Calendar No. 525

103D CONGRESS
2D SESSION

S. 2296

[Report No. 103–317]

A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

JULY 19 (legislative day, JULY 11), 1994

Placed on the calendar

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IN THE SENATE OF THE UNITED STATES

JULY 19 (legislative day, JULY 11), 1994

Mr. KENNEDY, from the Committee on Labor and Human Resources, reported the following original bill; which was read twice and placed on the calendar

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A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Security Act''.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) Under the current health care system in the United States—

(A) individuals risk losing their health care coverage when they move, when they lose or change jobs, when they become seriously ill, or when the coverage becomes unaffordable;

(B) continued escalation of health care costs threatens the economy of the United States, undermines the international competitiveness of the Nation, and strains Federal, State, and local budgets;

(C) an excessive burden of forms, paperwork, and bureaucratic procedures confuses consumers and overwhelms health care providers;

(D) fraud and abuse sap the strength of the health care system; and

(E) health care is a critical part of the economy of the United States and interstate commerce, consumes a significant percentage of public and private spending, and affects all industries and individuals in the United States.

(2) Under any reform of the health care system—

(A) health insurance and high quality health care should be secure, uninterrupted, and affordable for all individuals in the United States;

(B) comprehensive health care benefits that meet the full range of health needs, including primary, preventive, and specialized care, should be available to all individuals in the United States;

(C) the current high quality of health care in the United States should be maintained;

(D) individuals in the United States should be afforded a meaningful opportunity to choose among a range of health plans, health care providers, and treatments;

(E) regulatory and administrative burdens should be reduced;

(F) the rapidly escalating costs of health care should be contained without sacrificing high quality or impeding technological improvements;

(G) competition in the health care industry should ensure that health plans and health care

providers are efficient and charge reasonable prices;

(H) a partnership between the Federal Government and each State should allow the State and its local communities to design an effective, high-quality system of care that serves the residents of the State;

(I) all individuals should have a responsibility to pay their fair share of the costs of health care coverage;

(J) a health care system should build on the strength of the employment-based coverage arrangements that now exist in the United States;

(K) the penalties for fraud and abuse should be swift and severe; and

(L) an individual's medical information should remain confidential and should be protected from unauthorized disclosure and use.

SEC. 3. PURPOSES.

The purposes of this Act are as follows:

(1) To guarantee comprehensive and secure health care coverage.

(2) To simplify the health care system for consumers and health care professionals.

(3) To control the cost of health care for employers, employees, and others who pay for health care coverage.

(4) To promote individual choice among health plans and health care providers.

(5) To ensure high quality health care.

(6) To encourage all individuals to take responsibility for their health care coverage.

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Subtitle A—Universal Coverage and Individual Responsibility

PART 1—UNIVERSAL COVERAGE

SEC. 1001. ENTITLEMENT TO HEALTH BENEFITS.

(a) IN GENERAL.—In accordance with this part, each eligible individual is entitled to the comprehensive benefit package under subtitle B through the applicable health plan in which the individual is enrolled consistent with this title.

(b) HEALTH SECURITY CARD.—Each eligible individual is entitled to a health security card to be issued in accordance with this Act.

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this Act, the term ''eligible individual'' means an individual who is residing in the United States and who is—

(1)(A) a citizen or national of the United States;

(B) a citizen of another country legally residing in the United States (as defined in section 1902(6)); or

(C) a long-term nonimmigrant (as defined in section 1902(27)); and

(2) not an exempt individual (as defined in section 1902(18)).

(d) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—Subject to section 1012(a), a medicare-eligible individual is entitled to health benefits under the medicare program instead of the entitlement under subsection (a).

(e) TREATMENT OF PRISONERS.—A prisoner (as defined in section 1902(37)) is entitled to health care services provided by the authority responsible for the prisoner instead of the entitlement under subsection (a).

SEC. 1002. INDIVIDUAL RESPONSIBILITIES.

(a) IN GENERAL.—In accordance with this Act, each eligible individual (other than a medicare-eligible individual)—

(1) must enroll in an applicable health plan for the individual, and

(2) must pay any premium required, consistent with this Act, with respect to such enrollment.

(b) LIMITATION ON DISENROLLMENT.—No eligible individual shall be disenrolled from an applicable health plan until the individual—

(1) is enrolled under another applicable health plan, or

(2) becomes a medicare-eligible individual.

SEC. 1003. PROTECTION OF CONSUMER CHOICE.

Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services.

(2) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care services not included within the comprehensive benefit package.

(3) An individual who is not an eligible individual from purchasing health insurance.

(4) Employers from providing coverage for benefits in addition to the comprehensive benefit package (subject to part 2 of subtitle E).

(5) An individual from obtaining (at the expense of such individual) health care from any health care provider of such individual's choice.

SEC. 1004. HEALTH PLAN PRINCIPLES.

In accordance with this Act, the following principles shall apply to all health plans:

(1) No health plan may discriminate on the basis of medical history, pre-existing medical conditions, or genetic predisposition to medical conditions.

(2) A health plan—

(A) shall offer an annual open enrollment period and accept all eligible individuals for coverage;

(B) shall not impose a rider that serves to exclude coverage to an individual; and

(C) shall not impose waiting periods before coverage begins.

(3) A health plan shall ensure that all medically necessary or appropriate services, as defined in the benefits package, are provided, including access to specialty care.

(4) Health benefits coverage shall be portable from one health plan to another.

Nothing in this section shall be construed so as to relieve a health plan of any obligation or requirement imposed under this Act.

SEC. 1005. APPLICABLE HEALTH PLAN PROVIDING COVERAGE.

(a) SPECIFICATION OF APPLICABLE HEALTH PLAN.—Except as otherwise provided:

(1) GENERAL RULE: COMMUNITY-RATED HEALTH PLANS.—The applicable health plan for a family is a community-rated health plan for the health care coverage area in which the family resides.

(2) EXPERIENCE-RATED HEALTH PLANS.—In the case of a family member that is eligible to enroll in an experienced-rated health plan under subtitle B,

the applicable health plan for the family is such an experienced-rated health plan.

(b) CHOICE OF PLANS FOR CERTAIN GROUPS.—

(1) MILITARY PERSONNEL AND FAMILIES.—For military personnel and families who elect a Uniformed Services Health Plan of the Department of Defense under section 1073a(d) of title 10, United States Code, as inserted by section 8001(a) of this Act, that plan shall be the applicable health plan.

(2) VETERANS.—For veterans and families who elect to enroll in a veterans health plan under section 1801 of title 38, United States Code, as inserted by section 8101(a) of this Act, that plan shall be the applicable health plan.

(3) AMERICAN INDIANS.—For those individuals who are eligible to enroll, and who elect to enroll, in a health program of the Indian Health Service under section 8302(b) or 8306(b), that program shall be the applicable health plan.

SEC. 1006. TREATMENT OF OTHER NONIMMIGRANTS.

(a) CERTAIN ALIENS INELIGIBLE FOR BENEFITS.—An alien who is not an eligible individual or otherwise not made eligible under this Act for benefits is not eligible to obtain the comprehensive benefit package through enrollment in a health plan under this Act.

(b) DIPLOMATS AND OTHER FOREIGN GOVERNMENT OFFICIALS.—Subject to conditions established by the National Health Board in consultation with the Secretary of State, a nonimmigrant under subparagraph (A) or (G) of section 101(a)(15) of the Immigration and Nationality Act may obtain the comprehensive benefit package through enrollment in the community-rated health plan for the health care coverage area in which the nonimmigrant resides.

(c) RECIPROCAL TREATMENT OF OTHER NONIMMIGRANTS.—With respect to those classes of individuals who are lawful nonimmigrants but who are not long-term nonimmigrants (as defined in section 1902(27)) or described in subsection (b), such individuals may obtain such benefits through enrollment with community-rated health plans only in accordance with such reciprocal agreements between the United States and foreign states as may be entered into.

(d) CONSTRUCTION.—The National Health Board shall adopt procedures that assure that each person who is eligible for enrollment in an applicable health plan is able to enroll in such a plan.

SEC. 1007. EFFECTIVE DATE OF ENTITLEMENT.

(a) COMMUNITY RATE ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—In the case of community rate eligible individuals residing in a State, the enti-

tlement under this part (and requirements under section 1002) shall not take effect until the State becomes a participating State (as defined in section 1200).

(2) TRANSITIONAL RULE FOR LARGE GROUP SPONSORS.—

(A) IN GENERAL.—In the case of a State that becomes a participating State before the general effective date (as defined in subsection (c)) and for periods before such date, under rules established by the Board, an individual who is covered under a plan (described in subparagraph (C)) based on the individual (or the individual's spouse) being a qualifying employee of a qualifying employer, the individual shall not be treated under this Act as a community rate eligible individual.

(B) QUALIFYING EMPLOYER DEFINED.—In subparagraph (A), the term ''qualifying employer'' means an employer that—

(i) is described in section 1401(2), or is participating in a multiemployer plan described in section 1401(6)(B) or plan described in section 1401(7), and

(ii) provides such notice to the State involved as the Board specifies.

(C) BENEFITS PLAN DESCRIBED.—A plan described in this subparagraph is an employee benefit plan that—

(i) provides (through insurance or otherwise) the comprehensive benefit package, and

(ii) provides an employer contribution of at least 80 percent of the premium (or premium equivalent) for coverage.

(b) EXPERIENCE-RATE ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—In the case of experience rate eligible individuals, the entitlement under this part shall not take effect until the general effective date.

(2) TRANSITION.—For purposes of this Act and before the general effective date, in the case of an eligible individual who resides in a participating State, the individual is deemed a community rate eligible individual until the individual becomes an experience rate eligible individual, unless subsection (a)(2)(A) applies to the individual.

(c) GENERAL EFFECTIVE DATE DEFINED.—In this Act, the term ''general effective date'' means January 1, 1998.

PART 2—TREATMENT OF FAMILIES AND SPECIAL RULES

SEC. 1011. GENERAL RULE OF ENROLLMENT OF FAMILY IN SAME HEALTH PLAN.

(a) IN GENERAL.—Except as provided in this part or otherwise, all members of the same family (as defined in subsection (b)) shall be enrolled in the same applicable health plan.

(b) FAMILY DEFINED.—In this Act, unless otherwise provided, the term ''family''—

(1) means, with respect to an eligible individual who is not a child (as defined in subsection (c)), the individual; and

(2) includes the following persons (if any):

(A) The individual's spouse if the spouse is an eligible individual.

(B) The individual's children (and, if applicable, the children of the individual's spouse) if they are eligible individuals.

(c) CLASSES OF FAMILY ENROLLMENT; TERMINOLOGY.—

(1) IN GENERAL.—In this Act, each of the following is a separate class of family enrollment:

(A) Coverage only of an individual (referred to in this Act as the ''individual'' enrollment or class of enrollment).

(B) Coverage of a married couple without children (referred to in this Act as the ''couple-only'' enrollment or class of enrollment).

(C) Coverage of an unmarried individual and one or more children (referred to in this Act as the ''single parent'' enrollment or class of enrollment).

(D) Coverage of a married couple and one or more children (referred to in this Act as the ''dual parent'' enrollment or class of enrollment).

(2) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this Act:

(A) FAMILY.—The terms ''family enrollment'' and ''family class of enrollment'', refer to enrollment in a class of enrollment described in subparagraph (B), (C), or (D) of paragraph (1).

(B) COUPLE.—The term ''couple class of enrollment'' refers to enrollment in a class of

enrollment described in subparagraph (B) or (D) of paragraph (1).

(d) SPOUSE; MARRIED; COUPLE.—

(1) IN GENERAL.—In this Act, the terms ''spouse'' and ''married'' mean, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

(2) COUPLE.—The term ''couple'' means an individual and the individual's spouse.

(e) CHILD DEFINED.—

(1) IN GENERAL.—In this Act, except as otherwise provided, the term ''child'' means an eligible individual who (consistent with paragraph (3))—

(A) is under 25 years of age, and

(B) is a dependent of an eligible individual.

