

103<sup>D</sup> CONGRESS  
2<sup>D</sup> SESSION

# S. 2096

To improve private health insurance, to provide equitable tax treatment of health insurance, to reform Federal health care programs, to provide health care cost reduction measures, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

MAY 10 (legislative day, MAY 2), 1994

Mr. DOMENICI introduced the following bill; which was read the first time

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## A BILL

To improve private health insurance, to provide equitable tax treatment of health insurance, to reform Federal health care programs, to provide health care cost reduction measures, 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; DEFINI-**  
4 **TIONS.**

5 (a) SHORT TITLE.—This Act may be cited as the  
6 “Health Care Reform Act of 1994”.

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

Sec. 1. Short title; table of contents; definitions.

TITLE I—IMPROVING PRIVATE HEALTH INSURANCE

Subtitle A—Federal and State Roles

- Sec. 101. Federal reform and State implementation.
- Sec. 102. Applicable regulatory authority for health plans.
- Sec. 103. State health reform program requirements.

Subtitle B—Health Plan Requirements

- Sec. 111. Certified health plan requirements.
- Sec. 112. Additional requirements for accountable health plans.
- Sec. 113. Standard benefits.

Subtitle C—Improved Health Plan Delivery

- Sec. 121. Small group purchasing pools.
- Sec. 122. Employer responsibility.

TITLE II—TAX AND ENFORCEMENT PROVISIONS

- Sec. 200. Amendment of 1986 Code.

Subtitle A—General Tax Provisions

- Sec. 201. Certain employer health plan contributions included in income.
- Sec. 202. Deductions for costs of health plans.

TITLE III—FINANCING AND REFORMING FEDERAL PROGRAMS

Subtitle A—Medicare

- Sec. 301. Medicare choice.
- Sec. 302. Other medicare provisions.
- Sec. 303. Income-tested medicare premiums.
- Sec. 304. Medicare administrative simplification.

Subtitle B—Health Discount and Medicaid Reform

PART I—HEALTH DISCOUNT

- Sec. 311. State health discount programs.
- Sec. 312. Health discount program design.
- Sec. 313. Financing health discounts.

PART II—TERMINATION OF AUTHORITY TO FURNISH ACUTE CARE SERVICES UNDER THE MEDICAID PROGRAM

- Sec. 321. Termination of authority to furnish acute care services under the medicaid program.

Subtitle C—Increase in Tax on Tobacco Products

- Sec. 330. Amendment of 1986 Code.
- Sec. 331. Increase in excise taxes on tobacco products.
- Sec. 332. Modifications of certain tobacco tax provisions.
- Sec. 333. Imposition of excise tax on manufacture or importation of roll-your-own tobacco.

TITLE IV—IMPROVING ACCESS IN RURAL AREAS

- Sec. 401. Community health centers.
- Sec. 402. National health service corps.
- Sec. 403. Tax incentives for practice in frontier, rural, and urban underserved areas.
- Sec. 404. Incentives for primary care residents.

TITLE V—OTHER HEALTH CARE COST REDUCTION MEASURES

Subtitle A—Medical Liability Reform

- Sec. 501. Federal standards for State-based medical liability reform.
- Sec. 502. Certification.
- Sec. 503. Relation to other laws.

Subtitle B—Antitrust Provisions

- Sec. 511. Publication of guidelines for accountable health plans.
- Sec. 512. Issuance of health care certificates of public advantage.

Subtitle C—Administrative Cost Savings

- Sec. 521. Establishment of standards.
- Sec. 522. Enforcement.

1 (c) DEFINITIONS.—For purposes of this Act:

2 (1) AHP.—The term “AHP” means an ac-  
3 countable health plan.

4 (2) ELIGIBLE EMPLOYEE.—The term “eligible  
5 employee” means an individual employed by an em-  
6 ployer, and includes the spouse and any dependent  
7 of such employee. Such term also includes an em-  
8 ployee within the meaning of section 401(c)(1) of  
9 the Internal Revenue Code of 1986.

10 (3) ELIGIBLE INDIVIDUAL.—The term “eligible  
11 individual” means an individual who is otherwise not  
12 eligible for coverage under—

13 (A) an employer-sponsored health plan, or

14 (B) the medicare program under title  
15 XVIII of the Social Security Act.

1 The term “eligible individual” includes the spouse  
2 and any dependent of such individual unless such  
3 spouse or dependent is not an eligible individual.

4 (4) ELIGIBLE SMALL EMPLOYER.—The term  
5 “eligible small employer” means, with respect to a  
6 calendar year, an employer that normally employs  
7 more than 1 but less than 51 employees on a typical  
8 business day. For the purposes of this paragraph,  
9 the term “employee” includes a self-employed indi-  
10 vidual.

11 (5) HEALTH PLAN.—The term “health plan”  
12 (including self-insured plans) means any hospital or  
13 medical service policy or certificate, hospital or medi-  
14 cal service plan contract, or health maintenance or-  
15 ganization group contract and, in States which have  
16 distinct licensure requirements, a multiple employer  
17 welfare arrangement, but does not include any of the  
18 following offered by an insurer—

19 (A) accident only, dental only, disability  
20 only insurance, or long-term care only insur-  
21 ance;

22 (B) coverage issued as a supplement to li-  
23 ability insurance or Medicare;

24 (C) workmen’s compensation or similar in-  
25 surance; or

1 (D) automobile medical-payment insur-  
2 ance.

3 (6) INSURER.—The term “insurer” means any  
4 person that offers a health plan to an eligible small  
5 employer or eligible individual.

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

8 **TITLE I—IMPROVING PRIVATE**  
9 **HEALTH INSURANCE**  
10 **Subtitle A—Federal and State**  
11 **Roles**

12 **SEC. 101. FEDERAL REFORM AND STATE IMPLEMENTA-**  
13 **TION.**

14 (a) CERTIFICATION OF STATE HEALTH REFORM  
15 PROGRAMS.—

16 (1) CERTIFICATION.—The Secretary shall es-  
17 tablish by regulation a process by which each State  
18 shall submit a health reform program to the Sec-  
19 retary, and the Secretary shall determine and certify  
20 whether such State program is consistent with the  
21 requirements of section 103.

22 (2) PERIODIC REVIEW.—The Secretary may,  
23 from time-to-time, review a State program after  
24 such program has been originally certified to ensure

1 continued compliance with section 103 and may de-  
2 certify such program based on such review.

3 **SEC. 102. APPLICABLE REGULATORY AUTHORITY FOR**  
4 **HEALTH PLANS.**

5 (a) IN GENERAL.—Except as provided in subsection  
6 (b), each State shall ensure that health plans offered to  
7 individuals residing in such State meet the requirements  
8 of this Act, including sections 111 and 112, as applicable.

9 (b) EXCEPTIONS.—

10 (1) ERISA PLANS.—The Secretary of Labor  
11 shall ensure that health plans established pursuant  
12 to the requirements of the Employee Retirement In-  
13 come Security Act of 1974 (29 U.S.C. 1001 et seq.)  
14 meet the requirements under section 112 for AHPs.

15 (2) INADEQUATE STATE PLANS.—The Secretary  
16 shall ensure that health plans in a State meet the  
17 requirements of sections 111 and 112, as applicable,  
18 if the Secretary does not certify the health reform  
19 program submitted by such State or if the Secretary  
20 decertifies the State's program.

21 (c) EFFECTIVE DATE.—The requirements of this  
22 title shall apply to health plans offered, issued, or renewed  
23 on or after the later of—

24 (1) January 1, 1996; or

1           (2) in the case of a State which the Secretary  
2 identifies as requiring State legislation in order to  
3 implement this title, the first day of the first cal-  
4 endar quarter beginning after the close of the first  
5 regular legislative session of the State legislature  
6 that begins after enactment of this Act, but not be-  
7 fore January 1, 1996.

8 For purposes of the previous sentence, in the case of a  
9 State that has a 2-year legislative session, each year of  
10 such session shall be deemed to be a regular legislative  
11 session of the State legislature.

12 **SEC. 103. STATE HEALTH REFORM PROGRAM REQUIRE-**  
13 **MENTS.**

14           (a) IN GENERAL.—To be certified by the Secretary  
15 as meeting the requirements of this section, a State health  
16 reform program must include the following requirements,  
17 in addition to any other requirements established by the  
18 Secretary by regulation for carrying out this Act:

19           (1) HEALTH PLAN MARKET AREAS.—A State  
20 shall establish health plan market areas, ensuring  
21 that—

22                   (A) every resident resides within 1 such  
23 market area based on place of residence;

24                   (B) market areas do not overlap;

1 (C) a metropolitan statistical area is not  
2 included in more than 1 such market area; and

3 (D) the maximum number of State resi-  
4 dents have the opportunity to select from com-  
5 peting health plans and AHPs that are likely to  
6 be available in such market areas.

7 (2) INTERSTATE COORDINATION.—A State shall  
8 coordinate its health reform program with the pro-  
9 grams of bordering and nearby States so that—

10 (A) 1 health plan market area covers a  
11 metropolitan statistical area which crosses State  
12 borders; and

13 (B) residents of a State may have access  
14 to providers of health care services of bordering  
15 or nearby States.

16 (3) HEALTH PLAN REGULATION.—A State shall  
17 ensure that certified health plans and AHPs offered  
18 to residents of the State (other than those plans reg-  
19 ulated by the Secretary of Labor under section  
20 102(b)(1)) meet the requirements of section 111 and  
21 112, respectively.

22 (4) NO BENEFIT MANDATES, ANTIMANAGED  
23 CARE REQUIREMENTS.—A State shall ensure that  
24 AHPs are not—

1 (A) required to cover any service in the  
2 standard benefits package not otherwise re-  
3 quired by the Secretary under section 113;

4 (B) prohibited or limited from including fi-  
5 nancial incentives for enrollees to use the serv-  
6 ices of participating providers;

7 (C) prohibited or limited from restricting  
8 coverage of services to those—

9 (i) provided by a participating pro-  
10 vider; or

11 (ii) authorized by a designated partici-  
12 pating provider;

13 (D) restricted in the amount of payment  
14 made to participating providers for services pro-  
15 vided to enrollees or restricted in the ability of  
16 such AHPs to pay participating providers for  
17 services provided to enrollees on a per-enrollee  
18 basis;

19 (E) prohibited or limited from restricting  
20 the location, number, type, or professional  
21 qualifications of participating providers;

22 (F) prohibited or limited from requiring  
23 that services be authorized by a primary care  
24 physician selected by the enrollee from a list of  
25 available participating providers;

1 (G) prohibited or limited in the use of uti-  
2 lization review procedures or criteria;

3 (H) required to make public utilization re-  
4 view procedures or criteria;

5 (I) prohibited or limited from determining  
6 the location or hours of operation of a utiliza-  
7 tion review, provided that emergency services  
8 furnished during the hours in which the utiliza-  
9 tion review program is not open are not subject  
10 to utilization review;

11 (J) required to pay providers for the ex-  
12 penses associated with responding to requests  
13 for information needed to conduct utilization re-  
14 view;

15 (K) restricted in the amount of payment  
16 made for the conduct of utilization review;

17 (L) restricted in the access to medical in-  
18 formation or personnel required to conduct uti-  
19 lization review;

20 (M) required to define utilization review as  
21 the practice of medicine or another health care  
22 profession; or

23 (N) required to ensure that utilization re-  
24 view be conducted—

1 (i) by a resident of the State in which  
2 the treatment is to be offered or by an in-  
3 dividual licensed in such State, or

4 (ii) by a physician in any particular  
5 specialty or with any board certified spe-  
6 cialty of the same medical specialty as the  
7 provider whose services are being rendered.

8 (5) SMALL BUSINESS PURCHASING POOL.—

9 (A) IN GENERAL.—A State shall ensure  
10 that small group purchasing pools meet the re-  
11 quirements of section 121.

12 (B) STATE-SPONSORED POOLS.—If, any  
13 market area established by the State (or market  
14 area that is within the borders of more than 1  
15 State) does not have a small group purchasing  
16 group in operation that meets the requirements  
17 of section 121, the State shall sponsor such a  
18 pool meeting the requirements of section 121.

19 (6) HEALTH DISCOUNT PROGRAM.—A State  
20 shall establish a health discount program meeting  
21 the requirements of part I of subtitle B of title III.

22 (7) MEDICAL LIABILITY REFORM.—A State  
23 shall ensure that medical liability laws in the State  
24 meet the requirements of subtitle A of title V.

25 (b) STATE FLEXIBILITY.—

1           (1) IN GENERAL.—The Secretary shall ensure  
2 that State health reform programs are consistent  
3 with—

4           (A) a nationwide private health insurance  
5 system;

6           (B) cost control based on cost-conscious  
7 consumers and fair competition among compet-  
8 ing health plans based on the cost and quality  
9 of such plans; and

10          (C) freedom for residents to choose and  
11 pay for health care providers and health insur-  
12 ance as such residents wish.

13          (2) FLEXIBILITY.—The Secretary may allow  
14 States to propose alterations to the framework of  
15 this Act if such alterations are consistent with para-  
16 graph (1), do not increase the Federal budget deficit  
17 in any year, and—

18           (A) the State had enacted a State health  
19 reform program prior to enactment of this Act  
20 that supercedes provisions of this Act; or

21           (B) the State can demonstrate that provi-  
22 sions of this Act do not provide sufficient access  
23 to health care services for residents of a portion  
24 of the State (particularly in underserved rural  
25 areas) and alterations to the State health re-

1 form program will improve access without jeop-  
2 arding the quality of health care and without  
3 undue State regulation of health care providers.

4 (3) NO SINGLE PAYER PLANS.—The Secretary  
5 may not certify any State health reform program  
6 which proposes to create a single payer health insur-  
7 ance plan in any portion of the State.

8 (c) ENFORCEMENT.—If a State does not have a cer-  
9 tified State health reform program, Federal spending for  
10 health discounts in the State under title III shall be lim-  
11 ited to the level of Federal spending that would have oc-  
12 curred in such State under title XIX of the Social Security  
13 Act (42 U.S.C. 1396 et seq.) if this Act had not been en-  
14 acted.

## 15 **Subtitle B—Health Plan** 16 **Requirements**

### 17 **SEC. 111. CERTIFIED HEALTH PLAN REQUIREMENTS.**

18 (a) IN GENERAL.—To be certified as meeting the re-  
19 quirements of this section, a health plan shall meet the  
20 requirements of the following subsections.

21 (b) LIMITATION IN PREEXISTING CONDITION  
22 CLAUSES.—

23 (1) IN GENERAL.—To be certified as meeting  
24 the requirements of this subsection, a health plan  
25 may, subject to the succeeding provisions of this

1 subsection, exclude coverage with respect to services  
2 related to treatment of a preexisting condition, but  
3 the period of such exclusion may not exceed 6  
4 months. The exclusion of coverage shall not apply to  
5 services furnished to newborns.

6 (2) CREDITING OF PREVIOUS COVERAGE.—

7 (A) IN GENERAL.—A health plan shall pro-  
8 vide that if an individual under such plan is in  
9 a period of continuous coverage (as defined in  
10 subparagraph (B)) with respect to particular  
11 services as of the date of initial coverage under  
12 such plan, any period of exclusion of coverage  
13 with respect to a preexisting condition for such  
14 services or type of services shall be reduced by  
15 1 month for each month in the period of contin-  
16 uous coverage.

17 (B) PERIOD OF CONTINUOUS COVERAGE.—

18 For purposes of this paragraph, the term “pe-  
19 riod of continuous coverage” means, with re-  
20 spect to particular services, the period begin-  
21 ning on the date an individual is enrolled under  
22 a health plan, titles XVIII or XIX of the Social  
23 Security Act, or other health benefits arrange-  
24 ment which provides benefits with respect to  
25 such services and ends on the date the individ-

1           ual is not so enrolled for a continuous period of  
2           more than 3 months.

3           (3) PREEEXISTING CONDITION.—For purposes of  
4           this subsection, the term “preexisting condition”  
5           means, with respect to coverage under a health plan  
6           issued, a condition which has been diagnosed or  
7           treated during the 3-month period ending on the day  
8           before the first date of such coverage (without re-  
9           gard to any waiting period).

10          (c) SMALL GROUP MARKET REFORM.—To be cer-  
11         tified as meeting the requirements of this subsection, a  
12         health plan shall meet the following:

13                 (1) GUARANTEED ELIGIBILITY.—

14                         (A) IN GENERAL.—No health plan may ex-  
15                         clude from coverage—

16                                 (i) any eligible individual who does not  
17                                 qualify for assistance under section 311, or

18                                 (ii) any eligible employee to whom  
19                                 coverage is made available by an eligible  
20                                 small employer.

21                         (B) WAITING PERIODS.—Subparagraph  
22                         (A)(ii) shall not apply to any period an eligible  
23                         employee is excluded from coverage under the  
24                         health plan solely by reason of a requirement  
25                         applicable to all employees that a minimum pe-

1           riod of service with the eligible small employer  
2           is required before the employee is eligible for  
3           such coverage.

4           (2) GUARANTEED AVAILABILITY.—

5                 (A) IN GENERAL.—A health plan offered  
6           to any eligible small employer or eligible indi-  
7           vidual in a health plan market area shall be  
8           made available to all eligible small employers  
9           and eligible individuals in the health plan mar-  
10          ket area.

11                (B) STATE OPTION.—To ensure availabil-  
12          ity, each State may require all health plans of-  
13          fered to eligible small employers or eligible indi-  
14          viduals in a health plan market area be made  
15          available through small group purchasing pools,  
16          and that such pools be open to all eligible small  
17          employers and eligible individuals.

18           (3) GUARANTEED RENEWABILITY.—

19                 (A) IN GENERAL.—A health plan issued to  
20          an eligible small employer or eligible individual  
21          shall be renewed, at the option of the eligible  
22          small employer or eligible individual, unless the  
23          plan is terminated for a reason specified in sub-  
24          paragraph (B) or (C).

1 (B) TERMINATION OF SMALL EMPLOYER  
2 OR INDIVIDUAL BUSINESS.—An insurer is not  
3 required to renew a health plan with respect to  
4 an eligible small employer or such an eligible in-  
5 dividual, as the case may be, if the insurer—

6 (i) elects not to renew all of its health  
7 plans issued to eligible small employers or  
8 eligible individuals, as the case may be, in  
9 a health plan market area; and

10 (ii) provides notice to the applicable  
11 regulatory authority in the State and to  
12 each eligible small employer or eligible in-  
13 dividual covered under a plan of such ter-  
14 mination at least 180 days before the date  
15 of expiration of the plan.

16 In the case of such a termination, the insurer  
17 may not provide for issuance of any health in-  
18 surance plan to an eligible small employer or el-  
19 igible individual, as the case may be, in the  
20 State during the 5-year period beginning on the  
21 date of termination of the last plan not so re-  
22 newed.

23 (C) GROUNDS FOR REFUSAL TO RENEW.—

1 (i) IN GENERAL.—An insurer may  
 2 refuse to renew, or may terminate, a  
 3 health plan only for—

4 (I) nonpayment of premiums,

5 (II) fraud or misrepresentation,

6 or

7 (III) failure to maintain mini-  
 8 mum participation rates (consistent  
 9 with clause (ii).

10 (ii) MINIMUM PARTICIPATION  
 11 RATES.—An insurer may require, with re-  
 12 spect to a health plan issued to an eligible  
 13 small employer, that a minimum percent-  
 14 age of eligible employees who do not other-  
 15 wise have health plan coverage are enrolled  
 16 in such plan if such percentage is applied  
 17 uniformly to all plans offered to employers  
 18 of comparable size.

19 (4) PREMIUMS.—

20 (A) LIMITATION ON PREMIUM VARI-  
 21 ATION.—

22 (i) IN GENERAL.—The premium  
 23 charged by an insurer for each type of ben-  
 24 efits package offered as a certified health  
 25 plan to any eligible employee or eligible in-

1 individual in a health plan market area with-  
2 in a class of family enrollment and age  
3 band may not exceed the premium charged  
4 for the same benefits package offered to  
5 any other eligible employee or eligible indi-  
6 vidual by more than 20 percent.

7 (ii) ENROLLMENT CLASS.—For pur-  
8 poses of this subparagraph, the classes of  
9 family enrollment are—

10 (I) individual;

11 (II) couple;

12 (III) individual with children;

13 and

14 (IV) couple with children.

15 (iii) AGE BANDS.—The Secretary shall  
16 establish appropriate age bands with re-  
17 spect to principal enrollees for determining  
18 the compliance with this subparagraph.

19 (B) RISK ADJUSTMENTS.—

20 (i) IN GENERAL.—Premiums paid to  
21 health plans offered in the small group  
22 market in a health plan market area shall  
23 be adjusted to reflect the relative risk of  
24 enrollees in such plan compared to all eligi-

1           ble employees and eligible individuals in  
2           the health plan market area.

3           (ii) MODEL PROGRAMS.—The Sec-  
4           retary shall establish model risk adjust-  
5           ment programs that States may adopt to  
6           ensure compliance with clause (i).

7           (d) PARITY COVERAGE OF SEVERE MENTAL ILL-  
8           NESSES.—

9           (1) IN GENERAL.—To be certified as meeting  
10          the requirements of this subsection, a health plan  
11          shall provide parity coverage for all severe mental ill-  
12          nesses (as defined in regulations by the Secretary),  
13          including parity cost-sharing for services necessary  
14          to treat such illnesses.

15          (2) DEFINITION.—

16           (A) IN GENERAL.—Except as provided in  
17          subparagraph (B), for purposes of paragraph  
18          (1), the Secretary shall define severe mental ill-  
19          ness through diagnosis, disability, and duration,  
20          and include in such definition the following dis-  
21          orders with psychotic symptoms:

22                   (i) Schizophrenia.

23                   (ii) Schizoaffective disorder.

24                   (iii) Manic depressive disorder.

25                   (iv) Autism.

1 (v) Severe forms of other disorders  
2 such as major depression, panic disorder,  
3 and obsessive compulsive disorder.

4 (B) CHILDREN.—For purposes of para-  
5 graph (1), the Secretary shall define severe  
6 mental illness for individuals under age 22 to  
7 also include—

8 (i) psychotic disorders;

9 (ii) attention deficit hyperactivity dis-  
10 order;

11 (iii) autism and pervasive development  
12 disorder;

13 (iv) severe childhood eating disorders;

14 (v) Tourette's syndrome; and

15 (vi) any behavioral disorder that  
16 would result in conduct which may place  
17 the individual or another individual in dan-  
18 ger of death or serious bodily injury.

19 (3) DIAGNOSIS.—For purposes of paragraph  
20 (1), services necessary to properly diagnose an indi-  
21 vidual's mental health disorder shall be considered  
22 services necessary to treat a severe mental illness.

1 **SEC. 112. ADDITIONAL REQUIREMENTS FOR ACCOUNTABLE**  
2 **HEALTH PLANS.**

3 (a) CERTIFICATION.—To be certified as an AHP, a  
4 health plan must meet the requirements of the following  
5 subsections of this section in addition to the requirements  
6 of section 111.

7 (b) GENERAL REQUIREMENTS.—A health plan  
8 shall—

9 (1) provide all medically necessary and effective  
10 health benefits (as covered by the benefits package  
11 specified in an AHP contract) for a fixed premium  
12 for each enrollee for a specified period of time; and

13 (2) collect and report to the plan’s enrollees and  
14 the general public objective measures of the quality  
15 of the plan’s health care, the impact of the plan’s  
16 health care on the health status of enrollees, and en-  
17 rollee satisfaction with the plan’s cost, quality, and  
18 service.

19 (c) CAPACITY LIMITS AND NONDISCRIMINATION.—

20 (1) IN GENERAL.—A health plan may apply to  
21 the applicable regulatory authority to impose a limit  
22 on enrollment if enrollment beyond the limit is—

23 (A) not discriminatory and is based on a  
24 “first-come, first-served” enrollment policy, and

25 (B) is necessary to ensure quality of care  
26 for enrollees.

1           (2) PROHIBITION OF DISCRIMINATION BASED  
2           ON HEALTH STATUS.—A health plan may not deny,  
3           limit, or condition the coverage under (or benefits  
4           of) the plan based on the health status of the indi-  
5           vidual, claims experience of an individual, receipt of  
6           health care by an individual, receipt of public sub-  
7           sidies by an individual, lack of evidence of insurabil-  
8           ity of an individual, or any other characteristic of an  
9           individual that may relate to the utilization of health  
10          care services.

11          (3) SERVICE AREAS.—A health plan may not  
12          discriminate in the drawing of service area bound-  
13          aries on the basis of race, ethnicity, socio-economic  
14          status, age, or anticipated need for health services.

15          (d) ADJUSTED COMMUNITY RATING IN THE SMALL  
16          GROUP MARKET.—

17               (1) IN GENERAL.—A health plan shall charge a  
18               standard premium for each type of benefits package  
19               offered to eligible employees of eligible small employ-  
20               ers and eligible individuals in a health plan market  
21               area, but may elect to adjust the premium for the  
22               class of family enrollment and the age of the prin-  
23               cipal enrollee.

24               (2) EXEMPTION FOR SMALL GROUP PURCHAS-  
25               ING POOLS.—The standard premium charged for a

1 health plan offered to eligible employees of eligible  
2 small employers and eligible individuals through a  
3 small group purchasing pool may be lower than the  
4 premium required pursuant to paragraph (1) if at  
5 least 30 percent of all health plan premiums paid in  
6 the small group market in the health plan market  
7 area are made through such a pool.

8 (3) ENROLLMENT CLASS.—For purposes of this  
9 subsection, the classes of family enrollment are—

10 (A) individual;

11 (B) couple;

12 (C) individual with children; and

13 (D) couple with children.

14 (4) AGE BANDS.—The Secretary may establish  
15 appropriate age bands with respect to principal en-  
16 rollees for determining the compliance with this sub-  
17 section.

