utilization review, and quality
22 assurance proceedings conducted by the cooperative
23 should be considered confidential and protected from
24 release outside of the cooperative. The provider
25 members of the cooperative shall be indemnified by

1 the cooperative for the good faith participation by
2 such members in such the required activities.

3 “(d) LINKAGES.—A cooperative shall create linkages
4 among member health care providers, employers, and pay-
5 ers for the joint consultation and formulation of the types,
6 rates, costs, and quality of health care provided in rural
7 areas served by the cooperative.

8 “(e) MATCHING REQUIREMENT.—An entity that re-
9 ceives a grant under subsection (a) shall make available
10 (directly or through donations from public or private enti-
11 ties), non-Federal contributions towards the costs of the
12 operations of the network in an amount equal to the
13 amount of the grant.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section,
16 \$15,000,000 for each of the fiscal years 1993 through
17 1997.”.

18 **Subtitle B—Provision Relating to**
19 **Social Security**

20 **SEC. 511. RURAL HEALTH CARE TRANSITION GRANT PRO-**
21 **GRAM.**

22 Section 4005(e)(9) of the Omnibus Budget Reconcili-
23 ation Act of 1987 (42 U.S.C. 1395ww note) is amended
24 by striking “\$15,000,000” and all that follows through

1 the end thereof and inserting “\$50,000,000 for each of
2 the fiscal years 1993 through 1997.”.

3 **SEC. 512. ESSENTIAL ACCESS COMMUNITY HOSPITAL PRO-**
4 **GRAM.**

5 Section 1820(k) of the Social Security Act (42 U.S.C.
6 1395i-4(k)) is amended to read as follows:

7 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to carry out this section,
9 \$50,000,000 for each of the fiscal years 1993 through
10 1997.”.

11 **TITLE VI—INCENTIVES TO EN-**
12 **COURAGE PREVENTIVE SERV-**
13 **ICES**

14 **SEC. 601. PREVENTIVE SERVICES TAX CREDIT.**

15 (a) IN GENERAL.—Subpart C of part IV of sub-
16 chapter A of chapter 1 of the Internal Revenue Code of
17 1986 (relating to refundable credits), as amended by sec-
18 tion 101, is further amended by inserting after section
19 34A the following new section:

20 **“SEC. 34B. PREVENTIVE SERVICES CREDIT.**

21 “(a) ALLOWANCE OF CREDIT.—There shall be al-
22 lowed as a credit against the tax imposed by this subtitle
23 for the taxable year expenditures paid or incurred during
24 the taxable year for any qualified preventive services which

1 are included in the list under subsection (c) and which
2 are not compensated by insurance or otherwise, as follows:

3 “(1) ELIGIBLE INDIVIDUAL.—In the case of an
4 eligible individual, the amount of the credit allowable
5 under this subsection shall not exceed—

6 “(A) \$250, or

7 “(B) \$200 in the case of a taxpayer with
8 taxable income for the taxable year in excess of
9 the maximum rate of taxable income to which
10 the 15-percent rate applies under the applicable
11 table under section 1.

12 “(2) QUALIFIED PREVENTIVE SERVICES PRO-
13 VIDER.—In the case of a qualified preventive serv-
14 ices provider, the amount of the credit allowable
15 under this subsection shall be an amount equal to
16 the product of—

17 “(A) the lower of—

18 “(i) the usual and customary charges
19 for qualified preventive services, or

20 “(ii) the rate of payment established
21 by the Health Care Financing Administra-
22 tion for qualified preventive services,
23 multiplied by—

1 “(B) the number of qualified preventive
2 services provided without charge during the tax-
3 able year to qualifying low-income individuals.

4 “(b) DEFINITIONS.—For purposes of subsection
5 (a)—

6 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
7 individual’ means an individual who is—

8 “(A) the taxpayer,

9 “(B) the taxpayer’s spouse, or

10 “(C) any individual for whom the taxpayer
11 is allowed an exemption under section 151.

12 “(2) QUALIFIED PREVENTIVE SERVICES PRO-
13 VIDER.—The term ‘qualified preventive services pro-
14 vider’ means a medical practitioner, facility, hospital,
15 laboratory, or similar institution licensed under
16 State law to provide 1 or more qualified preventive
17 services.

18 “(3) QUALIFYING LOW-INCOME INDIVIDUAL.—
19 The term ‘qualifying low-income individual’ means
20 an individual—

21 “(A) whose income level does not exceed
22 150 percent of the official poverty line (as de-
23 fined by the Office of Management and Budget
24 and revised annually in accordance with section
25 673(2) of the Omnibus Budget Reconciliation

1 Act of 1981) applicable to a family of the size
2 involved, and

3 “(B) with respect to whom identifying in-
4 formation is maintained.

5 “(c) QUALIFIED PREVENTIVE SERVICES.—

6 “(1) IN GENERAL.—For purposes of this sec-
7 tion, the Secretary, after consultation with the Sec-
8 retary of Health and Human Services and cancer re-
9 search and prevention organizations, shall publish,
10 not later than December 31, 1992, and annually
11 thereafter, a list of preventive services which qualify
12 for the credit allowable under this section.

13 “(2) PREVENTIVE SERVICES.—

14 “(A) IN GENERAL.—The list of preventive
15 services which qualify under this section shall
16 include at least the following:

17 “(i) Cancer screening tests.

18 “(ii) Childhood immunization.

19 “(iii) Well child care.

20 “(B) CANCER SCREENING TESTS.—The
21 term ‘cancer screening tests’ shall include at
22 least the following:

23 “(i) Physical breast examination and
24 mammogram for female breast cancer.

1 “(ii) Digital rectal examination,
2 proctosigmoidoscopy, and blood stool test
3 for colon and rectum cancer.

4 “(iii) Rectal examination for prostate
5 cancer.

6 “(iv) Pap test for uterine cancer.

7 “(v) Pelvic examination for ovarian
8 cancer.

9 “(d) IDENTIFYING INFORMATION.—No credit shall
10 be allowed under this section unless the qualified preven-
11 tive services provider maintains, to the satisfaction of the
12 Secretary, adequate records regarding the name and ad-
13 dress, date of services, and type of services provided with
14 respect to each qualifying low-income individual with re-
15 spect to whom a credit is claimed.”.

16 (b) COORDINATION WITH DEDUCTIONS FOR MEDI-
17 CAL EXPENSES.—Section 213(e) of such Code (relating
18 to coordination with health expenses credit under section
19 34A), as added by section 101, is amended—

20 (1) by inserting “and the amount (if any) of
21 the preventive services credit allowable to the tax-
22 payer for the taxable year under section 34B(a)(1)”
23 before the end period; and

1 (2) by inserting “AND PREVENTIVE SERVICES
2 CREDIT UNDER SECTION 34B” in the heading after
3 “SECTION 34A”.

4 (c) CLERICAL AMENDMENT.—The table of sections
5 for subpart C of part IV of subchapter A of chapter 1
6 of such Code, as amended by section 101, is further
7 amended by inserting after the item relating to section
8 34A the following new item:

 “Sec. 34B. Preventive services credit.”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 December 31, 1992.

12 **SEC. 602. INCREASE IN AUTHORIZATION FOR CHILDHOOD**
13 **IMMUNIZATIONS.**

14 Section 317(j)(1)(B) of the Public Health Service Act
15 (42 U.S.C. 247b(j)(1)(B)) is amended by striking “such
16 sums as may be necessary” and inserting “\$238,865,000
17 for fiscal year 1993, and \$240,000,000 for each of the
18 fiscal years 1994 through 1997”.



1 **TITLE VII—TAX TREATMENT OF**
2 **LONG-TERM CARE INSUR-**
3 **ANCE AND PLANS**
4 **Subtitle A—Treatment of Long-**
5 **Term Care Insurance**

6 **SEC. 701. QUALIFIED LONG-TERM CARE INSURANCE TREAT-**
7 **ED AS ACCIDENT AND HEALTH INSURANCE**
8 **FOR PURPOSES OF TAXATION OF LIFE INSUR-**
9 **ANCE COMPANIES.**

10 (a) IN GENERAL.—Section 818 of the Internal Reve-
11 nue Code of 1986 (relating to other definitions and special
12 rules) is amended by adding at the end the following new
13 subsection:

14 “(g) QUALIFIED LONG-TERM CARE INSURANCE
15 TREATED AS ACCIDENT OR HEALTH INSURANCE.—For
16 purposes of this part—

17 “(1) IN GENERAL.—Any reference to accident
18 or health insurance shall be treated as including a
19 reference to qualified long-term care insurance.