The Board may adjust the age limitation in subparagraph (A) with respect to part-time or full-time students if the Board, through a Congressional Budget Office study, determines that such limitation necessitates adjustments for cost savings purposes.

(2) APPLICATION OF STATE LAW.—Subject to paragraph (3), determinations of whether a person is the child of another person shall be made in accordance with applicable State law.

(3) NATIONAL RULES.—The National Health Board may establish such national rules respecting individuals who will be treated as children under this Act as the Board determines to be necessary. Such rules shall be consistent with the following principles:

(A) STEP CHILD.—A child includes a step child who is an eligible individual living with an adult in a regular parent-child relationship.

(B) DISABLED CHILD.—A child includes an unmarried dependent eligible individual regardless of age who is incapable of self-support because of mental or physical disability which existed before age 21.

(C) CERTAIN INTERGENERATIONAL FAMILIES.—A child includes the grandchild of an individual if—

(i) the parent of the grandchild is a child and the parent and grandchild are living with the grandparent; or

(ii) the grandparent has legal custody of the grandchild.

(D) TREATMENT OF EMANCIPATED MINORS AND MARRIED INDIVIDUALS.—An emanci-

pated minor or married individual shall not be treated as a child.

(E) CHILDREN PLACED FOR ADOPTION.—A child includes a child who is placed for adoption with an eligible individual, except when the child is a child in State supervised care.

(f) ADDITIONAL RULES.—The Board shall provide for such additional exceptions and special rules, including rules relating to—

(1) families in which members are not residing in the same area or in which children are not residing with their parents,

(2) the treatment of eligible individuals who are under 25 years of age and who are not a dependent of an eligible individual,

(3) changes in family composition occurring during a year,

(4) treatment of children in State supervised care, and

(5) treatment of children of parents who are separated or divorced,

as the Board finds appropriate.

SEC. 1012. TREATMENT OF CERTAIN FAMILIES.

(a) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS WHO ARE QUALIFYING EMPLOYEES OR SPOUSES OF QUALIFYING EMPLOYEES.—

(1) IN GENERAL.—Except as specifically provided, in the case of an individual who is an individual described in paragraph (2) with respect to 2 consecutive months in a year (and it is anticipated would be in the following month and in such following month would be a medicare-eligible individual but for this paragraph), the individual shall not be treated as a medicare-eligible individual under this Act during such following month and the remainder of the year.

(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph with respect to a month is an individual who is a qualifying employee or the spouse or family member of a qualifying employee in the month.

(b) SEPARATE TREATMENT FOR CERTAIN GROUPS OF INDIVIDUALS.—In the case of a family that includes one or more individuals in a group described in subsection (c)—

(1) all the individuals in each such group within the family shall be treated collectively as a separate family, and

(2) all the individuals not described in any such group shall be treated collectively as a separate family.

(c) GROUPS OF INDIVIDUALS DESCRIBED.—Each of the following is a group of individuals described in this subsection:

(1) AFDC recipients (as defined in section 1902(2)).

(2) Disabled SSI recipients (as defined in section 1902(14)) .

(3) SSI recipients (as defined in section 1902(46)) who are not disabled SSI recipients.

(4) Electing veterans (as defined in subsection (d)(1)).

(5) Active duty military personnel (as defined in subsection (d)(2)).

(6) Electing American Indians (as defined in subsection (d)(3)).

(7) Prisoners (as defined in section 1902(37)).

(d) SPECIAL RULES.—In this Act:

(1) ELECTING VETERANS.—

(A) DEFINED.—Subject to subparagraph (B), the term ''electing veteran'' means a veteran who makes an election to enroll with a health plan of the Department of Veterans Af-

fairs under chapter 18 of title 38, United States Code, as added by section 8101(a)(1).

(B) FAMILY EXCEPTION.—Subparagraph (A) shall not apply with respect to coverage under a health plan referred to in such subparagraph if, for the area in which the electing veteran resides, such health plan offers coverage to family members of an electing veteran and the veteran elects family enrollment under such plan (instead of individual enrollment).

(2) ACTIVE DUTY MILITARY PERSONNEL.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''active duty military personnel'' means an individual on active duty in the Uniformed Services of the United States.

(B) EXCEPTION.—If an individual described in subparagraph (A) elects family coverage under section 1073a(e)(2)(A) of title 10, United States Code (as added by section 8001(a)), then paragraph (5) of subsection (c) shall not apply with respect to such coverage.

(3) ELECTING AMERICAN INDIANS.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''electing American In-

dian'' means an eligible individual who makes an election under section 8302(b) of this Act.

(B) FAMILY ELECTION FOR ALL INDIVIDUALS ELIGIBLE TO ELECT.—No such election shall be made with respect to an individual in a family (as defined without regard to this section) unless such election is made for all eligible individuals (described in section 8302(a)) who are family members of the family.

(4) MULTIPLE CHOICE.—Eligible individuals who are permitted to elect coverage under more than one health plan or program referred to in this subsection may elect which of such plans or programs will be the applicable health plan under this Act.

(e) QUALIFYING STUDENTS.—

(1) IN GENERAL.—In the case of a qualifying student (described in paragraph (2)), the student may elect to enroll in a community-rate health plan offered for the health care coverage area in which the school is located.

(2) QUALIFYING STUDENT.—In paragraph (1), the term ''qualifying student'' means an individual who—

(A) but for this subsection would receive coverage under a health plan as a child of another person, and

(B) is a full-time student at a school in a health care coverage area that is different from the area (or, in the case of a large group sponsor, such coverage area as the Board may specify) providing the coverage described in subparagraph (A).

(3) PAYMENT RULES.—

(A) CONTINUED TREATMENT AS FAMILY.—Except as provided in subparagraph (B), nothing in this subsection shall be construed as affecting the payment liabilities between families and community-rated health plans.

(B) TRANSFER PAYMENT.—In the case of an election under paragraph (1), for transfer payments see section 1238.

(f) SPOUSES LIVING IN DIFFERENT HEALTH CARE COVERAGE AREAS.—The Board shall provide for such special rules in applying this Act in the case of a couple in which the spouses reside in different health care coverage areas as the Board finds appropriate.

(g) CHILDREN IN STATE-SUPERVISED CARE.—

(1) IN GENERAL.—In the case of a qualifying child in State-supervised care (as described in paragraph (2)), the child shall be considered as a family of one and enrolled by the State agency who has been awarded temporary or permanent custody of the child (or which has legal responsibility for the child) in a fee-for-service plan unless the State agency has established a special health service delivery system designated to customize and more efficiently provide health services to children in State-supervised care, in which case the State agency will enroll the child in the plan appropriate to ensure access to such a special health service delivery system.

(2) CHILDREN IN STATE-SUPERVISED CARE.—For purposes of paragraph (1), the term ''child in State-supervised care'' means any child who is residing away from his or her parents and is temporarily or permanently, on a voluntary or involuntary basis, under the responsibility of a public child welfare or juvenile services agency or court. Such term includes children who are not yet made wards of the court or adjudicated as delinquents residing in emergency shelter care, children in the physical custody of public or private agencies, and children who are with foster parents, or other group or residential care

providers. Such term also includes children who are legally adopted and for whom the Federal or State government is providing adoption assistance payments.

SEC. 1013. MULTIPLE EMPLOYMENT SITUATIONS.

(a) MULTIPLE EMPLOYMENT OF AN INDIVIDUAL.—In the case of an individual who—

(1)(A) is not married or (B) is married and whose spouse is not a qualifying employee (as defined in section 1901(b)(1)),

(2) is not a child, and

(3) who is a qualifying employee both of a community rate employer and of a experience rate employer (or of 2 large group sponsor employers),

the individual may elect the applicable health plan to be either a community-rated health plan (for the health care coverage area in which the individual resides) or an experience-rated health plan (for an employer employing the individual).

(b) MULTIPLE EMPLOYMENT WITHIN A FAMILY.—

(1) MARRIED COUPLE WITH EMPLOYMENT COMMUNITY RATE EMPLOYER AND WITH A EXPERIENCE RATE EMPLOYER.—In the case of a married individual—

(A) who is a qualifying employee of a community rate employer and whose spouse is a qualifying employee of a experience rate employer, or

(B) who is a qualifying employee of an experience rate employer and whose spouse is a qualifying employee of a community rate employer,

the individual and the individual's spouse may elect the applicable health plan to be either a community-rated health plan (for the health care coverage area in which the couple resides) or an experience-rated health plan (for an employer employing the individual or the spouse).

(2) MARRIED COUPLE WITH DIFFERENT EMPLOYERS.—In the case of a married individual—

(A) who is a qualifying employee of a experience rate employer, and

(B) whose spouse is a qualifying employee of a different experience rate employer,

the individual and the individual's spouse may elect the applicable health plan to be an experience-rated health plan for an employer employing either the individual or the spouse.

SEC. 1014. TREATMENT OF RESIDENTS OF STATES WITH STATEWIDE SINGLE-PAYER SYSTEMS.

(a) UNIVERSAL COVERAGE.—Notwithstanding the previous provisions of this title, except as provided in part 2 of subtitle C, in the case of an individual who resides in a State that has a Statewide single-payer system under section 1223, universal coverage shall be provided consistent with section 1222(3).

(b) INDIVIDUAL RESPONSIBILITIES.—In the case of an individual who resides in a single-payer State, the responsibilities of such individual under such system shall supersede the obligations of the individual under section 1002.

Subtitle B—Benefits

PART 1—COMPREHENSIVE BENEFIT PACKAGE

SEC. 1101. PROVISION OF COMPREHENSIVE BENEFITS BY PLANS.

(a) IN GENERAL.—Subject to the provisions of section 1603, the comprehensive benefit package shall consist of the following items and services (as described in this part), subject to the cost sharing requirements described in part 3, the exclusions described in part 4, and the duties and authority of the National Health Board described in part 5:

(1) Hospital services.

(2) Services of health professionals.

(3) Emergency and ambulatory medical and surgical services.

(4) Clinical preventive services.

(5) Mental illness and substance abuse services.

(6) Family planning services and services for pregnant women.

(7) Hospice care.

(8) Home health care.

(9) Extended care services.

(10) Ambulance services.

(11) Outpatient laboratory, radiology, and diagnostic services.

(12) Outpatient prescription drugs and biologicals.

(13) Outpatient rehabilitation services.

(14) Durable medical equipment and prosthetic and orthotic devices.

(15) Vision care.

(16) Hearing aids for children.

(17) Dental care.

(18) Investigational treatments.

(19) Optional services, such as—

(A) health education classes; and

(B) extra contractual services.

(b) NO OTHER LIMITATIONS OR COST SHARING.—The items and services in the comprehensive benefit package shall not be subject to any duration or scope limitation or any deductible, copayment, or coinsurance amount that is not required or authorized under this Act.

SEC. 1102. HOSPITAL SERVICES.

(a) COVERAGE.—The hospital services described in this section are the following items and services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) 24-hour a day hospital emergency services.

(b) LIMITATION.—The hospital services described in this section do not include hospital services provided for the treatment of a mental or substance abuse disorder (which are subject to section 1106), except for medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is not covered under such section).

SEC. 1103. SERVICES OF HEALTH PROFESSIONALS.

(a) COVERAGE.—The items and services described in this section are—

(1) inpatient and outpatient health professional services, including consultations, that are provided in—

(A) a home, office, or other ambulatory care setting; or

(B) an institutional setting; and

(2) services and supplies (including drugs and biologicals which cannot be self-administered) furnished as an incident to such health professional services, of kinds which are commonly furnished in the office of a health professional and are commonly either rendered without charge or included in the bill of such professional.

(b) DEFINITIONS.—Unless otherwise provided in this Act, for purposes of this Act:

(1) HEALTH PROFESSIONAL.—The term ''health professional'' means an individual who provides health professional services.

(2) HEALTH PROFESSIONAL SERVICES.—The term ''health professional services'' means professional services that—

(A) are lawfully provided by a physician; or

(B) would be described in subparagraph (A) if provided by a physician, but are provided by another person who is legally authorized to provide such services in the State in which the services are provided.