18 (e) QUALITY ASSURANCE.—

19 (1) INTERNAL QUALITY ASSURANCE AND QUAL-  
20 ITY IMPROVEMENT PROGRAM.—A health plan offer-  
21 ing covered services that must or may be obtained  
22 from participating providers must administer an in-  
23 ternal quality assurance and quality improvement  
24 program that—

25 (A) meets the following criteria:

- 1 (i) Is clearly identified and fully ex-  
2 plained to all participants in the program.
- 3 (ii) Is coordinated with other medical  
4 management activities.
- 5 (iii) Communicates findings to provid-  
6 ers and consumers with the primary goal  
7 of improving care outcomes.
- 8 (iv) Measures the impact of such find-  
9 ings on the care delivered by providers.
- 10 (v) Documents the monitoring and  
11 evaluation of the quality of care to identify  
12 areas for improvement.
- 13 (vi) Develops and implements explicit  
14 strategies to improve care.
- 15 (vii) Collects and analyzes data to fa-  
16 cilitate evaluation of improvement strate-  
17 gies.
- 18 (viii) Measures the effect of such  
19 strategies on care outcomes and the quality  
20 of care.
- 21 (ix) Incorporates a credentialing proc-  
22 ess that encompasses initial credentialing,  
23 recredentialing, recertifying or reappoint-  
24 ment of providers, or both.

1 (x) Is accountable directly to the gov-  
2 erning body of the AHP or, in instances in  
3 which the governing body's participation in  
4 quality assurance is not direct, to a des-  
5 ignated committee of senior management;  
6 or

7 (B) is accredited by an independent orga-  
8 nization, such as the National Committee for  
9 Quality Assurance, that conducts objective qual-  
10 ity reviews based upon comparable criteria.

11 (2) MEASURING AND COMPARING QUALITY.—

12 (A) IN GENERAL.—A health plan shall  
13 comply with a process, established by the Sec-  
14 retary by regulation, by which such plan shall  
15 provide to the appropriate regulatory authority  
16 (in an electronic form) standardized informa-  
17 tion necessary to—

18 (i) objectively measure and evaluate  
19 the performance of such plan;

20 (ii) fairly compare the performance of  
21 such plan with other AHPs; and

22 (iii) assess the health status of enroll-  
23 ees in such plan to allow fair risk adjust-  
24 ments among competing AHPs.

1 (B) REQUIRED DATA.—The Secretary shall  
2 establish by regulation the necessary informa-  
3 tion such plan must provide, including—

4 (i) quality measures, especially meas-  
5 ures of health outcomes, including the clin-  
6 ical health, functional status, and well  
7 being of enrollees before and after treat-  
8 ments and other services provided by the  
9 plan;

10 (ii) measures of patient access and  
11 satisfaction;

12 (iii) membership and utilization infor-  
13 mation;

14 (iv) financial information;

15 (v) health plan management activities  
16 information; and

17 (vi) any other information determined  
18 to be necessary by the Secretary for ensur-  
19 ing fair competition among AHPs based on  
20 cost and quality.

21 (C) USE OF DATA.—

22 (i) IN GENERAL.—The Secretary shall  
23 establish by regulation a process by which  
24 such standardized information may be dis-  
25 tributed by the appropriate regulatory au-

1           thority in a manner that promotes ac-  
2           countability to AHP enrollees and fair  
3           competition among AHPs based on cost  
4           and quality.

5           (ii) WIDE ACCESS.—The Secretary  
6           shall ensure that small business purchasing  
7           pools and State health discount programs  
8           have access to such information to ensure  
9           fair competition among AHPs in those  
10          such pools and health discount programs.

11          (iii) PATIENT CONFIDENTIALITY.—  
12          The Secretary shall ensure by regulation  
13          that the confidentiality of medical records  
14          of individual enrollees is protected.

15          (f) MARKET CONDUCT REQUIREMENTS.—

16               (1) REQUIRED WRITTEN MATERIALS.—A health  
17          plan shall provide written descriptions of the  
18          plan's—

19                       (A) covered benefits, services, and proce-  
20                       dures that clearly and fully describe any and all  
21                       limitations of coverage, use of participating pro-  
22                       viders and other limits on enrollees' use of serv-  
23                       ices; and

24                       (B) out-of-pocket costs, including  
25                       copayments, deductibles, coinsurance, and es-

1           tablISHED aggregate maximums on out-of-pocket  
2           costs.

3           (2) ADVERTISING.—All health plan advertising,  
4           promotional materials, and other communications  
5           with enrollees of the public must be factually accu-  
6           rate and understandable to diverse populations.

7           (g) ENROLLEE GRIEVANCES.—A health plan shall  
8           maintain procedures for hearing and resolving grievances  
9           between the plan (and any entity or individual through  
10          which the plan provides health care services) and the en-  
11          rollees.

12          (h) POINT OF SERVICE PLAN.—A health plan offer-  
13          ing covered services that must be obtained from participat-  
14          ing providers shall make available an alternative insurance  
15          plan that provides for a point of service option under  
16          which an enrollee may select any licensed health care pro-  
17          vider to obtain services and such a plan shall pay such  
18          provider not less than 50 percent of the cost of such pro-  
19          vider's services. A health plan may charge a higher pre-  
20          mium for such an alternative insurance plan.

21          (i) FINANCIAL SOLVENCY.—

22                  (1) IN GENERAL.—A health plan shall be re-  
23          quired to demonstrate evidence of adequate capital-  
24          ization and other indicators of fiscal health, includ-  
25          ing—

1 (A) total assets greater than total  
2 unsubordinated liabilities;

3 (B) sufficient cash flow and adequate li-  
4 quidity to meet obligations as such obligations  
5 become due;

6 (C) an insolvency protection plan; and

7 (D) insurance or other acceptable arrange-  
8 ments to protect the health plan against liabil-  
9 ity and casualty risks, including professional li-  
10 ability.

11 (2) INSOLVENCY.—

12 (A) Enrollees in the health plan shall be  
13 held harmless from incurring liability for any  
14 fees that are the legal obligation of an insolvent  
15 plan.

16 (B) A health plan offering coverage in a  
17 market area in which an AHP has become in-  
18 solvent shall be required to accept enrollment of  
19 enrollees of such insolvent AHP, subject to ca-  
20 pacity limits.

21 (j) MEDICAL LIABILITY REFORM.—A health plan  
22 shall comply with requirements established pursuant to  
23 section 501(d).

1 (k) ADMINISTRATIVE COST REDUCTION.—A health  
2 plan shall comply with the requirements established pursu-  
3 ant to subtitle C of title V.

4 (l) PARTICIPATION IN HEALTH DISCOUNT PRO-  
5 GRAMS.—Except for health plans established pursuant to  
6 the Employee Retirement Income Security Act of 1974  
7 (29 U.S.C. 1001 et seq.), a health plan shall comply with  
8 the requirements established by the State in accordance  
9 with subtitle B of title III for making AHPs available to  
10 individuals eligible for health discounts.

11 **SEC. 113. STANDARD BENEFITS.**

12 (a) STANDARD BENEFITS PACKAGE.—The Secretary  
13 shall promulgate regulations establishing a standard bene-  
14 fits package meeting the following requirements:

15 (1) COVERAGE.—The standard benefits package  
16 shall cover—

17 (A) inpatient and outpatient hospital serv-  
18 ices;

19 (B) physician services;

20 (C) diagnostic services and tests;

21 (D) outpatient prescription drugs;

22 (E) preventive services; and

23 (F) such other services as determined nec-  
24 essary and appropriate by the Secretary.

1           (2) PARITY COVERAGE OF SEVERE MENTAL ILL-  
2           NESSES.—The standard benefits package shall be  
3           consistent with the requirement for parity coverage  
4           of severe mental illnesses, pursuant to section  
5           111(d).

6           (3) COST SHARING.—The Secretary shall estab-  
7           lish for the standard benefits package—

8                   (A) a cost-sharing arrangement consistent  
9                   with health care delivered by health mainte-  
10                  nance organizations, including an annual limit  
11                  on an enrollee’s out-of-pocket expenses (exclud-  
12                  ing an enrollee’s expenses for services provided  
13                  under an AHP point of service option);

14                  (B) a cost-sharing arrangement consistent  
15                  with health care covered by fee-for-service  
16                  health insurance which is actuarially equivalent  
17                  to the arrangement established under subpara-  
18                  graph (A); and

19                  (C) any other actuarially equivalent cost-  
20                  sharing arrangements consistent with other  
21                  health care delivery systems.

22           (b) NOMINAL COST-SHARING BENEFITS PACKAGE.—  
23           For each cost-sharing arrangement established under sub-  
24           section (a)(3), the Secretary shall also establish a nominal  
25           cost-sharing benefits package for purposes of determining

1 health discounts for poor eligible individuals and poor eli-  
2 gible employees under part I of subtitle B of title III. Such  
3 benefits packages shall cover the same services as the  
4 standard benefits package but with cost-sharing require-  
5 ments that are not excessive for such individuals and em-  
6 ployees.

7 (c) ALTERNATIVE BENEFITS PACKAGE.—For each  
8 cost-sharing arrangement established under subsection  
9 (a)(3), the Secretary shall also establish an alternative  
10 benefits package that may be necessary for determining  
11 health discounts for low income eligible individuals and  
12 low income eligible employees under part I of subtitle B  
13 of title III. Such alternative benefits packages shall cover  
14 the same services as the standard benefits package but  
15 with cost-sharing requirements that are sufficient to de-  
16 crease the average actuarial value of the standard benefits  
17 package by 50 percent.

## 18 **Subtitle C—Improved Health Plan** 19 **Delivery**

### 20 **SEC. 121. SMALL GROUP PURCHASING POOLS.**

21 (a) IN GENERAL.—Each small group purchasing pool  
22 in a health plan market area in a State shall provide a  
23 process for eligible employees of eligible small employers  
24 and eligible individuals who are not entitled to health dis-  
25 counts under part I of subtitle B of title III to have the

1 opportunity to select annually from among competing  
2 AHPs offering the standard benefits package (and, for  
3 poor eligible employees, the nominal cost-sharing benefits  
4 package) at an adjusted community rate for the coverage  
5 period.

6 (b) REQUIREMENTS.—Each small group purchasing  
7 pool shall—

8 (1) be established as a private, not-for-profit  
9 corporation serving eligible small employers and eli-  
10 gible individuals in a health plan market area;

11 (2) contract with eligible small employers and  
12 eligible individuals to provide services for a defined  
13 period for a fixed administrative fee per coverage pe-  
14 riod;

15 (3) be governed by a board of directors elected  
16 by members of the pool;

17 (4) contract only with AHPs capable of provid-  
18 ing coverage to the members of the pool throughout  
19 the health plan market area;

20 (5) require all AHPs to offer at least the stand-  
21 ard benefits package and any other package of bene-  
22 fits as specified by the pool, and, if an AHP offers  
23 covered services that must be obtained from partici-  
24 pating providers, the alternative point of service in-  
25 surance plan for such AHP;

1           (6) provide information to members concerning  
2           the cost and quality of the competing AHPs offered  
3           through the pool; and

4           (7) offer to provide administrative services to  
5           members for the collection of premiums to be for-  
6           warded to AHPs.

7           (c) PROHIBITIONS.—Small group purchasing groups  
8           may not—

9           (1) decline to contract with an AHP if the in-  
10          surer seeks to offer to members of the pool and the  
11          plan meets the requirements of subsection (b);

12          (2) decline membership to any eligible small  
13          employer or eligible individual located in the health  
14          plan market area;

15          (3) negotiate AHP premiums on behalf of mem-  
16          bers; or

17          (4) negotiate payment rates for health care pro-  
18          viders contracting with AHPs offered through the  
19          pool.

20       **SEC. 122. EMPLOYER RESPONSIBILITY.**

21           (a) AHP AVAILABILITY.—

22           (1) IN GENERAL.—Each employer shall—

23           (A) offer to each eligible employee enroll-  
24           ment in an AHP providing a standard benefits  
25           package that serves the area in which the em-

1            ployee resides, both on an individual basis, and,  
2            if applicable and at the employee's option, on a  
3            family basis, and, if an AHP offers covered  
4            services that must be obtained from participat-  
5            ing providers, the alternative point of service in-  
6            surance plan for such AHP;

7            (B) provide, at the option of the employee,  
8            for deduction from wages or other compensa-  
9            tion of amount of any premiums due for such  
10           enrollment (taking into account the amount of  
11           any employer contribution); and

12           (C) if such employer is an eligible small  
13           employer, also make available an AHP provid-  
14           ing the nominal cost-sharing benefits package.

15           Nothing in this paragraph shall be construed as pre-  
16           venting an employer from offering, or an employee  
17           from electing enrollment in, an AHP that serves the  
18           area in which the employee is employed, rather than  
19           the area in which the employee resides.

20           (2) SMALL EMPLOYERS.—Each eligible small  
21           employer may comply with the requirements of this  
22           subsection by participating in a small group pur-  
23           chasing pool.

24           (b) ENFORCEMENT.—

1           (1) CIVIL MONEY PENALTIES FOR FAILURE TO  
2 OFFER COVERAGE OR PROVIDE FOR WAGE DEDUC-  
3 TION.—Failure to offer coverage or provide for de-  
4 duction from wages required under subsection (a)(1)  
5 is subject to a civil monetary penalty (not to exceed  
6 \$500) for each day in which the violation continues.

7           (2) DIRECT ENFORCEMENT.—The obligation to  
8 offer coverage under subsection (a) with respect to  
9 an eligible employee is directly enforceable by civil  
10 action by the employee. In any such action, if the  
11 employee substantially prevails, the employee is enti-  
12 tled to reasonable attorneys' fees.

## 13                           **TITLE II—TAX AND** 14                           **ENFORCEMENT PROVISIONS**

### 15   **SEC. 200. AMENDMENT OF 1986 CODE.**

16           Except as otherwise expressly provided, whenever in  
17 this title an amendment or repeal is expressed in terms  
18 of an amendment to, or repeal of, a section or other provi-  
19 sion, the reference shall be considered to be made to a  
20 section or other provision of the Internal Revenue Code  
21 of 1986.

1 **Subtitle A—General Tax Provisions**

2 **SEC. 201. CERTAIN EMPLOYER HEALTH PLAN CONTRIBU-**  
 3 **TIONS INCLUDED IN INCOME.**

4 (a) EXCLUSION FOR EMPLOYER HEALTH PLAN CON-  
 5 TRIBUTIONS LIMITED TO CONTRIBUTIONS TO ACCOUNT-  
 6 ABLE HEALTH PLANS OR CERTIFIED HEALTH PLANS.—

7 (1) IN GENERAL.—Section 106 (relating to con-  
 8 tributions by employer to accident and health plans)  
 9 is amended to read as follows:

10 **“SEC. 106. CONTRIBUTIONS BY EMPLOYER TO HEALTH**  
 11 **PLANS.**

12 “Except as provided in section 91, gross income of  
 13 an employee does not include employer-provided coverage  
 14 under an accountable health plan (within the meaning of  
 15 section 112 of the Health Care Reform Act of 1994) or  
 16 employer-provided coverage under a certified health plan  
 17 (within the meaning of section 111 of such Act)”.

18 (2) CLERICAL AMENDMENT.—The table of sec-  
 19 tions of part III of subchapter B of chapter 1 is  
 20 amended by striking the item relating to section 106  
 21 and inserting the following new item:

“Sec. 106. Contributions by employer to health plans.”.

22 (b) INCLUSION IN INCOME.—

23 (1) IN GENERAL.—Part II of subchapter B of  
 24 chapter 1 (relating to items specifically included in

1 gross income) is amended by adding at the end the  
2 following new section:

3 **“SEC. 91. EXCESS EMPLOYER CONTRIBUTIONS TO HEALTH**  
4 **PLANS.**

5 “(a) GENERAL RULE.—Notwithstanding section 106,  
6 if—

7 “(1) an employee is covered by an accountable  
8 health plan or a certified health plan at any time  
9 during any month, and

10 “(2) there is an excess employer contribution  
11 with respect to the employee to such plan for such  
12 month,

13 the gross income of such employee for the taxable year  
14 which includes such month shall include an amount equal  
15 to such excess employer contribution for such month.

16 “(b) EXCESS EMPLOYER CONTRIBUTION DE-  
17 FINED.—

18 “(1) IN GENERAL.—For purposes of this sec-  
19 tion, the term ‘excess employer contribution’ means,  
20 with respect to an employee enrolled in an account-  
21 able health plan or a certified health plan for any  
22 month, the excess of—

23 “(A) the employer contribution to such  
24 plan for such month, over

1           “(B) the applicable percentage of the ap-  
2           pplicable dollar limit for such employee for such  
3           month.

4           “(2) APPLICABLE DOLLAR LIMIT.—

5           “(A) IN GENERAL.—For purposes of para-  
6           graph (1) and except as provided in subpara-  
7           graph (B), the applicable dollar limit for an em-  
8           ployee for any month is equal to—

9                   “(i) in the case of individual coverage,  
10                   \$340,

11                   “(ii) in the case of couple coverage,  
12                   \$690,

13                   “(iii) in the case of individual with de-  
14                   pendent child or children coverage, \$670,  
15                   and

16                   “(iv) in the case of couple with de-  
17                   pendent child or children, \$910.

18           For any calendar year beginning after 2000,  
19           the dollar amounts specified in this paragraph  
20           for such year shall equal the dollar amounts  
21           under this paragraph for the previous calendar  
22           year increased by the percentage increase in the  
23           per capita Gross Domestic Product for the pre-  
24           vious calendar year.

1           “(B) REDUCTION OF APPLICABLE DOLLAR  
2           LIMIT.—

3           “(i) IN GENERAL.—Each dollar  
4           amount contained in clauses (i), (ii), (iii),  
5           and (iv) of subparagraph (A) for the cal-  
6           endar year shall be reduced (but not below  
7           50 percent of such dollar amount) by the  
8           amount determined under clause (ii).

9           “(ii) AMOUNT OF REDUCTION.—The  
10          amount determined under this clause with  
11          respect to any dollar amount shall be the  
12          amount which bears the same ratio to 50  
13          percent of such dollar amount as the ex-  
14          cess of—

15                 “(I) the taxpayer’s adjusted  
16                 gross income (determined without re-  
17                 gard to this section) for the taxable  
18                 year ending in the calendar year, over

19                 “(II) the applicable income  
20                 amount,  
21                 bears to \$25,000.

22                 “(iii) APPLICABLE INCOME  
23                 AMOUNT.—For purposes of clause (ii)(II),  
24                 the term ‘applicable income amount’ means

1           \$75,000 (\$50,000, in the case of a tax-  
2           payer described in section 1(c)).

3           “(3) APPLICABLE PERCENTAGE.—For purposes  
4           of paragraph (1), the applicable percentage for any  
5           taxable year—

6           “(A) in the case of an accountable health  
7           plan, is 100 percent, and

8           “(B) in the case of a certified health plan,  
9           is 100 percent reduced by 20 percentage points  
10          (but not below zero percent) for each taxable  
11          year beginning after December 31, 1996.

12          “(c) SPECIAL RULE FOR MULTIEMPLOYER HEALTH  
13          PLANS.—In the case of employer contributions with re-  
14          spect to any employee made to a multiemployer health  
15          plan on a basis other than per employee per month, the  
16          Secretary may by regulations prescribe the method of de-  
17          termining that portion of such contributions that is not  
18          included in gross income of the employee.

19          “(d) OTHER DEFINITIONS AND SPECIAL RULES.—  
20          For purposes of this section—

21          “(1) ACCOUNTABLE OR CERTIFIED HEALTH  
22          PLAN.—The terms ‘accountable health plan’ and  
23          ‘certified health plan’ have the meanings given to  
24          such terms by section 106.

1           “(2) EMPLOYEE INCLUDES FORMER EM-  
2           PLOYEE.—The term ‘employee’ includes a former  
3           employee.

4           “(3) DETERMINATION OF EMPLOYER CON-  
5           TRIBUTION.—

6                   “(A) IN GENERAL.—The employer con-  
7                   tribution to any accountable health plan or cer-  
8                   tified health plan for any month shall be that  
9                   portion of the cost of such plan for such month  
10                  which is incurred by the employer.

11                   “(B) SELF-INSURED PLAN MAY USE AN-  
12                   NUAL ESTIMATES.—An employer who maintains  
13                   a self-insured health plan may elect (in such  
14                   manner and at such time as may be provided  
15                   in regulations) to determine the actual employer  
16                   contribution under subsection (b)(1)(A) for any  
17                   period of not more than 12 months on the basis  
18                   of a reasonable estimate of the cost of providing  
19                   coverage for such month. To the extent prac-  
20                   ticable, such estimate shall be made on an actu-  
21                   arial basis, and in the making of any such esti-  
22                   mate, there shall be taken into account such  
23                   factors as may be required under regulations.

24                   “(C) EMPLOYEES ONLY TAKEN INTO AC-  
25                   COUNT FOR PERIODS COVERED.—For purposes

1 of determining the employer contribution,  
2 amounts shall be taken into account with re-  
3 spect to an employee only for periods during  
4 which such employee is covered by the plan.

5 “(4) COVERAGE FOR ONLY PART OF MONTH.—  
6 If an employee is covered under an accountable  
7 health plan or certified health plan for only a por-  
8 tion of a month, the amount required to be included  
9 under subsection (a) in the gross income of such em-  
10 ployee with respect to such month shall be an  
11 amount which bears the same ratio to the excess em-  
12 ployer contribution for such month as such portion  
13 bears to the entire month.

14 “(5) CERTAIN RELATED EMPLOYERS TREATED  
15 AS 1 EMPLOYER.—Rules similar to the rules pro-  
16 vided by subsections (b) and (c) of section 414 shall  
17 apply.

18 “(6) MONTH.—The term ‘month’ means a cal-  
19 endar month.

20 “(7) MULTIEMPLOYER HEALTH PLAN.—The  
21 term ‘multiemployer health plan’ means an account-  
22 able health plan which is part of an employee wel-  
23 fare benefit plan (within the meaning of section 3(1)  
24 of the Employee Retirement Income Security Act of  
25 1974)—



1 For purposes of paragraph (1), an employer may elect to  
2 prorate any such amount to any payroll period (or portion  
3 thereof) covering such month rather than treat it as being  
4 paid at the close of such month.

5 “(b) SPECIAL RULES IN THE CASE OF SELF-IN-  
6 SURED PLANS.—

7 “(1) SAFE HARBOR FOR EMPLOYEES WHOSE  
8 ESTIMATES ARE AT LEAST 95 PERCENT OF ACTUAL  
9 EMPLOYER CONTRIBUTIONS.—In the case of an em-  
10 ployer who maintains a self-insured health plan, if  
11 for any calendar year the excess of—

12 “(A) the actual employer contributions de-  
13 termined under section 91 with respect to all  
14 employees for such year, over

15 “(B) the amount estimated by the em-  
16 ployer under section 91(d)(3)(B) as the em-  
17 ployer contributions with respect to all employ-  
18 ees for such year,

19 is not greater than 5 percent of the amount deter-  
20 mined under subparagraph (A) then, except as pro-  
21 vided in paragraph (2), no penalty shall be imposed  
22 under section 6672 on the employer for failure to  
23 pay, or to deduct and withhold, any tax imposed by  
24 this subtitle on such excess.

1           “(2) EMPLOYER MUST PAY CERTAIN TAXES ON  
2           EXCESS.—Paragraph (1) shall not apply to any tax  
3           imposed, or required to be deducted and withheld,  
4           under sections 3111, 3221, 3301, and 3402 on the  
5           excess described in paragraph (1) unless the em-  
6           ployer pays any such tax within the time prescribed  
7           by the Secretary under regulations.

8           “(3) SPECIAL RULES FOR EMPLOYEE’S SOCIAL  
9           SECURITY TAX AND CREDIT.—In the case of the ex-  
10          cess described in paragraph (1)—

11                   “(A) no tax shall be imposed by section  
12                   3101, and

13                   “(B) the amount of such excess shall not  
14                   be taken into account for purposes of section  
15                   209 of the Social Security Act.

16          “(c) LIABILITY FOR WITHHOLDING AND PAYMENT  
17          OF TAX.—

18                   “(1) IN GENERAL.—Except as provided in para-  
19                   graph (2), the applicable payer shall withhold, and  
20                   be liable for, payment of any tax required to be  
21                   withheld or paid under this subtitle on any amount  
22                   described in subsection (a).

23                   “(2) SPECIAL RULES FOR MULTIEMPLOYER  
24                   HEALTH PLANS.—In the case of any multiemployer  
25                   health plan, the plan administrator shall comply

1 with such rules with respect to the withholding of,  
2 and liability for, any tax required to be withheld or  
3 paid under this subtitle as the Secretary may require  
4 by regulations.

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

6 “(1) APPLICABLE PAYER.—The term ‘applica-  
7 ble payer’ means the payer of remuneration for serv-  
8 ices which qualifies the employee for coverage under  
9 a multiemployer health plan.

10 “(2) EMPLOYEE.—The term ‘employee’ does  
11 not include a former employee.

12 “(3) MULTIEMPLOYER HEALTH PLAN.—The  
13 term ‘multiemployer health plan’ has the meaning  
14 given such term by section 91(d)(7).”.

15 (2) CLERICAL AMENDMENT.—The table of sec-  
16 tions for chapter 25 is amended by adding at the  
17 end the following new item:

“Sec. 3510. Treatment of excess employer contributions.”.

18 (d) EFFECTIVE DATES.—

19 (1) IN GENERAL.—The amendments made by  
20 subsections (a) and (b) shall apply to taxable years  
21 beginning after December 31, 1995.

22 (2) EMPLOYMENT TAX.—The amendments  
23 made by subsection (c) shall take effect on and after  
24 January 1, 1996.