20 “(2) QUALIFIED LONG-TERM CARE INSUR-
21 ANCE.—For purposes of this subsection—

22 “(A) IN GENERAL.—Subject to subpara-
23 graphs (B) and (C), the term ‘qualified long-
24 term care insurance’ means insurance under a

1 policy or rider, which is issued by a qualified is-
2 suer, which meets standards at least as strin-
3 gent as those set forth in the January 1990
4 Long-Term Care Insurance Model Regulation
5 of the National Association of Insurance Com-
6 missioners, and which is certified by the Sec-
7 retary of Health and Human Services (in ac-
8 cordance with procedures similar to the proce-
9 dures prescribed in section 1882 of the Social
10 Security Act (42 U.S.C. 1385ss) used in the
11 certification of medicare supplemental policies
12 (as defined in subsection (g)(1) of such sec-
13 tion)) to be advertised, marketed, offered, or
14 designed to provide coverage—

15 “(i) for not less than 12 consecutive
16 months for each covered person who has
17 attained age 50,

18 “(ii) on an expense incurred, indem-
19 nity, or prepaid basis,

20 “(iii) for 1 or more medically nec-
21 essary, diagnostic services, preventive serv-
22 ices, therapeutic services, rehabilitation
23 services, maintenance services, or personal
24 care services, and

1 “(iv) provided in a setting other than
2 an acute care unit of a hospital.

3 The requirement of clause (iv) shall be met only
4 if at least 1 of the settings in which such cov-
5 erage is provided is the patient’s home.

6 “(B) COVERAGE SPECIFICALLY EX-
7 CLUDED.—Such term does not include any in-
8 surance under any policy or rider which is of-
9 fered primarily to provide any combination of
10 the following kinds of coverage:

11 “(i) Basic Medicare supplement cov-
12 erage.

13 “(ii) Basic hospital-based acute care
14 expense coverage.

15 “(iii) Basic medical-surgical expense
16 coverage.

17 “(iv) Hospital confinement indemnity
18 coverage.

19 “(v) Major medical expense coverage.

20 “(vi) Disability income protection cov-
21 erage.

22 “(vii) Accident only coverage.

23 “(viii) Specified disease coverage.

24 “(ix) Specified accident coverage.

25 “(x) Limited benefit health coverage.

1 “(C) QUALIFIED ISSUER.—For purposes of
2 subparagraph (A), the term ‘qualified issuer’
3 means any of the following:

4 “(i) Private insurance company.

5 “(ii) Fraternal benefit society.

6 “(iii) Nonprofit health corporation.

7 “(iv) Nonprofit hospital corporation.

8 “(v) Nonprofit medical service cor-
9 poration.

10 “(vi) Prepaid health plan.”

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall apply to taxable years beginning after
13 December 31, 1992.

14 **SEC. 702. QUALIFIED LONG-TERM CARE INSURANCE TREAT-**
15 **ED AS ACCIDENT AND HEALTH INSURANCE**
16 **FOR PURPOSES OF EXCLUSION FOR BENE-**
17 **FITS RECEIVED UNDER SUCH INSURANCE**
18 **AND FOR EMPLOYER CONTRIBUTIONS FOR**
19 **SUCH INSURANCE.**

20 (a) IN GENERAL.—Section 105 of the Internal Reve-
21 nue Code of 1986 (relating to amounts received under ac-
22 cident and health plans) is amended by adding at the end
23 the following new subsection:

1 “(j) SPECIAL RULES RELATING TO QUALIFIED
2 LONG-TERM CARE INSURANCE.—For purposes of section
3 104, this section, and section 106—

4 “(1) BENEFITS TREATED AS PAYABLE FOR
5 SICKNESS, ETC.—Any benefit received through quali-
6 fied long-term care insurance (as defined in section
7 818(g)) shall be treated as received for personal in-
8 juries or sickness.

9 “(2) EXPENSES FOR WHICH REIMBURSEMENT
10 PROVIDED UNDER QUALIFIED LONG-TERM CARE IN-
11 SURANCE TREATED AS INCURRED FOR MEDICAL
12 CARE.—Expenses incurred by a taxpayer for which
13 reimbursement is paid through qualified long-term
14 care insurance (as so defined) shall be treated for
15 purposes of subsection (b) as incurred for medical
16 care (as defined in section 213(d)).

17 “(3) REFERENCES TO ACCIDENT AND HEALTH
18 PLANS.—Any reference to an accident or health plan
19 shall be treated as including a reference to a plan
20 providing qualified long-term care insurance.”

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to taxable years beginning after
23 December 31, 1992.

1 **SEC. 703. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**
2 **WITHDRAWN FROM INDIVIDUAL RETIRE-**
3 **MENT PLANS OR 401(k) PLANS FOR QUALI-**
4 **FIED LONG-TERM CARE INSURANCE.**

5 (a) IN GENERAL.—Part III of subchapter B of chap-
6 ter 1 of the Internal Revenue Code of 1986 (relating to
7 items specifically excluded from gross income), as amend-
8 ed by section 105(b), is amended by redesignating section
9 137 as section 138 and by inserting after section 136 the
10 following new section:

11 **“SEC. 137. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT**
12 **ACCOUNTS AND SECTION 401(k) PLANS FOR**
13 **QUALIFIED LONG-TERM CARE INSURANCE.**

14 “(a) GENERAL RULE.—The amount includible in the
15 gross income of an individual for the taxable year by rea-
16 son of qualified distributions during such taxable year
17 shall not exceed the excess of—

18 “(1) the amount which would (but for this sec-
19 tion) be so includible by reason of such distributions,
20 over

21 “(2) the aggregate premiums paid by such indi-
22 vidual during such taxable year for any policy of
23 qualified long-term care insurance (as defined in sec-
24 tion 818(g)) for the benefit of such individual or the
25 spouse of such individual.

1 “(b) QUALIFIED DISTRIBUTION.—For purposes of
2 this section, the term ‘qualified distribution’ means any
3 distribution to an individual from an individual retirement
4 account or a section 401(k) plan if such individual has
5 attained age 59½ on or before the date of the distribution
6 (and, in the case of a distribution used to pay premiums
7 for the benefit of the spouse of such individual, such
8 spouse has attained age 59½ on or before the date of the
9 distribution).

10 “(c) DEFINITIONS.—For purposes of this section—

11 “(1) INDIVIDUAL RETIREMENT ACCOUNT.—The
12 term ‘individual retirement account’ has the mean-
13 ing given such term by section 408(a).

14 “(2) SECTION 401(k) PLAN.—The term ‘section
15 401(k) plan’ means any employer plan which meets
16 the requirements of section 401(a) and which in-
17 cludes a qualified cash or deferred arrangement (as
18 defined in section 401(k)).

19 “(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

20 “(1) WITHDRAWALS CANNOT EXCEED ELEC-
21 TIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR
22 DEFERRED ARRANGEMENT.—This section shall not
23 apply to any distribution from a section 401(k) plan
24 to the extent the aggregate amount of such distribu-
25 tions for the use described in subsection (a) exceeds

1 the aggregate employer contributions made pursuant
2 to the employee's election under section 401(k)(2).

3 “(2) WITHDRAWALS NOT TO CAUSE DISQUALI-
4 FICATION.—A plan shall not be treated as failing to
5 satisfy the requirements of section 401, and an ar-
6 rangement shall not be treated as failing to be a
7 qualified cash or deferred arrangement (as defined
8 in section 401(k)(2)), merely because under the plan
9 or arrangement distributions are permitted which
10 are excludable from gross income by reason of this
11 section.”

12 (b) CONFORMING AMENDMENTS.—

13 (1) Section 401(k) of such Code is amended by
14 adding at the end the following new paragraph:

15 “(11) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals
for payment of long-term care premiums, see section
137.”

16 (2) Section 408(d) of such Code is amended by
17 adding at the end the following new paragraph:

18 “(8) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals
from individual retirement accounts for payment of
long-term care premiums, see section 137.”

19 (3) The table of sections for such part III is
20 amended by striking the last item and inserting the
21 following new items:

“Sec. 317. Distributions from individual retirement accounts and section 401(k) plans for qualified long-term care insurance.

“Sec. 138. Cross references to other Acts.”

1 (c) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to taxable years beginning after
3 December 31, 1992.

4 **SEC. 704. EXCHANGE OF LIFE INSURANCE POLICY FOR**
5 **QUALIFIED LONG-TERM CARE POLICY NOT**
6 **TAXABLE.**

7 (a) IN GENERAL.—Subsection (a) of section 1035 of
8 the Internal Revenue Code of 1986 (relating to certain
9 exchanges of insurance policies) is amended by striking
10 the period at the end of paragraph (3) and inserting “;
11 or” and by adding at the end the following new paragraph:

12 “(4) in the case of an individual who has at-
13 tained age 59½, a contract of life insurance or a
14 contract of endowment insurance or an annuity con-
15 tract for a contract of qualified long-term care insur-
16 ance (as defined in section 818(g)) for the benefit of
17 such individual or the spouse of such individual if
18 such spouse has attained age 59½ on or before the
19 date of the exchange.”