SEC. 1104. EMERGENCY AND AMBULATORY MEDICAL AND SURGICAL SERVICES.

The items and services described in this section are 24 hour-a-day emergency services, and ambulatory medical and surgical services provided by a facility that is not a hospital and that is legally authorized to provide the services in the State in which they are provided.

SEC. 1105. CLINICAL PREVENTIVE SERVICES.

(a) COVERAGE.—The clinical preventive services described in this section are the following items or services provided consistent with any periodicity schedule or other modification promulgated by the Board under section 1153, including regulations establishing periodicity schedules for high risk populations:

(1) Age appropriate immunizations consistent with the periodicity schedule recommended by the Advisory Council on Immunization Practices, in consultation with the American Academy of Pediatrics.

(2) Age appropriate tests and clinician visits (including preventive counseling and health advice) for individuals under the age of 20, consistent with a periodicity schedule recommended by the American Academy of Pediatrics and other experts in clinical preventive services for children and adolescents.

(3) Clinician visits for individuals age 20 and over as follows:

(A) Every 3 years for individuals age 20 through 39.

(B) Biannually for individuals age 40 through 64.

(C) Annually for individuals age 65 and over.

(4) Cholesterol tests every 5 years for individuals age 20 and over.

(5) Papanicolaou smears and pelvic exams for females who are at risk for cervical cancer—

(A) annually between the ages of 13 through 64 unless three consecutive annual pap smears have been negative and it has been determined that the female is not at risk for sexually transmitted diseases, in which case coverage shall be once every 2 years; and

(B) every 2 years for females age 65 and over.

(6) Annual screening for chlamydia and gonorrhea for sexually active females unless such individual is determined by the health care provider not to be at risk for sexually transmitted diseases.

(7) Mammograms for females as follows:

(A) Ages 40 through 49, every 2 years in consultation with their physician.

(B) Ages 50 through 64, every year.

(C) Age 65 and over, every 2 years.

(b) COLORECTAL CANCER SCREENINGS.—The comprehensive benefit package shall include any revisions to colorectal cancer screenings that are recommended by the U.S. Preventive Services Task Force in the periodic update of the Guide to Clinical Preventive Services planned for release in November, 1994. The National Health Board shall utilize any subsequent U.S. Preventive Services Task Force updates as its primary guidance in updating these clinical preventive services.

(c) CLINICIAN VISIT.—For purposes of this section, the term ''clinician visit'' includes the following health professional services (as defined in section 1102(c)):

(1) A complete medical history.

(2) An appropriate physical examination.

(3) Risk assessment, including for domestic violence.

(4) Targeted health advice and counseling, including nutrition counseling.

(5) The administration of age-appropriate immunizations and tests specified in subsection (a).

SEC. 1106. MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.

(a) COVERAGE.—The mental illness and substance abuse services that are described in this section are the following items and services for eligible individuals, as defined in section 1001(c), including individuals with multiple mental disorders or mental retardation and mental illness, who satisfy the eligibility requirements in subsection (b):

(1) Inpatient mental illness and substance abuse treatment (described in subsection (d)).

(2) Residential mental illness and substance abuse treatment (described in subsection (e)).

(3) Intensive nonresidential mental illness and substance abuse treatment (described in subsection (f)).

(4) Outpatient mental illness and substance abuse treatment (described in subsection (g)), including case management, screening and assessment, crisis services, and collateral services.

(b) ELIGIBILITY.—The eligibility requirements referred to in subsection (a) are as follows:

(1) INPATIENT, RESIDENTIAL, NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—An eligible individual is eligible to receive coverage for inpatient and residential mental illness and substance

abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment (except case management, screening and assessment, crisis services, and collateral services) if the individual—

(A) has, or has had during the 1-year period preceding the date of such treatment, a diagnosable mental disorder or a diagnosable substance abuse disorder or, in the case of a child 5 years of age or less, is at risk of a mental disorder; and

(B) is experiencing, or is at significant risk of experiencing, functional impairment in family, work, school, or community activities.

For purposes of this paragraph, an individual who has a diagnosable mental disorder or a diagnosable substance abuse disorder, is receiving treatment for such disorder, but does not satisfy the functional impairment criterion in subparagraph (B) shall be treated as satisfying such criterion if the individual would satisfy such criterion without such treatment.

(2) CASE MANAGEMENT.—An eligible individual is eligible to receive coverage for case management if the individual is eligible to receive coverage for,

and is receiving, mental illness and substance abuse treatment with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

(3) SCREENING AND ASSESSMENT AND CRISIS SERVICES.—All eligible individuals enrolled under a health plan are eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of screening and assessment and crisis services.

(4) COLLATERAL SERVICES.—An eligible individual is eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of collateral services if the individual is a family member (described in section 1011(b)) of an individual who is receiving inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment.

(c) HEALTH PROFESSIONAL.—

(1) IN GENERAL.—The National Health Board shall specify those health professional services described in section 1103 that shall be treated as inpatient, residential, intensive nonresidential, and out-

patient mental illness and substance abuse treatment.

(2) RULE OF CONSTRUCTION.—Nothing in section 1861(e) of the Social Security Act, including paragraph (4), shall be construed as requiring that individuals receiving items and services under this section be under the care of a physician when such individuals are under the care of a mental health or substance abuse health professional in a State in which such care is permitted by State law.

(d) INPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term ''inpatient mental illness and substance abuse treatment'' means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an inpatient of a hospital or psychiatric hospital.

(2) LIMITATIONS.—Coverage for inpatient mental illness and substance abuse treatment is subject to the following limitations:

(A) INPATIENT HOSPITAL TREATMENT FOR SUBSTANCE ABUSE.—Such treatment, when provided in a hospital or a psychiatric hospital

with respect to a diagnosable substance abuse disorder, is covered under this section only for detoxification requiring the management of psychiatric conditions associated with withdrawal from alcohol or drugs. The items and services described in this section do not include medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is covered under section 1102).

(B) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment, when furnished to an inpatient of a hospital or psychiatric hospital is subject to an aggregate annual limit of 34 days, 15 of which may not be reduced in substitution for other covered services. On or after such date, such annual aggregate limit shall not apply.

(e) RESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term ''residential mental illness and substance abuse treatment'' means the items and services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to a resident of a residential treatment center, residential de-

toxification center, crisis residential program, mental illness residential treatment program, therapeutic family home, therapeutic community, group treatment home, community residential treatment program, or recovery center for substance abuse.

(2) ANNUAL LIMIT.—

(A) IN GENERAL.—Prior to January 1, 2001, the number of covered days of residential mental illness and substance abuse treatment that are available to an individual under the 34-day limit described in the first sentence of subsection (d)(2)(B), shall be reduced by 1 day for each 4 covered days of residential mental illness and substance abuse treatment that are provided to the individual, until such number is reduced to 15. After such number is reduced to 15, no residential treatment may be covered, except as provided in subparagraph (B). On or after such date, such annual aggregate limit shall not apply.

(B) NONAPPLICATION.—The limit contained in subparagraph (A) shall not apply to mental health and substance abuse treatment provided in a therapeutic community, halfway house, recovery center or other comparably in-

expensive residential mental health and substance abuse treatment facility, as determined by the National Health Board.

(f) INTENSIVE NONRESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term ''intensive nonresidential mental illness and substance abuse treatment'' means diagnostic or therapeutic items or services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an individual—

(A) participating in a partial hospitalization program, a mental health consumer-run service center, a day treatment program, a psychiatric rehabilitation program, or an ambulatory detoxification program; or

(B) receiving home-based mental illness services or behavioral aide mental illness services.

(2) LIMITATIONS.—Coverage for intensive nonresidential mental illness and substance abuse treatment is subject to the following limitations:

(A) TREATMENT PURPOSES.—Such treatment is covered only when provided—

(i) to avert the need for treatment in residential or inpatient settings;

(ii) to facilitate the earlier discharge of an individual receiving inpatient or residential care;

(iii) to restore the functioning of an individual with a diagnosable mental disorder or a diagnosable substance abuse disorder; or

(iv) to assist such an individual to develop the skills and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

(B) DETOXIFICATION.—Intensive nonresidential substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(g) OUTPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term ''outpatient mental illness and substance abuse treatment'' means the following services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder in an outpatient setting:

(A) Screening and assessment.

(B) Diagnosis.

(C) Medications management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

(2) LIMITATIONS.—Coverage for outpatient mental illness and substance abuse treatment is subject to the following limitations:

(A) HEALTH PROFESSIONAL SERVICES.—Such treatment is covered only when it constitutes health professional services (as defined in section 1103(b)(2)).

(B) DETOXIFICATION.—Outpatient substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(h) MANAGEMENT OF CARE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE.—

(1) PROVISION OF TREATMENT.—Quality managed care techniques shall be utilized by health plans to ensure that all necessary care is provided in the

most appropriate, cost effective setting, and that unnecessary care is not provided.

(2) QUALITY MANAGED CARE.—The term ''quality managed care'' refers to the administration of benefits through the methods of central intake, preauthorization, and utilization review. Health plans may contract with specialized behavioral care entities to administer benefits if such entities are certified by the State as proficient in the use of quality managed care techniques that facilitate the provision of clinically appropriate, cost-effective, and confidential treatment, providing continuity of care between and among treatment providers.

(3) TREATMENT DECISIONS.—

(A) Treatment placement decisions shall be based primarily on medical necessity. Criteria used for placement shall be based on uniform assessment tools recognized by treatment and other professional organizations in the fields of mental illness and substance abuse or approved for use by the National Health Board and shall be publicly available.

(B) All treatment assessment and placement decisions or review of such decisions shall be made by personnel—

(i) licensed, certified, or otherwise credentialed by the State in the field for which the assessment or treatment is sought (such as mental health or substance abuse) and qualified to review utilization of the specific treatment delivered; and

(ii) with no financial stake in the outcome of such decisions.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting health plans from providing mental health and substance abuse treatment through fee-for-service arrangements.

(i) SPECIAL DELIVERY REQUIREMENTS FOR SERVICES PROVIDED TO CHILDREN.—

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—Health plans shall ensure that the mental illness and substance abuse services described in this section and furnished to an eligible person are furnished through organized systems of care, as described in paragraph (2), if the eligible person is a person under 22 years of age who has a serious emotional disturbance or a substance abuse disorder, and who is, or is at imminent risk of being, involved with one or more pub-

lic child-serving agencies, including child welfare, special education, and juvenile or criminal justice.

(2) REQUIREMENTS OF SYSTEM OF CARE.—As used in this subsection, the term ''organized system of care'' means a community-based service delivery network, which may consist of public and private providers, that meets the following requirements:

(A) The system has established linkages with existing mental illness and substance abuse service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile or criminal justice, health care, mental health, and substance abuse prevention and treatment.

(C) The system provides for the involvement of the families of children to whom mental illness and substance abuse services are pro-

vided in the planning of treatment and the delivery of services.

(D) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multiagency teams, that are recognized and followed by the applicable agencies and providers in the area.

(E) The system ensures the delivery and coordination of the range of mental illness and substance abuse services required by individuals under 22 years of age who have a serious emotional disturbance or a substance abuse disorder.

(F) The system provides for the management of the individualized treatment plans described in subparagraph (D) and for a flexible response to changes in treatment needs over time.

(3) FULL IMPLEMENTATION OF PLAN.—Subject to paragraph (2)(F), the State shall assure that public or philanthropic resources are available to implement each child's plan, including residential treatment in excess of the limit set forth in subsection (e)

if the State determines that such treatment is clinically appropriate.

(4) RULE OF CONSTRUCTION.—The organized system of care shall not exclude health professionals whose services are covered by the health plan selected by the child or the child's legal guardian.

(5) REQUIREMENTS OF STATES.—The State shall ensure that public agencies furnishing services to children with serious emotional disturbances, including mental health, child welfare, special education, juvenile justice, and other agencies, establish policies that result in effective collaboration and coordination among such agencies and the health plans established in the State. Such collaboration may include policies to blend public funds with health plan resources to meet such children's needs or risk adjustment payments to health plans.