1 **SEC. 202. DEDUCTIONS FOR COSTS OF HEALTH PLANS.**

2 (a) BUSINESS EXPENSE DEDUCTION FOR HEALTH  
3 INSURANCE.—Section 162 (relating to trade or business  
4 expenses) is amended by redesignating subsection (m) as  
5 subsection (n) and by inserting after subsection (l) the fol-  
6 lowing new subsection:

7 “(m) GROUP HEALTH PLANS.—The amount of ex-  
8 penses paid or incurred by an employer for a group health  
9 plan shall not be allowed as a deduction under this sec-  
10 tion—

11 “(1) unless the plan is an accountable health  
12 plan or certified health plan (as defined in section  
13 106),

14 “(2) unless such employer does not vary the  
15 amount incurred among plans offered to each em-  
16 ployee (other than with respect to the benefits pack-  
17 age and family class of enrollment coverage), and

18 “(3) with respect to each employee, to the ex-  
19 tent such amount exceeds the applicable dollar limit  
20 for such employee (within the meaning of section  
21 91(b)(2) (without regard to subparagraph (B) there-  
22 of) and determined on an annual basis).”.

23 (b) PERMANENT EXTENSION AND INCREASE IN  
24 HEALTH INSURANCE TAX DEDUCTION FOR SELF-EM-  
25 PLOYED INDIVIDUALS.—

26 (1) PERMANENT EXTENSION OF DEDUCTION.—

1 (A) IN GENERAL.—Subsection (l) of sec-  
2 tion 162 (relating to special rules for health in-  
3 surance costs of self-employed individuals) is  
4 amended by striking paragraph (6).

5 (B) EFFECTIVE DATE.—The amendment  
6 made by this paragraph shall apply to taxable  
7 years beginning after December 31, 1993.

8 (2) INCREASE IN AMOUNT OF DEDUCTION; IN-  
9 SURANCE PURCHASED MUST MEET CERTAIN STAND-  
10 ARDS.—

11 (A) INCREASE IN AMOUNT OF DEDUC-  
12 TION.—Paragraph (1) of section 162(l) is  
13 amended—

14 (i) by striking “25 percent of” and in-  
15 serting “100 percent of”, and

16 (ii) by striking “dependents.” and in-  
17 serting “dependents, and only to the extent  
18 such amount does not exceed the applica-  
19 ble dollar limit for such taxpayer (within  
20 the meaning of section 91(b)(2) and deter-  
21 mined on an annual basis).”

22 (B) INSURANCE PURCHASED MUST MEET  
23 CERTAIN STANDARDS.—Paragraph (2) of sec-  
24 tion 162(l) is amended by adding at the end the  
25 following new subparagraph:

1           “(C) INSURANCE MUST MEET CERTAIN  
2           STANDARDS.—Paragraph (1) shall apply only to  
3           insurance which is an accountable health plan  
4           or certified health plan (as defined in section  
5           106).”.

6           (C) TREATMENT OF MULTIEMPLOYER  
7           HEALTH PLANS.—Subsection (l) of section 162  
8           is amended by adding at the end the following  
9           new paragraph:

10          “(6) TREATMENT OF MULTIEMPLOYER HEALTH  
11          PLANS.—For purposes of this subsection, an amount  
12          paid into a multiemployer health plan (as defined in  
13          section 91(d)(7) shall be deemed to be an amount  
14          paid for insurance which constitutes medical care.”.

15          (c) EFFECTIVE DATE.—Except as provided in sub-  
16          section (b)(1)(B), the amendments made by this section  
17          shall apply to taxable years beginning after December 31,  
18          1995.

1 **TITLE III—FINANCING AND RE-**  
2 **FORMING FEDERAL PRO-**  
3 **GRAMS**

4 **Subtitle A—Medicare**

5 **SEC. 301. MEDICARE CHOICE.**

6 (a) IN GENERAL.—Section 1876 of the Social Secu-  
7 rity Act (42 U.S.C. 1395mm) is amended to read as fol-  
8 lows:

9 “MEDICARE CHOICE

10 “SEC. 1876. (a) ESTABLISHMENT OF MEDICARE  
11 MARKET AREAS.—The Secretary shall establish various  
12 medicare market areas within the United States in such  
13 manner as to—

14 “(1) ensure that each individual entitled to ben-  
15 efits under part A and enrolled under part B, or en-  
16 rolled under part B only, resides in a medicare mar-  
17 ket area;

18 “(2) maintain all portions of each metropolitan  
19 statistical area within one medicare market area;  
20 and

21 “(3) maximize the number of such individuals  
22 who will have the opportunity for a meaningful  
23 choice among competing medicare health plans  
24 under contract with the Secretary under this section.

25 “(b) MEDICARE HEALTH PLANS.—

1           “(1) CONTRACTS WITH MEDICARE HEALTH  
2 PLANS.—The Secretary shall enter into a contract  
3 with any medicare health plan desiring to do busi-  
4 ness in a medicare market area and to receive pay-  
5 ment under this section, but only if the Secretary  
6 certifies that such plan meets the requirements of  
7 paragraph (2).

8           “(2) CERTIFICATION REQUIREMENTS.—Each  
9 medicare health plan must—

10           “(A) be certified as an accountable health  
11 plan by the appropriate regulatory authority  
12 pursuant to title I of the Health Care Reform  
13 Act of 1994;

14           “(B) except as provided in paragraph (3),  
15 provide those services covered by this title  
16 (hereafter in this section referred to as ‘medi-  
17 care benefits’) when medically necessary for a  
18 uniform monthly premium for a year;

19           “(C) not discriminate against beneficiaries  
20 based on their health status, claims experience,  
21 medical history, or other factors that are gen-  
22 erally related with utilization of health care  
23 services;

24           “(D) demonstrate the ability to provide  
25 medicare benefits to all potential enrollees

1 throughout the medicare market area, unless  
2 the Secretary determines it appropriate for such  
3 plan to provide services to a subset of such  
4 market area;

5 “(E) collect and provide such standard in-  
6 formation as the Secretary shall prescribe by  
7 regulation as necessary to evaluate the perform-  
8 ance and quality of such plan, including en-  
9 rollee satisfaction, to compare such performance  
10 and quality with competing plans, and to pre-  
11 pare comparative materials for distribution to  
12 beneficiaries;

13 “(F) demonstrate the ability to integrate  
14 additional benefits into such plan for qualified  
15 medicare beneficiaries as provided in section  
16 321 of the Health Care Reform Act of 1994;  
17 and

18 “(G) offer the supplementary coverage  
19 plans established by the Secretary under sub-  
20 section (g)(3)(B).

21 “(3) COST SHARING.—

22 “(A) ACTUARIALLY EQUIVALENT MEDI-  
23 CARE BENEFITS.—Each medicare health plan  
24 must offer either—

1           “(i) medicare benefits, including the  
2           cost-sharing requirements otherwise pro-  
3           vided in this title; or

4           “(ii) actuarially equivalent medicare  
5           benefits, as established by the Secretary in  
6           regulations, which are medicare benefits,  
7           but with cost-sharing requirements that  
8           are actuarially equivalent to the cost-shar-  
9           ing requirements otherwise provided in this  
10          title and consistent with common practices  
11          among health maintenance organizations  
12          and other managed care health plans.

13          In establishing actuarially equivalent medicare  
14          benefits, the Secretary shall not include in the  
15          calculation any change in costs associated with  
16          alternative forms of health care delivery, man-  
17          agement, or utilization control.

18          “(B) OUT-OF-NETWORK COST SHARING.—  
19          Each medicare health plan may require enroll-  
20          ees to pay higher cost sharing for services than  
21          is otherwise required by this title (or required  
22          in the actuarially equivalent alternative) if—

23                 “(i) the plan maintains a network of  
24                 providers for all medicare benefits that  
25                 would not require higher cost sharing; and

1                   “(ii) the plan provides enrollees with  
2                   such information.

3                   “(4) CAPACITY LIMITS.—Each medicare health  
4                   plan may apply to have limits placed on the number  
5                   of beneficiaries that may enroll in the plan in an en-  
6                   rollment period if the plan can demonstrate—

7                   “(A) that enrolling more than the limit  
8                   would impair the plan’s ability to provide serv-  
9                   ices to other enrollees; and

10                  “(B) enrollment in the plan is on a first-  
11                  come first-served basis, except for individuals  
12                  enrolled in the prior year.

13                  “(c) EMPLOYER-SPONSORED HEALTH PLANS.—

14                  “(1) CRITERIA FOR CERTIFICATION.—The Sec-  
15                  retary shall prescribe, by regulation, criteria for cer-  
16                  tifying medicare health plans sponsored by employ-  
17                  ers which will be offered only to current or former  
18                  employees, including requirements that such health  
19                  plans—

20                  “(A) are certified as accountable health  
21                  plans pursuant to title I of the Health Care Re-  
22                  form Act of 1994;

23                  “(B) provide benefits that cover at least  
24                  those services covered by this title at a premium  
25                  for the enrollee that does not exceed the base

1 beneficiary premium (as defined pursuant to  
2 subsection (f)); and

3 “(C) are available to all eligible current  
4 and former employees in the medicare market  
5 area.

6 “(2) SECONDARY PAYER COVERAGE.—To be  
7 certified under paragraph (1), employer-sponsored  
8 health plans shall accept, at the option of individuals  
9 eligible only for secondary coverage under this title  
10 pursuant to section 1862(b), a fixed monthly pay-  
11 ment from the Secretary to provide such individuals  
12 coverage at least actuarially equivalent to the sec-  
13 ondary coverage available to such individuals under  
14 this title.

15 “(d) MANAGING MEDICARE CHOICE.—

16 “(1) MEDICARE HEALTH PLAN TOTAL MONTH-  
17 LY PREMIUMS.—Before the beginning of each cal-  
18 endar year, each medicare health plan or employer-  
19 sponsored health plan under contract pursuant to  
20 subsection (b) or (c) shall submit to the Secretary  
21 the total monthly premium that such plan intends to  
22 charge in such year.

23 “(2) ANNUAL OPEN ENROLLMENT.—

24 “(A) IN GENERAL.—The Secretary shall  
25 provide for an annual open enrollment period

1 during which all individuals entitled to benefits  
2 under part A and enrolled under part B, or en-  
3 rolled under part B only, residing in a medicare  
4 market area—

5 “(i) shall choose enrollment for the  
6 next calendar year in—

7 “(I) a medicare health plan in  
8 such area,

9 “(II) an employer-sponsored  
10 health plan, or

11 “(III) coverage otherwise pro-  
12 vided under this title (hereafter in this  
13 section referred to as ‘medicare fee-  
14 for-service’); and

15 “(ii) may choose supplementary bene-  
16 fits offered by such health plan or a medi-  
17 care supplemental policy (certified under  
18 section 1882).

19 “(B) SECONDARY PAYER.—Individuals who  
20 are eligible for secondary coverage under this  
21 title pursuant to section 1862(b), may not en-  
22 roll in a medicare health plan but may enroll in  
23 an employer-sponsored health plan, to which the  
24 Secretary shall make a monthly payment, pur-  
25 suant to subsection (e)(2)(C).

1 “(C) PERIOD OF ENROLLMENT.—

2 “(i) IN GENERAL.—Except as pro-  
3 vided in clauses (ii), (iii), and (iv), an indi-  
4 vidual may not choose another enrollment  
5 until the next annual period provided  
6 under subparagraph (A).

7 “(ii) ENROLLMENT UPON ELIGI-  
8 BILITY.—The Secretary shall provide an  
9 enrollment period of 30 days to any indi-  
10 vidual beginning 30 days before the date  
11 such individual first becomes entitled to  
12 benefits under part A or enrolled under  
13 part B only. Such enrollment shall be ef-  
14 fective on the date of such entitlement.

15 “(iii) TERMINATION OF PLAN.—If a  
16 contract for a medicare health plan under  
17 this section is terminated during any cal-  
18 endar year, the Secretary shall provide for  
19 an enrollment period of 30 days to any in-  
20 dividual enrolled in such plan beginning on  
21 the date of such termination.

22 “(iv) INDIVIDUAL NO LONGER IN  
23 AREA.—An individual terminating resi-  
24 dence in a medicare market area may ter-  
25 minate enrollment with the medicare

1 health plan of such area as of the begin-  
2 ning of the first calendar month following  
3 the date on which the request is made for  
4 such termination, and the Secretary shall  
5 provide for an open enrollment period of  
6 30 days to such individual for enrollment  
7 in the new medicare market area in which  
8 such individual resides beginning on the  
9 date of such termination. In the case of an  
10 individual's termination of enrollment, the  
11 medicare health plan shall provide the indi-  
12 vidual with a copy of the written request  
13 for termination of enrollment and a written  
14 explanation of the period (ending on the  
15 effective date of the termination) during  
16 which the individual continues to be en-  
17 rolled with the plan and may not receive  
18 medicare benefits other than through such  
19 plan.

20 “(v) EFFECTIVE DATE OF NEW EN-  
21 ROLLMENT.—Enrollment under clause (iii)  
22 or (iv) shall be effective 30 days after the  
23 end of the enrollment period, or, if the  
24 Secretary determines that such date is not

1 feasible, such other date as the Secretary  
2 specifies.

3 “(D) DEFAULT ENROLLMENT.—

4 “(i) IN GENERAL.—If an individual  
5 does not choose an enrollment option dur-  
6 ing an enrollment period under this para-  
7 graph, such individual shall be automati-  
8 cally enrolled in—

9 “(I) the same option into which  
10 such individual enrolled in the preced-  
11 ing enrollment period; or

12 “(II) if the individual was not en-  
13 rolled in such preceding period, the  
14 medicare fee-for-service.

15 “(ii) NO MEDICARE HEALTH PLANS IN  
16 AREA.—If there are no medicare health  
17 plans in the medicare market area in  
18 which the individual resides, such individ-  
19 ual shall be automatically enrolled in the  
20 medicare fee-for-service.

21 “(3) INFORMATION REGARDING MEDICARE OP-  
22 TIONS IN MARKET AREA.—

23 “(A) IN GENERAL.—The Secretary shall  
24 provide each individual making an enrollment  
25 decision during any enrollment period described

1 in paragraph (2) with the following information,  
2 in comparative form, regarding the medicare  
3 health plans and medicare fee-for-service avail-  
4 able in the medicare market area in which such  
5 individual resides:

6 “(i) The individual’s premiums for  
7 medicare benefits.

8 “(ii) The individual’s premiums for  
9 any supplementary benefits.

10 “(iii) Enrollee restrictions.

11 “(iv) Quality information, including  
12 enrollee satisfaction and health outcomes.

13 “(v) Any other necessary information  
14 as determined by the Secretary.

15 “(B) MARKETING REQUIREMENTS.—The  
16 Secretary shall prescribe the procedures and  
17 conditions under which a medicare health plan  
18 that has entered into a contract with the Sec-  
19 retary under this section may inform individ-  
20 uals eligible to enroll under this section with the  
21 plan about the plan. No brochures, application  
22 forms, or other promotional or informational  
23 material may be distributed by such plan to (or  
24 for the use of) individuals eligible to enroll with  
25 the plan under this section unless—

1           “(i) at least 45 days before its dis-  
2           tribution, the plan has submitted the mate-  
3           rial to the Secretary for review;

4           “(ii) the material is made available to  
5           all individuals eligible to enroll in the medi-  
6           care health plan in the medicare market  
7           area; and

8           “(iii) the Secretary has not dis-  
9           approved the distribution of the material.

10          The Secretary shall review all such material  
11          submitted and shall disapprove such material if  
12          the Secretary determines, in the Secretary’s dis-  
13          cretion, that the material is materially inac-  
14          curate or misleading or otherwise makes a ma-  
15          terial misrepresentation.

16          “(4) RISK ADJUSTMENTS.—

17                 “(A) IN GENERAL.—The Secretary shall  
18          adjust the payments made to medicare health  
19          plans and employer-sponsored health plans  
20          under this title to reflect the relative health  
21          risks of classes of beneficiaries enrolled in such  
22          plans in the medicare market area. The Sec-  
23          retary may define appropriate classes of bene-  
24          ficiaries, based on age, disability status, and  
25          such other factors as the Secretary determines

1 to be appropriate, so as to ensure actuarial  
2 equivalence and the efficient delivery of health  
3 care. The Secretary may add to, modify, or sub-  
4 stitute for such classes, if such changes will im-  
5 prove the determination of actuarial equiva-  
6 lence.

7 “(B) PENALTIES FOR DISCRIMINATION.—  
8 The Secretary shall have the authority to im-  
9 pose financial penalties on medicare health  
10 plans or employer-sponsored health plans that  
11 knowingly violate the prohibition against dis-  
12 crimination against potential enrollees based on  
13 their health status, claims experience, medical  
14 history, or other factors that are generally re-  
15 lated with utilization of health care services.

16 “(5) PAYMENTS TO PLANS.—

17 “(A) IN GENERAL.—The Secretary shall  
18 forward to each medicare health plan or em-  
19 ployer-sponsored health plan the medicare per  
20 capita rate for the medicare market area, as de-  
21 termined under subsection (e), for every bene-  
22 ficiary enrolled in such plan for that month, ex-  
23 cluding any beneficiary premium but reflecting  
24 any adjustments required pursuant to para-  
25 graph (4)(A).

1           “(B) COLLECTION OF BENEFICIARY PRE-  
2           MIUMS AND REBATES.—

3           “(i) PREMIUMS.—Each medicare  
4           health plan or employer-sponsored plan  
5           shall be responsible for collecting pre-  
6           miums owed by beneficiaries for enrolling  
7           in such plan, including premiums for medi-  
8           care benefits and any supplementary bene-  
9           fits.

10          “(ii) REBATES.—Any medicare health  
11          plan or employer-sponsored plan which  
12          charges a total monthly premium which is  
13          less than the medicare per capita rate for  
14          an enrollee shall be responsible for paying  
15          to such enrollee a rebate equal to the ex-  
16          cess medicare per capita rate or may use  
17          such rebate to offset any premium owed by  
18          the enrollee for any supplementary benefits  
19          selected by the enrollee.

20          “(C) SOURCE OF PAYMENT.—The amounts  
21          paid to medicare health plans and employer-  
22          sponsored health plans shall be made from the  
23          Federal Hospital Insurance Trust Fund and  
24          the Supplementary Insurance Trust Fund

1 based on an allocation determined by the Sec-  
2 retary.

3 “(e) MEDICARE PER CAPITA RATE.—

4 “(1) ANNOUNCEMENT.—With respect to each  
5 medicare market area, the Secretary shall announce,  
6 not later than October 1 (beginning with 1995) the  
7 per capita rate that will apply to such market area  
8 beginning with the enrollment year (which coincides  
9 with the next calendar year).

10 “(2) PER CAPITA RATE.—

11 “(A) IN GENERAL.—Except as provided in  
12 subparagraphs (B) and (C), the per capita rate  
13 for a medicare market area shall be equal to  
14 the lesser of the maximum per capita rate or  
15 the sum of—

16 “(i) the excess of—

17 “(I) the benchmark premium for  
18 such area, over

19 “(II) the base beneficiary pre-  
20 mium for such area; and

21 “(ii) the applicable percentage of the  
22 excess of—

23 “(I) the fee-for-service per capita  
24 costs (hereafter in this section re-

1                   ferred to as ‘FFSPCC’) for such area,  
 2                   over

3                   “(II) such benchmark premium.

4                   For purposes of the preceding sentence, the ap-  
 5                   plicable percentage shall be determined by the  
 6                   following table:

<b>“Enrollment year:</b>	<b>Applicable percentage:</b>
1996 .....	90
1997 .....	80
1998 .....	70
1999 .....	60
2000 and thereafter .....	50.

7                   “(B) SECONDARY PAYER PER CAPITA  
 8                   RATE.—For individuals who are eligible for sec-  
 9                   ondary coverage under this title pursuant to  
 10                  section 1862(b) and elect to enroll in an em-  
 11                  ployer-sponsored health plan, the Secretary  
 12                  shall determine a per capita rate for each medi-  
 13                  care market area equal to the costs of providing  
 14                  secondary coverage to all individuals in such  
 15                  market area divided by the number of individ-  
 16                  uals eligible for such coverage in such market  
 17                  area.

18                  “(C) RURAL ENROLLEES.—

19                  “(i) FIVE-YEAR BONUS.—For enroll-  
 20                  ment periods beginning in 1996 through  
 21                  2000, the per capita rate in each medicare  
 22                  market area (otherwise determined under

1 this paragraph) shall be increased by 10  
2 percent (without regard to the maximum  
3 established under paragraph (3)) with re-  
4 spect to each individual enrolling in a med-  
5 icare health plan or employer-sponsored  
6 health plan who resides in an underserved  
7 rural area within such market area, as de-  
8 termined by the Secretary.

9 “(ii) IMPROVE ACCESS.—The bonus  
10 amount paid under this subparagraph shall  
11 be used by such health plans to improve  
12 access and coordinated service delivery in  
13 the underserved rural area in which the  
14 enrollee resides. The bonus amount shall  
15 not reduce the premiums owed by the en-  
16 rollee for medicare benefits or any supple-  
17 mentary coverage.

18 “(iii) STUDY AND RECOMMENDA-  
19 TIONS.—The Secretary shall report to the  
20 Congress at the end of the 5-year period  
21 described in clause (ii) on the status of  
22 health care access in underserved rural  
23 areas and shall make recommendations re-  
24 garding continuation of bonus per capita  
25 payments.

1 “(3) MAXIMUM PER CAPITA RATE.—

2 “(A) IN GENERAL.—Except as provided in  
3 subparagraph (E), the maximum per capita  
4 rate in any medicare market area shall be the  
5 excess of—

6 “(i) the product of—

7 “(I) FFSPCC in all medicare  
8 market areas, and

9 “(II) an adjustment factor for  
10 such market area; over

11 “(ii) the fee-for-service beneficiary  
12 premium required pursuant to subsection  
13 (f)(2)(B)(ii).

14 “(B) ADJUSTMENT FACTOR.—For pur-  
15 poses of subparagraph (A)(i)(II), and except as  
16 provided in subparagraph (D):

17 “(i) FFSPCC RATIO LESS THAN .8.—  
18 For medicare market areas with a  
19 FFSPCC ratio less than or equal to .8, the  
20 adjustment factor shall be .8.

21 “(ii) FFSPCC RATIO BETWEEN .8 AND  
22 .95.—For medicare market areas with a  
23 FFSPCC ratio less than .95 but greater  
24 than .8, the adjustment factor shall be the  
25 sum of .85, plus—

1 “(I) .1, multiplied by

2 “(II) the ratio of the excess of  
3 the FFSPCC ratio over .8, to .15.

4 “(iii) FFSPCC RATIO BETWEEN .95  
5 AND 1.05.—For medicare market areas  
6 with a FFSPCC ratio of at least .95 but  
7 less than 1.05, the adjustment factor shall  
8 be the FFSPCC ratio.

9 “(iv) FFSPCC RATIO BETWEEN 1.05  
10 AND 1.2.—For medicare market areas with  
11 a FFSPCC ratio of at least 1.05 but less  
12 than 1.2, the adjustment factor shall be  
13 the sum of 1.05, plus—

14 “(I) .1, multiplied by

15 “(II) the ratio of the excess of  
16 the FFSPCC ratio over 1.05, to .15.

17 “(v) FFSPCC RATIO GREATER THAN  
18 1.2.—For medicare market areas with a  
19 FFSPCC ratio greater than or equal to  
20 1.2, the adjustment factor shall be 1.2.

21 “(C) FFSPCC RATIO.—For purposes of  
22 subparagraph (B), for each medicare market  
23 area, the Secretary shall determine a FFSPCC  
24 ratio by dividing FFSPCC in such market area  
25 by FFSPCC for all medicare market areas.

1           “(D) BUDGET NEUTRALITY.—The Sec-  
2           retary shall change the adjustment factors as  
3           necessary to ensure that total spending under  
4           this title shall not exceed the level of spending  
5           that would occur if the maximum per capita  
6           rate in each medicare market area were equal  
7           to the FFSPCC in each such market area.

8           “(E) ALTERNATIVE FORMULA.—The Sec-  
9           retary may substitute an alternative formula for  
10          determining the maximum rate in each medi-  
11          care market area. Such an alternative formula  
12          shall generally conform to the pattern of adjust-  
13          ment factors specified in subparagraph (B), ex-  
14          cept that such formula shall maintain a consist-  
15          ent mathematical relationship between the ad-  
16          justment factor and the FFSPCC ratio in each  
17          such market area in a manner that achieves  
18          budget neutrality.

19          “(4) DEFINITIONS.—For purposes of this sub-  
20          section:

21                 “(A) BENCHMARK PREMIUM.—The bench-  
22                 mark premium for a medicare market area shall  
23                 be equal to the sum of—

24                         “(i) the lowest health plan total  
25                         monthly premium submitted by a medicare

1 health plan in such area for the enrollment  
 2 year; and

3 “(ii) the applicable percentage of the  
 4 excess of—

5 “(I) the average of all medicare  
 6 health plan total monthly premiums  
 7 submitted in such area, over

8 “(II) the lowest health plan total  
 9 monthly premium in such area.

10 For purposes of the preceding sentence, the ap-  
 11 plicable percentage shall be determined by the  
 12 following table:

<b>“Enrollment year:</b>	<b>Applicable percentage:</b>
1996 .....	80
1997 .....	60
1998 .....	40
1999 and thereafter .....	20.

13 “(B) FEE-FOR-SERVICE PER CAPITA  
 14 COSTS.—The Secretary shall determine  
 15 FFSPCC for a medicare market area by divid-  
 16 ing—

17 “(i) the total spending for medicare  
 18 benefits (not including beneficiary cost  
 19 sharing) for individuals who reside in such  
 20 area, who are not enrolled in a medicare  
 21 health plan or employer-sponsored health

1 plan, and who are not in secondary payer  
2 status; by

3 “(ii) the number of such individuals.