20 (b) EFFECTIVE DATE.—The amendment made by
21 this section shall apply to taxable years beginning after
22 December 31, 1992.

1 **Subtitle B—Employer Funding of**
2 **Medical Benefits**

3 **SEC. 711. MEDICAL BENEFITS FOR RETIRED EMPLOYEES**
4 **AND THEIR SPOUSES AND DEPENDENTS.**

5 (a) IN GENERAL.—Section 401(h) of the Internal
6 Revenue Code of 1986 (relating to medical, etc., benefits
7 for retired employees and their spouses and dependents)
8 is amended to read as follows:

9 “(h) RETIREE HEALTH ACCOUNTS.—

10 “(1) GENERAL RULE.—Under regulations pre-
11 scribed by the Secretary, a defined benefit plan may
12 establish and maintain a separate health benefits ac-
13 count for the payment of medical benefits of retired
14 employees and their spouses and dependents.

15 “(2) SEPARATE ACCOUNTING REQUIRED.—An
16 employer establishing a health benefits account shall
17 maintain separate accounts within the health bene-
18 fits account for funded reserve accounts established
19 under section 420A.

20 “(3) USE OF ASSETS.—Subject to the provi-
21 sions of part III of this subchapter, the corpus or in-
22 come of a health benefits account shall not be used
23 for, or diverted to, any purpose other than providing
24 medical benefits to retired employees and their
25 spouses and dependents.

1 “(4) KEY EMPLOYEES.—

2 “(A) IN GENERAL.—In the case of an em-
3 ployee who is a key employee—

4 “(i) a separate account shall be estab-
5 lished and maintained for medical benefits
6 payable to such employee (and the employ-
7 ee’s spouse or dependents), and

8 “(ii) medical benefits of such em-
9 ployee, spouse, or dependents which are at-
10 tributable to plan years beginning after
11 March 31, 1984, for which the employee is
12 a key employee may be payable only from
13 such account.

14 “(B) KEY EMPLOYEE.—For purposes of
15 subparagraph (A), the term ‘key employee’
16 means any employee who, at any time during
17 the plan year or any preceding plan year during
18 which contributions were made on behalf of
19 such employee, is or was a key employee (as de-
20 fined in section 416(i)).

21 “(5) APPLICABLE RULES.—For rules applicable
22 to health benefits accounts, see subpart F of this
23 part (sec. 420A et seq.).”

24 (b) CONFORMING AMENDMENT.—Section 415(l)(2)
25 of such Code (relating to treatment of certain medical ben-

1 efits) is amended by inserting “by reason of section
2 401(h)(4)” after “dependents” in subparagraph (B).

3 (c) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in para-
5 graph (2), the amendments made by this section
6 shall apply to years beginning after December 31,
7 1992.

8 (2) TRANSITION RULE.—In the case of—

9 (A) a plan other than a defined benefit
10 plan, or

11 (B) a defined benefit plan which elects, at
12 such time and in such manner as the Secretary
13 of the Treasury or his delegate may prescribe,
14 to have this paragraph apply,

15 which on or before the date of the enactment of this
16 Act established an account to which section 401(h)
17 of the Internal Revenue Code of 1986 (as in effect
18 before the amendments made by this section) ap-
19 plied (and which is in existence on such date), the
20 amendments made by this section shall not apply to
21 such account.

22 **SEC. 712. TREATMENT OF HEALTH BENEFITS ACCOUNTS.**

23 (a) IN GENERAL.—Part I of subchapter D of chapter
24 1 of the Internal Revenue Code of 1986 is amended by
25 adding at the end the following new subpart:

1 **“Subpart F—Treatment of Health Benefits Accounts**

“Sec. 420A. Deduction for employer contributions to health benefits accounts.

“Sec. 420B. Funded reserve account.

“Sec. 420C. Definitions; special rules.

2 **“SEC. 420A. DEDUCTION FOR EMPLOYER CONTRIBUTIONS**
3 **TO HEALTH BENEFITS ACCOUNTS.**

4 “(a) GENERAL RULE.—Amounts paid by an em-
5 ployer to a defined benefit plan which are allocated to a
6 health benefits account—

7 “(1) shall not be allowed as a deduction under
8 this chapter, but

9 “(2) if they would otherwise be deductible, shall
10 be allowed as a deduction under this section for the
11 taxable year in which paid.

12 “(b) LIMITATION.—The amount of the deduction al-
13 lowable under subsection (a)(2) for any taxable year shall
14 not exceed the health benefits account’s qualified cost for
15 the taxable year.

16 “(c) QUALIFIED COST.—For purposes of this sec-
17 tion—

18 “(1) IN GENERAL.—The term ‘qualified cost’
19 means, with respect to any taxable year, the sum
20 of—

21 “(A) the qualified direct cost for such tax-
22 able year, plus

1 “(B) subject to the limitation of section
2 420B(b), any addition to the funded reserve ac-
3 count established under section 420B.

4 “(2) QUALIFIED DIRECT COST.—

5 “(A) IN GENERAL.—The term ‘qualified
6 direct cost’ means, with respect to any taxable
7 year, the aggregate amount (including adminis-
8 trative expenses) which would have been allow-
9 able as a deduction to the employer with re-
10 spect to the qualified section 401(h) medical
11 benefits provided through the health benefits
12 account during the taxable year if—

13 “(i) such benefits were provided di-
14 rectly by the employer, and

15 “(ii) the employer used the cash re-
16 ceipts and disbursements method of ac-
17 counting.

18 “(B) TIME WHEN BENEFITS PROVIDED.—
19 For purposes of subparagraph (A), a benefit
20 shall be treated as provided when such benefit
21 would be includible in the gross income of the
22 employee if provided directly by the employer
23 (or would be so includible but for any provision
24 of this chapter excluding such benefit from
25 gross income).

1 **“SEC. 420B. FUNDED RESERVE ACCOUNT.**

2 “(a) GENERAL RULE.—For purposes of this subpart
3 and section 401(h), the term ‘funded reserve account’
4 means an account within a health benefits account—

5 “(1) to which contributions paid or accrued to
6 a defined benefit plan are allocated to provide a re-
7 serve for the payment of qualified section 401(h)
8 medical benefits of employees and their spouses and
9 dependents,

10 “(2) with respect to which the only contribu-
11 tions allocated are employer contributions, and

12 “(3) with respect to which—

13 “(A) the vesting requirements of sub-
14 section (c),

15 “(B) the portability requirements of sub-
16 section (d), and

17 “(C) the availability requirements of sub-
18 section (e),

19 are met.

20 “(b) LIMITATION ON ALLOCATION TO ACCOUNT.—

21 “(1) IN GENERAL.—No amount may be allo-
22 cated to a funded reserve account (and taken into
23 account under section 420A(c)(1)(B)) to the extent
24 such addition results in the amount allocated to such
25 account exceeding the account limit.

1 “(2) ACCOUNT LIMIT.—The account limit for
2 any taxable year is an amount equal to 125 percent
3 of the termination liability of the account as of the
4 close of the last plan year ending with or within the
5 taxable year.

6 “(3) TERMINATION LIABILITY.—For purposes
7 of this section—

8 “(A) IN GENERAL.—The term ‘termination
9 liability’ means the present value of the quali-
10 fied section 401(h) medical benefits—

11 “(i) which are to be provided to em-
12 ployees (and their spouses and depend-
13 ents), and

14 “(ii) any portion of which is to be pro-
15 vided through a funded reserve account.

16 “(B) DETERMINATIONS.—The termination
17 liability under subparagraph (A) shall be deter-
18 mined—

19 “(i) on the basis of actuarial assump-
20 tions which are used in determining the
21 full-funding limitation of the plan under
22 section 412(c)(7),

23 “(ii) as if the benefits under the plan
24 commenced at Social Security retirement
25 age, and

1 “(iii) by not taking into account any
2 portion of the maximum annual benefit
3 under the plan for—

4 “(I) benefits (other than post-re-
5 tirement long-term health care bene-
6 fits) in excess of \$1,500, or

7 “(II) post-retirement long-term
8 health care benefits in excess of
9 \$1,500.

10 “(C) ADJUSTMENTS TO ACCOUNT.—The
11 amount in the account shall be adjusted at such
12 time and in such manner as the Secretary may
13 prescribe to take into account income, gains,
14 deductions, or losses which are properly alloca-
15 ble to amounts in the account.

16 “(D) ACTUARIAL ADJUSTMENT.—For pur-
17 poses of determining termination liability, the
18 benefits provided to any participant under the
19 plan shall be actuarially adjusted to reflect any
20 commencement of benefits before or after Social
21 Security retirement age.

22 “(E) EMPLOYEE.—For purposes of this
23 paragraph, the term ‘employee’ does not include
24 a former employee.

1 “(F) COST-OF-LIVING ADJUSTMENT.—In
2 the case of years beginning after 1995, the
3 \$1,500 amounts in subparagraph (B) shall be
4 adjusted annually at the same time and in the
5 same manner as under section 415(d).