SEC. 1107. FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.

The services described in this section are the following items and services:

(1) Voluntary comprehensive family planning services, including family planning counseling and education.

(2) Contraceptive drugs and devices, subject to approval by the Secretary under the Federal Food, Drug, and Cosmetic Act.

(3) Services for pregnant women.

SEC. 1108. HOSPICE CARE.

The hospice care described in this section is the items and services described in paragraph (1) of section 1861(dd) of the Social Security Act, as defined in paragraphs (2), (3), and (4)(A) of such section, except that all references to the Secretary of Health and Human Services in such paragraphs shall be treated as references to the National Health Board.

SEC. 1109. HOME HEALTH CARE.

(a) COVERAGE.—The home health care described in this section is—

(1) the items and services described in section 1861(m) of the Social Security Act; and

(2) home infusion drug therapy services.

(b) LIMITATIONS.—Coverage for home health care is subject to the following limitations:

(1) INPATIENT TREATMENT ALTERNATIVE.—Such care is covered only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility as a result of an illness, injury, disorder or other health condition.

(2) REEVALUATION.—At the end of each 60-day period of home health care, the need for continued care shall be reevaluated by the person who is primarily responsible for providing the home health care. Additional periods of care are covered only if such person determines that the requirement in paragraph (1) is satisfied.

SEC. 1110. EXTENDED CARE SERVICES.

(a) COVERAGE.—The extended care services described in this section are the items and services described in section 1861(h) of the Social Security Act when provided to an inpatient of a skilled nursing facility or a rehabilitation facility.

(b) LIMITATIONS.—Coverage for extended care services is subject to the following limitations:

(1) HOSPITAL SERVICES ALTERNATIVE.—Such services are covered only as an alternative to treatment for inpatient hospital services as a result of an illness, injury, disorder or other health condition.

(2) ANNUAL LIMIT.—Such services are subject to an aggregate annual limit of 100 days, except that such limit may be waived if the need for continued care is re-evaluated by the prescribing health care professional and determined to be a cost effective alternative to necessary hospital services.

SEC. 1111. AMBULANCE SERVICES.

The ambulance services described in this section are covered only when indicated by the medical condition of the individual concerned. Such services include—

(1) ground transportation by ambulance; or

(2) air or water transportation by an aircraft or vessel equipped for transporting an injured or sick individual in cases in which there is no other method of transportation or where the use of another method of transportation is contraindicated by the medical condition of the individual concerned.

SEC. 1112. OUTPATIENT LABORATORY, RADIOLOGY, AND DIAGNOSTIC SERVICES.

The items and services described in this section are laboratory, radiology, and diagnostic services (including genetic testing and counseling) provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

SEC. 1113. OUTPATIENT PRESCRIPTION DRUGS AND BIOLOGICALS.

The items described in this section are the following:

(1) Covered outpatient drugs described in section 1861(t) of the Social Security Act—

(A) except that, for purposes of this section, a medically accepted indication with respect to the use of a covered outpatient drug in-

cludes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia; or

(iii) such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this clause by the Secretary; and

(B) notwithstanding any exclusion from coverage that may be made with respect to such a drug under title XVIII of such Act pursuant to section 1862(a)(18) of such Act.

(2) Blood clotting factors when provided on an outpatient basis.

(3) Medical foods prescribed by a physician that comply with the requirements of the Federal Food, Drug, and Cosmetic Act and that treat inborn errors of metabolism identified by the Secretary as rendering a person unable to sustain life without significant mental or physical impairment by the ingestion of conventional foods.

(4) Accessories and supplies that are used directly with drugs and biologics to achieve the therapeutic benefit of such drugs or biologics.

SEC. 1114. OUTPATIENT REHABILITATION SERVICES.

(a) COVERAGE.—The outpatient rehabilitation services described in this section are—

(1) outpatient occupational therapy;

(2) outpatient physical therapy;

(3) outpatient respiratory therapy; and

(4) outpatient speech-language pathology services and audiology services.

(b) LIMITATIONS.—Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS.—Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder or other health condition.

(2) MAINTENANCE OF FUNCTION OR PREVENTION OF DETERIORATION.—To the extent that the services described in paragraph (1) are for the purpose of maintaining functioning or preventing deterioration, such services shall be limited to—

(A) the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;

(B) the designing by the qualified rehabilitation health professional of a maintenance or prevention program that is appropriate considering the capacity and tolerance of the patient and the treatment objectives;

(C) the instruction of the patient, family members, or support personnel in carrying out the program; and

(D) reevaluations.

(3) REEVALUATION.—

(A) IN GENERAL.—At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (2)), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

(B) QUALIFIED REHABILITATION HEALTH PROFESSIONAL.—Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

SEC. 1115. DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.

(a) COVERAGE.—The items and services described in this section are—

(1) durable medical equipment;

(2) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ (including devices that are surgically inserted, devices that are physically attached to the body, such as colostomy bags and supplies di-

rectly related to colostomy care, and external devices);

(3) orthotics (leg, arm, back and neck braces) and prosthetics (artificial legs, arms and eyes);

(4)(A) accessories and supplies which are used directly with equipment or devices described in paragraphs (1) through (3) to achieve the therapeutic benefits of such equipment or devices or to assure the proper functioning of such equipment or device;

(B) replacement of such equipment or devices when required in cases of loss irreparable damage, wear, or because of a change in the patient's condition; and

(C) repair and maintenance of such equipment and devices; and

(5) fitting (including adjustments) and training for use of the items described in paragraphs (1) through (4).

(b) LIMITATION.—An item or service described in this section is covered only if it improves functional ability or prevents or minimizes deterioration in function.

(c) DURABLE MEDICAL EQUIPMENT.—For purposes of this subtitle, the term ''durable medical equipment'' has the meaning given such term in section 1861(n) of the Social Security Act.

SEC. 1116. VISION CARE.

(a) COVERAGE.—The vision care described in this section is routine eye examinations, diagnosis, and treatment for defects in vision.

(b) LIMITATION.—Eyeglasses and contact lenses are covered only for individuals less than 18 years of age, according to a periodicity schedule established by the Board.

SEC. 1117. HEARING AIDS FOR CHILDREN.

The items described in this section are hearing aids for individuals up to age 18 when recommended by a physician or audiologist.

SEC. 1118. DENTAL CARE.

(a) COVERAGE.—The dental care described in this section is the following:

(1) Emergency dental treatment, including simple extractions, for acute infections, bleeding, and injuries to natural teeth and oral structures for conditions requiring immediate attention to prevent risks to life or significant medical complications, as specified by the National Health Board.

(2) Prevention and diagnosis of dental disease, including oral dental examinations, radiographs, dental sealants, fluoride application, and dental prophylaxis.

(3) Treatment of dental disease, including routine fillings, prosthetics for genetic defects, periodontal maintenance, and endodontic services.

(4) Space maintenance procedures to prevent orthodontic complications.

(5) Interceptive orthodontic treatment to prevent severe malocclusion.

(b) LIMITATIONS.—Coverage for dental care is subject to the following limitations:

(1) Prior to January 1, 2001, the items and services described in paragraphs (2) and (3) of subsection (a) are covered only for individuals less than 18 years of age. On or after such date, such items and services are covered for all eligible individuals enrolled under a health plan, except that dental sealants and endodontic services are not covered for individuals 18 years of age or older.

(2) The items and services described in subsection (a)(4) are covered only for individuals at least 3 years of age but less than 13 years of age when determined to be medically necessary or appropriate to prevent future need for more costly services otherwise covered under this section.

(3) Prior to January 1, 2001, the items and services described in subsection (a)(5) are not cov-

ered. On or after such date, such items and services are covered only for individuals at least 6 years of age, but less than 12 years of age.

SEC. 1119. INVESTIGATIONAL TREATMENTS.

(a) COVERAGE.—The items and services described in this section are qualifying investigational treatments (as defined in subsection (c)) that are administered for a disease, disorder, or other health conditions. A health plan shall allow individuals, when medically appropriate, to participate in an investigational therapy, and shall cover the patient care provided pursuant to investigational treatments as described in subsection (b).

(b) PATIENT CARE DURING INVESTIGATIONAL TREATMENTS.—The comprehensive benefit package includes an item or service described in any other section of this part, subject to the limitations and cost sharing requirements applicable to the item or service, when the item or service is provided to an individual in the course of an investigational treatment, if—

(1) the treatment is a qualifying investigational treatment; and

(2) the item or service is required to provide patient care pursuant to the design of the trial, except those services normally paid for by other funding sources (as defined by the National Health

Board) such as the cost of the investigational agent or device itself, and the costs of managing the research.

Items or services subject to the exception in paragraph (2), may be covered in addition to patient care at the discretion of the health plan so long as the plan makes a determination based on objective protocols applied consistently to all enrollees.

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

(1) QUALIFYING INVESTIGATIONAL TREATMENT.—The term ''qualifying investigational treatment'' means a treatment—

(A) the effectiveness of which has not been determined; and

(B) that is under clinical investigation as part of an approved research trial.

(2) APPROVED RESEARCH TRIAL.—The term ''approved research trial'' means—

(A) a research trial approved by the Secretary of Health and Human Services, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovern-

mental research entity as defined in guidelines of the National Institutes of Health; or

(B) a peer-reviewed and approved research program, as defined by the Secretary of Health and Human Services, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary or appropriate.

Nothing in this section shall be construed as limiting the authority of the Commissioner of Food and Drugs over clinical investigations of products within the Commissioner's jurisdiction.

SEC. 1120. OPTIONAL SERVICES.

(a) HEALTH EDUCATION.—Health education and training programs, including community-based programs, may be provided at the discretion of the health plan to encourage the reduction of behavioral risk factors and to promote health activities. Such education and training programs may include smoking cessation, nutrition counseling, stress management, support groups, and physical training classes. This subsection shall not be construed to include or limit education or training that is provided in the course of the delivery of health professional services

under section 1102. Health care providers may refer plan members to health education programs that best meet their needs based on an assessment of individual risks and learning styles. Health plans shall inform health providers about the availability of such health education programs annually, either at the time of paying the first claim to that provider, or in the case of a network plan, at the time of contracting with the provider.

(b) EXTRA CONTRACTUAL SERVICES.—

(1) IN GENERAL.—A health plan may provide coverage to individuals enrolled under the plan for extra contractual items and services determined appropriate by the plan and the individual (or in appropriate circumstances the parent or legal guardian of the individual).

(2) DEFINITION.—As used in this section, the term ''extra contractual items and services'' means, with respect to a health plan, case management services and those medically appropriate alternatives (either alternative items or services or alternative care settings) to traditional covered items or services that are determined by the health plan to be the most cost effective way to provide appropriate treatment to the enrolled individual.

(c) DISPUTED CLAIMS.—A decision by a health plan to permit or deny the provision of optional services shall not be subject to a benefit discrimination review or other review unless such review involves a claim of discrimination under this Act.

PART 2—COST SHARING

SEC. 1131. COST SHARING.

(a) IN GENERAL.—Each health plan shall offer to individuals enrolled under the plan one, but not more than one, of the following cost sharing schedules, which schedule shall be offered to all such enrollees:

(1) Lower cost sharing (described in section 1132).

(2) Higher cost sharing (described in section 1133).

(3) Combination cost sharing (described in section 1134).

(b) COST SHARING FOR LOW-INCOME FAMILIES.—For provisions relating to reducing cost sharing for certain low-income families, see section 1281.

(c) DEDUCTIBLES, COST SHARING, AND OUT-OF-POCKET LIMITS ON COST SHARING.—

(1) APPLICATION ON AN ANNUAL BASIS.—The deductibles and out-of-pocket limits on cost sharing for a year under the schedules referred to in sub-

section (a) shall be applied based upon expenses incurred for items and services furnished in the year.

(2) INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.—

(A) INDIVIDUAL.—Subject to subparagraph (B), with respect to an individual enrolled under a health plan (regardless of the class of enrollment), any individual general deductible in the cost sharing schedule offered by the plan represents the amount of countable expenses (as defined in subparagraph (C)) that the individual may be required to incur in a year before the plan incurs liability for expenses for such items and services furnished to the individual.