4 The Secretary shall make such other adjust-  
5 ments as may be necessary to allow an accurate  
6 comparison of FFSPCC for the medicare mar-  
7 ket area with total monthly premiums charged  
8 by medicare health plans in such area.

9 “(f) BENEFICIARY PREMIUMS.—For purposes of this  
10 section:

11 “(1) BASE BENEFICIARY PREMIUM.—The base  
12 beneficiary premium for each medicare market area  
13 shall be equal to the product of—

14 “(A) the ratio of the monthly premium de-  
15 termined under section 1839 to the national av-  
16 erage cost per beneficiary under this title in  
17 1995, as determined by the Secretary; and

18 “(B) the benchmark premium for such  
19 area.

20 “(2) MONTHLY BENEFICIARY PREMIUMS.—

21 “(A) HEALTH PLAN BENEFICIARY PRE-  
22 MIUM.—To be enrolled for coverage in a medi-  
23 care health plan during an enrollment year for  
24 medicare benefits, each beneficiary shall pay a  
25 monthly premium equal to the excess of—

1           “(i) the premium charged by the plan  
2           selected by the beneficiary; over

3           “(ii) the medicare per capita rate in  
4           the medicare market area in which the  
5           beneficiary resides.

6           “(B) FEE-FOR-SERVICE BENEFICIARY PRE-  
7           MIUM.—

8           “(i) IN GENERAL.—To be enrolled for  
9           coverage in a medicare fee-for-service in a  
10          medicare market area during an enroll-  
11          ment year for medicare benefits, each ben-  
12          eficiary shall pay a monthly premium equal  
13          to the estimated FFSPCC for the medicare  
14          market area, multiplied by the ratio deter-  
15          mined under paragraph (1)(A).

16          “(g) SUPPLEMENTARY COVERAGE PLANS.—

17                 “(1) IN GENERAL.—The Secretary shall ensure  
18                 that all supplementary coverage plans meet the re-  
19                 quirements of this subsection, in addition to any re-  
20                 quirements that may be applicable under section  
21                 1882.

22                 “(2) COORDINATION WITH MEDICARE  
23                 CHOICE.—Supplementary coverage plans may only  
24                 be offered to beneficiaries during the same annual  
25                 open enrollment period during which beneficiaries

1 select medicare coverage and must be offered to all  
2 beneficiaries in the same medicare market area for  
3 the same, uniform monthly premium during the en-  
4 rollment period.

5 “(3) STANDARD BENEFITS.—

6 “(A) IN GENERAL.—Medicare health plans  
7 may only offer standardized supplementary cov-  
8 erage plans, as established by the Secretary,  
9 after consultation with the National Association  
10 of Insurance Commissioners.

11 “(B) REQUIRED OPTIONS.—Among the  
12 standardized plans, the Secretary shall include  
13 a plan—

14 “(i) covering only outpatient prescrip-  
15 tion drugs; and

16 “(ii) which, together with medicare  
17 benefits, would resemble coverage typically  
18 offered by health maintenance organiza-  
19 tions to employer groups, including an an-  
20 nual out-of-pocket maximum beneficiary li-  
21 ability (covering coinsurance, copayments,  
22 and deductibles).

23 “(4) ONE SPONSOR.—A sponsor of supple-  
24 mentary coverage may not offer such coverage to a  
25 beneficiary selecting a medicare health plan from a

1 different sponsor, except that sponsors of supple-  
2 mentary coverage may offer such coverage to any in-  
3 dividual selecting medicare fee-for-service.

4 “(5) SURCHARGE ON CERTAIN PLANS.—Not-  
5 withstanding any other provision of this section, if  
6 an individual chooses to purchase a medicare supple-  
7 mental policy certified pursuant to section 1882 and  
8 the coverage under such policy results in increased  
9 costs to the program under this title, the monthly  
10 beneficiary premium otherwise applicable under this  
11 section shall be increased by a surcharge actuarially  
12 equivalent to such increased costs.

13 “(6) DEFINITIONS.—The term ‘supplementary  
14 coverage plan’ means any health insurance coverage  
15 offered by a medicare health plan or medicare sup-  
16 plemental policy (as defined in section 1882) that  
17 covers health care costs not covered as medicare  
18 benefits and for which the enrollee must pay a pre-  
19 mium.”.

20 (b) CONFORMING AMENDMENTS.—

21 (1) Section 1882(c) of the Social Security Act  
22 (42 U.S.C. 1395ss(c)) is amended—

23 (A) by striking “with respect to paragraph

24 (3)” and inserting “with respect to paragraphs

25 (3) and (6)”.

1 (B) by striking “and” at the end of para-  
2 graph (4),

3 (C) by striking the period at the end of  
4 paragraph (5) and inserting “; and”, and

5 (D) by adding at the end the following new  
6 paragraph:

7 “(6) agrees—

8 “(A) to offer such policy during the annual  
9 open enrollment period specified in section  
10 1876(c)(2) at a uniform monthly premium to  
11 all beneficiaries in a medicare market area es-  
12 tablished under section 1876(a); and

13 “(B) not to discriminate against bene-  
14 ficiaries based on their health status, claims ex-  
15 perience, medical history, or other factors that  
16 are generally related with utilization of health  
17 care services.”.

18 (2) Section 1882(s) of such Act (42 U.S.C.  
19 1395ss(s)) is amended—

20 (A) by striking paragraph (2),

21 (B) by striking “paragraphs (1) and (2)”  
22 in paragraph (3) and inserting “paragraph  
23 (1)”, and

24 (C) by redesignating paragraph (3) as  
25 paragraph (2).

1           (3) Section 1839(e) of such Act (42 U.S.C.  
2           1395r(e)) is amended to read as follows:

3           “(e) Notwithstanding the provisions of subsection (a),  
4           the monthly premium for each individual enrolled under  
5           this part for each month—

6                   “(1) in 1994 shall be \$41.10;

7                   “(2) in 1995 shall be \$46.10; and

8                   “(3) after December 1995 shall be an amount  
9           equal to 25 percent of the monthly actuarial rate for  
10          enrollees age 65 and over, as determined under sub-  
11          section (a)(1) and applicable to such month.”.

12          (c) EFFECTIVE DATE.—The amendments made by  
13          this section shall apply to contracts entered into with re-  
14          spect to calendar years beginning after December 31,  
15          1995.

16          **SEC. 302. OTHER MEDICARE PROVISIONS.**

17               (a) APPLICATION OF COMPETITIVE ACQUISITION FOR  
18          FEE-FOR-SERVICE ITEMS AND SERVICES.—

19                   (1) GENERAL RULE.—Part B of title XVIII of  
20          the Social Security Act (42 U.S.C. 1395j et seq.) is  
21          amended by inserting after section 1846 the follow-  
22          ing:

23          “COMPETITIVE ACQUISITION FOR ITEMS AND SERVICES

24               “SEC. 1847. (a) ESTABLISHMENT OF BIDDING  
25          AREAS.—

1           “(1) IN GENERAL.—The Secretary shall, in  
2 each medicare market area, award a contract or con-  
3 tracts for the furnishing under this part of the items  
4 and services described in subsection (c) on or after  
5 January 1, 1996.

6           “(2) ALTERNATIVE AREAS.—The Secretary  
7 may establish areas other than medicare market  
8 areas for competitive acquisition of an item or serv-  
9 ice described in subsection (c), if the establishment  
10 of such an area increases the availability and acces-  
11 sibility of suppliers and the probability and amount  
12 of savings to be realized by the use of such competi-  
13 tive acquisition in such area.

14           “(b) AWARDING OF CONTRACTS IN AREAS.—

15           “(1) IN GENERAL.—The Secretary shall con-  
16 duct a competition among individuals and entities  
17 supplying items and services under this part for  
18 each competitive acquisition area established under  
19 subsection (a) for each class of items and services.

20           “(2) CONDITIONS FOR AWARDING CONTRACT.—  
21 The Secretary may not award a contract to any indi-  
22 vidual or entity under the competition conducted  
23 pursuant to paragraph (1) to furnish an item or  
24 service under this part unless the Secretary finds  
25 that the individual or entity—

1           “(A) meets quality standards specified by  
2           the Secretary for the furnishing of such item or  
3           service; and

4           “(B) offers to furnish a total quantity of  
5           such item or service that is sufficient to meet  
6           the expected need within the competitive acqui-  
7           sition area.

8           “(3) CONTENTS OF CONTRACT.—A contract en-  
9           tered into with an individual or entity under the  
10          competition conducted pursuant to paragraph (1)  
11          shall specify (for all of the items and services within  
12          a class)—

13                 “(A) the quantity of items and services the  
14                 entity shall provide; and

15                 “(B) such other terms and conditions as  
16                 the Secretary may require.

17          “(c) SERVICES DESCRIBED.—The items and services  
18          to which the provisions of this section shall apply are as  
19          follows:

20                 “(1) Magnetic resonance imaging tests and  
21                 computerized axial tomography scans, including a  
22                 physician’s interpretation of the results of such tests  
23                 and scans.

24                 “(2) Oxygen and oxygen equipment.

25                 “(3) Clinical diagnostic laboratory tests.

1           “(4) Such other items and services for which  
2           the Secretary determines that the use of competitive  
3           acquisition under this section will be appropriate and  
4           cost-effective.”.

5           (2) ITEMS AND SERVICES TO BE FURNISHED  
6           ONLY THROUGH COMPETITIVE ACQUISITION.—Sec-  
7           tion 1862(a) of such Act (42 U.S.C. 1395y(a)) is  
8           amended—

9                   (A) by striking “or” at the end of para-  
10                  graph (15),

11                  (B) by striking the period at the end of  
12                  paragraph (16) and inserting “; or”, and

13                  (C) by inserting after paragraph (16) the  
14                  following new paragraph:

15           “(17) where such expenses are for an item or  
16           service furnished in a competitive acquisition area  
17           (as established by the Secretary under section  
18           1847(a)) by an individual or entity other than the  
19           supplier with whom the Secretary has entered into  
20           a contract under section 1847(b) for the furnishing  
21           of such item or service in that area, unless the Sec-  
22           retary finds that such expenses were incurred in a  
23           case of urgent need.”.

24           (3) REDUCTION IN PAYMENT AMOUNTS IF COM-  
25           PETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM

1 REDUCTION IN PAYMENTS.—Notwithstanding any  
2 other provision of title XVIII of the Social Security  
3 Act (42 U.S.C. 1395 et seq.), if the establishment  
4 of competitive acquisition areas under section 1847  
5 of such Act (as added by paragraph (1)) and the  
6 limitation of coverage for items and services under  
7 part B of such title (42 U.S.C. 1395j et seq.) to  
8 items and services furnished by providers with com-  
9 petitive acquisition contracts under such section does  
10 not result in a reduction of at least 10 percent in  
11 the projected payment amount that would have ap-  
12 plied to the item or service under such part B if the  
13 item or service had not been furnished through com-  
14 petitive acquisition under such section, the Secretary  
15 shall reduce the payment amount by such percentage  
16 as the Secretary determines necessary to result in  
17 such a reduction.

18 (4) EFFECTIVE DATE.—The amendments made  
19 by this subsection shall apply to items and services  
20 furnished under part B of title XVIII of the Social  
21 Security Act (42 U.S.C. 1395j et seq.) on or after  
22 January 1, 1995.

23 (b) EXPANSION OF CENTERS OF EXCELLENCE.—

24 (1) IN GENERAL.—The Secretary shall use a  
25 competitive process to contract with centers of excel-

1 lence for cataract surgery, coronary artery by-pass  
2 surgery, and such other services as the Secretary de-  
3 termines to be appropriate for individuals enrolled in  
4 medicare fee-for-service. Payment under title XVIII  
5 of the Social Security Act (42 U.S.C. 1395 et seq.)  
6 will be made for services subject to such contracts  
7 on the basis of negotiated or all-inclusive rates as  
8 follows:

9 (A) The center shall cover services pro-  
10 vided in a medicare market area (established  
11 pursuant to section 1876(a) of the Social Secu-  
12 rity Act) for years beginning with fiscal year  
13 1996.

14 (B) The amount of payment made by the  
15 Secretary to the center under title XVIII of the  
16 Social Security Act (42 U.S.C. et seq.) for serv-  
17 ices covered under the project shall be less than  
18 the aggregate amount of the payments that the  
19 Secretary would have made to the center for  
20 such services had the project not been in effect.

21 (C) The Secretary shall make payments to  
22 the center on such a basis for the following  
23 services furnished to individuals enrolled in  
24 medicare fee-for-service and entitled to benefits  
25 under such title:

1 (i) Facility, professional, and related  
2 services relating to cataract surgery.

3 (ii) Coronary artery by-pass surgery  
4 and related services.

5 (iii) Such other services as the Sec-  
6 retary and the center may agree to cover  
7 under the agreement.

8 (2) REBATE OF PORTION OF SAVINGS.—In the  
9 case of any services provided under a demonstration  
10 project conducted under paragraph (1), the Sec-  
11 retary shall make a payment to each individual to  
12 whom such services are furnished (at such time and  
13 in such manner as the Secretary may provide) in an  
14 amount equal to 10 percent of the amount by  
15 which—

16 (A) the amount of payment that would  
17 have been made by the Secretary under title  
18 XVIII of the Social Security Act (42 U.S.C.  
19 1395 et seq.) to the center for such services if  
20 the services had not been provided under the  
21 project, exceeds

22 (B) the amount of payment made by the  
23 Secretary under such title to the center for such  
24 services.

25 (c) MEDICARE SECONDARY PAYER CHANGES.—

1 (1) EXTENSION OF DATA MATCH.—

2 (A) Section 1862(b)(5)(C) of the Social  
3 Security Act (42 U.S.C. 1395y(b)(5)(C)) is  
4 amended by striking clause (iii).

5 (B) Section 6103(l)(12) of the Internal  
6 Revenue Code of 1986 is amended by striking  
7 subparagraph (F).

8 (2) REPEAL OF SUNSET ON APPLICATION TO  
9 DISABLED EMPLOYEES OF EMPLOYERS WITH MORE  
10 THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii)  
11 of such Act (42 U.S.C. 1395y(b)(1)(B)(iii)), as  
12 amended by section 13561(b) of the Omnibus Budg-  
13 et Reconciliation Act of 1993, is amended—

14 (A) in the heading, by striking “SUNSET”  
15 and inserting “EFFECTIVE DATE”, and

16 (B) by striking “, and before October 1,  
17 1998”.

18 (3) EXTENSION OF PERIOD FOR END STAGE  
19 RENAL DISEASE BENEFICIARIES.—Section  
20 1862(b)(1)(C) of such Act (42 U.S.C.  
21 1395y(b)(1)(C)), as amended by section 13561(c) of  
22 the Omnibus Budget Reconciliation Act of 1993, is  
23 amended in the second sentence by striking “and on  
24 or before October 1, 1998,”.

1 (d) REDUCTION IN UPDATE FOR INPATIENT HOS-  
2 PITAL SERVICES.—Section 1886(b)(3)(B)(i) of the Social  
3 Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended  
4 by section 13501(a)(1) of the Omnibus Budget Reconcili-  
5 ation Act of 1993, is amended—

6 (1) in subclause (XII)—

7 (A) by striking “fiscal year 1997” and in-  
8 serting “for each of the fiscal years 1997  
9 through 2000”, and

10 (B) by striking “0.5 percentage point” and  
11 inserting “2.0 percentage points”; and

12 (2) in subclause (XIII), by striking “fiscal year  
13 1998” and inserting “fiscal year 2003”.

14 (e) REDUCTION IN ADJUSTMENT FOR INDIRECT  
15 MEDICAL EDUCATION.—

16 (1) IN GENERAL.—Section 1886(d)(5)(B)(ii) of  
17 the Social Security Act (42 U.S.C.  
18 1395ww(d)(5)(B)(ii)) is amended to read as follows:

19 “(ii) For purposes of clause (i)(II), the indirect  
20 teaching adjustment factor is equal to  $c * (((1+r)$   
21  $\text{to the } n\text{th power}) - 1)$ , where ‘r’ is the ratio of the  
22 hospital’s full-time equivalent interns and residents  
23 to beds and ‘n’ equals .405. For discharges occur-  
24 ring on or after—

1           “(I) May 1, 1986, and before October 1,  
2           1995, ‘c’ is equal to 1.89, and

3           “(II) October 1, 1995, ‘c’ is equal to  
4           0.74.”.

5           (2) NO RESTANDARDIZATION OF PAYMENT  
6           AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) of  
7           such Act (42 U.S.C. 1395ww(d)(2)(C)(i)) is amend-  
8           ed by striking “of 1985” and inserting “of 1985,  
9           but not taking into account the amendments made  
10          by section 302(e)(1) of the Health Care Reform Act  
11          of 1994”.

12          (f) ELIMINATION OF BAD DEBT RECOGNITION FOR  
13          HOSPITAL SERVICES.—

14               (1) IN GENERAL.—Effective October 1, 1995,  
15               in making any payment to hospitals under title  
16               XVIII of the Social Security Act (42 U.S.C. 1395 et  
17               seq.), the Secretary shall discontinue payments  
18               under title XVIII of such Act to providers of service  
19               for reasonable costs relating to unrecovered costs as-  
20               sociated with unpaid deductible and coinsurance  
21               amounts incurred under such title.

22               (2) CONFORMING AMENDMENTS.—

23                       (A) IN GENERAL.—(i) Subsection (c) of  
24                       section 4008 of the Omnibus Budget Reconcili-  
25                       ation Act of 1987 is repealed.

1           (ii) Section 1833 of the Social Security Act  
2           (42 U.S.C. 1395l) is amended—

3                   (I) in subsection (l)(5), by striking  
4                   subparagraph (C), and

5                   (II) in subsection (r), by striking  
6                   paragraph (4).

7           (B) EFFECTIVE DATE.—The amendments  
8           made by subparagraph (A) shall take effect on  
9           October 1, 1995.

10          (g) EXTENSION OF FREEZE ON UPDATES TO ROU-  
11          TINE SERVICE COSTS OF SKILLED NURSING FACILI-  
12          TIES.—

13                   (1) PAYMENTS BASED ON COST LIMITS.—Sec-  
14                   tion 1888(a) of the Social Security Act (42 U.S.C.  
15                   1395yy(a)) is amended by striking “112 percent”  
16                   each place it appears and inserting “100 percent  
17                   (adjusted by such amount as the Secretary deter-  
18                   mines to be necessary to preserve the savings result-  
19                   ing from the enactment of section 13503(a)(1) of  
20                   the Omnibus Budget Reconciliation Act of 1993)”.

21                   (2) PAYMENTS DETERMINED ON PROSPECTIVE  
22                   BASIS.—Section 1888(d)(2)(B) of such Act (42  
23                   U.S.C. 1395yy(d)(2)(B)) is amended by striking  
24                   “105 percent” and inserting “100 percent (adjusted  
25                   by such amount as the Secretary determines to be

1 necessary to preserve the savings resulting from the  
2 enactment of section 13503(b) of the Omnibus  
3 Budget Reconciliation Act of 1993”.

4 (3) EFFECTIVE DATE.—The amendments made  
5 by paragraphs (1) and (2) shall apply to cost report-  
6 ing periods beginning on or after October 1, 1995.

7 (h) ESTABLISHMENT OF CUMULATIVE EXPENDI-  
8 TURE GOALS FOR PHYSICIAN SERVICES.—

9 (1) USE OF CUMULATIVE PERFORMANCE  
10 STANDARD.—Section 1848(f)(2) of the Social Secu-  
11 rity Act (42 U.S.C. 1395w-4(f)(2)) is amended—

12 (A) in subparagraph (A)—

13 (i) in the heading, by striking “IN  
14 GENERAL” and inserting “FISCAL YEARS  
15 1991 THROUGH 1994.—”,

16 (ii) in the matter preceding clause (i),  
17 by striking “a fiscal year (beginning with  
18 fiscal year 1991)” and inserting “fiscal  
19 years 1991, 1992, 1993, and 1994”, and

20 (iii) in the matter following clause  
21 (iv), by striking “subparagraph (B)” and  
22 inserting “subparagraph (C)”;

23 (B) in subparagraph (B), by striking “sub-  
24 paragraph (A)” and inserting “subparagraphs  
25 (A) and (B)”;

1 (C) by redesignating subparagraphs (B)  
2 and (C) as subparagraphs (C) and (D); and

3 (D) by inserting after subparagraph (A)  
4 the following new subparagraph:

5 “(B) FISCAL YEARS BEGINNING WITH FIS-  
6 CAL YEAR 1995.—Unless Congress otherwise  
7 provides, the performance standard rate of in-  
8 crease, for all physicians’ services and for each  
9 category of physicians’ services, for a fiscal year  
10 beginning with fiscal year 1995 shall be equal  
11 to the performance standard rate of increase  
12 determined under this paragraph for the pre-  
13 vious fiscal year, increased by the product of—

14 “(i) 1 plus the Secretary’s estimate of  
15 the weighted average percentage increase  
16 (divided by 100) in the fees for all physi-  
17 cians’ services or for the category of physi-  
18 cians’ services, respectively, under this part  
19 for portions of calendar years included in  
20 the fiscal year involved,

21 “(ii) 1 plus the Secretary’s estimate of  
22 the percentage increase or decrease (di-  
23 vided by 100) in the average number of in-  
24 dividuals enrolled under this part (other

1 than HMO enrollees) from the previous fis-  
2 cal year to the fiscal year involved,

3 “(iii) 1 plus the Secretary’s estimate  
4 of the average annual percentage growth  
5 (divided by 100) in volume and intensity of  
6 all physicians’ services or of the category  
7 of physicians’ services, respectively, under  
8 this part for the 5-fiscal-year period ending  
9 with the preceding fiscal year (based upon  
10 information contained in the most recent  
11 annual report made pursuant to section  
12 1841(b)(2)), and

13 “(iv) 1 plus the Secretary’s estimate  
14 of the percentage increase or decrease (di-  
15 vided by 100) in expenditures for all physi-  
16 cians’ services or of the category of physi-  
17 cians’ services, respectively, in the fiscal  
18 year (compared with the previous fiscal  
19 year) which are estimated to result from  
20 changes in law or regulations affecting the  
21 percentage increase described in clause (i)  
22 and which is not taken into account in the  
23 percentage increase described in clause (i),

1           minus 1, multiplied by 100, and reduced by the  
2           performance standard factor (specified in sub-  
3           paragraph (C)).”.

4           (2) TREATMENT OF DEFAULT UPDATE.—

5           (A) IN GENERAL.—Section 1848(d)(3)(B)  
6           of such Act (42 U.S.C. 1395w-4(d)(3)(B)) is  
7           amended—

8           (i) in clause (i)—

9           (I) in the heading, by striking  
10           “IN GENERAL” and inserting “1992  
11           THROUGH 1996”, and

12           (II) by striking “for a year” and  
13           inserting “for 1992, 1993, 1994,  
14           1995, and 1996”; and

15           (ii) by adding after clause (ii) the fol-  
16           lowing new clause:

17           “(iii) YEARS BEGINNING WITH 1997.—

18           “(I) IN GENERAL.—The update  
19           for a category of physicians’ services  
20           for a year beginning with 1997 pro-  
21           vided under subparagraph (A) shall be  
22           increased or decreased by the same  
23           percentage by which the cumulative  
24           percentage increase in actual expendi-  
25           tures for such category of physicians’

1 services for such year was less or  
2 greater, respectively, than the per-  
3 formance standard rate of increase  
4 (established under subsection (f)) for  
5 such category of services for such  
6 year.

7 “(II) CUMULATIVE PERCENTAGE  
8 INCREASE DEFINED.—In subclause  
9 (I), the ‘cumulative percentage in-  
10 crease in actual expenditures’ for a  
11 year shall be equal to the product of  
12 the adjusted increases for each year  
13 beginning with 1995 up to and includ-  
14 ing the year involved, minus 1 and  
15 multiplied by 100. In the previous  
16 sentence, the ‘adjusted increase’ for a  
17 year is equal to 1 plus the percentage  
18 increase in actual expenditures for the  
19 year.”.

20 (B) CONFORMING AMENDMENT.—Section  
21 1848(d)(3)(A)(i) of such Act (42 U.S.C.  
22 1395w-4(d)(3)(A)(i)) is amended by striking  
23 “subparagraph (B)” and inserting “subpara-  
24 graphs (B) and (C)”.

1 (i) LIMITATIONS ON PAYMENT FOR PHYSICIANS'  
2 SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDI-  
3 CAL STAFFS.—

4 (1) IN GENERAL.—

5 (A) LIMITATIONS DESCRIBED.—Part B of  
6 title XVIII of the Social Security Act (42  
7 U.S.C. 1395j et seq.), as amended by section  
8 302(a)(1), is amended by inserting after section  
9 1848 the following new section:

10 “LIMITATIONS ON PAYMENT FOR PHYSICIANS’ SERVICES  
11 FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

12 “SEC. 1849. (a) SERVICES SUBJECT TO REDUC-  
13 TION.—

14 “(1) DETERMINATION OF HOSPITAL-SPECIFIC  
15 PER ADMISSION RELATIVE VALUE.—Not later than  
16 October 1 of each year (beginning with 1997), the  
17 Secretary shall determine for each hospital—

18 “(A) the hospital-specific per admission  
19 relative value under subsection (b)(2) for the  
20 following year; and

21 “(B) whether such hospital-specific relative  
22 value is projected to exceed the allowable aver-  
23 age per admission relative value applicable to  
24 the hospital for the following year under sub-  
25 section (b)(1).

1           “(2) REDUCTION FOR SERVICES AT HOSPITALS  
2           EXCEEDING ALLOWABLE AVERAGE PER ADMISSION  
3           RELATIVE VALUE.—If the Secretary determines  
4           (under paragraph (1)) that a medical staff’s hos-  
5           pital-specific per admission relative value for a year  
6           (beginning with 1998) is projected to exceed the al-  
7           lowable average per admission relative value applica-  
8           ble to the medical staff for the year, the Secretary  
9           shall reduce (in accordance with subsection (c)) the  
10          amount of payment otherwise determined under this  
11          part for each physician’s service furnished during  
12          the year to an inpatient of the hospital by an indi-  
13          vidual who is a member of the hospital’s medical  
14          staff.