6 “(c) VESTING REQUIREMENTS.—

7 “(1) IN GENERAL.—The requirements of this
8 subsection are met if the requirements of either sub-
9 paragraph (A) or (B) of section 411(a)(2) are met
10 with respect to the accrued qualified section 401(h)
11 medical benefits derived from amounts which are al-
12 located to the funded reserve account.

13 “(2) UNIFORM RATE OF ACCRUAL OF BENE-
14 FITS.—

15 “(A) IN GENERAL.—Except as provided in
16 this paragraph, a plan shall not be treated as
17 meeting the requirements of this subsection un-
18 less the rate at which benefits accrue during a
19 plan year is the same for all participants.

20 “(B) SPECIAL RULES FOR CERTAIN INDI-
21 VIDUALS AGE 55 AND OVER.—A plan shall not
22 be treated as failing to meet the requirements
23 of this subsection if the plan provides that an
24 employee who as of the close of the plan year
25 in which he attains age 55 has accrued less

1 than 30 percent of the maximum amount of
2 benefits which may be accrued under the plan
3 may accrue benefits during succeeding plan
4 years at a greater rate than the rate for other
5 employees (but not in excess of 125 percent of
6 such other rate).

7 “(C) MINIMUM HOURS OF SERVICE.—For
8 purposes of subparagraph (A), an employee
9 shall not be treated as a participant for any
10 plan year unless such individual completes more
11 than 500 hours of service during such year.

12 “(3) CERTAIN RULES MADE APPLICABLE.—Ex-
13 cept to the extent inconsistent with the provisions of
14 this subpart, the rules of section 411 shall apply for
15 purposes of this subsection.

16 “(d) PORTABILITY REQUIREMENTS.—

17 “(1) IN GENERAL.—Except as provided in para-
18 graph (2), the requirements of this subsection are
19 met if, in accordance with procedures determined by
20 the Secretary, the plan provides that—

21 “(A) except as provided in regulations, the
22 plan shall transfer, within 120 days after an
23 employee separates from service with the em-
24 ployer or after the termination of the plan, the
25 present value of the nonforfeitable accrued

1 qualified section 401(h) medical benefits of the
2 employee attributable to amounts which are al-
3 located to the funded reserve account to—

4 “(i) a plan which is maintained by an
5 employer of such employee and which
6 maintains a health benefits account, or

7 “(ii) if the employer does not main-
8 tain a plan described in clause (i), an indi-
9 vidual retirement account established for
10 the benefit of such employee, and

11 “(B) the plan accepts transfers under sub-
12 paragraph (A) from another plan or individual
13 retirement account.

14 “(2) NO TRANSFERS AFTER EMPLOYEE IS DIS-
15 ABLED OR ATTAINS RETIREMENT AGE.—Except in
16 the case of a termination of a plan, a plan shall not
17 meet the requirements of this subsection if it per-
18 mits the transfer of a benefit after—

19 “(A) an employee has attained Social Se-
20 curity retirement age, or

21 “(B) an employee has become disabled
22 (within the meaning of section 72(m)(7)).

23 “(3) INCLUSION IN INCOME WHERE MORE
24 THAN 1 ACCOUNT.—

25 “(A) IN GENERAL.—If—

1 “(i) an individual is a participant or
2 beneficiary under 2 or more plans main-
3 taining a funded reserve account or indi-
4 vidual retirement account to which assets
5 were transferred from such a plan, and

6 “(ii) such individual does not (within
7 a reasonable period) consolidate the
8 present value of the individual’s nonforfeit-
9 able accrued benefit in all such plans and
10 the assets so transferred to all such ac-
11 counts into 1 such plan or into 1 such ac-
12 count,

13 then an amount equal to the sum of the present
14 value of such benefits and the fair market value
15 of such assets shall be treated as distributed in
16 cash to such individual at the close of the plan
17 year for the plan or account involved and such
18 distribution shall be included in gross income.

19 “(B) SPECIAL RULES.—

20 “(i) EMPLOYEE MUST CONSOLIDATE
21 INTO PLAN OF CURRENT EMPLOYER.—In
22 the case of an employee who is employed
23 by an employer maintaining a plan de-
24 scribed in subparagraph (A)(i), a consoli-
25 dation satisfies subparagraph (A) only if

1 such consolidation is into such a plan
2 maintained by such employer.

3 “(ii) MORE THAN 1 CURRENT EM-
4 PLOYER.—If an individual is a participant
5 in more than 1 plan described in subpara-
6 graph (A)(i) by reason of being currently
7 employed by more than 1 employer, such
8 plans shall be treated as 1 plan for pur-
9 poses of subparagraph (A).

10 “(iii) EMPLOYEE WITH NO CURRENT
11 EMPLOYER MAINTAINING PLAN.—In the
12 case of an employee who is currently not
13 employed by an employer maintaining a
14 plan described in subparagraph (A)(i), a
15 consolidation satisfies subparagraph (A)
16 only if such consolidation is into—

17 “(I) a plan described in subpara-
18 graph (A)(i) maintained by his most
19 recent employer maintaining such
20 plan, or

21 “(II) an individual retirement ac-
22 count of the individual.

23 “(C) AMOUNT TRANSFERRED NOT INCLUD-
24 IBLE IN INCOME.—No amount shall be includ-
25 ible in gross income by reason of any transfer

1 which is part of a consolidation required under
2 this paragraph.

3 “(e) RETIRED EMPLOYEES NOT COVERED BY
4 HEALTH BENEFITS ACCOUNT MAY ELECT COVERAGE.—

5 “(1) IN GENERAL.—The requirements of this
6 subsection are met if the plan provides that a former
7 employee who—

8 “(A) is in pay status under the plan, but

9 “(B) is not eligible to receive all or any
10 portion of qualified section 401(h) medical ben-
11 efits provided for any period through the fund-
12 ed reserve account,

13 is entitled to elect such benefits for himself or his
14 spouse and dependents. A plan shall not be treated
15 as failing to meet the requirements of this sub-
16 section if an employee is required to pay a premium
17 for such benefits as long as such premium does not
18 exceed 102 percent of applicable premium for the
19 period such benefits are provided.

20 “(2) APPLICABLE PREMIUM.—For purposes of
21 paragraph (1), the applicable premium for any pe-
22 riod shall be determined in the same manner as
23 under section 4980B(f)(4).

1 **SEC. 420C. DEFINITIONS; SPECIAL RULES.**

2 “(a) QUALIFIED SECTION 401(h) MEDICAL BENE-
3 FITS.—For purposes of this subpart, the term ‘qualified
4 section 401(h) medical benefits’ means benefits—

5 “(1) which are—

6 “(A) benefits for sickness, accident, hos-
7 pitalization, and medical expenses of former
8 employees who are in pay status under the plan
9 (and their spouse or dependents) after the
10 former employee—

11 “(i) has attained Social Security re-
12 tirement age, or

13 “(ii) is disabled (within the meaning
14 of section 72(m)(7)), or

15 “(B) post-retirement long-term health care
16 benefits, and

17 “(2) which are provided through 1 or more of
18 the following:

19 “(A) insurance acquired by the plan, or

20 “(B) self-insurance by the employer or the
21 plan.

22 “(b) POST-RETIREMENT LONG-TERM HEALTH
23 CARE.—For purposes of this subpart—

24 “(1) IN GENERAL.—The term ‘post-retirement
25 long-term health care’ means long-term health care
26 benefits provided to a former employee (or the

1 spouse of the former employee) who is in pay status
2 under the plan after the former employee—

3 “(A) has attained Social Security retire-
4 ment age, or

5 “(B) is disabled (within the meaning of
6 section 72(m)(7)).

7 “(2) SPOUSE OF DECEASED EMPLOYEE.—For
8 purposes of paragraph (1), the spouse of a deceased
9 employee shall be treated—

10 “(A) as a former employee, and

11 “(B) as satisfied the requirements of para-
12 graph (1) if such spouse was receiving benefits
13 immediately before the death of the employee.

14 “(3) LONG-TERM HEALTH CARE BENEFIT.—

15 “(A) IN GENERAL.—The term ‘long-term
16 health care benefit’ means a benefit which con-
17 sists of the providing by a qualified provider in
18 a qualified facility of necessary diagnostic, pre-
19 ventive, therapeutic, rehabilitative, and personal
20 care services, required by a chronically ill indi-
21 vidual.

22 “(B) CERTAIN ITEMS NOT INCLUDED.—

23 The term ‘long-term health care benefits’ does
24 not include basic medicare supplement cov-
25 erage, basic hospital expense coverage, basic

1 medical-surgical expense coverage, hospital con-
2 finement indemnity coverage, major medical ex-
3 pense coverage, disability income protection cov-
4 erage, accident only coverage, specified disease
5 or specified accident coverage, or limited benefit
6 health coverage.