(B) FAMILY.—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the individual general deductible under subparagraph (A) shall not apply to countable expenses incurred by any member of the individual's family in a year at such time as the family has incurred, in the aggregate, countable expenses in the amount of the family general deductible for the year.

(C) COUNTABLE EXPENSE.—In this paragraph, the term ''countable expense'' means, with respect to an individual for a year, an expense for an item or service covered by the comprehensive benefit package that is subject to the general deductible and for which, but for such deductible and any other cost sharing under this subtitle, a health plan is liable for payment. The amount of countable expenses for an individual for a year under this paragraph shall not exceed the individual general deductible for the year.

(3) COINSURANCE AND COPAYMENTS.—After a general or separate deductible that applies to an item or service covered by the comprehensive benefit package has been satisfied for a year, subject to paragraph (4), coinsurance and copayments are amounts (expressed as a percentage of an amount otherwise payable or as a dollar amount, respectively) that an individual may be required to pay with respect to the item or service.

(4) INDIVIDUAL AND FAMILY LIMITS ON COST SHARING.—

(A) INDIVIDUAL.—Subject to subparagraph (B), with respect to an individual en-

rolled under a health plan (regardless of the class of enrollment), the individual out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that the individual may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit package that are provided to the individual.

(B) FAMILY.—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the family out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that members of the individual's family, in the aggregate, may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit

package that are provided to any member of the individual's family.

(C) AMOUNT OF OUT OF POCKET LIMITS.—The amount of the out of pocket limit described—

(i) in subparagraph (A) is $2,500, and

(ii) in subparagraph (B), is $3,000.

SEC. 1132. LOWER COST SHARING.

(a) IN GENERAL.—The lower cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) shall have a deductible of $250 per inpatient hospital admission, and shall not have any other required deductibles;

(2) except as provided in paragraph (4)—

(A) shall prohibit payment of any coinsurance; and

(B) subject to section 1152, shall require payment of the copayment for items or services as follows—

(i) for items and services described in sections 1102(a)(1), 1104, 1105, 1106(g)(1)(H), 1107, 1108, 1109, 1110, 1111, 1112, 1115, 1117, and for clinician

visits and associated services related to prenatal care and one postpartum visit, no copayment is permitted;

(ii) for items and services described in sections 1102(a)(2), 1103, 1106 (subject to clause (i)), 1113, 1114, 1115, and 1116, the copayment is $10 per visit (or per prescription in the case of items described in section 1113);

(iii) for services described in section 1118(a)(4) and 1118(a)(5), the copayment is $20 per visit;

(iv) for items and services described in section 1102(a)(3) and 1104, the copayment is $25 per visit unless the patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act; and

(v) for items and services described in sections 1119, all cost sharing rules shall be determined by the health plans; and

(3) shall require payment of coinsurance for an out-of-network item or service (as defined in section 1502(f)) in an amount that is a percentage (determined under subsection (b)) of the applicable pay-

ment rate for the item or service established under section 1211(b), but only if the item or service is subject to coinsurance under the higher cost sharing schedule described in section 1133 or is a clinical preventive service as defined in section 1104.

(b) OUT-OF-NETWORK COINSURANCE PERCENTAGE.—

(1) IN GENERAL.—The National Health Board shall determine a percentage referred to in subsection (a)(3). The percentage—

(A) may not be less than 20 percent; and

(B) shall be the same with respect to all out-of-network items and services that are subject to coinsurance, except as provided in paragraph (2).

(2) EXCEPTION.—The National Health Board may provide for a percentage that is greater than a percentage determined under paragraph (1) in the case of an out-of-network item or service for which, under the higher cost sharing schedule described in section 1133, the coinsurance is greater than 20 percent of the applicable payment rate.

SEC. 1133. HIGHER COST SHARING.

The higher cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) shall have an annual individual general deductible of $200 and an annual family general deductible of $400 that apply with respect to expenses incurred for all items and services in the comprehensive benefit package except—

(A) an item or service with respect to which a separate individual deductible applies under paragraph (2); or

(B) an item or service described in paragraph (3), (4), or (5) with respect to which a deductible does not apply;

(2) shall require an individual to incur expenses in a year for outpatient prescription drugs and biologicals (described in section 1113) equal to $250 before the plan provides benefits for such items to the individual;

(3) shall require an individual to incur expenses in a year for dental care described in section 1118, except the items and services for prevention and diagnosis of dental disease described in section 1118(a)(2), equal to $50 before the plan provides benefits for such care to the individual;

(4) may not require any deductible for clinical preventive services (described in section 1105);

(5) may not require any deductible for family planning services as defined in section 1107(1), clinician visits and associated services related to prenatal care or 1 post-partum visit under section 1107;

(6) may not require any deductible for the items and services for prevention and diagnosis of dental disease described in section 1126(a)(2);

(7) shall prohibit payment of any copayment; and

(8) subject to section 1152, shall require payment of coinsurance for an item or service as follows—

(A) for items and services described in section 1105, family planning services and clinical visits and associated services related to prenatal care and one post partum visit, and case management services under section 1106, no coinsurance is permitted;

(B) for items and services described in section 1118(a)(4) and 1118(a)(5), the coinsurance is 40 percent of the applicable payment rate;

(C) for outpatient services under section 1106(g)(1)(G)—

(i) the coinsurance with respect to the first five outpatient psychotherapy visits is 20 percent of the applicable payment rate;

(ii) the coinsurance with respect to any subsequent outpatient psychotherapy visits is 50 percent of the applicable payment rate; and

(iii) the coinsurance with respect to children for outpatient psychotherapy visits is 20 percent of the applicable payment rate; and

(D) for all other items and services, the coinsurance is 20 percent of the applicable payment rate.

For purposes of this section, the term ''applicable payment rate'', when used with respect to an item or service, means the applicable payment rate for the item or service established under section 1523(e).

SEC. 1134. COMBINATION COST SHARING.

(a) IN GENERAL.—The combination cost sharing schedule referred to in section 1131 that is offered by a health plan shall require different cost sharing for in-network items and services than for out-of-network items and services.

(b) IN-NETWORK ITEMS AND SERVICES.—With respect to an in-network item or service (as defined in section 1514(c)(1)), the combination cost sharing schedule that is offered by a health plan—

(1) shall have a deductible of $250 per inpatient hospital admission, and shall not have any other required deductibles;

(2) shall prohibit payment of any coinsurance; and

(3) shall require payment of a copayment in accordance with the lower cost sharing schedule described in section 1132.

(c) OUT-OF-NETWORK ITEMS AND SERVICES.—With respect to an out-of-network item or service (as defined in section 1514(c)(2)), the combination cost sharing schedule that is offered by a health plan—

(1) shall require an individual and a family to incur expenses before the plan provides benefits for the item or service in accordance with the deductibles under the higher cost sharing schedule described in section 1133;

(2) shall prohibit payment of any copayment; and

(3) shall require payment of coinsurance in accordance with such schedule, except with respect to

clinical preventive services obtained out-of-network that shall be subject to a coinsurance percentage as determined by the National Health Board under section 1132.

SEC. 1135. INDEXING DOLLAR AMOUNTS RELATING TO COST SHARING.

(a) IN GENERAL.—Any deductible, copayment, out-of-pocket limit on cost sharing, or other amount expressed in dollars in this subtitle for items or services provided in a year after 1994 shall be such amount increased by the product of the factors described in subsection (b) for the year and for each previous year after 1994, minus 1. Any increase (or decrease) under this subsection shall be rounded.

(b) FACTOR.—

(1) IN GENERAL.—The factor described in this subsection for a year is 1 plus the general health care inflation factor (as specified in section 6001(a)(3) and determined under paragraph (2)) for the year.

(2) DETERMINATION.—In computing such factor for a year, the percentage increase in the CPI for a year (referred to in section 6001(b)) shall be determined based upon the percentage increase in the average of the CPI for the 12-month period end-

ing with August 31 of the previous year over such average for the preceding 12-month period.

PART 3—EXCLUSIONS

SEC. 1141. EXCLUSIONS.

(a) MEDICAL NECESSITY.—The comprehensive benefit package does not include—

(1) an item or service that is not medically necessary or appropriate; or

(2) an item or service that the National Health Board may determine is not medically necessary or appropriate in a regulation promulgated under section 1154.

(b) ADDITIONAL EXCLUSIONS.—The comprehensive benefit package does not include the following items and services:

(1) Custodial care, except in the case of hospice care under section 1107.

(2) Surgery and other procedures performed solely for cosmetic purposes and hospital or other services incident thereto, unless—

(A) required to correct a congenital anomaly; or

(B) required to restore or correct a part of the body that has been altered as a result of—

(i) accidental injury;

(ii) disease; or

(iii) surgery that is otherwise covered under this subtitle.

(3) Hearing aids, except as provided in section 1117.

(4) Eyeglasses and contact lenses for individuals at least 18 years of age.

(5) In vitro fertilization services.

(6) Sex change surgery and related services.

(7) Private duty nursing.

(8) Personal comfort items, except in the case of hospice care under section 1107.

(9) Any dental procedures involving orthodontic care, inlays, gold or platinum fillings, bridges, crowns, pin/post retention, dental implants, surgical periodontal procedures, or the preparation of the mouth for the fitting or continued use of dentures, except as specifically described in section 1118.

PART 4—ROLE OF THE NATIONAL HEALTH BOARD

SEC. 1151. DEFINITION OF BENEFITS.

(a) IN GENERAL.—The National Health Board may promulgate such regulations or establish such guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health

plans. All plans shall comply with any regulation or guidelines established by the Board under this section.

(b) FLEXIBILITY IN DELIVERY.—The regulations or guidelines under subsection (a) shall permit a health plan to deliver covered items and services to individuals enrolled under the plan using the providers and methods that the plan determines to be appropriate and consistent with standards of quality care and so long as the plan complies with the provisions of this Act.

SEC. 1152. ACCELERATION OF EXPANDED BENEFITS.

(a) IN GENERAL.—Subject to subsection (b), at any time prior to January 1, 2001, the National Health Board, in its discretion, may by regulation expand the comprehensive benefit package by—

(1) adding any item or service that is added to the package as of January 1, 2001; and

(2) requiring that a cost sharing schedule described in part 2 of this subtitle reflect (wholly or in part) any of the cost sharing requirements that apply to the schedule as of January 1, 2001.

No such expansion shall be effective except as of January 1 of a year.

(b) CONDITION.—The Board may not expand the benefit package under subsection (a) which is to become effective with respect to a year, by adding any item or

service or altering any cost sharing schedule, unless the Board estimates that the additional increase in per capita health care expenditures resulting from the addition or alteration, for each health care coverage area for the year, will not cause any health care coverage area to exceed its per capita target (as determined under section 6003).

SEC. 1153. AUTHORITY WITH RESPECT TO CLINICAL PREVENTIVE SERVICES.

(a) IN GENERAL.—With respect to clinical preventive services described in section 1104, the National Health Board—

(1) shall specify and define specific items and services as clinical preventive services for high risk populations within 1 year of the date of enactment of this Act and shall establish and update a periodicity schedule for such items and services;

(2) shall establish and update periodicity schedules for the age-appropriate immunizations;

(3) shall establish a periodicity schedule for age appropriate tests and clinician visits for individuals under the age of 20;

(4) shall establish rules with respect to coverage for an immunization, test, or clinician visit that is not provided to an individual during the age range

for such immunization, test, or clinician visit that is specified in such section; and

(5) may otherwise modify the items and services described in such section, taking into account age and other risk factors, but may not modify the cost sharing for any such item or service.

(b) CONSULTATION.—In performing the functions described in subsection (a), the National Health Board shall consult with experts in clinical preventive services, including those specified in section 1105.

SEC. 1154. ESTABLISHMENT OF STANDARDS REGARDING MEDICAL NECESSITY.