15          “(3) TIMING OF DETERMINATION; NOTICE TO  
16          HOSPITALS AND CARRIERS.—Not later than October  
17          1 of each year (beginning with 1997), the Secretary  
18          shall notify the medical executive committee of each  
19          hospital (as set forth in the Standards of the Joint  
20          Commission on the Accreditation of Health Organi-  
21          zations) of the determinations made with respect to  
22          the medical staff under paragraph (1).

23          “(b) DETERMINATION OF ALLOWABLE AVERAGE  
24          PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPE-  
25          CIFIC PER ADMISSION RELATIVE VALUES.—

1           “(1) ALLOWABLE AVERAGE PER ADMISSION  
2 RELATIVE VALUE.—

3           “(A) URBAN HOSPITALS.—In the case of a  
4 hospital located in an urban area, the allowable  
5 average per admission relative value established  
6 under this subsection for a year is equal to 125  
7 percent (or 120 percent for years after 1999) of  
8 the median of 1996 hospital-specific per admis-  
9 sion relative values determined under paragraph  
10 (2) for all hospital medical staffs.

11           “(B) RURAL HOSPITALS.—In the case of a  
12 hospital located in a rural area, the allowable  
13 average per admission relative value established  
14 under this subsection for 1998 and each suc-  
15 ceeding year, is equal to 140 percent of the me-  
16 dian of the 1996 hospital-specific per admission  
17 relative values determined under paragraph (2)  
18 for all hospital medical staffs.

19           “(2) HOSPITAL-SPECIFIC PER ADMISSION REL-  
20 ATIVE VALUE.—

21           “(A) IN GENERAL.—The hospital-specific  
22 per admission relative value projected for a hos-  
23 pital (other than a teaching hospital) for a cal-  
24 endar year, shall be equal to the average per  
25 admission relative value (as determined under

1 section 1848(c)(2)) for physicians' services fur-  
2 nished to inpatients of the hospital by the hos-  
3 pital's medical staff (excluding interns and resi-  
4 dents) during the second year preceding such  
5 calendar year, adjusted for variations in case-  
6 mix and disproportionate share status among  
7 hospitals (as determined by the Secretary under  
8 subparagraph (C)).

9 “(B) SPECIAL RULE FOR TEACHING HOS-  
10 PITALS.—The hospital-specific relative value  
11 projected for a teaching hospital in a calendar  
12 year shall be equal to the sum of—

13 “(i) the average per admission relative  
14 value (as determined under section  
15 1848(c)(2)) for physicians' services fur-  
16 nished to inpatients of the hospital by the  
17 hospital's medical staff (excluding interns  
18 and residents) during the second year pre-  
19 ceding such calendar year; and

20 “(ii) the equivalent per admission rel-  
21 ative value (as determined under section  
22 1848(c)(2)) for physicians' services fur-  
23 nished to inpatients of the hospital by in-  
24 terns and residents of the hospital during  
25 the second year preceding such calendar

1 year, adjusted for variations in case-mix,  
2 disproportionate share status, and teaching  
3 status among hospitals (as determined by  
4 the Secretary under subparagraph (C)).  
5 The Secretary shall determine such equiva-  
6 lent relative value unit per admission for  
7 interns and residents based on the best  
8 available data for teaching hospitals and  
9 may make such adjustment in the aggre-  
10 gate.

11 “(C) ADJUSTMENT FOR TEACHING AND  
12 DISPROPORTIONATE SHARE HOSPITALS.—The  
13 Secretary shall adjust the allowable per admis-  
14 sion relative values otherwise determined under  
15 this paragraph to take into account the needs  
16 of teaching hospitals and hospitals receiving ad-  
17 ditional payments under subparagraphs (F) and  
18 (G) of section 1886(d)(5). The adjustment for  
19 teaching status or disproportionate share shall  
20 not be less than zero.

21 “(c) AMOUNT OF REDUCTION.—The amount of pay-  
22 ment otherwise made under this part for a physician’s  
23 service that is subject to a reduction under subsection (a)  
24 during a year shall be reduced 15 percent, in the case of  
25 a service furnished by a member of the medical staff of

1 the hospital for which the Secretary determines under sub-  
2 section (a)(1) that the hospital medical staff's projected  
3 relative value per admission exceeds the allowable average  
4 per admission relative value.

5 “(d) RECONCILIATION OF REDUCTIONS BASED ON  
6 HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION  
7 WITH ACTUAL RELATIVE VALUES.—

8 “(1) DETERMINATION OF ACTUAL AVERAGE  
9 PER ADMISSION RELATIVE VALUE.—Not later than  
10 October 1 of each year (beginning with 1999), the  
11 Secretary shall determine the actual average per ad-  
12 mission relative value (as determined pursuant to  
13 section 1848(c)(2)) for the physicians' services fur-  
14 nished by members of a hospital's medical staff to  
15 inpatients of the hospital during the previous year,  
16 on the basis of claims for payment for such services  
17 that are submitted to the Secretary not later than  
18 90 days after the last day of such previous year. The  
19 actual average per admission shall be adjusted by  
20 the appropriate case-mix, disproportionate share fac-  
21 tor, and teaching factor for the hospital medical  
22 staff (as determined by the Secretary under sub-  
23 section (b)(2)(C)). Notwithstanding any other provi-  
24 sion of this title, no payment may be made under  
25 this part for any physician's service furnished by a

1 member of a hospital's medical staff to an inpatient  
2 of the hospital during a year unless the hospital sub-  
3 mits a claim to the Secretary for payment for such  
4 service not later than 90 days after the last day of  
5 the year.

6 “(2) RECONCILIATION WITH REDUCTIONS  
7 TAKEN.—In the case of a hospital for which the pay-  
8 ment amounts for physicians' services furnished by  
9 members of the hospital's medical staff to inpatients  
10 of the hospital were reduced under this section for  
11 a year—

12 “(A) if the actual average per admission  
13 relative value for such hospital's medical staff  
14 during the year (as determined by the Secretary  
15 under paragraph (1)) did not exceed the allow-  
16 able average per admission relative value appli-  
17 cable to the hospital's medical staff under sub-  
18 section (b)(1) for the year, the Secretary shall  
19 reimburse the fiduciary agent for the medical  
20 staff by the amount by which payments for  
21 such services were reduced for the year under  
22 subsection (c), including interest at an appro-  
23 priate rate determined by the Secretary;

24 “(B) if the actual average per admission  
25 relative value for such hospital's medical staff

1 during the year is less than 15 percentage  
2 points above the allowable average per admis-  
3 sion relative value applicable to the hospital's  
4 medical staff under subsection (b)(1) for the  
5 year, the Secretary shall reimburse the fidu-  
6 ciary agent for the medical staff, as a percent  
7 of the total allowed charges for physicians' serv-  
8 ices performed in such hospital (prior to the  
9 withhold), the difference between 15 percentage  
10 points and the actual number of percentage  
11 points that the staff exceeds the limit allowable  
12 average per admission relative value, including  
13 interest at an appropriate rate determined by  
14 the Secretary; and

15 “(C) if the actual average per admission  
16 relative value for such hospital's medical staff  
17 during the year exceeded the allowable average  
18 per admission relative value applicable to the  
19 hospital's medical staff by 15 percentage points  
20 or more, none of the withhold is paid to the fi-  
21 duciary agent for the medical staff.

22 “(3) MEDICAL EXECUTIVE COMMITTEE OF A  
23 HOSPITAL.—Each medical executive committee of a  
24 hospital whose medical staff is projected to exceed  
25 the allowable relative value per admission for a year,

1 shall have one year from the date of notification that  
2 such medical staff is projected to exceed the allow-  
3 able relative value per admission to designate a fidu-  
4 ciary agent for the medical staff to receive and dis-  
5 burse any appropriate withhold amount made by the  
6 carrier.

7 “(4) ALTERNATIVE REIMBURSEMENT TO MEM-  
8 BERS OF STAFF.—At the request of a fiduciary  
9 agent for the medical staff, if the fiduciary agent for  
10 the medical staff is owed the reimbursement de-  
11 scribed in paragraph (2)(B) for excess reductions in  
12 payments during a year, the Secretary shall make  
13 such reimbursement to the members of the hospital’s  
14 medical staff, on a pro-rata basis according to the  
15 proportion of physicians’ services furnished to inpa-  
16 tients of the hospital during the year that were fur-  
17 nished by each member of the medical staff.

18 “(e) DEFINITIONS.—In this section, the following  
19 definitions apply:

20 “(1) MEDICAL STAFF.—An individual furnish-  
21 ing a physician’s service is considered to be on the  
22 medical staff of a hospital—

23 “(A) if (in accordance with requirements  
24 for hospitals established by the Joint Commis-

1           sion on Accreditation of Health Organiza-  
2           tions)—

3                   “(i) the individual is subject to by-  
4                   laws, rules, and regulations established by  
5                   the hospital to provide a framework for the  
6                   self-governance of medical staff activities;

7                   “(ii) subject to such bylaws, rules, and  
8                   regulations, the individual has clinical  
9                   privileges granted by the hospital’s govern-  
10                  ing body; and

11                  “(iii) under such clinical privileges,  
12                  the individual may provide physicians’  
13                  services independently within the scope of  
14                  the individual’s clinical privileges, or

15                  “(B) if such physician provides at least one  
16                  service to a medicare beneficiary in such hos-  
17                  pital.

18                  “(2) RURAL AREA; URBAN AREA.—The terms  
19                  ‘rural area’ and ‘urban area’ have the meaning given  
20                  such terms under section 1886(d)(2)(D).

21                  “(3) TEACHING HOSPITAL.—The term ‘teaching  
22                  hospital’ means a hospital which has a teaching pro-  
23                  gram approved as specified in section 1861(b)(6).”.

24                  (B) CONFORMING AMENDMENTS.—(i) Sec-  
25                  tion 1833(a)(1)(N) of such Act (42 U.S.C.

1           1395l(a)(1)(N)) is amended by inserting “(sub-  
2           ject to reduction under section 1849)” after  
3           “1848(a)(1)”.

4           (ii) Section 1848(a)(1)(B) of such Act (42  
5           U.S.C. 1395w-4(a)(1)(B)) is amended by strik-  
6           ing “this subsection,” and inserting “this sub-  
7           section and section 1849,”.

8           (2) REQUIRING PHYSICIANS TO IDENTIFY HOS-  
9           PITAL AT WHICH SERVICE FURNISHED.—Section  
10          1848(g)(4)(A)(i) of such Act (42 U.S.C. 1395w-  
11          4(g)(4)(A)(i)) is amended by striking “beneficiary,”  
12          and inserting “beneficiary (and, in the case of a  
13          service furnished to an inpatient of a hospital, report  
14          the hospital identification number on such claim  
15          form),”.

16          (3) EFFECTIVE DATE.—The amendments made  
17          by this subsection shall apply to services furnished  
18          on or after January 1, 1998.

19          (j) IMPOSITION OF COINSURANCE ON LABORATORY  
20          SERVICES.—

21                 (1) IN GENERAL.—Paragraphs (1)(D) and  
22                 (2)(D) of section 1833(a) of the Social Security Act  
23                 (42 U.S.C. 1395l(a)) are each amended—

24                         (A) by striking “(or 100 percent” and all  
25                         that follows through “the first opinion))”, and

1 (B) by striking “100 percent of such nego-  
2 tiated rate” and inserting “80 percent of such  
3 negotiated rate”.

4 (2) EFFECTIVE DATE.—The amendments made  
5 by paragraph (1) shall apply to tests furnished on  
6 or after January 1, 1995.

7 (k) REDUCTION IN ROUTINE COST LIMITS FOR  
8 HOME HEALTH SERVICES.—

9 (1) REDUCTION IN UPDATE TO MAINTAIN  
10 FREEZE IN 1996.—Section 1861(v)(1)(L)(i) of the  
11 Social Security Act (42 U.S.C. 1395x(v)(1)(L)(i)) is  
12 amended—

13 (A) in subclause (II), by striking “or” at  
14 the end,

15 (B) in subclause (III), by striking “112  
16 percent,” and inserting “and before July 1,  
17 1996, 112 percent, or”, and

18 (C) by inserting after subclause (III) the  
19 following new subclause:

20 “(IV) July 1, 1996, 100 percent (adjusted by  
21 such amount as the Secretary determines to be nec-  
22 essary to preserve the savings resulting from the en-  
23 actment of section 13564(a)(1) of the Omnibus  
24 Budget Reconciliation Act of 1993),”.

1           (2) BASING LIMITS IN SUBSEQUENT YEARS ON  
2           MEDIAN OF COSTS.—

3                   (A)           IN           GENERAL.—Section  
4           1861(v)(1)(L)(i) of such Act (U.S.C.  
5           1395x(v)(1)(L)(i)), as amended by paragraph  
6           (1), is amended in the matter following  
7           subclause (IV) by striking “the mean” and in-  
8           serting “the median”.

9                   (B) EFFECTIVE DATE.—The amendment  
10           made by subparagraph (A) shall apply to cost  
11           reporting periods beginning on or after July 1,  
12           1997.

13           (l) IMPOSITION OF COPAYMENT FOR CERTAIN HOME  
14           HEALTH VISITS.—

15                   (1) IN GENERAL.—

16                   (A) PART A.—Section 1813(a) of the So-  
17           cial Security Act (42 U.S.C. 1395e(a)) is  
18           amended by adding at the end the following  
19           new paragraph:

20           “(5) The amount payable for home health services  
21           furnished to an individual under this part shall be reduced  
22           by a copayment amount equal to 10 percent of the average  
23           of all per visit costs for home health services furnished  
24           under this title determined under section 1861(v)(1)(L)  
25           (as determined by the Secretary on a prospective basis for

1 services furnished during a calendar year), unless such  
2 services were furnished to the individual during the 30-  
3 day period that begins on the date the individual is dis-  
4 charged as an inpatient from a hospital.”.

5 (B) PART B.—Section 1833(a)(2) of such  
6 Act (42 U.S.C. 1395l(a)(2)) is amended—

7 (i) in subparagraph (A), by striking  
8 “to home health services,” and by striking  
9 the comma after “opinion”),

10 (ii) in subparagraph (D), by striking  
11 “and” at the end,

12 (iii) in subparagraph (E), by striking  
13 the semicolon at the end and inserting “;  
14 and”, and

15 (iv) by adding at the end the following  
16 new subparagraph:

17 “(F) with respect to home health serv-  
18 ices—

19 “(i) the lesser of —

20 “(I) the reasonable cost of such  
21 services, as determined under section  
22 1861(v), or

23 “(II) the customary charges with  
24 respect to such services,

1 less the amount a provider may charge as  
2 described in clause (ii) of section  
3 1866(a)(2)(A),

4 “(ii) if such services are furnished by  
5 a public provider of services, or by another  
6 provider which demonstrates to the satis-  
7 faction of the Secretary that a significant  
8 portion of its patients are low income (and  
9 requests that payment be made under this  
10 clause), free of charge or at nominal  
11 charges to the public, the amount deter-  
12 mined in accordance with section  
13 1814(b)(2), or

14 “(iii) if (and for so long as) the condi-  
15 tions described in section 1814(b)(3) are  
16 met, the amounts determined under the re-  
17 imbursement system described in such sec-  
18 tion,

19 less a copayment amount equal to 10 percent of  
20 the average of all per visit costs for home  
21 health services furnished under this title deter-  
22 mined under section 1861(v)(1)(L) (as deter-  
23 mined by the Secretary on a prospective basis  
24 for services furnished during a calendar year),  
25 unless such services were furnished to the indi-

1           vidual during the 30-day period that begins on  
2           the date the individual is discharged as an inpa-  
3           tient from a hospital;”.

4           (C)       PROVIDER        CHARGES.—Section  
5           1866(a)(2)(A)(i) of such Act (42 U.S.C.  
6           1395cc(a)(2)(A)(i)) is amended—

7                   (i) by striking “deduction or coinsur-  
8                   ance” and inserting “deduction, coinsur-  
9                   ance, or copayment”, and

10                   (ii) by striking “or (a)(4)” and insert-  
11                   ing “(a)(4), or (a)(5)”.

12           (2) EFFECTIVE DATE.—The amendments made  
13           by paragraph (1) shall apply to home health services  
14           furnished on or after July 1, 1995.

15           (m) REDUCTION IN HOSPITAL OUTPATIENT SERV-  
16           ICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAY-  
17           MENT SYSTEM.—

18           (1) IN GENERAL.—Section 1833(a)(2)(B) of the  
19           Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is  
20           amended by striking “section 1886)—” and all that  
21           follows and inserting the following: “section 1886),  
22           an amount equal to a prospectively determined pay-  
23           ment rate established by the Secretary that provides  
24           for payments for such items and services to be based  
25           upon a national rate adjusted to take into account

1 the relative costs of furnishing such items and serv-  
 2 ices in various geographic areas, except that for  
 3 items and services furnished during cost reporting  
 4 periods (or portions thereof) in years beginning with  
 5 1995, such amount shall be equal to 90 percent of  
 6 the amount that would otherwise have been deter-  
 7 mined;”.

8 (2) ESTABLISHMENT OF PROSPECTIVE PAY-  
 9 MENT SYSTEM.—Not later than July 1, 1995, the  
 10 Secretary shall establish the prospective payment  
 11 system for hospital outpatient services necessary to  
 12 carry out section 1833(a)(2)(B) of the Social Secu-  
 13 rity Act (as amended by paragraph (1)).

14 (3) EFFECTIVE DATE.—The amendment made  
 15 by paragraph (1) shall apply to items and services  
 16 furnished on or after July 1, 1995.

17 **SEC. 303. INCOME-TESTED MEDICARE PREMIUMS.**

18 (a) IN GENERAL.—Subchapter A of chapter 1 of the  
 19 Internal Revenue Code of 1986 (relating to determination  
 20 of tax liability) is amended by adding at the end the fol-  
 21 lowing new part:

22 **“PART VIII—CERTAIN MEDICARE SUBSIDIES**  
 23 **RECEIVED BY HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Recapture of certain medicare subsidies.

1 **“SEC. 59B. RECAPTURE OF CERTAIN MEDICARE SUBSIDIES.**

2       “(a) IMPOSITION OF RECAPTURE AMOUNT.—In the  
3 case of an individual, if the modified adjusted gross in-  
4 come of the taxpayer for the taxable year exceeds the  
5 threshold amount, such taxpayer shall pay (in addition to  
6 any other amount imposed by this subtitle) a recapture  
7 amount for such taxable year equal to the aggregate of  
8 the Medicare recapture amounts (if any) for months dur-  
9 ing such year that a premium is paid under section 1876  
10 of the Social Security Act for the coverage of the individ-  
11 ual under such title.

12       “(b) MEDICARE RECAPTURE AMOUNT FOR  
13 MONTH.—For purposes of this section, the Medicare re-  
14 capture amount for any month is the amount equal to the  
15 excess of—

16           “(1) either—

17               “(A) the total monthly premium charged  
18               by the medicare health plan in which the indi-  
19               vidual was enrolled (as determined under sec-  
20               tion 1876(d)(1) of the Social Securty Act), or

21               “(B) the fee-for-service per capita costs (as  
22               defined in section 1876(e)(4)(B) of such Act)  
23               for individuals enrolled in medicare fee-for-serv-  
24               ice during the month in the medicare market  
25               area in which the individual was residing, over

26           “(2) the sum of—

1           “(A) the monthly beneficiary premium  
2           owed by the individual (as determined by sec-  
3           tion 1876(f)(2) of such Act), and

4           “(B) 50 percent of the benchmark pre-  
5           mium in the medicare market area in which the  
6           individual was residing (as determined under  
7           section 1876(e)(4)(A) of such Act).

8           “(c) PHASE IN OF RECAPTURE AMOUNT.—If the  
9           modified adjusted gross income of the taxpayer for any  
10          taxable year exceeds the threshold amount by less than  
11          \$25,000, the recapture amount imposed by this section for  
12          such taxable year shall be an amount which bears the  
13          same ratio to the recapture amount which would (but for  
14          this subsection) be imposed by this section for such tax-  
15          able year as such excess bears to \$25,000.

16          “(d) OTHER DEFINITIONS AND SPECIAL RULES.—  
17          For purposes of this section—

18                 “(1) THRESHOLD AMOUNT.—The term ‘thresh-  
19                 old amount’ means—

20                         “(A) except as otherwise provided in this  
21                         paragraph, \$75,000,

22                         “(B) \$100,000 in the case of a joint re-  
23                         turn, and

24                         “(C) zero in the case of a taxpayer who—

1           “(i) is married (as determined under  
2           section 7703) but does not file a joint re-  
3           turn for such year, and

4           “(ii) does not live apart from his  
5           spouse at all times during the taxable year.

6           “(2) MODIFIED ADJUSTED GROSS INCOME.—  
7           The term ‘modified adjusted gross income’ means  
8           adjusted gross income—

9           “(A) determined without regard to sections  
10           135, 911, 931, and 933, and

11           “(B) increased by the amount of interest  
12           received or accrued by the taxpayer during the  
13           taxable year which is exempt from tax.

14           “(3) JOINT RETURNS.—In the case of a joint  
15           return—

16           “(A) the recapture amount under sub-  
17           section (a) shall be the sum of the recapture  
18           amounts determined separately for each spouse,  
19           and

20           “(B) subsections (a) and (c) shall be ap-  
21           plied by taking into account the combined modi-  
22           fied adjusted gross income of the spouses.

23           “(4) COORDINATION WITH OTHER PROVI-  
24           SIONS.—

1           “(A) TREATED AS TAX FOR SUBTITLE F.—  
2           For purposes of subtitle F, the recapture  
3           amount imposed by this section shall be treated  
4           as if it were a tax imposed by section 1.

5           “(B) NOT TREATED AS TAX FOR CERTAIN  
6           PURPOSES.—The recapture amount imposed by  
7           this section shall not be treated as a tax im-  
8           posed by this chapter for purposes of determin-  
9           ing—

10                   “(i) the amount of any credit allow-  
11                   able under this chapter, or

12                   “(ii) the amount of the minimum tax  
13                   under section 55.

14           “(C) TREATED AS PAYMENT FOR MEDICAL  
15           INSURANCE.—The recapture amount imposed  
16           by this section shall be treated as an amount  
17           paid for insurance covering medical care, within  
18           the meaning of section 213(d).”.

19           (b) TRANSFERS TO MEDICARE TRUST FUNDS.—

20                   (1) IN GENERAL.—There are hereby appro-  
21                   priated to the Hospital Insurance and the Supple-  
22                   mental Medical Insurance Trust Funds amounts  
23                   equivalent to the aggregate increase in liabilities  
24                   under chapter 1 of the Internal Revenue Code of  
25                   1986 which is attributable to the application of sec-

1       tion 59B(a)(1) of such Code, as added by this sec-  
2       tion.

3           (2) TRANSFERS.—The amounts appropriated  
4       by paragraph (1) shall be transferred from time to  
5       time (but not less frequently than quarterly) from  
6       the general fund of the Treasury on the basis of es-  
7       timates made by the Secretary of the Treasury of  
8       the amounts referred to in paragraph (1), and shall  
9       be allocated between the Hospital Insurance and the  
10      Supplemental Medical Insurance Trust Funds ac-  
11      cording to a formula established by the Secretary of  
12      Health and Human Services. Any quarterly payment  
13      shall be made on the first day of such quarter and  
14      shall take into account the recapture amounts re-  
15      ferred to in such section 59B(a)(1) for such quarter.  
16      Proper adjustments shall be made in the amounts  
17      subsequently transferred to the extent prior esti-  
18      mates were in excess of or less than the amounts re-  
19      quired to be transferred.

20      (c) REPORTING REQUIREMENTS.—

21           (1) Paragraph (1) of section 6050F(a) of the  
22      Internal Revenue Code of 1986 (relating to returns  
23      relating to social security benefits) is amended by  
24      striking “and” at the end of subparagraph (B) and

1 by inserting after subparagraph (C) the following  
2 new subparagraph:

3 “(D) the number of months during the cal-  
4 endar year for which a premium was paid under  
5 section 1876 of the Social Security Act for the  
6 coverage of such individual under such part,  
7 and”.

8 (2) Paragraph (2) of section 6050F(b) of such  
9 Code (relating to statements to be furnished with re-  
10 spect to whom information is required) is amended  
11 to read as follows:

12 “(2) the information required to be shown on  
13 such return with respect to such individual.”.

14 (3) Subparagraph (A) of section 6050F(c)(1) of  
15 such Code (defining appropriate Federal official) is  
16 amended by inserting before the comma “and in the  
17 case of the information specified in subsection  
18 (a)(1)(D)”.

19 (4) The heading for section 6050F of such  
20 Code is amended by inserting “**AND MEDICARE**  
21 **COVERAGE**” before the period.

22 (5) The item relating to section 6050F in the  
23 table of sections for subpart B of part III of sub-  
24 chapter A of chapter 61 is amended by inserting  
25 “and Medicare coverage” before the period.

1 (d) WAIVER OF CERTAIN ESTIMATED TAX PEN-  
2 ALTIES.—No addition to tax shall be imposed under sec-  
3 tion 6654 of the Internal Revenue Code of 1986 (relating  
4 to failure to pay estimated income tax) for any period be-  
5 fore April 16, 1997, with respect to any underpayment  
6 to the extent that such underpayment resulted from sec-  
7 tion 59B(a) of the Internal Revenue Code of 1986, as  
8 added by this section.

9 (e) CLERICAL AMENDMENT.—The table of parts for  
10 subchapter A of chapter 1 is amended by adding at the  
11 end thereof the following new item:

“Part VIII. Certain medicare subsidies received by high-income  
individuals.”.