7 “(4) QUALIFIED FACILITY.—The term ‘quali-
8 fied facility’ means—

9 “(A) a rehabilitative, hospice, or adult day
10 care facility, including a hospital, retirement
11 home, skilled nursing facility (within the mean-
12 ing of section 1919(a) of the Social Security
13 Act), or other similar facility determined by the
14 plan administrator, or

15 “(B) a home where the chronically ill indi-
16 vidual resides.

17 “(5) CHRONICALLY ILL INDIVIDUAL.—The term
18 ‘chronically ill individual’ means an individual whose
19 disability is such that the individual has been cer-
20 tified as requiring assistance with daily living (as de-
21 fined by the plan administrator) for a period of at
22 least 90 days.

23 “(6) QUALIFIED PROVIDER.—The term ‘quali-
24 fied provider’ means a medical practitioner licensed
25 under State law, registered nurse, licensed vocational

1 nurse, qualified therapist, or trained home health
2 aide (or any organization employing such providers),
3 but does not include a relative or other person who
4 ordinarily resides in the home where the chronically
5 ill individual resides.

6 “(c) HEALTH BENEFITS ACCOUNT.—For purposes of
7 this subpart, the term ‘health benefits account’ means an
8 account established and maintained under section 401(h).

9 “(d) SOCIAL SECURITY RETIREMENT AGE.—For
10 purposes of this subpart, the term ‘Social Security retire-
11 ment age’ has the meaning given such term by section
12 415(b)(8).”

13 (b) INDIVIDUAL RETIREMENT ACCOUNTS.—

14 (1) IN GENERAL.—Section 408 of such Code is
15 amended by redesignating subsection (p) as sub-
16 section (q) and by inserting after subsection (o) the
17 following new subsection:

18 “(p) SPECIAL RULES FOR FUNDED RESERVE AC-
19 COUNTS.—

20 “(1) IN GENERAL.—A trust shall not be treated
21 as an individual retirement account under subsection
22 (a) unless the trust instrument provides that the
23 trust will accept transfers of assets as provided in
24 section 420B(d)(1).

1 “(2) ACCOUNTING.—The trustee of an individ-
2 ual retirement account shall maintain separate ac-
3 counting for assets transferred to the account under
4 section 420B(d)(1) (and any income allocable there-
5 to).”

6 “(2) PENALTY FOR EARLY DISTRIBUTIONS.—
7 Section 72(t) of such Code (relating to 10-percent
8 additional tax on early distributions) is amended by
9 adding at the end the following new paragraph:

10 “(6) EARLY DISTRIBUTION OF MEDICAL BENE-
11 FITS.—If—

12 “(A) a taxpayer receives a distribution of
13 amounts transferred to an individual retirement
14 account under section 420B(d)(1) (or any in-
15 come or gain allocable thereto), and

16 “(B) such distribution—

17 “(i) is made before the individual at-
18 tains Social Security retirement age (with-
19 in the meaning of section 415(b)(8)) or be-
20 comes disabled (within the meaning of sub-
21 section (m)(7)), or

22 “(ii) exceeds the amount of qualified
23 section 401(h) medical expenses of the tax-
24 payer, his spouse, or dependents for the
25 taxable year, then paragraph (1) shall

1 apply to such distribution or such excess,
2 except that ‘50 percent’ shall be sub-
3 stituted for ‘10 percent’. Paragraph (2)
4 shall not apply to a distribution to which
5 this paragraph applies.”

6 (c) EXCISE TAX ON ALLOCATED ASSETS NOT USED
7 TO PROVIDE RETIREE HEALTH BENEFITS.—Section
8 4980 of such Code (relating to tax on reversion of quali-
9 fied plan assets to employers) is amended by adding at
10 the end the following new subsection:

11 “(e) ASSETS ALLOCATED TO RETIREE HEALTH BEN-
12 EFITS ACCOUNTS.—In the case of a plan which establishes
13 a health benefits account described in section 401(h), if—

14 “(1) amounts are allocated to a funded reserve
15 account under section 420B, and

16 “(2) any amount in such account is paid or dis-
17 tributed other than to pay for qualified section
18 401(h) medical benefits (as defined in section
19 420C(a)) provided through such account,

20 the amount so paid or distributed shall be treated as an
21 employer reversion for purposes of this section, except that
22 subsection (a) shall be applied by substituting ‘100 per-
23 cent’ for ‘25 percent’.”

24 (d) CONFORMING AMENDMENTS.—

1 (1) Section 419(e) of such Code (defining wel-
2 fare benefit fund) is amended by adding at the end
3 the following new paragraph:

4 “(5) HEALTH BENEFITS ACCOUNTS.—The term
5 ‘welfare benefits fund’ does not include any health
6 benefits account established under section 401(h).”

7 (2) The table of subparts for part I of sub-
8 chapter D of chapter 1 of such Code is amended by
9 adding at the end the following new item:

“Subpart F. Treatment of health benefit accounts.”

10 (e) EFFECTIVE DATE.—

11 (1) IN GENERAL.—Except as provided in para-
12 graph (2), the amendments made by this section
13 shall apply to contributions after December 31,
14 1992.

15 (2) INDIVIDUAL RETIREMENT ACCOUNTS.—The
16 amendments made by subsection (b) shall apply to
17 accounts established after December 31, 1992.

18 **Subtitle C—Reverse Mortgage**
19 **Insurance for Older Americans**

20 **SEC. 721. MAXIMUM AMOUNT INSURED.**

21 Section 255(g) of the National Housing Act (12
22 U.S.C. 1715z-20(g)) is amended by striking the third sen-
23 tence and inserting the following new sentence: “In no
24 case may the benefits of insurance under this section ex-
25 ceed the greater of 95 percent of the median 1-family

1 house price in the United States or 95 percent of the me-
2 dian 1-family house price in the area, as determined by
3 the Secretary.”

4 **Subtitle D—Income Tax Credits**

5 **SEC. 731. REFUNDABLE CREDIT FOR CUSTODIAL CARE OF** 6 **CERTAIN DEPENDENTS IN TAXPAYER’S** 7 **HOME.**

8 (a) IN GENERAL.—Subpart C of part IV of sub-
9 chapter A of chapter 1 of the Internal Revenue Code of
10 1986 (relating to refundable credits) is amended by redес-
11 ignating section 35 as section 37 and by inserting after
12 section 34 the following new section:

13 **“SEC. 35. CREDIT FOR TAXPAYERS WITH CERTAIN PERSONS** 14 **REQUIRING CUSTODIAL CARE IN THEIR** 15 **HOUSEHOLDS.**

16 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
17 dividual who maintains a household which includes as a
18 member one or more qualified persons, there shall be al-
19 lowed as a credit against the tax imposed by this chapter
20 for the taxable year an amount equal to \$2,000 for each
21 such person.

22 “(b) DEFINITIONS.—For purposes of this section—

23 “(1) QUALIFIED PERSON.—The term ‘qualified
24 person’ means any individual—

1 “(A) who is a parent, grandparent, de-
2 pendent (as defined in section 152), or spouse
3 of the taxpayer,

4 “(B) who has been certified by a physician
5 as—

6 “(i) being unable to perform (without
7 substantial assistance from another indi-
8 vidual) at least 2 activities of daily living
9 (as defined in paragraph (2)), or

10 “(ii) having a similar level of disabil-
11 ity due to cognitive impairment, and

12 “(C) who has as his principal place of
13 abode for more than half of the taxable year the
14 home of the taxpayer.

15 “(2) ACTIVITIES OF DAILY LIVING.—For pur-
16 poses of paragraph (1), each of the following is an
17 activity of daily living:

18 “(A) BATHING.—The overall complex be-
19 havior of getting water and cleansing the whole
20 body, including turning on the water for a bath,
21 shower, or sponge bath, getting to, in, and out
22 of a tub or shower, and washing and drying
23 oneself.

1 “(B) DRESSING.—The overall complex be-
2 havior of getting clothes from closets and draw-
3 ers and then getting dressed.

4 “(C) TOILETING.—The act of going to the
5 toilet room for bowel and bladder function,
6 transferring on and off the toilet, cleaning after
7 elimination, and arranging clothes.

8 “(D) TRANSFER.—The process of getting
9 in and out of bed or in and out of a chair or
10 wheelchair.

11 “(E) EATING.—The process of getting
12 food from a plate or its equivalent into the
13 mouth.

14 “(3) PHYSICIAN.—The term ‘physician’ means
15 a doctor of medicine or osteopathy legally authorized
16 to practice medicine or surgery in the jurisdiction in
17 which he makes the determination under paragraph
18 (1).

19 “(d) SPECIAL RULES.—For purposes of this sec-
20 tion—

21 “(1) MAINTAINING A HOUSEHOLD.—An individ-
22 ual shall be treated as maintaining a household for
23 any period if over half the cost of maintaining the
24 household for such period is furnished by such indi-

1 vidual (or, is such individual is married during such
2 period, by such individual and his spouse).