The National Health Board may promulgate such regulations as may be necessary to carry out section 1141(a)(2) (relating to the exclusion of certain services that are not medically necessary or appropriate).

SEC. 1155. BALANCE BILLING.

The Board shall provide for methods to ensure the prohibition of balance billing.

PART 5—ADDITIONAL PROVISIONS RELATING TO HEALTH CARE PROVIDERS

SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE LAWS.

No State may, through licensure or otherwise, restrict the practice of any class of health professionals be-

yond what is justified by the skills and training of such professionals.

SEC. 1162. PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

SEC. 1163. DUTY TO DISCLOSE INCORRECT TEST RESULTS.

(a) IN GENERAL.—Any facility, including hospitals, clinics, and clinical laboratories, which provides diagnostic testing or other health care items or services covered under this Act shall promptly notify the individual provider who ordered the test of any errors in the test results. The individual provider who ordered the test must promptly notify the patient of the error if the new results affect the patient's diagnosis or treatment.

(b) REGULATIONS.—To carry out subsection (a), the Secretary shall promptly issue proposed regulations, and within 9 months of the date of enactment of this Act shall issue final regulations.

Subtitle C—State Responsibilities

SEC. 1200. PARTICIPATING STATE.

(a) IN GENERAL.—For purposes of the approval of a State health care system by the Board under section 1611, a State is a ''participating State'' if the State meets the applicable requirements of this subtitle.

(b) SUBMISSION OF SYSTEM DOCUMENT.—

(1) IN GENERAL.—In order to be approved as a participating State under section 1611, a State shall submit to the National Health Board a document (in a form and manner specified by the Board) that describes the State health care system that the State is establishing (or has established).

(2) DEADLINE.—If a State is not a participating State with a State health care system in operation by January 1, 1998, the provisions of subpart C of part 1 of subtitle F (relating to responsibilities in absence of State systems) shall take effect.

(3) SUBMISSION OF INFORMATION SUBSEQUENT TO APPROVAL.—A State approved as a participating State under section 1611 shall submit to the Board an annual update to the State health care system not later than February 15 of each year following the first year for which the State is a participating State. The update shall contain—

(A) such information as the Board may require to determine that the system shall meet the applicable requirements of this Act for the succeeding year; and

(B) such information as the Board may require to determine that the State operated the system during the previous year in accordance with the Board's approval of the system for such previous year.

PART 1—GENERAL STATE RESPONSIBILITIES

SEC. 1201. GENERAL STATE RESPONSIBILITIES.

A participating State is responsible for:

(1) HEALTH CARE COVERAGE AREA.—Establishing one or more health care coverage areas (in accordance with section 1202).

(2) HEALTH PLANS.—Certifying and overseeing health plans in accordance with subtitle F.

(3) PROVIDERS.—Assessing such licensing fees as may be necessary to adequately fund State health profession boards. (Nothing in this paragraph shall preempt State authority to license or register health care providers.) State health professional boards shall—

(A) investigate complaints with a reasonable probability of validity, and issue appropriate sanctions;

(B) have adequate public, consumer, and non-physician representatives; and

(C) report all final disciplinary actions to the National Practitioner Data Bank.

(4) PREMIUM ADJUSTMENT.—Administering risk adjustment, reinsurance and other premium adjustment programs consistent with this Act.

(5) REDUCTIONS IN COST SHARING.—Administering reductions in cost sharing in accordance wuth section 1281 and 1282 and a premium discount program in accordance with subtitle B of title VI.

(6) COOPERATIVES.—Certification of at least one consumer purchasing cooperative in each area, consistent with the provisions of subtitle D.

(7) OTHER RESPONSIBILITIES.—Carrying out all other responsibilities of participating States specified under this Act.

SEC. 1202. ASSURING COMMUNITY-RATED PREMIUMS THROUGH ESTABLISHMENT OF HEALTH CARE COVERAGE AREAS.

(a) IN GENERAL.—In accordance with this section, a participating State shall provide for the division of the State into 1 or more health care coverage areas.

(b) MULTIPLE AREAS.—With respect to a health care coverage area—

(1) no metropolitan statistical area in a State may be incorporated into more than 1 such area in the State;

(2) the number of individuals residing within such an area may not be less than 150,000; and

(3) no area incorporated in a health care coverage area may be incorporated into another such area.

(c) BOUNDARIES.—

(1) IN GENERAL.—In establishing boundaries for health care coverage areas, a State shall comply with the antidiscrimination requirements of section 1914.

(2) COORDINATING MULTIPLE HEALTH CARE COVERAGE AREAS.—Nothing in this section shall be construed as preventing a State from coordinating the activities of one or more health care coverage areas in the State.

(3) INTERSTATE HEALTH CARE COVERAGE AREAS.—Health care coverage areas with respect to interstate areas shall be established in accordance with rules established by the Board.

(4) COORDINATION IN MULTI-STATE AREAS.—One or more States may coordinate their operations in contiguous health care coverage areas. Such coordination may include, the following activities, adoption of joint operating rules, contracting with health plans, enforcement activities, and establishment of fee schedules for health providers.

SEC. 1203. USE OF INCENTIVES.

(a) USE OF INCENTIVES TO ENROLL AND SERVE DISADVANTAGED GROUPS.—A State may provide—

(1) for an additional adjustment to the risk-adjustment methodology under section 1641(b), or in accordance with the standards under section 1642, and other financial incentives to community-rated health plans to ensure that such plans enroll individuals who are members of disadvantaged groups or populations vulnerable to discrimination due to their health status, and

(2) for appropriate extra services, such as outreach to encourage enrollment and transportation and interpreting services to ensure access to care,

for certain population groups that face barriers to access because of geographic location, income levels, disability or racial or cultural differences.

(b) USE OF INCENTIVES TO ADDRESS NEEDS IN AREAS WITH INADEQUATE HEALTH SERVICES.—

(1) PAYMENT ADJUSTMENT.—To ensure that plans are available to all eligible individuals residing in all portions of a health care coverage area, a State may adjust payments to plans or use other financial incentives to encourage health plans to expand into areas that have inadequate health services.

(2) ENCOURAGING NEW PLANS.—Subject to section 1202(c), to encourage the establishment of a new health plan in an area that has inadequate health services, a State may—

(A) organize health providers to create such a plan in such an area that is targeted at such area;

(B) provide assistance with the establishment and administration of such a plan; and

(C) arrange favorable financing for such a plan.

SEC. 1204. RESTRICTIONS ON FUNDING OF ADDITIONAL BENEFITS.

If a participating State provides benefits (either directly or through community-rated health plans or otherwise) in addition to those covered under the comprehensive benefit package, the State may not provide for payment for such benefits through funds provided under this Act.

SEC. 1205. CONSUMER INFORMATION AND MARKETING.

(a) CONSUMER INFORMATION.—Before each open enrollment period, each State shall ensure the availability to eligible enrollees of information, in an easily understood and useful form, that allows such enrollees (and other community-rate eligible individuals) to make valid comparisons among community-rated health plans and veterans and Uniformed Services health plans offered in the State, including information about plan price, the characteristics and availability of participating health professionals and institutions, any restrictions on access to providers or services and a summary of the annual quality performance report described in section 5005. Such information shall be made available in a brochure, published not less often than annually, in accordance with section 1603(e). In the case of a health care coverage area that includes a significant number or proportion of residents with limited English speaking proficiency, the State shall ensure the availability of all written materials in languages

other than English as appropriate to the health care coverage area.

(b) MARKETING.—Each participating State shall ensure that health plans meet the marketing requirements under section 1515.

SEC. 1206. STATE RESPONSIBILITIES WITH RESPECT TO WORKSITE HEALTH PROMOTION DISCOUNTS.

Each State shall provide for the administration of wellness discounts in accordance with rules established by the Secretary in accordance with section 1687. Such duties shall include the receipt of employer self-certification forms, enforcement of compliance, dispute resolution and implementation of wellness discounts in a manner consistent with section 1687.

SEC. 1207. CONSUMER ADVOCATE.

(a) IN GENERAL.—The Secretary shall establish (by grant or contract) and oversee a National Center of Consumer Advocacy to provide technical assistance, adequate training and support to States and Offices of Consumer Advocacy in each State (hereafter referred to in this section as the ''Office'') to carry out the duties of this section, including providing public education to consumers concerning this Act. The National Center of Consumer Advocacy shall be a national non-profit organization with public education and health policy expertise

and shall have sufficient staff to carry out its duties and a demonstrated ability to represent and work with a broad spectrum of consumers, including vulnerable and under served populations. The Office in each State shall perform public outreach and provide education and assistance regarding consumer rights and responsibilities under this Act, and assist consumers in dealing with problems that arise with consumer purchasing cooperatives, large group purchasers, health plans, and health care providers operating in such State.

(b) CONTRACTS.—

(1) SOLICITATION.—The Secretary shall solicit contracts from private non-profit organizations to fulfill the duties of the Office in the State. The Secretary may develop such regulations and guidelines as necessary to oversee the process of considering and awarding competitive contracts under this section. In awarding such contracts, the Secretary shall consult with the State and National Center of Consumer Advocacy, and shall, at a minimum, consider the demonstrated ability of the organization to represent and work with a broad spectrum of consumers, including vulnerable and underserved populations.

(2) CONTRACT PERIOD.—The contract period for the State Offices of Consumer Advocacy and the National Center of Consumer Advocacy under this section shall be not less than 4 years and not more than 7 years.

(c) FUNCTIONS AND RESPONSIBILITIES.—Each Office shall have sufficient staff, local offices throughout the State, and a State-wide toll-free hotline to carry out the duties of this section. Through direct contact and the hotline, the Office shall provide the following services in the State, including appropriate assistance to individuals with limited English language ability—

(1) outreach and education relating to consumer rights and responsibilities under this Act, including such rights and services available through the Office;

(2) assistance with enrollment in health plans, or obtaining services or reimbursement from health plans;

(3) assistance with filing an application for premium or cost sharing subsidies;

(4) information to enrollees about existing grievance procedures and coordination with other entities to assist in identifying, investigating, and re-

solving enrollee grievances under this Act (including grievances before State medical boards);

(5) regular and timely access in the area to the services provided through the Office and its local offices and timely responses from representatives of the Office to complaints;

(6) referrals to appropriate local providers of legal assistance and to appropriate State and Federal agencies which may be of assistance to aggrieved individuals in the area; and

(7) conduct public hearings no less frequently than once a year to identify and address community health care needs.

(d) ACCESS TO INFORMATION.—The Secretary and the States shall ensure that, for purposes of carrying out the Office's duties under this section, the Office (and officers and employees of the Office in local offices) have appropriate access to relevant information subject to protections for confidentiality of enrollee information.

(e) EVALUATION AND REPORT.—The Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract. The Office shall report to the Secretary and the State annually on the nature and patterns of consumer complaints received in the Office and its local offices dur-

ing each year and any policy, regulatory, and legislative recommendations for needed improvements together with a record of the activities of the Office.

(f) FUNDING.—The funding for the establishment of an Office in each State is specified in section 1213, of which $5,000,000 shall be for the National Center for Consumer Advocacy.

(g) CONFLICTS OF INTEREST.—The Secretary shall ensure that no individual involved in the designation of the Office, the Office itself, or of any delegate thereof is subject to a conflict of interest, including affiliation with (through ownership or common control) a health care facility, managed care organization, health insurance company or association of health care facilities or providers. No grantee under this part may have a direct involvement with the licensing, certification, or accreditation of a health care facility, a health care plan, or a provider of health care services.

(h) LEGAL COUNSEL.—The Secretary shall ensure that adequate legal counsel is available, and is able, without conflict of interest, to assist the Office, and the local offices thereof in the performance of their official duties.

(i) COORDINATION.—The Office shall coordinate its activities with all appropriate entities including Quality Improvement Foundations (established under section

5008) and the State's long term care ombudsman or other agency esignated to carry out client advocacy activities pursuant to section 2106.

(j) CONSTRUCTION.—Nothing in this section shall replace grievance procedures established or otherwise required under this Act.