12 (f) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to periods after December 31,  
14 1995, in taxable years ending after such date.

15 **SEC. 304. MEDICARE ADMINISTRATIVE SIMPLIFICATION.**

16 (a) CONSOLIDATION OF PARTS A AND B.—By not  
17 later than October 1, 1995, the Secretary shall submit to  
18 the Congress a proposal to consolidate entitlement for part  
19 A of the title XVIII of the Social Security Act (42 U.S.C.  
20 1395c et seq.) and enrollment in part B of such title (42  
21 U.S.C. 1395j et seq.) into eligibility or enrollment into the  
22 entire medicare program under such title. In preparing  
23 such a proposal, the Secretary shall consider phasing in  
24 such a consolidation, and shall ensure that no beneficiary

1 shall pay higher premiums for coverage under such pro-  
2 gram than under such program as of the date of the enact-  
3 ment of this Act.

4 (b) CONSOLIDATION OF FEE-FOR-SERVICE ADMINIS-  
5 TRATION.—

6 (1) IN GENERAL.—The Secretary shall take  
7 such steps as may be necessary to consolidate the  
8 administration (including processing systems) of  
9 parts A and B of the medicare program (under title  
10 XVIII of the Social Security Act), including medi-  
11 care supplemental policies, over a 5-year period.

12 (2) COMBINATION OF INTERMEDIARY AND CAR-  
13 RIER FUNCTIONS.—In taking such steps, the Sec-  
14 retary may contract with a single entity that com-  
15 bines the fiscal intermediary and carrier functions in  
16 each area except where the Secretary finds that spe-  
17 cial regional or national contracts are appropriate.  
18 No medicare market area (established under section  
19 1876(a) of the Social Security Act) may be subject  
20 to more than 1 entity.

21 (3) STREAMLINED PROCESSING SYSTEMS.—In  
22 carrying out this subsection, the Secretary may en-  
23 sure—

1 (A) a streamlined, standardized, and  
 2 paperless process for handling all fee-for-service  
 3 claims, and

4 (B) that payments under title XVIII of the  
 5 Social Security Act (42 U.S.C. 1395 et seq.)  
 6 are made first by the medicare program and  
 7 medicare supplemental policies before providers  
 8 can bill beneficiaries for services using stand-  
 9 ardized forms.

10 (4) SUPERSEDING CONFLICTING REQUIRE-  
 11 MENTS.—The provisions of sections 1816 and 1842  
 12 of the Social Security Act (42 U.S.C. 1395h and  
 13 1395u) (including provider nominating provisions in  
 14 such section 1816) are superseded to the extent re-  
 15 quired to carry out this subsection.

16 **Subtitle B—Health Discount and**  
 17 **Medicaid Reform**

18 **PART I—HEALTH DISCOUNT**

19 **SEC. 311. STATE HEALTH DISCOUNT PROGRAMS.**

20 (a) IN GENERAL.—To be certified by the Secretary  
 21 as meeting the requirements of this Act, each State shall  
 22 include within the State health reform plan a State admin-  
 23 istered program, consistent with this subtitle and such  
 24 other requirements as determined necessary by the Sec-  
 25 retary and issued in regulations, under which eligible per-

1 sons shall receive premium assistance (hereafter in this  
2 part referred to as “health discounts”) for purchasing  
3 health care coverage from AHPs.

4 (b) CATEGORIES OF ELIGIBILITY.—Persons who oth-  
5 erwise meet the criteria for entitlement under this part  
6 shall be divided into the following categories of eligibility:

7 (1) Eligible individuals, as defined in section  
8 1(c)(3).

9 (2) Eligible employees, as defined in section  
10 1(c)(2).

11 (c) SWITCHING CATEGORIES OF ELIGIBILITY.—Indi-  
12 viduals and employees who are determined to be in 1 cat-  
13 egory of eligibility under subsection (b) but whose cir-  
14 cumstances change and cause such individuals and em-  
15 ployees to fall within the other such category shall remain  
16 in the category of eligibility in which such individuals and  
17 employees were originally placed until the next open en-  
18 rollment period under section 312(a)(2).

19 **SEC. 312. HEALTH DISCOUNT PROGRAM DESIGN.**

20 (a) ELIGIBLE INDIVIDUALS.—

21 (1) IN GENERAL.—A State health discount pro-  
22 gram shall allow each eligible individual who other-  
23 wise meets the requirements for entitlement under  
24 this part to select from among competing AHPs in  
25 the market area in which such individual resides

1 based on the price and quality of the competing  
2 AHPs and to use the discount to which such individ-  
3 ual is entitled only to offset the premium charged by  
4 the AHP for the benefits package selected by the in-  
5 dividual.

6 (2) ANNUAL OPEN ENROLLMENT.—

7 (A) IN GENERAL.—A State health discount  
8 program shall provide for an annual open en-  
9 rollment period during which each eligible indi-  
10 vidual shall choose enrollment in an AHP to  
11 which the health discount to which such individ-  
12 ual is entitled shall be paid.

13 (B) ENROLLMENT UPON ELIGIBILITY.—  
14 Eligible individuals shall have an open enroll-  
15 ment period upon becoming eligible for a health  
16 discount.

17 (C) PERIOD OF ENROLLMENT.—After se-  
18 lecting an AHP during an open enrollment pe-  
19 riod, an eligible individual may not choose an-  
20 other AHP to which a health discount may be  
21 paid until the next annual open enrollment pe-  
22 riod, except that—

23 (i) an eligible individual moving to a  
24 new market area in the State shall be pro-

1           vided with a new open enrollment period,  
2           and

3                   (ii) an eligible individual in an AHP  
4           that is terminated from the health discount  
5           program shall be provided with a new open  
6           enrollment period.

7           (3) COMPARATIVE INFORMATION ON ENROLL-  
8           MENT OPTIONS.—During an open enrollment period,  
9           a State health discount program shall provide to the  
10          individual such information as may be necessary to  
11          ensure such individual may compare the price and  
12          quality of the AHPs available in the market area, in-  
13          cluding—

14                   (A) premiums by type of benefits package  
15                  of the competing AHPs,

16                   (B) any restrictions by AHPs on enrollees'  
17                  selection or use of health care providers and  
18                  services,

19                   (C) quality information, including enrollee  
20                  satisfaction and measures of health outcomes,

21                   (D) appeal rights of enrollees, and

22                   (E) any other necessary information, as  
23                  determined by the Secretary.

24           (4) AHP BENEFITS AND PREMIUMS.—AHPs,  
25          other than AHPs offered by employers as self-in-

1       sured plans under the Employee Retirement Income  
2       Security Act of 1974 (29 U.S.C. 1001 et seq.), in  
3       order to be certified pursuant to section 112 of this  
4       Act, shall—

5               (A) agree to participate in the State health  
6       discount program and make available to eligible  
7       individuals—

8                       “(i) the standard benefits package, as  
9       determined by the Secretary pursuant to  
10      section 113(a),

11                      “(ii) the nominal cost-sharing benefits  
12      package, as determined by the Secretary  
13      pursuant to section 113(b), and

14                      “(iii) the alternative benefits package,  
15      as determined by the Secretary pursuant  
16      to section 113(c), if required pursuant to  
17      section 313, and

18               (B) submit, for each benefits package for  
19      each enrollment period, a uniform monthly pre-  
20      mium for all eligible individuals in the market  
21      area, allowing adjustments in such premium  
22      only for those factors provided in section  
23      112(d).

24               (5) DISCOUNTS.—Each eligible individual who  
25      otherwise meets the criteria for entitlement under

1 this part shall be entitled to a health discount, as  
2 determined under subsection (c).

3 (6) INDIVIDUAL PREMIUMS.—To enroll in an  
4 AHP, an eligible individual must pay a premium  
5 equal to the excess of—

6 (A) the premium charged by the AHP for  
7 the benefits package selected by the individual,  
8 over

9 (B) the discount to which the individual is  
10 entitled.

11 (7) PAYMENTS TO AHPS.—

12 (A) IN GENERAL.—A State health discount  
13 program shall collect premiums from eligible in-  
14 dividuals and forward to AHPs such premiums  
15 and health discounts to which such individuals  
16 are entitled.

17 (B) RISK ADJUSTMENT.—

18 (i) IN GENERAL.—A State health dis-  
19 count program shall adjust the health dis-  
20 counts paid to the AHPs to reflect the rel-  
21 ative health risks of classes of eligible indi-  
22 viduals choosing to enroll in such plans in  
23 a market area. The Secretary may define  
24 appropriate classes of eligible individuals,  
25 based on age, disability status, and such

1 other factors as the Secretary determines  
2 to be appropriate.

3 (ii) PENALTIES FOR DISCRIMINA-  
4 TION.—A State health discount program  
5 shall have the authority to impose financial  
6 penalties on AHPs that knowingly violate  
7 the prohibition against discrimination  
8 against potential enrollees based on their  
9 health status, claims experience, medical  
10 history, or other factors that are generally  
11 related with utilization of health care serv-  
12 ices.

13 (b) ELIGIBLE EMPLOYEES.—

14 (1) IN GENERAL.—An eligible employee who  
15 otherwise meets the criteria for entitlement under  
16 this part and is enrolled in an AHP in a market  
17 area in a State shall get a health discount which  
18 may only be used to reduce the employee's premium  
19 for enrolling in such AHP.

20 (2) DISCOUNTS.—Each eligible employee who  
21 otherwise meets the criteria for entitlement under  
22 this part shall be entitled to a health discount, as  
23 determined under subsection (c).

24 (3) PAYMENTS TO AHPS.—A State health dis-  
25 count program shall forward to AHPs such health

1 discounts to which such eligible employees are enti-  
2 tled.

3 (c) DETERMINING DISCOUNTS.—

4 (1) BENCHMARK.—

5 (A) IN GENERAL.—Each calendar year, a  
6 State health discount program shall determine  
7 benchmark monthly premiums for the calendar  
8 year for each class of family enrollment within  
9 each category of eligibility and within each mar-  
10 ket area.

11 (B) AHP BENEFITS AND PREMIUMS.—For  
12 purposes of determining discounts, AHP pre-  
13 miums shall be—

14 (i) for poor eligible individuals, those  
15 AHP premiums submitted pursuant to  
16 subsection (a)(4)(ii),

17 (ii) for low income eligible individuals,  
18 those AHP premiums submitted pursuant  
19 to subsection (a)(4)(i), or, if required by  
20 section 313, subsection (a)(4)(iii),

21 (iii) for poor eligible employees, those  
22 AHP premiums charged for the nominal  
23 cost-sharing benefits package in the small  
24 group market pursuant to section 112(d),  
25 and

1 (iv) for low income eligible employees,  
 2 those AHP premiums charged for the  
 3 standard benefits package in the small  
 4 group market pursuant to section 112(d),  
 5 except that AHPs may be required to es-  
 6 tablish separate monthly premiums for the  
 7 alternative benefits package pursuant to  
 8 section 313.

9 (C) CALCULATION.—The benchmark  
 10 monthly premium shall equal the sum of the  
 11 lowest premium charged by an AHP for the ap-  
 12 plicable benefits package plus the applicable  
 13 percentage of the excess of—

14 (i) the average of all monthly pre-  
 15 miums charged by AHPs, over

16 (ii) the lowest premium charged by an  
 17 AHP.

18 For purposes of the preceding sentence, the ap-  
 19 plicable percentage shall be determined by fol-  
 20 lowing table:

<b>Year:</b>	<b>Applicable percentage:</b>
1996 .....	80
1997 .....	60
1998 .....	40
1999 and thereafter .....	20

21 (2) POOR ELIGIBLE INDIVIDUALS AND EMPLOY-  
 22 EES.—For poor eligible individuals and poor eligible

1 employees, the amount of the discount shall be equal  
2 to the benchmark for each category of eligibility.

3 (3) LOW INCOME ELIGIBLE INDIVIDUALS AND  
4 EMPLOYEES.—For low income eligible individuals  
5 and low income eligible employees, the amount of the  
6 discount shall be equal to the benchmark for each  
7 category of eligibility multiplied by—

8 (A) 100 percent, reduced by

9 (B) each percentage point by which the eli-  
10 gible individual's or eligible employee's family  
11 adjusted total income exceeds 100 percent of  
12 the Federal poverty line.

13 (4) DEFINITIONS.—For purposes of this part:

14 (A) POOR ELIGIBLE INDIVIDUALS AND EM-  
15 PLOYEES.—The terms “poor eligible individual”  
16 and “poor eligible employee” mean an eligible  
17 individual or eligible employee with family ad-  
18 justed total income not in excess of 100 percent  
19 of the Federal poverty line.

20 (B) LOW INCOME ELIGIBLE INDIVIDUALS  
21 AND EMPLOYEES.—The terms “low income eli-  
22 gible individual” and “low income eligible em-  
23 ployee” mean an eligible individual or eligible  
24 employee with family adjusted total income ex-

1           ceeding 100 percent but not 200 percent of the  
2           Federal poverty line.

3           (C) FAMILY ADJUSTED TOTAL INCOME.—

4           (i) IN GENERAL.—The term “family  
5           adjusted total income” means, with respect  
6           to an eligible individual or eligible em-  
7           ployee, the sum of the modified total in-  
8           come for the individual or employee and all  
9           the other eligible family members.

10          (ii) MODIFIED FAMILY INCOME.—The  
11          term “modified family income” means the  
12          sum of—

13               (I) the adjusted gross income (as  
14               defined in section 62(a) of the Inter-  
15               nal Revenue Code of 1986) of the tax-  
16               payer and family members for the tax-  
17               able year determined without regard  
18               to sections 911, 931, and 933 of such  
19               Code, determined without the applica-  
20               tion of paragraphs (6) and (7) of sec-  
21               tion 62(a) of such Code and without  
22               the application of section 162(l) of  
23               such Code, plus

24               (II) the interest received or ac-  
25               crued by the taxpayer and family

1 members during such taxable year  
2 which is exempt from income, plus

3 (III) the amount of social secu-  
4 rity benefits (described in section  
5 86(d) of such Code) which is not in-  
6 cludable in gross income of the tax-  
7 payer and family members under sec-  
8 tion 86 of such Code.

9 (D) FEDERAL POVERTY LINE.—The term  
10 “Federal poverty line” means the income offi-  
11 cial poverty line as defined by the Office of  
12 Management and Budget, and revised annually  
13 in accordance with section 673(2) of the Omni-  
14 bus Budget Reconciliation Act of 1981.

15 (d) APPLICATIONS FOR HEALTH DISCOUNTS.—

16 (1) IN GENERAL.—Any individual who seeks as-  
17 sistance under this part shall submit a written appli-  
18 cation to the State health discount program.

19 (2) BASIS FOR DETERMINATION.—Subject to  
20 annual enforcement under subsection (e), health dis-  
21 counts under this part shall be based on 4 times the  
22 family adjusted total income during the 3 months  
23 preceding the month in which the application is  
24 filed.

1           (3) FORM AND CONTENTS.—An application for  
2 assistance under this part shall be in a form and  
3 manner specified by the State health discount pro-  
4 gram and shall require—

5                   (A) the provision of information necessary  
6 to make the determinations described in sub-  
7 section (b), and

8                   (B) with respect to eligible employees, the  
9 provision of information with respect to the  
10 AHP in which the employee is enrolled (or in  
11 the process of enrolling).

12           (4) VERIFICATION.—The State health discount  
13 program shall provide for verification, on a sample  
14 or other basis, of the information supplied in appli-  
15 cations under this part.

16           (5) PENALTIES FOR INACCURATE INFORMA-  
17 TION.—

18                   (A) UNDERSTATED INCOME.—A State  
19 health discount program shall require individ-  
20 uals who knowingly understate income reported  
21 in an application to pay interest on the excess  
22 health discounts paid on behalf of such individ-  
23 ual, in addition to repayment of the health dis-  
24 count.

1 (B) MISREPRESENTATION.—A State  
2 health discount program shall require individ-  
3 uals who knowingly misrepresent material infor-  
4 mation in an application for health discounts  
5 under this part to pay \$1000 or, if greater, 3  
6 times the excess health discounts paid based on  
7 such material misrepresentations.

8 (e) ANNUAL ENFORCEMENT OF HEALTH DISCOUNT  
9 ENTITLEMENT.—

10 (1) ANNUAL INCOME STATEMENT.—An individ-  
11 ual receiving health discounts under this part in any  
12 year shall file with the State health discount pro-  
13 gram, by not later than April 15 of the following  
14 year, a statement verifying total adjusted family in-  
15 come for the taxable year ending during the previous  
16 year. Such a statement shall provide information  
17 necessary to determine the family adjusted total in-  
18 come during the year and the number of family  
19 members as of the last day of the year.

20 (2) USE OF INCOME TAX RETURNS.—The State  
21 health discount program shall provide a process  
22 under which the filing of a Federal income tax re-  
23 turn shall constitute the filing of an income state-  
24 ment under paragraph (1).

1           (3) RECONCILIATION BASED ON ACTUAL AN-  
2           NUAL INCOME.—

3           (A) IN GENERAL.—Based on the informa-  
4           tion reported in the statement filed under para-  
5           graph (1), the State health discount program  
6           shall compute the annual health discount that  
7           should have been paid on behalf of the eligible  
8           individual or employee.

9           (B) RECONCILIATION.—If the health dis-  
10          count computed is—

11           (i) greater than the health discount  
12           paid, the program shall provide for pay-  
13           ment to the individual or employee an  
14           amount equal to the amount of the  
15           underpayment, or

16           (ii) less than the health discount paid,  
17           the program shall require the individual or  
18           employee to repay the excess health dis-  
19           count.

20          (4) FAILURE TO FILE.—If an individual re-  
21          quired to file an income statement under this sub-  
22          section fails to file such a statement, the State  
23          health discount program shall disqualify such indi-  
24          vidual for health discounts after May 1 of such year.  
25          The program shall waive the application of this dis-

1 qualification if there is established, to the satisfac-  
2 tion of the program, good cause for the failure to file  
3 the statement on a timely basis.

4 (5) PENALTIES.—Any individual providing false  
5 information in a statement under paragraph (1) is  
6 subject to criminal penalties to the same extent as  
7 such penalties may be imposed under section  
8 1128B(a) of the Social Security Act (42 U.S.C.  
9 1320a-7b(a)) with respect to an individual described  
10 in clause (ii) of such section.

11 (6) NOTICE.—A State health discount program  
12 shall provide for written notice each year of the re-  
13 quirement under paragraph (1) to all individuals to  
14 whom the requirement applies.

15 (7) TRANSMITTAL OF INFORMATION.—The Sec-  
16 retary of the Treasury shall transmit annually to the  
17 State such information relating to the adjusted total  
18 income of individuals for the taxable year ending in  
19 the previous year as may be necessary to verify the  
20 reconciliation of health discounts under this sub-  
21 section.

22 (f) SMALL GROUP PURCHASING POOLS.—A State  
23 may contract with small group purchasing pools to admin-  
24 ister portions of the health discount program, as appro-  
25 priate.

1 **SEC. 313. FINANCING HEALTH DISCOUNTS.**

2 (a) IN GENERAL.—Health discounts shall be financed  
3 with—

4 (1) available Federal spending,

5 (2) required State Medicaid maintenance of ef-  
6 fort spending and State matching amounts, and

7 (3) optional State supplementation.

8 (b) AVAILABLE FEDERAL SPENDING.—

9 (1) IN GENERAL.—For purposes of subsection  
10 (a), Federal spending for health discounts in a fiscal  
11 year shall be limited to the excess of—

12 (A) the amount specified in paragraph (2),  
13 over

14 (B) the estimated Federal expenditures  
15 under titles XVIII and XIX of the Social Secu-  
16 rity Act (42 U.S.C. 1395 et seq.) for such year.

17 (2) SPECIFIED AMOUNT.—For purposes of  
18 paragraph (1), the amount specified in this para-  
19 graph for fiscal year—

20 (A) 1996, is \$282,800,000,000,

21 (B) 1997, is \$311,000,000,000,

22 (C) 1998, is \$343,100,000,000,

23 (D) 1999, is \$378,800,000,000,

24 (E) 2000, is \$416,300,000,000,

25 (F) 2001, is \$449,600,000,000,

26 (G) 2002, is \$481,100,000,000,

1 (H) 2003, is \$510,000,000,000,

2 (I) 2004, is \$540,600,000,000, and

3 (J) 2005 and any succeeding fiscal year, is  
4 the specified amount under this paragraph for  
5 the previous fiscal year increased by the per-  
6 centage increase in the Gross Domestic Product  
7 for the previous fiscal year.

8 (3) LOOK BACK PROCEDURE.—The Secretary  
9 shall reduce (or increase) the amount specified in  
10 paragraph (2) for any fiscal year (beginning with  
11 1997) by the amount by which actual Federal ex-  
12 penditures for titles XVIII and XIX of the Social  
13 Security Act (42 U.S.C. 1395 et seq.) and Federal  
14 spending for health discounts for the preceding year  
15 are greater than (or less than) the amounts specified  
16 in paragraph (2) for the preceding fiscal year (deter-  
17 mined after the application of this paragraph).

18 (c) STATE SPENDING.—For purposes of subsection  
19 (a)—

20 (1) MAINTENANCE OF EFFORT.—

21 (A) IN GENERAL.—For each calendar  
22 quarter beginning after December 31, 1995, a  
23 State shall make available for the health dis-  
24 count program administered by the State under  
25 this part an amount equal to one-quarter of the

1           annual maintenance of effort amount for the  
2           State for the fiscal year in which such quarter  
3           occurs as determined under subparagraph (B).

4           (B) ANNUAL STATE MAINTENANCE OF EF-  
5           FORT AMOUNT.—

6           (i) IN GENERAL.—Except as provided  
7           in subparagraph (C), the annual mainte-  
8           nance of effort amount for any fiscal year  
9           shall equal the base maintenance of effort  
10          amount determined pursuant to clause (ii),  
11          updated by the index in clause (iii) for  
12          such fiscal year.

13          (ii) BASE AMOUNT.—For each State,  
14          the base maintenance of effort amount  
15          shall be the amount of total State expendi-  
16          tures during fiscal year 1994 under title  
17          XIX of the Social Security Act (42 U.S.C.  
18          1396 et seq.) for acute care services.

19          (iii) INDEX.—

20           (I) IN GENERAL.—The Director  
21           of the Office of Management and  
22           Budget shall determine the index by  
23           which the base amounts shall be up-  
24           dated for each fiscal year after fiscal  
25           year 1994 by determining the pro-

1           jected change from the preceding fis-  
2           cal year in medicaid acute care spend-  
3           ing (Federal and State) projected in  
4           the baseline in effect at the time of  
5           enactment of this Act.

6                   (II) OUT YEARS.—For fiscal  
7           years after the last fiscal year in the  
8           baseline projections, the index shall  
9           reflect overall change from the preced-  
10          ing fiscal year in the Gross Domestic  
11          Product.

12                   (iv) ACUTE CARE SERVICES.—For  
13          purposes of this subparagraph, the term  
14          “acute care services” means all of the care  
15          and services furnished under a State plan  
16          under title XIX of the Social Security Act  
17          (42 U.S.C. 1936 et seq.) except the follow-  
18          ing:

19                   (I) Nursing facility services (as  
20           defined in section 1905(f) of the So-  
21           cial Security Act (42 U.S.C.  
22           1396d(f))).

23                   (II) Intermediate care facility for  
24           the mentally retarded services (as de-

1            fined in section 1905(d) of such Act  
2            (42 U.S.C. 1396d(d)).

3            (III) Personal care services (as  
4            described in section 1905(a)(24) of  
5            such Act (42 U.S.C. 1396d(a)(24))).

6            (IV) Private duty nursing serv-  
7            ices (as referred to in section  
8            1905(a)(8) of such Act (42 U.S.C.  
9            1396d(a)(8))).

10           (V) Home or community-based  
11           services furnished under a waiver  
12           granted under subsection (c), (d), or  
13           (e) of section 1915 of such Act (42  
14           U.S.C. 1396n).

15           (VI) Home and community care  
16           furnished to functionally disabled el-  
17           derly individuals under section 1929  
18           of such Act (42 U.S.C. 1396t).

19           (VII) Community supported liv-  
20           ing arrangements services under sec-  
21           tion 1930 of such Act (42 U.S.C.  
22           1396v).

23           (VIII) Case-management services  
24           (as described in section 1915(g)(2) of  
25           such Act (42 U.S.C. 1396n(g)(2))).

1 (IX) Home health care services  
2 (as referred to in section 1905(a)(7)  
3 of such Act (42 U.S.C. 1396d(a)(7))).

4 (X) Hospice care (as defined in  
5 section 1905(o) of such Act (42  
6 U.S.C. 1396d(o))).

7 (C) EXCEPTION.—For fiscal years begin-  
8 ning in the first calendar year in which the an-  
9 nual health discount entitlement is the maxi-  
10 mum allowable (pursuant to subsection (d)), the  
11 State maintenance of effort amount shall be the  
12 amount for the preceding fiscal year increased  
13 by the estimated overall growth in spending for  
14 health discounts in the State as determined by  
15 the Secretary.

16 (D) ADMINISTRATIVE EXPENSES.—A State  
17 health discount program shall allocate a suffi-  
18 cient portion of State maintenance of effort  
19 spending to finance State expenses for admin-  
20 istering the program.

21 (2) STATE MATCHING AMOUNTS.—For each cal-  
22 endar quarter after December 31, 1995, each State  
23 shall be required to pay 10 percent of the excess  
24 of—

1 (A) the total costs of health discounts in a  
2 State in such quarter, over

3 (B) the amount equal to—

4 (i) the State maintenance of effort  
5 amount for such quarter, divided by

6 (ii) 1, minus the Federal medical as-  
7 sistance percentage for the State under  
8 title XIX of the Social Security Act (42  
9 U.S.C. 1396 et seq.) for such fiscal year.