3 “(2) MARRIED COUPLES MUST FILE JOINT RE-
4 TURN.—If the taxpayer is married at the close of
5 the taxable year, the credit under subsection (a)
6 shall be allowed only if the taxpayer and his spouse
7 file a joint return for the taxable year.

8 “(3) MARITAL STATUS.—An individual legally
9 separated from his spouse under a decree of divorce
10 or separate maintenance shall not be considered as
11 married.

12 “(4) CERTAIN MARRIED INDIVIDUALS LIVING
13 APART.—If—

14 “(A) an individual who is married and who
15 files a separate return—

16 “(i) maintains a household which in-
17 cludes as a member one or more qualified
18 persons, and

19 “(ii) furnishes over half of the cost of
20 maintaining such household during such
21 taxable year, and

22 “(B) during the last 6 months of such tax-
23 able year such individual’s spouse is not a mem-
24 ber of such household,

25 such individual shall not be considered as married.

1 “(e) REGULATIONS.—The Secretary shall prescribe
2 such regulations as may be necessary to carry out the pur-
3 poses of this section.”

4 (b) CLERICAL AMENDMENT.—The table of sections
5 for subpart C of part IV of subchapter A of chapter 1
6 of such Code is amended by striking the item relating to
7 section 35 and inserting the following:

“Sec. 35. Credit for taxpayers with certain persons requiring cus-
todial care in their households.”

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 1992.

11 **SEC. 732. CREDIT FOR EXPENSES FOR LONG-TERM CARE**
12 **SERVICES PROVIDED TO CERTAIN INDE-**
13 **PENDENT PERSONS REQUIRING SUCH CARE.**

14 (a) GENERAL RULE.—Subpart C of part IV of sub-
15 chapter A of chapter 1 of the Internal Revenue Code of
16 1986 (relating to refundable credits) is amended by insert-
17 ing after section 35 the following new section:

18 **“SEC. 36. CREDIT FOR EXPENSES FOR LONG-TERM CARE**
19 **SERVICES PROVIDED TO CERTAIN INDE-**
20 **PENDENT PERSONS REQUIRING SUCH CARE.**

21 “(a) GENERAL RULE.—In the case of an individual,
22 there shall be allowed as a credit against the tax imposed
23 by this subtitle for the taxable year an amount equal to

1 25 percent of the qualified long-term care expenses paid
2 during such taxable year.

3 “(b) MAXIMUM CREDIT.—

4 “(1) IN GENERAL.—The credit allowed by sub-
5 section (a) for any taxable year shall not exceed
6 \$2,000 with respect to each independent qualified
7 person.

8 “(2) PHASEOUT OF CREDIT FOR TAXPAYERS
9 WITH INCOMES EXCEEDING 150 PERCENT OF THE
10 POVERTY LEVEL.—If the adjusted gross income of
11 the taxpayer for the taxable year exceeds the base
12 amount, the \$2,000 amount in paragraph (1) shall
13 be reduced (but not below zero) by an amount which
14 bears the same ratio to \$2,000 as—

15 “(A) the excess of the taxpayer’s adjusted
16 gross income for the taxable year over the base
17 amount, bears to

18 “(B) \$10,000.

19 For purposes of the preceding sentence, the base
20 amount is 150 percent of the poverty level applicable
21 to the taxpayer.

22 “(c) DEFINITIONS.—For purposes of this section—

23 “(1) QUALIFIED LONG-TERM CARE EX-
24 PENSES.—

1 “(A) IN GENERAL.—The term ‘qualified
2 long-term care expenses’ means the amount
3 paid by the taxpayer during the taxable year for
4 1 or more medically necessary, diagnostic serv-
5 ices, preventive services, therapeutic services,
6 rehabilitation services, maintenance services, or
7 personal care services which are required by an
8 independent qualified person and which are pro-
9 vided in the household referred to in paragraph
10 (2)(C).

11 “(B) COVERAGE SPECIFICALLY EX-
12 CLUDED.—Such term does not include any com-
13 bination of the following kinds of coverage:

14 “(i) Basic Medicare supplement cov-
15 erage.

16 “(ii) Basic hospital-based acute care
17 expense coverage.

18 “(iii) Basic medical-surgical expense
19 coverage.

20 “(iv) Hospital confinement indemnity
21 coverage.

22 “(v) Major medical expense coverage.

23 “(vi) Disability income protection cov-
24 erage.

25 “(vii) Accident only coverage.

1 “(viii) Specified disease coverage.

2 “(ix) Specified accident coverage.

3 “(x) Limited benefit health coverage.

4 “(2) INDEPENDENT QUALIFIED PERSON.—The
5 term ‘independent qualified person’ means any indi-
6 vidual—

7 “(A) who is a parent, grandparent, or de-
8 pendent (as defined in section 152) of the tax-
9 payer,

10 “(B) who has been certified by a physician
11 as—

12 “(i) being unable to perform (without
13 substantial assistance from another indi-
14 vidual) at least 2 activities of daily living
15 (as defined in section 35(b)(2)), or

16 “(ii) having a similar level of disabil-
17 ity due to cognitive impairment, and

18 “(C) who maintains a household which is
19 his principal place of abode for more than half
20 of the taxable year of the taxpayer.

21 Such term shall not include any qualified person as
22 defined in section 35(b).”

23 (b) CLERICAL AMENDMENT.—The table of sections
24 for subpart C of part IV of subchapter A of chapter 1

1 of such Code is amended by adding at the end the follow-
2 ing:

“Sec. 36. Credit for expenses for long-term care services provided
to certain independent persons requiring such
care.”

“Sec. 37. Overpayments of tax.”

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 1992.

6 **Subtitle E—Treatment of** 7 **Accelerated Death Benefits**

8 **SEC. 741. TAX TREATMENT OF ACCELERATED DEATH BENE-** 9 **FITS UNDER LIFE INSURANCE CONTRACTS.**

10 (a) GENERAL RULE.—Section 101 of the Internal
11 Revenue Code of 1986 (relating to certain death benefits)
12 is amended by adding at the end thereof the following new
13 subsection:

14 “(g) TREATMENT OF CERTAIN ACCELERATED
15 DEATH BENEFITS.—

16 “(1) IN GENERAL.—For purposes of this sec-
17 tion, any amount paid to an individual under a life
18 insurance contract on the life of an insured who is
19 a terminally ill individual or who is permanently con-
20 fined to a nursing home shall be treated as an
21 amount paid by reason of the death of such insured.

22 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
23 poses of this subsection, the term ‘terminally ill indi-

1 vidual' means an individual who has been certified
2 by a physician, licensed under State law, as having
3 an illness or physical condition which can reasonably
4 be expected to result in death in 12 months or less.

5 “(3) PERMANENTLY CONFINED TO A NURSING
6 HOME.—For purposes of this subsection, an individ-
7 ual has been permanently confined to a nursing
8 home if the individual is presently confined to a
9 nursing home and has been certified by a physician,
10 licensed under State law, as having an illness or
11 physical condition which can reasonably be expected
12 to result in the individual remaining in a nursing
13 home for the rest of his life.”

14 (b) EFFECTIVE DATE.—The amendment made by
15 this section shall apply to taxable years beginning after
16 December 31, 1992.

17 **SEC. 742. TAX TREATMENT OF COMPANIES ISSUING QUALI-**
18 **FIED ACCELERATED DEATH BENEFIT RID-**
19 **ERS.**

20 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-
21 ERS TREATED AS LIFE INSURANCE.—Section 818 of the
22 Internal Revenue Code of 1986 (relating to other defini-
23 tions and special rules), as amended by section 701(a),
24 is amended by adding at the end thereof the following new
25 subsection:

1 “(h) QUALIFIED ACCELERATED DEATH BENEFIT
2 RIDERS TREATED AS LIFE INSURANCE.—For purposes of
3 this part—

4 “(1) IN GENERAL.—Any reference to a life in-
5 surance contract shall be treated as including a ref-
6 erence to a qualified accelerated death benefit rider
7 on such contract.

8 “(2) QUALIFIED ACCELERATED DEATH BENE-
9 FIT RIDERS.—For purposes of this subsection, the
10 term ‘qualified accelerated death benefit rider’
11 means any rider or addendum on, or other provision
12 of, a life insurance contract which provides for pay-
13 ments to an individual on the life of an insured upon
14 such insured becoming a terminally ill individual (as
15 defined in section 101(g)(2)) or being permanently
16 confined to a nursing home (as defined in section
17 101(g)(3)).”