SEC. 1208. ELECTION PROCEDURE FOR COMMUNITY-RATED EMPLOYERS.

(a) IN GENERAL.—Each participating State shall establish a procedure (consistent with rules established by the Board) through which exempt employers, as defined in section 6117, may make an election to be treated as a community-rated employer. Such procedure shall set forth the form and manner that such election shall be made.

(b) NOTIFICATION.—The procedure shall require that employees of a exempt employer are notified of an election or a termination of an election under this section prior to the first annual open enrollment period (as defined in section 1660) following such election or termination.

(c) TERMINATION.—The procedures shall permit exempt employers to terminate an election made under this section. If an employer terminates an election, the termination shall be effective on the first date of the year following such termination.

SEC. 1209. COORDINATED HEALTH CARE SERVICES FOR CHILDREN.

(a) DESIGNATION OF STATE AGENCY.—The State shall designate an agency (hereafter referred to in this as the ''lead agency'') to coordinate the delivery of medical and social services to children with special health care needs. The lead agency shall:

(1) Serve as an information resource for children with special health care needs and their families and health providers, providing technical assistance regarding available specialty and support services and referral networks for these children and their families.

(2) Coordinate activities with all other State agencies which provide services to children with special health care needs and their families, and establish mechanisms to identify and maximize resources available for these children and families.

(3) Provide assistance to the State in fulfilling functions under section 1201 in certifying and monitoring the performance of health plans in delivering appropriate services to children in a timely and efficient manner.

(4) Make recommendations to States, plans, and providers to identify what services are lacking for children with special health care needs.

(b) PROVISION OF ACTIVITIES.—The lead agency shall provide the activities under subsection (a) for all children with special health care needs or children under foster care who are referred by a qualified health plan, other health or social service provider, or publicly funded programs where children receive services.

SEC. 1210. STATE RESPONSIBILITIES FOR UTILIZATION MANAGEMENT.

(a) IN GENERAL.—A State shall certify or recertify a health plan only if the State reviews the utilization management activities of the plan and determines that such activities meet the standards described in subsection (b), or such other standards as the National Health Board or other appropriate Federal agency may determine.

(b) STANDARDS DESCRIBED.—The standards described in this subsection are as follows:

(1) A health plan may not employ or contract with a utilization management organization or utilization management reviewer whose conditions of employment or contract terms include reducing or limiting medically necessary or appropriate services provided to individuals enrolled in a health plan.

(2) Each health plan shall disclose to a participating provider or an enrollee, upon request, the utilization review protocols for controlling utilization

and costs used to review a plan of treatment recommended by the provider, and shall provide a description of plan protocols for controlling utilization and costs upon request to providers, enrollees, and prospective enrollees.

(3) Each health plan shall describe to an enrollee, prospective enrollee, or participating provider, upon request, the type of financial arrangements, if any, used by the plan for controlling utilization and costs.

(4) The protocols described in paragraph (2) shall be applied consistently among utilization management reviewers within any and each utilization management organization with which a plan contracts.

(5) Utilization management reviewers with whom a plan contracts shall be available to consumers during normal business hours for preauthorizations and other purposes, and during non-business hours the health plan shall make available a procedure for accessing medical care, preauthorization, or other related services.

SEC. 1211. ASSURING FAMILY CHOICE OF HEALTH PLANS.

(a) IN GENERAL.—A participating State shall ensure that all community-rated individuals have a choice of health plans in which to enroll.

(b) GUARANTEE OF A FEE-FOR-SERVICE OPTION.—

(1) IN GENERAL.—Each State shall ensure that at least one fee-for-service plan (as defined in paragraph (2)) is offered in each health care coverage area.

(2) FEE-FOR-SERVICE PLAN DEFINED.—

(A) IN GENERAL.—For purposes of this Act, the term ''fee-for-service plan'' means a health plan that—

(i) provides coverage for all items and services included in the comprehensive benefit package that are furnished by any lawful health care provider of the enrollee's choice, subject to reasonable restrictions (described in subparagraph (B)), and

(ii) makes payment to such a provider without regard to whether or not there is a contractual arrangement between the plan and the provider.

(B) REASONABLE RESTRICTIONS DESCRIBED.—The reasonable restrictions on coverage permitted under a fee-for-service plan (as

specified by the National Health Board) are as follows:

(i) Utilization review.

(ii) Prior approval for specified services.

(iii) Exclusion of providers on the basis of poor quality of care, based on evidence obtainable by the plan.

Clause (ii) shall not be construed as permitting a plan to require prior approval for health care services through a gatekeeper or other process for services that are not specified for services that are not specified.

(3) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to prevent a health plan from providing for a different basis or level of payment than the fee schedule established under this section as part of a contractual agreement with participating providers under the plan.

SEC. 1212. OVERSIGHT OF HEALTH PLAN ENROLLMENT ACTIVITIES.

(a) IN GENERAL.—Each participating State shall provide for the general oversight of health plan enrollment activities, implement regulations promulgated by the Board under section 1660, and assure that each commu-

nity-rated individual who resides in the State is enrolled in a community-rated plan or other applicable health plan of the individual's choosing. In carrying out this subsection, States shall ensure that individuals are permitted to enroll directly in health plans of their choice.

(b) ENROLLMENT THROUGH PROVIDERS.—Each State shall establish a mechanism for enrolling eligible individuals who are not enrolled in a plan when the individual seeks health services in accordance with rules promulgated by the Board.

(c) ENFORCEMENT OF ENROLLMENT REQUIREMENT.—In the case of a community-rated individual who resides in a State and fails to enroll in an applicable health plan as required under section 1002(a) such State shall require the payment of an amount equal to twice the family share of premiums that would have been payable under subtitle B of title VI if the individual had enrolled on a timely basis in the plan, unless the individual establishes to the satisfaction of the State good cause or financial hardship for the failure to enroll on a timely basis. The State shall provide, from the amounts collected under paragraph (2), for payments to plans under subsection (b).

SEC. 1213. ADMINISTRATIVE ALLOWANCE PERCENTAGE.

(a) SPECIFICATION BY STATE.—Before obtaining bids under section 6004 from health plans for a year, each State shall establish the administrative allowance for State administrative functions with respect to the oversight of health plan activities, the determination of enrollment, the determination of subsidy eligibility, and other responsibilities under this Act.

(b) ADMINISTRATIVE ALLOWANCE PERCENTAGE.—Subject to subsection (c), the State shall compute an administrative allowance percentage for each year equal to—

(1) the administrative allowance determined under subsection (a) for the year, divided by

(2) the total of the amounts payable to community-rated health plans under subpart A (as estimated by the State).

(c) LIMITATION TO 1.5 PERCENT.—In no case shall an administrative allowance percentage exceed 1.5 percent.

(d) DISTRIBUTION OF PERCENTAGE.—The administrative allowance percentage shall be divided as follows:

(1) 1.48 percent for State administrative functions, and

(2) .02 percent for the Office of the Consumer Advocate described in section 1207.

(e) RECEIPT OF FUNDS.—A State shall perform the duties required of States under this Act as a condition of receiving funds described in subsection (d)(1).

PART 2—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

SEC. 1221. SINGLE-PAYER SYSTEM DESCRIBED.

The Board shall approve the application of a State to operate a single-payer system if the Board finds that the system—

(1) meets the requirements of section 1222;

(2)(A) meets the requirements for a Statewide single-payer system under section 1223, in the case of a system offered throughout a State; or

(B) meets the requirements for an area specific single-payer system under section 1224, in the case of a system offered in a single health care coverage area of a State.

SEC. 1222. GENERAL REQUIREMENTS FOR SINGLE-PAYER SYSTEMS.

Each single-payer system shall meet the following requirements:

(1) ESTABLISHMENT BY STATE.—The system is established under State law, and State law provides for mechanisms to enforce the requirements of the system.

(2) OPERATION BY STATE.—The system is operated by the State or a designated agency of the State.

(3) ENROLLMENT OF ELIGIBLE INDIVIDUALS.—

(A) MANDATORY ENROLLMENT OF ALL COMMUNITY-RATED INDIVIDUALS.—The system provides for the enrollment of all eligible individuals residing in the State (or, in the case of an area-specific single-payer system, in the health care coverage area) for whom the applicable health plan would otherwise be a health care coverage area health plan.

(B) OPTIONAL ENROLLMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—At the option of the State, the system may provide for the enrollment of Medicare-eligible individuals residing in the State (or, in the case of an area-specific single-payer system, in the health care coverage area) if the Secretary of Health and Human Services has approved an application submitted by the State under section 1893 of the Social Security Act (as added by section 4001(a)) for the integration of Medicare beneficiaries into plans of the State. Nothing in this subparagraph shall be construed as requiring

that a State have a single-payer system in order to provide for such integration.

(C) OPTIONAL ENROLLMENT OF EXPERIENCE-RATED INDIVIDUALS IN STATEWIDE PLANS.—At the option of the State, a Statewide single-payer system may provide for the enrollment of individuals residing in the State who are otherwise eligible to enroll in an experience-rated health plan under subtitle E.

(D) OPTIONS INCLUDED IN STATE SYSTEM DOCUMENT.—A State may not exercise any of the options described in subparagraphs (A) or (B) for a year unless the State included a description of the option in the submission of its system document to the Board for the year under section 1200(b).

(E) EXCLUSION OF CERTAIN INDIVIDUALS.—A single-payer system may not require the enrollment of electing veterans, active duty military personnel, and electing American Indians (as defined in 1012(d)).

(4) DIRECT PAYMENT TO PROVIDERS.—

(A) IN GENERAL.—With respect to providers who furnish items and services included in the comprehensive benefit package to individ-

uals enrolled in the system, the State shall make payments directly to such providers and assume (subject to subparagraph (B)) all financial risk associated with making such payments.

(B) CAPITATED PAYMENTS PERMITTED.—Nothing in subparagraph (A) shall be construed to prohibit providers furnishing items and services under the system from receiving payments on a capitated, at-risk basis based on prospectively determined rates.

(5) PROVISION OF COMPREHENSIVE BENEFIT PACKAGE.—

(A) IN GENERAL.—The system shall provide for coverage of the comprehensive benefit package, including the cost sharing provided under the package (subject to subparagraph (B)), to all individuals enrolled in the system.

(B) IMPOSITION OF REDUCED COST SHARING.—The system may decrease the cost sharing otherwise provided in the comprehensive benefit package with respect to any individuals enrolled in the system or any class of services included in the package, so long as the system does not increase the cost sharing otherwise im-

posed with respect to any other individuals or services.

(6) COST CONTAINMENT.—The system shall provide for mechanisms to ensure, in a manner satisfactory to the Board, that—

(A) the rate of growth in health care spending will not be higher than the target established under this Act;

(B) the expenditures described in subparagraph (A) are computed and effectively monitored;

(C) automatic, mandatory, nondiscretionary reductions in payments to health care providers will be imposed to the extent required to assure that such per capita expenditures do not exceed the applicable target referred to in subparagraph (A); and

(D) Federal payments to a single payer State or health care coverage area shall be limited to the payments that would have been made in the absence of the implementation of the single payer system.

(7) REQUIREMENTS GENERALLY APPLICABLE TO HEALTH PLANS.—The system shall meet the re-

quirements applicable to a health plan under section 1502(1), except that—

(A) the system does not have the authority provided to health plans under section 1516(d) (relating to permissible limitations on the enrollment of eligible individuals on the basis of limits on the plan's capacity);

(B) the system is not required to meet the requirements of section 1515 (relating to restrictions on the marketing of plan materials); and

(C) the system is not required to meet the requirements of section 1512(a) (relating to plan solvency).

SEC. 1223. SPECIAL RULES FOR STATES OPERATING STATEWIDE SINGLE-PAYER SYSTEM.

(a) IN GENERAL.—In the case of a State operating a Statewide single-payer system—

(1) the State shall operate the system throughout the State;

(2) except as provided in subsection (b), the State shall meet the requirements for participating States under part 1; and

(3) the State shall assume the functions described in subsection (c) that are otherwise required

to be performed by health care coverage areas in participating States that do not operate a Statewide single-payer system.