10 (3) OPTIONAL STATE SUPPLEMENTATION.—A  
11 State, using State funds, may provide health dis-  
12 counts in excess of the amount that eligible individ-  
13 uals and eligible employees would otherwise be enti-  
14 tled to pursuant to subsection (d) and to eligible in-  
15 dividuals and eligible employees who would not oth-  
16 erwise be entitled to such discounts.

17 (d) DETERMINING ENTITLEMENT TO HEALTH DIS-  
18 COUNTS.—

19 (1) IN GENERAL.—At the beginning of each fis-  
20 cal year, the Secretary shall establish the level of en-  
21 titlement to health discounts for the upcoming cal-  
22 endar year by setting—

23 (A) the maximum annual income allowed  
24 for each category of eligibility under which eligi-

1           ble individuals and eligible employees are enti-  
2           tled to health discounts, and

3                   (B) the alternative benefits package used,  
4           if necessary, for calculating the benchmarks  
5           and health discounts for low income eligible in-  
6           dividuals and low income eligible employees.

7           The Secretary shall set the level of entitlement for  
8           a fiscal year so that the estimated total Federal  
9           spending on health discounts does not exceed the  
10          available Federal spending amount for such fiscal  
11          year.

12                   (2) STATE SPENDING.—In determining the an-  
13          nual level of entitlement, the Secretary shall include  
14          in the determination the State maintenance of effort  
15          spending and State matching amounts but not op-  
16          tional State supplementation.

17                   (3) ORDER OF ENTITLEMENT.—

18                           (A) POOR INDIVIDUALS AND EMPLOY-  
19                   EES.—

20                                   (i) IN GENERAL.—In any year, the  
21                                   Secretary shall first ensure that all poor el-  
22                                   igible individuals and poor eligible employ-  
23                                   ees are entitled to health discounts based  
24                                   on the nominal cost-sharing benefits pack-  
25                                   age determined pursuant to section 113(b).

1 (ii) EXCESS SPENDING.—If the Sec-  
2 retary determines that such a level of enti-  
3 tlement would cause Federal spending to  
4 exceed available amounts, the Secretary  
5 shall reduce the maximum family adjusted  
6 total income allowed for entitlement to  
7 health discounts to such a level so as to  
8 eliminate any estimated excess spending.

9 (B) OUT-OF-POCKET MAXIMUM FOR LOW  
10 INCOME INDIVIDUALS AND EMPLOYEES.—

11 (i) IN GENERAL.—If, in any year, the  
12 Secretary determines that all poor eligible  
13 individuals and poor eligible employees  
14 may be entitled to health discounts based  
15 on the nominal cost-sharing benefits pack-  
16 age, then the Secretary shall next ensure  
17 that all low income eligible individuals and  
18 low income eligible employees are entitled  
19 to health discounts based on the alter-  
20 native benefits package determined pursu-  
21 ant to section 113(c).

22 (ii) EXCESS SPENDING.—If the Sec-  
23 retary determines that providing entitle-  
24 ment to health discounts for low income el-  
25 ible individuals and low income eligible

1 employees based on the alternative benefits  
2 package would (together with spending on  
3 poor eligible individuals and poor eligible  
4 employees under subparagraph (B)) cause  
5 Federal spending to exceed available  
6 amounts, the Secretary may only set the  
7 maximum family adjusted total income al-  
8 lowed for entitlement to health discounts  
9 (based on the alternative benefits package)  
10 for such low income individuals and em-  
11 ployees at such a level so as to eliminate  
12 any estimated excess spending.

13 (C) STANDARD BENEFITS PACKAGE FOR  
14 LOW INCOME INDIVIDUALS AND EMPLOYEES.—

15 (i) IN GENERAL.—If the Secretary de-  
16 termines that all eligible individuals and el-  
17 igible employees described in subpara-  
18 graphs (A)(i) and (B)(i) may be entitled to  
19 health discounts, then the Secretary shall  
20 ensure that low income eligible individuals  
21 and low income eligible employees are enti-  
22 tled to health discounts based on the  
23 standard benefits package determined pur-  
24 suant to section 113(a).

1           (ii) EXCESS SPENDING.—If the Sec-  
2           retary determines that providing such a  
3           level of entitlement would cause Federal  
4           spending to exceed available amounts, the  
5           Secretary shall increase the value of the al-  
6           ternative benefits package above the value  
7           provided under section 113(c) but below  
8           the standard benefits package so as to  
9           eliminate any estimated excess spending.

10           (4) EXCEPTION FOR MEDICAID-ELIGIBLES.—  
11           For fiscal years 1996 through 2000, any individual  
12           who—

13                   (A) would have been eligible for medicaid  
14                   acute services based on eligibility standards on  
15                   the date of the enactment of this Act, and

16                   (B) is otherwise an eligible individual or el-  
17                   igible employee,

18           shall be considered to be a poor eligible individual or  
19           poor eligible employee for purposes of paragraph  
20           (3)(A) and shall be entitled to health discounts  
21           based on the nominal cost-sharing benefits package  
22           without regard to the limit in available Federal  
23           spending and prior to the entitlement of other indi-  
24           viduals under such paragraph.

1 **PART II—TERMINATION OF AUTHORITY TO FUR-**  
2 **NISH ACUTE CARE SERVICES UNDER THE**  
3 **MEDICAID PROGRAM**

4 **SEC. 321. TERMINATION OF AUTHORITY TO FURNISH**  
5 **ACUTE CARE SERVICES UNDER THE MEDIC-**  
6 **AID PROGRAM.**

7 Title XIX of the Social Security Act (42 U.S.C. 1396  
8 et seq.) is amended by redesignating section 1931 as sec-  
9 tion 1932 and by inserting after section 1930 the following  
10 new section:

11 “TERMINATION OF AUTHORITY TO FURNISH ACUTE CARE  
12 SERVICES

13 “SEC. 1931. (a) IN GENERAL.—Except as provided  
14 in subsection (b), the authority provided by this title to  
15 furnish acute care services to any individual eligible for  
16 medical assistance under this title shall terminate on De-  
17 cember 31, 1994.

18 “(b) EXCEPTION FOR QUALIFIED MEDICARE BENE-  
19 FICIARIES.—

20 “(1) IN GENERAL.—Individuals entitled to ben-  
21 efits under section 1905(p) shall remain entitled to  
22 such benefits under State plans.

23 “(2) ADDITIONAL BENEFIT.—Each state plan  
24 shall include as a mandatory benefit under section  
25 1905(p)(3) the payment of premiums for qualified

1 medicare beneficiaries to medicare health plans as  
2 provided in section 1876.

3 “(c) REPORT ON CONFORMING CHANGES.—By not  
4 later than 90 days after the date of the enactment of the  
5 Health Care Reform Act of 1994 the Secretary shall sub-  
6 mit to Congress a report on changes in laws that should  
7 be made in order to conform those laws to the termination  
8 of authority under this section.

9 “(d) ACUTE CARE SERVICES.—The term ‘acute care  
10 services’ means all of the care and services furnished  
11 under a State plan under this title, except the following:

12 “(1) Nursing facility services (as defined in sec-  
13 tion 1905(f)).

14 “(2) Intermediate care facility for the mentally  
15 retarded services (as defined in section 1905(d)).

16 “(3) Personal care services (as described in sec-  
17 tion 1905(a)(24)).

18 “(4) Private duty nursing services (as referred  
19 to in section 1905(a)(8)).

20 “(5) Home or community-based services fur-  
21 nished under a waiver granted under subsection (c),  
22 (d), or (e) of section 1915).

23 “(6) Home and community care furnished to  
24 functionally disabled elderly individuals under sec-  
25 tion 1929.

1           “(7) Community supported living arrangements  
2 services under section 1930.

3           “(8) Case-management services (as described in  
4 section 1915(g)(2)).

5           “(9) Home health care services (as referred to  
6 in section 1905(a)(7)).

7           “(10) Hospice care (as defined in section  
8 1905(o)).”.

9           **Subtitle C—Increase in Tax on**  
10           **Tobacco Products**

11 **SEC. 330. AMENDMENT OF 1986 CODE.**

12           Except as otherwise expressly provided, whenever in  
13 this subtitle an amendment or repeal is expressed in terms  
14 of an amendment to, or repeal of, a section or other provi-  
15 sion, the reference shall be considered to be made to a  
16 section or other provision of the Internal Revenue Code  
17 of 1986.

18 **SEC. 331. INCREASE IN EXCISE TAXES ON TOBACCO PROD-**  
19           **UCTS.**

20           (a) CIGARETTES.—Subsection (b) of section 5701 is  
21 amended—

22           (1) by striking “\$12 per thousand (\$10 per  
23 thousand on cigarettes removed during 1991 or  
24 1992)” in paragraph (1) and inserting “\$30 per  
25 thousand”, and

1           (2) by striking “\$25.20 per thousand (\$21 per  
2           thousand on cigarettes removed during 1991 or  
3           1992)” in paragraph (2) and inserting “\$63 per  
4           thousand”.

5           (b) CIGARS.—Subsection (a) of section 5701 is  
6 amended—

7           (1) by striking “\$1.125 cents per thousand  
8           (93.75 cents per thousand on cigars removed during  
9           1991 or 1992)” in paragraph (1) and inserting  
10          “\$19.125 cents per thousand”, and

11          (2) by striking “equal to” and all that follows  
12          in paragraph (2) and inserting “equal to 31.875 per-  
13          cent of the price for which sold but not more than  
14          \$75 per thousand.”

15          (c) CIGARETTE PAPERS.—Subsection (c) of section  
16 5701 is amended by striking “0.75 cent (0.625 cent on  
17 cigarette papers removed during 1991 or 1992)” and in-  
18 serting “1.875 cents”.

19          (d) CIGARETTE TUBES.—Subsection (d) of section  
20 5701 is amended by striking “1.5 cents (1.25 cents on  
21 cigarette tubes removed during 1991 or 1992)” and in-  
22 serting “3.75 cents”.

23          (e) SMOKELESS TOBACCO.—Subsection (e) of section  
24 5701 is amended—

1 (1) by striking “36 cents (30 cents on snuff re-  
2 moved during 1991 or 1992)” in paragraph (1) and  
3 inserting “\$6.36”, and

4 (2) by striking “12 cents (10 cents on chewing  
5 tobacco removed during 1991 or 1992)” in para-  
6 graph (2) and inserting “\$6.12”.

7 (f) PIPE TOBACCO.—Subsection (f) of section 5701  
8 is amended by striking “67.5 cents (56.25 cents on pipe  
9 tobacco removed during 1991 or 1992)” and inserting  
10 “\$6.675 cents”.

11 (g) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to articles removed (as defined in  
13 section 5702(k) of the Internal Revenue Code of 1986,  
14 as amended by this Act) after September 30, 1995.

15 (h) FLOOR STOCKS TAXES.—

16 (1) IMPOSITION OF TAX.—On tobacco products  
17 and cigarette papers and tubes manufactured in or  
18 imported into the United States which are removed  
19 before October 1, 1995, and held on such date for  
20 sale by any person, there is hereby imposed a tax in  
21 an amount equal to the excess of—

22 (A) the tax which would be imposed under  
23 section 5701 of the Internal Revenue Code of  
24 1986 on the article if the article had been re-  
25 moved on such date, over

1 (B) the prior tax (if any) imposed under  
2 section 5701 or 7652 of such Code on such ar-  
3 ticle.

4 (2) AUTHORITY TO EXEMPT CIGARETTES HELD  
5 IN VENDING MACHINES.—To the extent provided in  
6 regulations prescribed by the Secretary, no tax shall  
7 be imposed by paragraph (1) on cigarettes held for  
8 retail sale on October 1, 1995, by any person in any  
9 vending machine. If the Secretary provides such a  
10 benefit with respect to any person, the Secretary  
11 may reduce the \$500 amount in paragraph (3) with  
12 respect to such person.

13 (3) CREDIT AGAINST TAX.—Each person shall  
14 be allowed as a credit against the taxes imposed by  
15 paragraph (1) an amount equal to \$500. Such credit  
16 shall not exceed the amount of taxes imposed by  
17 paragraph (1) for which such person is liable.

18 (4) LIABILITY FOR TAX AND METHOD OF PAY-  
19 MENT.—

20 (A) LIABILITY FOR TAX.—A person hold-  
21 ing cigarettes on October 1, 1995, to which any  
22 tax imposed by paragraph (1) applies shall be  
23 liable for such tax.

24 (B) METHOD OF PAYMENT.—The tax im-  
25 posed by paragraph (1) shall be paid in such

1 manner as the Secretary shall prescribe by reg-  
2 ulations.

3 (C) TIME FOR PAYMENT.—The tax im-  
4 posed by paragraph (1) shall be paid on or be-  
5 fore December 31, 1995.

6 (5) ARTICLES IN FOREIGN TRADE ZONES.—  
7 Notwithstanding the Act of June 18, 1934 (48 Stat.  
8 998; 19 U.S.C. 81a) and any other provision of law,  
9 any article which is located in a foreign trade zone  
10 on October 1, 1995, shall be subject to the tax im-  
11 posed by paragraph (1) if—

12 (A) internal revenue taxes have been deter-  
13 mined, or customs duties liquidated, with re-  
14 spect to such article before such date pursuant  
15 to a request made under the 1st proviso of sec-  
16 tion 3(a) of such Act, or

17 (B) such article is held on such date under  
18 the supervision of a customs officer pursuant to  
19 the 2d proviso of such section 3(a).

20 (6) DEFINITIONS.—For purposes of this sub-  
21 section—

22 (A) IN GENERAL.—Terms used in this sub-  
23 section which are also used in section 5702 of  
24 the Internal Revenue Code of 1986 shall have  
25 the respective meanings such terms have in

1 such section, and such term shall include arti-  
2 cles first subject to the tax imposed by section  
3 5701 of such Code by reason of the amend-  
4 ments made by this Act.

5 (B) SECRETARY.—The term “Secretary”  
6 means the Secretary of the Treasury.

7 (7) CONTROLLED GROUPS.—Rules similar to  
8 the rules of section 5061(e)(3) of such Code shall  
9 apply for purposes of this subsection.

10 (8) OTHER LAWS APPLICABLE.—All provisions  
11 of law, including penalties, applicable with respect to  
12 the taxes imposed by section 5701 of such Code  
13 shall, insofar as applicable and not inconsistent with  
14 the provisions of this subsection, apply to the floor  
15 stocks taxes imposed by paragraph (1), to the same  
16 extent as if such taxes were imposed by such section  
17 5701. The Secretary may treat any person who bore  
18 the ultimate burden of the tax imposed by para-  
19 graph (1) as the person to whom a credit or refund  
20 under such provisions may be allowed or made.

21 **SEC. 332. MODIFICATIONS OF CERTAIN TOBACCO TAX PRO-**  
22 **VISIONS.**

23 (a) EXEMPTION FOR EXPORTED TOBACCO PROD-  
24 UCTS AND CIGARETTE PAPERS AND TUBES TO APPLY  
25 ONLY TO ARTICLES MARKED FOR EXPORT.—

1           (1) Subsection (b) of section 5704 is amended  
2           by adding at the end the following new sentence:  
3           “Tobacco products and cigarette papers and tubes  
4           may not be transferred or removed under this sub-  
5           section unless such products or papers and tubes  
6           bear such marks, labels, or notices as the Secretary  
7           shall by regulations prescribe.”.

8           (2) Section 5761 is amended by redesignating  
9           subsections (c) and (d) as subsections (d) and (e),  
10          respectively, and by inserting after subsection (b)  
11          the following new subsection:

12          “(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE  
13 PAPERS AND TUBES FOR EXPORT.—Except as provided  
14 in subsections (b) and (d) of section 5704—

15               “(1) every person who sells, relands, or receives  
16               within the jurisdiction of the United States any to-  
17               bacco products or cigarette papers or tubes which  
18               have been labeled or shipped for exportation under  
19               this chapter,

20               “(2) every person who sells or receives such  
21               relanded tobacco products or cigarette papers or  
22               tubes, and

23               “(3) every person who aids or abets in such  
24               selling, relanding, or receiving,

1 shall, in addition to the tax and any other penalty provided  
2 in this title, be liable for a penalty equal to the greater  
3 of \$1,000 or 5 times the amount of the tax imposed by  
4 this chapter. All tobacco products and cigarette papers  
5 and tubes relanded within the jurisdiction of the United  
6 States, and all vessels, vehicles, and aircraft used in such  
7 relanding or in removing such products, papers, and tubes  
8 from the place where relanded, shall be forfeited to the  
9 United States.”.

10 (3) Subsection (a) of section 5761 is amended  
11 by striking “subsection (b)” and inserting “sub-  
12 section (b) or (c)”.

13 (4) Subsection (d) of section 5761, as redesignig-  
14 nated by paragraph (2), is amended by striking  
15 “The penalty imposed by subsection (b)” and insert-  
16 ing “The penalties imposed by subsections (b) and  
17 (c)”.

18 (5)(A) Subpart F of chapter 52 is amended by  
19 adding at the end the following new section:

20 **“SEC. 5754. RESTRICTION ON IMPORTATION OF PRE-**  
21 **VIOUSLY EXPORTED TOBACCO PRODUCTS.**

22 “(a) IN GENERAL.—Tobacco products and cigarette  
23 papers and tubes previously exported from the United  
24 States may be imported or brought into the United States  
25 only as provided in section 5704(d).

1 “(b) CROSS REFERENCE.—

“For penalty for the sale of cigarettes in the United States which are labeled for export, see section 5761(d).”.

2 (B) The table of sections for subpart F of chap-  
3 ter 52 of such Code is amended by adding at the  
4 end the following new item:

“Sec. 5754. Restriction on importation of previously exported tobacco products.”.

5 (b) IMPORTERS REQUIRED TO BE QUALIFIED.—

6 (1) Sections 5712, 5713(a), 5721, 5722,  
7 5762(a)(1), 5763(b) and 5763(c) are each amended  
8 by inserting “or importer” after “manufacturer”.

9 (2) The heading of subsection (b) of section  
10 5763 is amended by inserting “QUALIFIED IMPORT-  
11 ERS,” after “MANUFACTURERS,”.

12 (3) The heading for subchapter B of chapter 52  
13 is amended by inserting “**and Importers**” after  
14 “**Manufacturers**”.

15 (4) The item relating to subchapter B in the  
16 table of subchapters for chapter 52 is amended by  
17 inserting “and importers” after “manufacturers”.

18 (c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES  
19 OF CIGARETTE MANUFACTURERS.—

20 (1) Subsection (a) of section 5704 is amend-  
21 ed—

1 (A) by striking “EMPLOYEE USE OR” in  
2 the heading, and

3 (B) by striking “for use or consumption by  
4 employees or” in the text.

5 (2) Subsection (e) of section 5723 is amended  
6 by striking “for use or consumption by their employ-  
7 ees, or for experimental purposes” and inserting  
8 “for experimental purposes”.

9 (d) REPEAL OF TAX-EXEMPT SALES TO UNITED  
10 STATES.—Subsection (b) of section 5704 is amended by  
11 striking “and manufacturers may similarly remove such  
12 articles for use of the United States;”.

13 (e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS  
14 SUBJECT TO TAX.—Subsection (c) of section 5701 is  
15 amended by striking “On each book or set of cigarette  
16 papers containing more than 25 papers,” and inserting  
17 “On cigarette papers,”.

18 (f) STORAGE OF TOBACCO PRODUCTS.—Subsection  
19 (k) of section 5702 is amended by inserting “under section  
20 5704” after “internal revenue bond”.

21 (g) AUTHORITY TO PRESCRIBE MINIMUM MANUFAC-  
22 TURING ACTIVITY REQUIREMENTS.—Section 5712 is  
23 amended by striking “or” at the end of paragraph (1),  
24 by redesignating paragraph (2) as paragraph (3), and by  
25 inserting after paragraph (1) the following new paragraph:

1           “(2) the activity proposed to be carried out at  
2           such premises does not meet such minimum capacity  
3           or activity requirements as the Secretary may pre-  
4           scribe, or”.

5           (h) EFFECTIVE DATE.—The amendments made by  
6           this section shall apply to articles removed (as defined in  
7           section 5702(k) of the Internal Revenue Code of 1986,  
8           as amended by this Act) after September 30, 1995.

9           **SEC. 333. IMPOSITION OF EXCISE TAX ON MANUFACTURE**  
10                                   **OR IMPORTATION OF ROLL-YOUR-OWN TO-**  
11                                   **BACCO.**

12           (a) IN GENERAL.—Section 5701 (relating to rate of  
13           tax) is amended by redesignating subsection (g) as sub-  
14           section (h) and by inserting after subsection (f) the follow-  
15           ing new subsection:

16           “(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own  
17           tobacco, manufactured in or imported into the United  
18           States, there shall be imposed a tax of \$6 per pound (and  
19           a proportionate tax at the like rate on all fractional parts  
20           of a pound).”.

21           (b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (re-  
22           lating to definitions) is amended by adding at the end the  
23           following new subsection:

24           “(p) ROLL-YOUR-OWN TOBACCO.—The term ‘roll-  
25           your-own tobacco’ means any tobacco which, because of

1 its appearance, type, packaging, or labeling, is suitable for  
2 use and likely to be offered to, or purchased by, consumers  
3 as tobacco for making cigarettes.”.

4 (c) TECHNICAL AMENDMENTS.—

5 (1) Subsection (c) of section 5702 is amended  
6 by striking “and pipe tobacco” and inserting “pipe  
7 tobacco, and roll-your-own tobacco”.

8 (2) Subsection (d) of section 5702 is amend-  
9 ed—

10 (A) in the material preceding paragraph  
11 (1), by striking “or pipe tobacco” and inserting  
12 “pipe tobacco, or roll-your-own tobacco”, and

13 (B) by striking paragraph (1) and insert-  
14 ing the following new paragraph:

15 “(1) a person who produces cigars, cigarettes,  
16 smokeless tobacco, pipe tobacco, or roll-your-own to-  
17 bacco solely for his own personal consumption or  
18 use, and”.

19 (3) The chapter heading for chapter 52 is  
20 amended to read as follows:

21 **“CHAPTER 52—TOBACCO PRODUCTS AND**  
22 **CIGARETTE PAPERS AND TUBES”.**

23 (4) The table of chapters for subtitle E is  
24 amended by striking the item relating to chapter 52  
25 and inserting the following new item:

“CHAPTER 52. Tobacco products and cigarette papers and tubes.”.

1 (d) EFFECTIVE DATE.—

2 (1) IN GENERAL.—The amendments made by  
3 this section shall apply to roll-your-own tobacco re-  
4 moved (as defined in section 5702(k) of the Internal  
5 Revenue Code of 1986, as amended by this Act)  
6 after September 30, 1995.

7 (2) TRANSITIONAL RULE.—Any person who—

8 (A) on the date of the enactment of this  
9 Act is engaged in business as a manufacturer of  
10 roll-your-own tobacco or as an importer of to-  
11 bacco products or cigarette papers and tubes,  
12 and

13 (B) before October 1, 1995, submits an  
14 application under subchapter B of chapter 52  
15 of such Code to engage in such business,  
16 may, notwithstanding such subchapter B, continue  
17 to engage in such business pending final action on  
18 such application. Pending such final action, all pro-  
19 visions of such chapter 52 shall apply to such appli-  
20 cant in the same manner and to the same extent as  
21 if such applicant were a holder of a permit under  
22 such chapter 52 to engage in such business.

1     **TITLE IV—IMPROVING ACCESS**  
2                     **IN RURAL AREAS**

3     **SEC. 401. COMMUNITY HEALTH CENTERS.**

4             Section 330(g)(1)(A) of the Public Health Service  
5 Act (42 U.S.C. 254c(g)(1)(A)) is amended by striking  
6 “and such sums” and inserting “such sums” and by in-  
7 serting before the period the following: “, \$800,000,000  
8 for fiscal year 1995, \$960,000,000 for fiscal year 1996,  
9 \$1,100,000,000 for fiscal year 1997, and \$1,200,000,000  
10 for fiscal year 1998”.

11     **SEC. 402. NATIONAL HEALTH SERVICE CORPS.**

12             Section 338H(b)(1) of the Public Health Act (42  
13 U.S.C. 254q(b)(1)) is amended by striking “and such  
14 sums” and inserting “such sums” and by inserting before  
15 the period the following: “, \$96,000,000 for fiscal year  
16 1995, \$115,000,000 for fiscal year 1996, \$138,000,000  
17 for fiscal year 1997, and \$160,000,000 for fiscal year  
18 1998”.

19     **SEC. 403. TAX INCENTIVES FOR PRACTICE IN FRONTIER,**  
20                     **RURAL, AND URBAN UNDERSERVED AREAS.**

21             (a) REFUNDABLE CREDIT FOR CERTAIN PRIMARY  
22 HEALTH SERVICES PROVIDERS.—

23                     (1) IN GENERAL.—Subpart C of part IV of sub-  
24 chapter A of chapter 1 of the Internal Revenue Code  
25 of 1986 (relating to refundable credits) is amended

1 by inserting after section 34 the following new sec-  
2 tion:

3 **“SEC. 34A. PRIMARY HEALTH SERVICES PROVIDERS.**

4 “(a) ALLOWANCE OF CREDIT.—In the case of a  
5 qualified primary health services provider, there is allowed  
6 as a credit against the tax imposed by this subtitle for  
7 any taxable year in a mandatory service period an amount  
8 equal to the product of—

9 “(1) the lesser of—

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

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

17 “(2) \$1,000 (\$500 in the case of a qualified  
18 primary health services provider who is a physician  
19 assistant or a nurse practitioner).