18 (b) DEFINITIONS OF LIFE INSURANCE AND MODI-
19 FIED ENDOWMENT CONTRACTS.—

20 (1) RIDER TREATED AS QUALIFIED ADDI-
21 TIONAL BENEFIT.—Paragraph (5)(A) of section
22 7702(f) of such Code is amended by striking “or”
23 at the end of clause (iv), by redesignating clause (v)
24 as clause (vi), and by inserting after clause (iv) the
25 following new clause:

1 “(v) any qualified accelerated death
2 benefit rider (as defined in section
3 818(h)(2)) or any qualified long-term care
4 insurance rider which reduces the death
5 benefit, or”.

6 (2) TRANSITIONAL RULE.—For purposes of ap-
7 plying section 7702 or 7702A of the Internal Reve-
8 nue Code of 1986 to any contract (or determining
9 whether either such section applies to such con-
10 tract), the issuance of a rider or addendum on, or
11 other provision of, a life insurance contract permit-
12 ting the acceleration of death benefits (as described
13 in section 101(g) of such Code) or for qualified long-
14 term care insurance (as defined in section 849(b) of
15 such Code) shall not be treated as a modification or
16 material change of such contract.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to taxable years beginning before,
19 on, or after December 31, 1992.

1 **Subtitle F—Federal National Long-**
2 **Term Care Reinsurance Cor-**
3 **poration**

4 **SEC. 751. AUTHORIZATION FOR ESTABLISHMENT OF COR-**
5 **PORATION.**

6 The Secretary of Health and Human Services (in this
7 subtitle referred to as the “Secretary”) is authorized to
8 provide, in accordance with this subtitle, for the incorpora-
9 tion of a corporation to be known as the Federal National
10 Long-Term Care Reinsurance Corporation (in this subtitle
11 referred to as the “Corporation”), which shall not be an
12 agency or establishment of the United States Government.

13 **SEC. 752. BOARD OF DIRECTORS AND OFFICERS.**

14 (a) BOARD OF DIRECTORS.—The Corporation shall
15 have a Board of Directors (in this subtitle referred to as
16 the “Board”) consisting of 9 members, of which—

17 (1) 3 shall be appointed by the President of the
18 United States, of which one shall be representative
19 of entities providing long-term care, one shall be a
20 representative from an insurer, and one shall be a
21 representative of consumers of long-term care; and

22 (2) 6 shall be elected annually by the stockhold-
23 ers of the Corporation entitled to vote for such mem-
24 bers.

1 Within the limitations of law and regulation, the Board
2 shall determine the general policies which shall govern the
3 operations of the Corporation, and shall have power to
4 adopt, amend, and repeal bylaws governing the perform-
5 ance of the powers and duties granted to or imposed upon
6 it by law.

7 (b) INITIAL BOARD.—Notwithstanding subsection
8 (a), the members described in subsection (a)(1) shall serve
9 as incorporators and are authorized to assist the Secretary
10 in taking whatever actions are necessary to incorporate
11 the Corporation.

12 (c) TERMS OF OFFICE.—The terms of office of each
13 member of the Board shall be one year, expiring on the
14 date of the annual meeting of the stockholders of the Cor-
15 poration, except that (1) in the case of a vacancy occurring
16 prior to the expiration of the term of a member, the va-
17 cancy shall be filled by the President (for members de-
18 scribed in subsection (a)(1)) or by the remaining members
19 of the Board (for other members) for the remainder of
20 such term, and (2) any member may be removed by the
21 President for good cause. Any vacancy in the Board shall
22 not affect its power.

23 (d) CHAIRMAN.—The President shall designate one
24 of the members described in subsection (a)(1) as the initial
25 Chairman of the Board. Thereafter, the members of the

1 Boards shall annually elect one of their number as Chair-
2 man.

3 (e) TREATMENT OF MEMBERS.—

4 (1) The members of the Board shall not by rea-
5 son of such membership, be deemed to be employees
6 of the United States Government. Except as pro-
7 vided in paragraph (2), each member of the Board
8 shall be entitled to receive the daily equivalent of the
9 maximum annual rate of basic pay in effect for
10 grade GS-18 of the General Schedule for each day
11 (including travel time) during which he is engaged
12 in the actual performance of duties vested in the
13 Corporation.

14 (2) Members of the Board who are full-time of-
15 ficers or employees of the United States shall receive
16 no additional pay by reason of their service on the
17 Board.

18 (f) OFFICERS.—The Corporation shall have a Presi-
19 dent and such other executive officers and employees as
20 may be appointed by the Board at rates of compensation
21 fixed by the Board, without regard to any provisions of
22 title 5, United States Code. No such executive officer may
23 receive any salary or other compensation from any source
24 other than the Corporation during the period of his em-
25 ployment by the Corporation.

1 **SEC. 753. PURPOSE AND AUTHORITY OF CORPORATION.**

2 (a) **PURPOSE.**—The Corporation shall confine its ac-
3 tivities to providing for the reinsurance of insurance com-
4 panies for extraordinary loss in the issuance or payment
5 of benefits for qualified long-term care insurance (as de-
6 fined in section 848(b) of the Internal Revenue Code of
7 1986). Except as may be provided by the Secretary in reg-
8 ulations, the Corporation may not refuse to provide for
9 such reinsurance for any insurance meeting the require-
10 ments of such section (other than paragraph (4)(C)(iii)
11 thereof).

12 (b) **PREMIUMS.**—The Corporation shall impose for
13 such reinsurance reasonable premiums which—

14 (1) are related to actuarial estimates of the
15 type and amount of financial risk assumed by the
16 Corporation, and

17 (2) in the aggregate (in conjunction with other
18 income which the Corporation may have) provide for
19 all the expenses of the Corporation.

20 (c) **NO POLITICAL CONTRIBUTIONS.**—The Corpora-
21 tion shall not contribute or otherwise support any political
22 party or candidate for elective public office.

23 (d) **GENERAL POWERS.**—Except as otherwise specifi-
24 cally provided in this subtitle, the Corporation and Board
25 shall have the powers of a corporation and board of direc-
26 tors in the State in which incorporated.

1 **SEC. 754. CAPITALIZATION.**

2 (a) COMMON STOCK.—The Corporation shall have
3 common stock, with such par value as the Board estab-
4 lishes, which shall be vested with all voting rights, each
5 share being entitled to one vote with rights of cumulative
6 voting at all elections of directors. The free transferability
7 of the common stock at all times to any person, firm, cor-
8 poration, or other entity shall not be restricted, except
9 that, as to the Corporation, it shall be transferable only
10 on the books of the Corporation. The Corporation shall
11 only issue such common stock with the approval of the
12 Secretary.

13 (b) DEBT.—

14 (1) For purposes of carrying out this subtitle,
15 the Corporation may with the approval of the Sec-
16 retary and consistent with section 258, issue obliga-
17 tions having such maturities and bearing such rate
18 or rates and having such conditions (including sub-
19 ordination to other such obligations) as the Board
20 determines to be appropriate.

21 (2) The full faith and credit of the United
22 States is not pledged to the obligations and debts of
23 the Corporation. The Corporation shall insert appro-
24 priate language in all of its obligations issued under
25 this subsection clearly indicating that such obliga-
26 tions, together with the interest thereon, are not

1 guaranteed by the United States and do not con-
2 stitute debt or obligation of the United States or of
3 any agency or instrumentality thereof. The Corpora-
4 tion may purchase in the open market any of its ob-
5 ligations outstanding under the subsection at any
6 time and at any price.

7 (3) All obligations, participations, or other in-
8 struments issued by the Corporation shall be lawful
9 investments, and may be accepted as security for all
10 fiduciary, trust, and public funds, the investment or
11 deposit of which shall be under the authority and
12 control of the United States or any officer or officers
13 thereof.

14 **SEC. 755. EXEMPTION FROM STATE REGULATION AND TAX-**
15 **ATION.**

16 (a) TAXATION.—The Corporation, including its cap-
17 ital, reserves, surplus, security holdings, and income, shall
18 be exempt from all taxation now or hereafter imposed by
19 any State, district, Commonwealth, county, municipality,
20 or local taxing authority, except that any real property of
21 the Corporation shall be subject to such taxation to the
22 same extent according to its value as other real property
23 is taxed.

24 (b) INSURANCE REGULATION.—Except to the extent
25 specified by the Secretary in regulations, the Corporation

1 shall not be subject to any regulation under the insurance
2 laws of any State, district, or Commonwealth.

3 **SEC. 756. AUDIT AND ANNUAL REPORT.**

4 (a) AUDIT.—The Board shall provide for an annual
5 audit of the operations of the Corporation. Such audit
6 shall be conducted by a certified public accountant in ac-
7 cordance with generally accepted auditing principles (as
8 recognized by the Comptroller General).

9 (b) ANNUAL REPORT.—The Board shall report annu-
10 ally to the President and the Congress on the activities
11 of the Corporation. Such report shall include a presen-
12 tation of the financial status of the Corporation, as cer-
13 tified under the audit described in subsection (a).