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

1           “(1) is providing primary health services—

2                 “(A) full-time, and

3                 “(B) to individuals at least 80 percent of  
4           whom reside in a health professional shortage  
5           area (as defined in subsection (d)(2)),

6           “(2) is not receiving during such year a scholar-  
7           ship under the National Health Service Corps Schol-  
8           arship Program or a loan repayment under the Na-  
9           tional Health Service Corps Loan Repayment Pro-  
10          gram,

11          “(3) is not fulfilling service obligations under  
12          such Programs, and

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

14          “(c) MANDATORY SERVICE PERIOD.—For purposes  
15          of this section, the term ‘mandatory service period’ means  
16          the period of 60 consecutive calendar months beginning  
17          with the first month the taxpayer is a qualified primary  
18          health services provider.

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

21                 “(1) BUREAU.—The term ‘Bureau’ means the  
22                 Bureau of Health Care Delivery and Assistance,  
23                 Health Resources and Services Administration of the  
24                 United States Public Health Service.

1           “(2) HEALTH PROFESSIONAL SHORTAGE  
2 AREA.—The term ‘health professional shortage area’  
3 means—

4           “(A) a geographic area in which there are  
5 6 or fewer individuals residing per square mile,

6           “(B) a health professional shortage area  
7 (as defined in section 332(a)(1)(A) of the Pub-  
8 lic Health Service Act),

9           “(C) an area which is determined by the  
10 Secretary of Health and Human Services as  
11 equivalent to an area described in subparagraph  
12 (A) and which is designated by the Bureau of  
13 the Census as not urbanized, or

14           “(D) a community that is certified as un-  
15 derserved by the Secretary for purposes of par-  
16 ticipation in the rural health clinic program  
17 under title XVIII of the Social Security Act.

18           “(3) PHYSICIAN.—The term ‘physician’ has the  
19 meaning given to such term by section 1861(r) or  
20 the Social Security Act.

21           “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-  
22 TIONER.—The terms ‘physician assistant’ and ‘nurse  
23 practitioner’ have the meanings given to such terms  
24 by section 1861(aa)(5) of the Social Security Act.

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

5           “(e) RECAPTURE OF CREDIT.—

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

10                   “(A) the applicable percentage, and

11                   “(B) the aggregate unrecaptured credits  
 12                   allowed to such taxpayer under this section for  
 13                   all prior taxable years.

14           “(2) APPLICABLE RECAPTURE PERCENTAGE.—

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

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

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

21           “(3) RECAPTURE EVENT DEFINED.—

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

6           “(B) CESSATION OF DESIGNATION.—The  
7 cessation of the designation of any area as a  
8 rural health professional shortage area after the  
9 beginning of the mandatory service period for  
10 any taxpayer shall not constitute a recapture  
11 event.

12           “(C) SECRETARIAL WAIVER.—The Sec-  
13 retary may waive any recapture event caused by  
14 extraordinary circumstances.

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

20           (2) CLERICAL AMENDMENT.—The table of sec-  
21 tions for subpart C of part IV of subchapter A of  
22 chapter 1 of such Code is amended by inserting  
23 after the item relating to section 34 the following  
24 new item:

“Sec. 34A. Primary health services providers.”.



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

          “Sec. 137. National Health Service Corps loan repayments.  
           “Sec. 138. Cross references to other Acts.”.

6           (4) EFFECTIVE DATE.—The amendments made  
 7           by this subsection shall apply to payments made  
 8           under section 338B(g) of the Public Health Service  
 9           Act (42 U.S.C. 2541-1(g)) after the date of the en-  
 10          actment of this Act.

11 **SEC. 404. INCENTIVES FOR PRIMARY CARE RESIDENTS.**

12          (a) IN GENERAL.—Section 1886(h) of the Social Se-  
 13          curity Act (42 U.S.C. 1395 ww(h)) is amended—

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

16               “(2) DETERMINATION OF APPROVED FTE RESI-  
 17               DENT AMOUNTS.—The Secretary shall determine an  
 18               approved FTE resident amount for each cost report-  
 19               ing period beginning after October 1, 1994, as fol-  
 20               lows:

21                       “(A) DETERMINING NATIONAL AVERAGE  
 22                       SALARY PER FTE RESIDENT IN FISCAL YEAR  
 23                       1992.—The Secretary shall determine the na-  
 24                       tional average salary for fiscal year 1992 for a

1 full-time-equivalent resident in an approved  
2 medical residency training program.

3 “(B) UPDATING TO A COST REPORTING  
4 PERIOD THAT BEGINS IN FISCAL YEAR 1995.—  
5 The Secretary shall update the amount deter-  
6 mined under subparagraph (A) by the esti-  
7 mated percentage change in the Consumer  
8 Price Index from the midpoint of fiscal year  
9 1992 to the midpoint of each cost reporting pe-  
10 riod that begins in fiscal year 1995.

11 “(C) UPDATING TO SUBSEQUENT COST RE-  
12 PORTING PERIODS.—For each subsequent cost  
13 reporting period, the Secretary shall update the  
14 amount determined under subparagraph (B) or  
15 this subparagraph for an immediately preceding  
16 cost reporting period by the estimated percent-  
17 age change in the Consumer Price Index from  
18 the midpoint of that preceding period to the  
19 midpoint of that subsequent period, with appro-  
20 priate adjustments to reflect previous under- or  
21 over-estimations in the estimated percentage  
22 change in that index.”,

23 (2) in paragraph (3)(B)(i), by striking “hos-  
24 pital’s”, and

1           (3) in paragraph (4), by striking subparagraph  
2           (C) and inserting the following new subparagraph:

3                   “(C) WEIGHTING FACTOR FOR CERTAIN  
4                   RESIDENTS.—Subject to subparagraph (D),  
5                   such rules shall provide, in calculating the num-  
6                   ber of full-time-equivalent residents in an ap-  
7                   proved residency program—

8                           “(i) that the weighting factor for a  
9                           primary care (as defined by the Secretary)  
10                          resident, or for an intern, is 2.2;

11                           “(ii) that the weighting factor for a  
12                          nonprimary care resident who is in the  
13                          resident’s initial residency period is 2.0;  
14                          and

15                           “(iii) that the weighting factor for a  
16                          nonprimary care resident who is not in the  
17                          resident’s initial residency period is 1.2.

18           The Secretary shall make such adjustments as  
19           are necessary to the weighting factors to main-  
20           tain aggregate payments under this section to  
21           all hospitals at the same level that such pay-  
22           ments would have been made under this section  
23           prior to enactment of the amendments made to  
24           this section by the Health Care Reform Act of  
25           1994.”.

1 (b) EFFECTIVE DATES.—

2 (1) IN GENERAL.—Except as otherwise pro-  
3 vided by paragraph (2), the amendments made by  
4 this section shall apply to cost reporting periods be-  
5 ginning after October 1, 1994.

6 (2) SPECIAL RULE.—For a cost reporting pe-  
7 riod that falls partly in fiscal year 1994 and partly  
8 in fiscal year 1995, the provisions of section  
9 1886(h), as in effect before the date of enactment of  
10 this Act, shall apply proportionally to that part of  
11 the cost reporting period that occurs before fiscal  
12 year 1995.

13 **TITLE V—OTHER HEALTH CARE**  
14 **COST REDUCTION MEASURES**  
15 **Subtitle A—Medical Liability**  
16 **Reform**

17 **SEC. 501. FEDERAL STANDARDS FOR STATE-BASED MEDI-**  
18 **CAL LIABILITY REFORM.**

19 (a) IN GENERAL.—The Secretary, in consultation  
20 with the Attorney General, shall develop and publish medi-  
21 cal liability reform standards in accordance with this sub-  
22 title that States must meet in order to be certified under  
23 section 502.

24 (b) BINDING ALTERNATIVE DISPUTE RESOLU-  
25 TION.—

1           (1) REQUIREMENTS.—The standards developed  
2 under subsection (a) shall require that a State—

3           (A) require all claims of medical injury  
4 arising in such State be resolved under binding  
5 dispute resolution systems that—

6           (i) provide timely and impartial deci-  
7 sions of liability and damage awards,

8           (ii) make determinations of liability  
9 and damage awards based on the best sci-  
10 entific learning and judgment of objective  
11 experts,

12           (iii) provide data and standardized in-  
13 formation regarding evidence of medical in-  
14 juries and the causes of such injuries to  
15 Federal and State agencies responsible for  
16 monitoring or disciplining health care pro-  
17 viders, and

18           (iv) do not employ lay juries or simi-  
19 larly constituted lay decisionmaking bodies  
20 to make such determinations;

21           (B) require that the decisions made  
22 through the binding dispute resolution system  
23 be final and not subject to further review by  
24 any court, except that a party to a dispute may  
25 obtain review of such decision in any court of

1 competent jurisdiction in the State wherein the  
2 decision was made if—

3 (i) the award under such decision was  
4 procured by corruption, fraud, or other  
5 undue means,

6 (ii) there was evident partiality or cor-  
7 ruption on the part of the arbiter,

8 (iii) the arbiter was guilty of mis-  
9 conduct in refusing to postpone the hear-  
10 ing, upon sufficient cause shown, or in re-  
11 fusing to hear evidence pertinent and ma-  
12 terial to the controversy, or of any mis-  
13 behavior by which the rights of any party  
14 were prejudiced, or

15 (iv) the arbiter exceeded its powers or  
16 so imperfectly executed them that a final  
17 and definite award upon the claim was not  
18 made; and

19 (C) require that where an arbiters award is  
20 vacated pursuant to State provisions established  
21 under subparagraph (B) that the court direct  
22 that the matter be reheard by another arbiter  
23 under the procedures prescribed by the State  
24 dispute resolution system.

1           (2) OPTIONS.—The standards developed under  
2 subsection (a) shall permit a State to—

3           (A) allow private entities to provide all or  
4 some of the dispute resolution services required  
5 by the State dispute resolution system, and

6           (B) allow alternative methods for deter-  
7 mining liability and compensation for personal  
8 injuries other than provider negligence and as-  
9 sessments of damage awards.

10          (3) BINDING ARBITRATION.—In the standards  
11 developed under subsection (a), the Secretary shall  
12 outline a standard arbitration process that States  
13 could adopt to meet Federal criteria (so long as  
14 other elements of the State system meet the require-  
15 ments of this section) and that includes the follow-  
16 ing:

17           (A) Decisionmaking by a 3-person arbitra-  
18 tion panel with expertise in medical injury dis-  
19 putes chosen from a roster of qualified and  
20 independent arbitrators.

21           (B) A period to permit the discovery of evi-  
22 dence.

23           (C) The right to a hearing.

1 (D) The right to a decision not later than  
2 6 months after the date on which the claim was  
3 filed.

4 (E) The right to a written decision.

5 (c) DAMAGES.—When a claim that is subject to reso-  
6 lution in accordance with State systems established under  
7 the standards developed under subsection (a) results in a  
8 finding of liability, States shall require that the damages  
9 awarded adhere to the following requirements:

10 (1) Awards for noneconomic damages shall not  
11 exceed \$250,000.

12 (2) Awards shall be reduced for any collateral  
13 source payments to which the patient is entitled for  
14 the medical injury for which the claim was filed.

15 (3) In the case of an award in excess of  
16 \$100,000, claimants shall accept periodic payment  
17 of the amount of such awards that are intended to  
18 compensate the claimant for damages expected to be  
19 incurred in the future such as lost income and medi-  
20 cal expenses.

21 (4) An award of punitive damages shall not be  
22 paid to the claimant, but shall be paid to the State  
23 if the State has submitted a plan to the Secretary,  
24 and the Secretary has certified such a plan as part  
25 of certifying the State medical liability reform in ac-

1 cordance with section 502, to use such funds to im-  
2 prove the monitoring, disciplining, and educating of  
3 health care providers in the State to ensure they  
4 meet standards of competency.

5 (d) ACCOUNTABLE HEALTH PLANS.—

6 (1) IN GENERAL.—To be approved by the appli-  
7 cable regulatory authority as an AHP under section  
8 112, a health plan shall clearly identify for the pur-  
9 chasers of the plan the individuals or entity that will  
10 be responsible for any findings of liability for claims  
11 of medical injury.

12 (2) ENFORCEMENT OF CONTRACTS.—A State  
13 shall ensure that provisions in AHP contracts that—

14 (A) cite medical practice guidelines, cer-  
15 tified pursuant to section 502, and which shall  
16 be followed in rendering services, shall be  
17 deemed to supply the standard of care to be  
18 employed in determining liability under the  
19 State dispute resolution system, and

20 (B) establish particular rules governing the  
21 resolution of medical injury claims, consistent  
22 with the State dispute resolution system, are re-  
23 quired elements for resolving any claims of  
24 medical injury for care provided in accordance  
25 with the AHP.

1 **SEC. 502. CERTIFICATION.**

2 (a) STATE REFORMS.—Not later than 12 months  
3 after the date of enactment of this Act, the Secretary, in  
4 consultation with the Attorney General, shall promulgate  
5 regulations that establish the criteria and procedures by  
6 which the Secretary (or individuals to whom the Secretary  
7 has delegated such authority) will determine whether or  
8 not a State has met the standards established under sec-  
9 tion 501(a) and any other standards determined necessary  
10 by the Secretary.

11 (b) STANDARDS FOR IMPOSING LIABILITY.—Not  
12 later than 12 months after the date of enactment of this  
13 Act, the Secretary shall promulgate regulations that estab-  
14 lish the criteria to be used for the certification of medical  
15 practice guidelines by the Secretary (or individuals to  
16 whom the Secretary has delegated such authority), includ-  
17 ing criteria to ensure that such guidelines—

18 (1) reflect up-to-date scientific learning and the  
19 judgment of objective experts,

20 (2) are supported by proper documentation, and

21 (3) are accompanied by justifications for the  
22 standards established.

23 (c) OTHER REGULATIONS.—Not later than 12  
24 months after the date of enactment of this Act, the Sec-  
25 retary of Health and Human Services shall promulgate  
26 other regulations necessary to carry out this Act.

1 **SEC. 503. RELATION TO OTHER LAWS.**

2 The procedures required under this Act for fairly and  
 3 quickly resolving claims against health care providers for  
 4 personal injury shall be exclusive, and no action seeking  
 5 recovery for any personal injury covered by this Act shall  
 6 be permitted in any Federal or State court except as ex-  
 7 pressly provided herein.

8 **Subtitle B—Antitrust Provisions**

9 **SEC. 511. PUBLICATION OF GUIDELINES FOR ACCOUNT-**  
 10 **ABLE HEALTH PLANS.**

11 (a) IN GENERAL.—The President shall provide for  
 12 the development and publication of explicit guidelines on  
 13 the application of antitrust laws to AHPs. The guidelines  
 14 shall be designed to facilitate AHP development and oper-  
 15 ation, consistent with the antitrust laws.

16 (b) REVIEW PROCESS.—The Attorney General shall  
 17 establish a review process under which an AHP (or organi-  
 18 zation that proposes to establish an AHP) may obtain a  
 19 prompt opinion from the Department of Justice on the  
 20 AHP’s conformity with the antitrust laws. If the Depart-  
 21 ment of Justice determines that an AHP conforms with  
 22 the antitrust laws, the AHP shall not be liable under such  
 23 laws regarding the development and operation of the  
 24 AHP, as reviewed by the Department.

25 (c) ANTITRUST LAWS DEFINED.—In this section, the  
 26 term “antitrust laws” has the meaning given such term

1 in subsection (a) of the first section of the Clayton Act  
2 (15 U.S.C. 12(a)), except that such term includes section  
3 5 of the Federal Trade Commission Act (15 U.S.C. 45)  
4 to the extent such section applies to unfair methods of  
5 competition.

6 **SEC. 512. ISSUANCE OF HEALTH CARE CERTIFICATES OF**  
7 **PUBLIC ADVANTAGE.**

8 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The  
9 Attorney General, after consultation with the Secretary,  
10 shall issue in accordance with this section a certificate of  
11 public advantage to each eligible health care collaborative  
12 effort that complies with the requirements in effect under  
13 this section on or after the expiration of the 1-year period  
14 that begins on the date of the enactment of this Act (with-  
15 out regard to whether or not the Attorney General has  
16 promulgated regulations to carry out this section by such  
17 date). Such collaborative effort, and the parties to such  
18 effort, shall not be liable under any of the antitrust laws  
19 for conduct described in such certificate and engaged in  
20 by such effort if such conduct occurs while such certificate  
21 is in effect.

22 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF  
23 CERTIFICATES.—

24 (1) STANDARDS TO BE MET.—The Attorney  
25 General shall issue a certificate to an eligible health

1 care collaborative effort if the Attorney General  
2 finds that—

3 (A) the benefits that are likely to result  
4 from carrying out the effort outweigh the re-  
5 duction in competition (if any) that is likely to  
6 result from the effort, and

7 (B) such reduction in competition is rea-  
8 sonably necessary to obtain such benefits.

9 (2) FACTORS TO BE CONSIDERED.—

10 (A) WEIGHING OF BENEFITS AGAINST RE-  
11 DUCION IN COMPETITION.—For purposes of  
12 making the finding described in paragraph  
13 (1)(A), the Attorney General shall consider  
14 whether the collaborative effort is likely—

15 (i) to maintain or to increase the  
16 quality of health care,

17 (ii) to increase access to health care,

18 (iii) to achieve cost efficiencies that  
19 will be passed on to health care consumers,  
20 such as economies of scale, reduced trans-  
21 action costs, and reduced administrative  
22 costs,

23 (iv) to preserve the operation of  
24 health care facilities located in underserved  
25 geographical areas,

1 (v) to improve utilization of health  
2 care resources, and

3 (vi) to reduce inefficient health care  
4 resource duplication.

5 (B) NECESSITY OF REDUCTION IN COM-  
6 PETITION.—For purposes of making the finding  
7 described in paragraph (1)(B), the Attorney  
8 General shall consider—

9 (i) the ability of the providers of  
10 health care services that are (or are likely  
11 to be) affected by the health care collabo-  
12 rative effort and the entities responsible  
13 for making payments to such providers to  
14 negotiate societally optimal payment and  
15 service arrangements,

16 (ii) the effects of the health care col-  
17 laborative effort on premiums and other  
18 charges imposed by the entities described  
19 in clause (i), and

20 (iii) the availability of equally effi-  
21 cient, less restrictive alternatives to achieve  
22 the benefits that are intended to be  
23 achieved by carrying out the effort.

24 (c) ESTABLISHMENT OF CRITERIA AND PROCE-  
25 DURES.—Subject to subsections (d) and (e), not later than

1 1 year after the date of the enactment of this Act, the  
2 Attorney General and the Secretary shall establish jointly  
3 by rule the criteria and procedures applicable to the issu-  
4 ance of certificates under subsection (a). The rules shall  
5 specify the form and content of the application to be sub-  
6 mitted to the Attorney General to request a certificate,  
7 the information required to be submitted in support of  
8 such application, the procedures applicable to denying and  
9 to revoking a certificate, and the procedures applicable to  
10 the administrative appeal (if such appeal is authorized by  
11 rule) of the denial and the revocation of a certificate. Such  
12 information may include the terms of the health care col-  
13 laborative effort (in the case of an effort in existence as  
14 of the time of the application) and implementation plan  
15 for the collaborative effort.

16 (d) ELIGIBLE HEALTH CARE COLLABORATIVE EF-  
17 FORT.—To be an eligible health care collaborative effort  
18 for purposes of this section, a health care collaborative ef-  
19 fort shall submit to the Attorney General an application  
20 that complies with the rules in effect under subsection (c)  
21 and that includes—

22 (1) an agreement by the parties to the effort  
23 that the effort will not foreclose competition by en-  
24 tering into contracts that prevent health care provid-

1       ers from providing health care in competition with  
2       the effort,

3           (2) an agreement that the effort will submit to  
4       the Attorney General annually a report that de-  
5       scribes the operations of the effort and information  
6       regarding the impact of the effort on health care  
7       and on competition in health care, and

8           (3) an agreement that the parties to the effort  
9       will notify the Attorney General and the Secretary of  
10      the termination of the effort not later than 30 days  
11      after such termination occurs.

12      (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—  
13      Not later than 30 days after an eligible health care col-  
14      laborative effort submits to the Attorney General an appli-  
15      cation that complies with the rules in effect under sub-  
16      section (c) and with subsection (d), the Attorney General  
17      shall issue or deny the issuance of such certificate. If, be-  
18      fore the expiration of such 30-day period, the Attorney  
19      General fails to issue or deny the issuance of such certifi-  
20      cate, the Attorney General shall be deemed to have issued  
21      such certificate.

22      (f) REVOCATION OF CERTIFICATE.—Whenever the  
23      Attorney General finds that a health care collaborative ef-  
24      fort with respect to which a certificate is in effect does

1 not meet the standards specified in subsection (b), the At-  
2 torney General shall revoke such certificate.

3 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

4 (1) DENIAL AND REVOCATION OF CERTIFI-  
5 CATES.—If the Attorney General denies an applica-  
6 tion for a certificate or revokes a certificate, the At-  
7 torney General shall include in the notice of denial  
8 or revocation a statement of the reasons relied upon  
9 for the denial or revocation of such certificate.

10 (2) JUDICIAL REVIEW.—

11 (A) AFTER ADMINISTRATIVE PROCEED-  
12 ING.—

13 (i) IN GENERAL.—If the Attorney  
14 General denies an application submitted or  
15 revokes a certificate issued under this sec-  
16 tion after an opportunity for hearing on  
17 the record, then any party to the health  
18 care collaborative effort involved may com-  
19 mence a civil action, not later than 60 days  
20 after receiving notice of the denial or rev-  
21 ocation, in an appropriate district court of  
22 the United States for review of the record  
23 of such denial or revocation.

24 (ii) CERTIFIED COPY OF RECORD.—As  
25 part of the Attorney General's answer, the

1 Attorney General shall file in such court a  
2 certified copy of the record on which such  
3 denial or revocation is based. The findings  
4 of fact of the Attorney General may be set  
5 aside only if found to be unsupported by  
6 substantial evidence in such record taken  
7 as a whole.

8 (B) DENIAL OR REVOCATION WITHOUT AD-  
9 MINISTRATIVE PROCEEDING.—If the Attorney  
10 General denies an application submitted or re-  
11 vokes a certificate issued under this section  
12 without an opportunity for hearing on the  
13 record, then any party to the health care col-  
14 laborative effort involved may commence a civil  
15 action, not later than 60 days after receiving  
16 notice of the denial or revocation, in an appro-  
17 priate district court of the United States for de  
18 novo review of such denial or revocation.

19 (h) EXEMPTION.—A person shall not be liable under  
20 any of the antitrust laws for conduct necessary—

21 (1) to prepare, agree to prepare, or attempt to  
22 agree to prepare an application to request a certifi-  
23 cate under this section, or

1           (2) to attempt to enter into any health care col-  
2           laborative effort with respect to which such a certifi-  
3           cate is in effect.

4           (i) DEFINITIONS.—In this section:

5           (1) The term “antitrust laws”—

6           (A) has the meaning given such term in  
7           subsection (a) of the first section of the Clayton  
8           Act (15 U.S.C. 12(a)), except that such term  
9           includes section 5 of the Federal Trade Com-  
10          mission Act (15 U.S.C. 45) to the extent such  
11          section applies to unfair methods of competi-  
12          tion, and

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

15          (2) The term “certificate” means a certificate  
16          of public advantage authorized to be issued under  
17          subsection (a).

18          (3) The term “health care collaborative effort”  
19          means an agreement (whether existing or proposed)  
20          between 2 or more providers of health care services  
21          that is entered into solely for the purpose of sharing  
22          in the provision of health care services and that in-  
23          volves substantial integration or financial risk-shar-  
24          ing between the parties, but does not include the ex-  
25          changing of information, the entering into of any

1 agreement, or the engagement in any other conduct  
2 that is not reasonably required to carry out such  
3 agreement.

4 (4) The term “health care services” includes  
5 services related to the delivery or administration of  
6 health care services.

7 (5) The term “liable” means liable for any civil  
8 or criminal violation of the antitrust laws.

9 (6) The term “provider of health care services”  
10 means any individual or entity that is engaged in the  
11 delivery of health care services in a State and that  
12 is required by State law or regulation to be licensed  
13 or certified by the State to engage in the delivery of  
14 such services in the State.

## 15 **Subtitle C—Administrative Cost** 16 **Savings**

### 17 **SEC. 521. ESTABLISHMENT OF STANDARDS.**

18 (a) IN GENERAL.—The Secretary shall establish,  
19 after consultation with the American National Standards  
20 Institute, data and transaction standards, conventions,  
21 and requirements that permit the electronic interchange  
22 of any health care data the Secretary determines nec-  
23 essary for the efficient and effective administration of the  
24 health care system.

1 (b) TIMETABLE AND COVERAGE.—The Secretary  
2 shall establish standards, conventions, and requirements  
3 for categories of health care data in the following order  
4 and at the appropriate time (as determined by the Sec-  
5 retary):

6 (1) Financial and administrative transactions,  
7 including enrollment, eligibility, claims, and claims  
8 status.

9 (2) Quality measurement indicators, including  
10 such data necessary to satisfy the requirements  
11 under section 521.

12 (3) Patient care records.

13 (c) PRIVACY AND CONFIDENTIALITY STANDARDS.—  
14 In developing the standards, conventions, and require-  
15 ments under subsection (a), the Secretary shall ensure the  
16 protection of privacy of participants in the health care sys-  
17 tem and ensure the confidentiality in the data interchange  
18 system.

19 **SEC. 522. ENFORCEMENT.**

20 (a) AHPs.—An AHP may not be certified by the ap-  
21 propriate regulatory authority unless such AHP complies  
22 with the standards established by the Secretary under sec-  
23 tion 521.

24 (b) HEALTH CARE PROVIDERS.—AHPs may only  
25 contract with or employ those health care providers that

- 1 comply with the electronic standards established by the
- 2 Secretary or submit standard paper forms with the same
- 3 data elements to a clearinghouse which forwards the data
- 4 electronically to AHPs.

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