14 **SEC. 757. PROTECTION OF NAME.**

15 No individual association, partnership, or corpora-
16 tion, except the Corporation, shall hereafter use the word
17 “Federal National Long-Term Care Reinsurance Corpora-
18 tion”, or any combination of such words, as the name or
19 a part thereof under which he or it shall do business. Vio-
20 lations of the foregoing sentence may be enjoined by any
21 court of general jurisdiction at the suit of the Corporation.
22 In any such suit, the Corporation may recover any actual
23 damages flowing from such violations, and, in addition,
24 shall be entitled to punitive damages (regardless of the
25 existence or nonexistence of actual damages) of not ex-

1 ceeding \$10,000 for each day during which such violation
2 is committed or repealed.

3 **SEC. 758. TERMINATION.**

4 The Corporation shall terminate its activities not
5 later than 10 years after the date of the enactment of this
6 Act.

7 **TITLE VIII—IMPROVEMENTS IN**
8 **PORTABILITY OF PRIVATE**
9 **HEALTH INSURANCE**

10 **SEC. 801. EXCISE TAX IMPOSED ON FAILURE TO PROVIDE**
11 **FOR PREEXISTING CONDITION.**

12 (a) IN GENERAL.—Chapter 47 (relating to taxes on
13 group health plans) is amended by adding at the end
14 thereof the following new section:

15 **“SEC. 5000A. FAILURE TO SATISFY PREEXISTING CONDI-**
16 **TION REQUIREMENTS OF GROUP HEALTH**
17 **PLANS.**

18 “(a) GENERAL RULE.—There is hereby imposed a
19 tax on the failure of—

20 “(1) a group health plan to meet the require-
21 ments of subsection (e), or

22 “(2) any person to meet the requirements of
23 subsection (f),

24 with respect to any covered individual.

25 “(b) AMOUNT OF TAX.—

1 “(1) IN GENERAL.—The amount of the tax im-
2 posed by subsection (a) on any failure with respect
3 to a covered individual shall be \$100 for each day
4 in the noncompliance period with respect to such
5 failure.

6 “(2) NONCOMPLIANCE PERIOD.—For purposes
7 of this section, the term ‘noncompliance period’
8 means, with respect to any failure, the period—

9 “(A) beginning on the date such failure
10 first occurs, and

11 “(B) ending on the date such failure is
12 corrected.

13 “(3) CORRECTION.—A failure of a group health
14 plan to meet the requirements of subsection (e) with
15 respect to any covered individual shall be treated as
16 corrected if—

17 “(A) such failure is retroactively undone to
18 the extent possible, and

19 “(B) the covered individual is placed in a
20 financial position which is as good as such indi-
21 vidual would have been in had such failure not
22 occurred.

23 For purposes of applying subparagraph (B), the cov-
24 ered individual shall be treated as if the individual
25 had elected the most favorable coverage in light of

1 the expenses incurred since the failure first oc-
2 curred.

3 “(e) LIMITATIONS ON AMOUNT OF TAX.—

4 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
5 DISCOVERED EXERCISING REASONABLE DILI-
6 GENCE.—No tax shall be imposed by subsection (a)
7 on any failure during any period for which it is es-
8 tablished to the satisfaction of the Secretary that
9 none of the persons referred to in subsection (d)
10 knew, or exercising reasonable diligence would have
11 known, that such failure existed.

12 “(2) TAX NOT TO APPLY TO FAILURES COR-
13 RECTED WITHIN 30 DAYS.—No tax shall be imposed
14 by subsection (a) on any failure if—

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

17 “(B) such failure is corrected during the
18 30-day period beginning on the first day any of
19 the persons referred to in subsection (d) knew,
20 or exercising reasonable diligence would have
21 known, that such failure existed.

22 “(3) WAIVER BY SECRETARY.—In the case of a
23 failure which is due to reasonable cause and not to
24 willful neglect, the Secretary may waive part or all
25 of the tax imposed by subsection (a) to the extent

1 that the payment of such tax would be excessive rel-
2 ative to the failure involved.

3 “(d) LIABILITY FOR TAX.—

4 “(1) IN GENERAL.—Except as otherwise pro-
5 vided in this subsection, the following shall be liable
6 for the tax imposed by subsection (a) on a failure:

7 “(A) In the case of a group health plan
8 other than a self-insured group health plan, the
9 issuer.

10 “(B)(i) In the case of a self-insured group
11 health plan other than a multiemployer group
12 health plan, the employer.

13 “(ii) In the case of a self-insured multiem-
14 ployer group health plan, the plan.

15 “(C) Each person who is responsible (other
16 than in a capacity as an employee) for admin-
17 istering or providing benefits under the group
18 health plan, health insurance plan, or other
19 health benefit arrangement (including a self-in-
20 sured plan) and whose act or failure to act
21 caused (in whole or in part) the failure.

22 “(2) SPECIAL RULES FOR PERSONS DESCRIBED
23 IN PARAGRAPH (1)(C).—A person described in sub-
24 paragraph (C) (and not in subparagraphs (A) and
25 (B)) of paragraph (1) shall be liable for the tax im-

1 posed by subsection (a) on any failure only if such
2 person assumed (under a legally enforceable written
3 agreement) responsibility for the performance of the
4 act to which the failure relates.

5 “(e) NO DISCRIMINATION BASED ON HEALTH STA-
6 TUS FOR CERTAIN SERVICES.—

7 “(1) IN GENERAL.—Except as provided under
8 paragraph (2), group health plans may not deny,
9 limit, or condition the coverage under (or benefits
10 of) the plan based on the health status, claims expe-
11 rience, receipt of health care, medical history, or
12 lack of evidence of insurability, of an individual.

13 “(2) TREATMENT OF PREEXISTING CONDITION
14 EXCLUSIONS FOR ALL SERVICES.—

15 “(A) IN GENERAL.—Subject to the suc-
16 ceeding provisions of this paragraph, group
17 health plans may exclude coverage with respect
18 to services related to treatment of a preexisting
19 condition, but the period of such exclusion may
20 not exceed 6 months. The exclusion of coverage
21 shall not apply to services furnished to
22 newborns.

23 “(B) CREDITING OF PREVIOUS COV-
24 ERAGE.—

1 “(i) IN GENERAL.—A group health
2 plan shall provide that if an individual
3 under such plan is in a period of continu-
4 ous coverage (as defined in clause (ii)(I))
5 with respect to particular services as of the
6 date of initial coverage under such plan
7 (determined without regard to any waiting
8 period under such plan), any period of ex-
9 clusion of coverage with respect to a pre-
10 existing condition for such services or type
11 of services shall be reduced by 1 month for
12 each month in the period of continuous
13 coverage without regard to any waiting pe-
14 riod.

15 “(ii) DEFINITIONS.—As used in this
16 subparagraph:

17 “(I) PERIOD OF CONTINUOUS
18 COVERAGE.—The term ‘period of con-
19 tinuous coverage’ means, with respect
20 to particular services, the period be-
21 ginning on the date an individual is
22 enrolled under a health insurance
23 plan, title XVIII or XIX of the Social
24 Security Act, or other health benefit
25 arrangement (including a self-insured

1 plan) which provides benefits with re-
2 spect to such services and ends on the
3 date the individual is not so enrolled
4 for a continuous period of more than
5 3 months.

6 “(II) PREEXISTING CONDI-
7 TION.—The term ‘preexisting condi-
8 tion’ means, with respect to coverage
9 under a group health plan, a condition
10 which has been diagnosed or treated
11 during the 3-month period ending on
12 the day before the first date of such
13 coverage without regard to any wait-
14 ing period.

15 “(f) DISCLOSURE OF COVERAGE, ETC.—Any person
16 who has provided coverage (other than under title XVIII
17 or XIX of the Social Security Act) during a period of con-
18 tinuous coverage (as defined in subsection (e)(2)(B)(ii)(I))
19 with respect to a covered individual shall disclose, upon
20 the request of a group health plan subject to the require-
21 ments of subsection (e), the coverage provided the covered
22 individual, the period of such coverage, and the benefits
23 provided under such coverage.

24 “(g) DEFINITIONS.—For purposes of this section—

1 “(1) COVERED INDIVIDUAL.—The term ‘cov-
2 ered individual’ means—

3 “(A) an individual who is (or will be) pro-
4 vided coverage under a group health plan by
5 virtue of the performance of services by the in-
6 dividual for 1 or more persons maintaining the
7 plan (including as an employee defined in sec-
8 tion 401(c)(1)), and

9 “(B) the spouse or any dependent child of
10 such individual.

11 “(2) GROUP HEALTH PLAN.—The term ‘group
12 health plan’ has the meaning given such term by
13 section 5000(b)(1).”.

14 (b) CLERICAL AMENDMENT.—The table of sections
15 for such chapter 47 is amended by adding at the end
16 thereof the following new item:

“Sec. 5000A. Failure to satisfy preexisting condition requirements
of group health plans.”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to plan years beginning after De-
19 cember 31, 1992.

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