(b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR PARTICIPATING STATES.—In the case of a State operating a Statewide single-payer system, the State is not required to meet the following requirements otherwise applicable to participating States under part 1:

(1) ESTABLISHMENT OF HEALTH CARE COVERAGE AREAS.—The requirements of section 1202 (relating to the establishment of health care coverage areas).

(2) HEALTH PLANS.—The requirements of subtitle F (relating to health plans), other than requirements relating to coordination of workers' compensation services and automobile liability insurance.

(3) FINANCIAL SOLVENCY.—Requirements relating to the financial solvency of health plans in the State.

(4) OTHER REFERENCES INAPPLICABLE.—All other references in this Act to health plans, or other entities, and the requirements applicable thereto, that would not exist under a State single payer system, shall not be applicable to a single payer system, except as provided in subsection (c).

(c) ASSUMPTION BY STATE OF CERTAIN REQUIREMENTS APPLICABLE TO HEALTH CARE COVERAGE AREAS.—A State operating a Statewide single-payer system shall be subject to the following requirements otherwise applicable to health care coverage areas in other participating States subject to the requirement that all references to health care coverage areas shall, with respect to this section, be deemed to refer to the single payer State, and references to health plans shall not apply under this section or shall be considered as references, where appropriate, to health caregivers:

(1) ENROLLMENT; ISSUANCE OF HEALTH SECURITY CARDS.—The requirements of subsection (a) of section 1211 and section 1406 shall apply to the State, eligible individuals residing in the State, and the single-payer system operated by the State in the same manner as such requirements apply to a health care coverage area, health care coverage area eligible individuals, and health care coverage area health plans.

(2) REDUCTIONS IN COST SHARING FOR LOW-INCOME INDIVIDUALS.—The requirement of section 1281 shall apply to the State in the same manner as such requirement applies to a health care coverage area.

(3) DATA COLLECTION; QUALITY.—The data collection and quality requirements of this Act shall apply to the State and the single-payer system operated by the State in the same manner as such requirement applies to a health care coverage area and health plans offered in a health care coverage area.

(4) ANTI-DISCRIMINATION.—In carrying out such activities as it may have in common with entities in other States as required under part 2 of subtitle D, a State may not discriminate against health caregivers on the basis of mix of health professionals, or location of the headquarters of the plan, except as the State may specifically provide otherwise to assure an equitable distribution of services or organizational arrangement.

(5) COORDINATION OF ENROLLMENT ACTIVITIES.—A State shall coordinate its activities, including enrollment and disenrollment activities—

(A) in a manner specified by the Board; and

(B) in a manner that ensures continuous, nonduplicative coverage of eligible individuals and that minimizes administrative procedures and paperwork.

(d) FINANCING.—

(1) IN GENERAL.—A State operating a State-wide single-payer system shall provide for the financing of the system using, at least in part, a payroll-based financing system that requires employers to pay at least the amount that the employers would be required to pay if the employers were subject to the requirements of subtitle B of title VI defined as the applicable percentage of the per capita cost of health care.

(2) USE OF FINANCING METHODS.—Such a State may use, consistent with paragraph (1), any other method of financing.

(e) SINGLE-PAYER STATE DEFINED.—In this Act, the term ''single-payer State'' means a State with a State-wide single-payer system in effect that has been approved by the Board in accordance with this part.

SEC. 1224. SPECIAL RULES FOR HEALTH CARE COVERAGE AREA-SPECIFIC SINGLE-PAYER SYSTEMS.

(a) IN GENERAL.—In the case of a State operating a health care coverage area specific single-payer system—

(1) the State shall meet the requirements for participating States under part 1; and

(2) the health care coverage area in which the system is operated shall meet the requirements of subsection (b).

(b) REQUIREMENTS FOR HEALTH CARE COVERAGE AREA IN WHICH SYSTEM OPERATES.—A health care coverage area in which an area-specific single payer system is operated shall meet the requirements applicable to health care coverage areas under subtitle C, except that the health care coverage area is not required to meet the following requirements of such subtitle:

(1) CONTRACTS WITH HEALTH PLANS.—The requirements of section 1302 (relating to contracts with health plans).

(2) CHOICE OF HEALTH PLANS OFFERED.—The requirements of section 1211 (relating to offering a choice of health plans to eligible enrollees).

(3) ADDRESSING NEEDS OF AREAS WITH INADEQUATE HEALTH SERVICES.—The health care coverage area does not have any of the authorities described in section 1203 (relating to adjusting payments to plans and encouraging the establishment of new plans).

PART 3—REDUCTIONS IN COST SHARING AND PREMIUMS

SEC. 1281. REDUCTION IN COST SHARING FOR LOW-INCOME FAMILIES.

(a) REDUCTION.—

(1) IN GENERAL.—Subject to subsection (b), in the case of a family that is enrolled in a community-rated health plan and that is either (A) an AFDC or SSI family or (B) is determined under this subpart to have family adjusted income below 200 percent of the applicable poverty level, the family is entitled to a reduction in cost sharing in accordance with this section.

(2) TIMING OF REDUCTION.—The reduction in cost sharing shall only apply to items and services furnished after the date the application for such reduction is approved under section 1282(c) and before the date of termination of the reduction under this subpart, or, in the case of an AFDC or SSI family, during the period in which the family is such a family.

(3) INFORMATION TO PROVIDERS AND PLANS.—Each State shall provide, through electronic means and otherwise, health care providers and community-rated health plans with access to such information as may be necessary in order to provide for the cost sharing reductions under this section.

(b) LIMITATION.—No reduction in cost sharing under subsection (c)(1) shall be available for—

(1) families residing in a health care coverage area if the cooperative for the area determines that there are sufficient low-cost plans (as defined in section 6104(b)(3)) that are lower or combination cost sharing plans available in the area to enroll AFDC and SSI families and families with family adjusted income below 150 percent of the applicable poverty level; or

(2) for families with family adjusted income between 150 and 200 percent of the applicable poverty level.

(c) AMOUNT OF COST SHARING REDUCTION.—

(1) IN GENERAL.—Subject to paragraph (2), the reduction in cost sharing under this section shall be such reduction as will reduce cost sharing to the level of a lower or combination cost sharing plan.

(2) SPECIAL TREATMENT OF CERTAIN FAMILIES.—

(A) AFDC, SSI AND FAMILIES BELOW POVERTY.—In the case of a family that—

(i) is enrolled in a community-rated health plan;

(ii) is an AFDC, SSI family or a family that is determined under this subpart to have a family adjusted income below

100 percent of the applicable poverty level; and

(iii) is enrolled in a lower or combination cost sharing plan or receiving a reduction in cost sharing under paragraph (1); the amount of cost sharing applied with respect to an item or service (other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) shall be an amount equal to 20 percent of the cost sharing amount otherwise applicable under subtitle B, rounded to the nearest dollar.

(B) FAMILIES WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY.—In the case of a family that—

(i) is enrolled in a community-rated health plan;

(ii) is determined under this subpart to have family adjusted income between 100 and 150 percent of the applicable poverty level;

(iii) is not an AFDC or SSI family; and

(iv) is enrolled in a lower or combination cost sharing plan or receiving a reduction in cost sharing under paragraph (1); the amount of cost sharing applied with respect to an item or service (other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) shall be an amount equal to 40 percent of the cost sharing amount otherwise applicable under subtitle B, rounded to the nearest dollar.

(C) FAMILIES WITH INCOMES BETWEEN 150 AND 200 PERCENT OF POVERTY.—In the case of a family that—

(i) is enrolled in a community-rated health plan;

(ii) is determined under this subpart to have family adjusted income between 150 and 200 percent of the applicable poverty level; and

(iii) is not an AFDC or SSI family;

the amount of cost sharing applied with respect to an item or service (other than with respect to hospital emergency room services for which

there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) shall be an amount equal to 40 percent of the cost sharing amount otherwise applicable under subtitle B, rounded to the nearest dollar.

(d) ADMINISTRATION.—

(1) IN GENERAL.—In the case of an approved family (as defined in section 1282(b)(2)) enrolled in a community-rated health plan, the State shall pay the plan for cost sharing reductions (other than cost sharing reductions under subsection (c)(2)(A), (B) and (C)) provided under this section out of Federal subsidy payments provided in section 9100(b)(2)(A). Payments made by health plans to providers shall include appropriate payments for cost sharing reductions.

(2) ESTIMATED PAYMENTS, SUBJECT TO RECONCILIATION.—Such payment shall be made initially on the basis of reasonable estimates of cost sharing reductions incurred by such a plan with respect to approved families and shall be reconciled not less often than quarterly based on actual claims for items and services provided.

(e) NO COST SHARING FOR AMERICAN INDIANS AND CERTAIN VETERANS AND MILITARY PERSONNEL.—The provisions of section 6104(a)(3) shall apply to cost sharing reductions under this section in the same manner as such provisions apply to premium discounts under section 6104.

SEC. 1282. APPLICATION PROCESS FOR COST-SHARING REDUCTIONS AND PREMIUM DISCOUNTS.

(a) IN GENERAL.—A community-rated family may apply for a determination of the family adjusted income or wage adjusted income of the family, for the purpose of establishing eligibility for cost sharing reductions under section 1281, and for premium discounts and reductions in liability under sections 6104 and 6112.

(b) ACTION ON APPLICATION.—

(1) IN GENERAL.—States shall act on such applications and ensure due process in a timely manner prescribed by the Board.

(2) APPROVED FAMILY DEFINED.—As used in this part, the term ''approved family'' means a family for which an application under this section has been approved and not yet terminated.

(c) HELP IN COMPLETING APPLICATIONS.—Each State shall ensure adequate distribution and assist individuals in the filing of applications and income reconciliation statements under this subpart.

(d) FAMILY ADJUSTED INCOME.—

(1) IN GENERAL.—Except as otherwise provided, in this Act the term ''family adjusted income'' means, with respect to a family, the sum of the adjusted incomes (as defined in paragraph (2)) for all members of the family (determined without regard to section 1012).

(2) ADJUSTED INCOME.—In paragraph (1), the term ''adjusted income'' means, with respect to an individual, adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

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

(B) increased by the amount of interest received or accrued by the individual which is exempt from tax.

(3) PRESENCE OF ADDITIONAL DEPENDENTS.—At the option of an individual, a family may include (and not be required to separate out) the income of other individuals who are claimed as dependents of the family for income tax purposes, but such individuals shall not be counted as part of the family for purposes of determining the size of the family.

(e) REQUIREMENT FOR PERIODIC CONFIRMATION AND VERIFICATION AND NOTICES.—

(1) CONFIRMATION AND VERIFICATION REQUIREMENT.—The continued eligibility of a family for cost sharing reductions, premium discounts and reductions in liability under this section shall be conditioned upon the family's eligibility being—

(A) confirmed periodically by the State; and

(B) verified (through the filing of a new application under this section) by the State at the time income reconciliation statements are required to be filed under section 1283.

(2) NOTICES OF CHANGES IN INCOME AND EMPLOYMENT STATUS.—Each approved family shall promptly notify the State of any material increase (as defined by the Secretary) in the family adjusted income or wage adjusted income of the family.

(f) PENALTIES FOR INACCURATE INFORMATION.—

(1) INTEREST FOR UNDERSTATEMENTS.—Each individual who knowingly understates income reported in an application to a State under this subpart or otherwise makes a material misrepresentation of information in such an application shall be liable to the State for excess payments made based

on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Secretary.

(2) PENALTIES FOR MISREPRESENTATION.—In addition to the liability established under paragraph (1), each individual who knowingly misrepresents material information in an application under this subpart to a State shall be liable to the State for $2,000 or, if greater, three times the excess payments made based on such misrepresentation.

(g) TERMINATION OF COST SHARING REDUCTION AND PREMIUM DISCOUNTS.—The State shall, after notice to the family, terminate the reduction of cost sharing, premium discounts or reduction in liability for an approved family if the family fails to provide for confirmation or verification on a timely basis or the State otherwise determines that the family is no longer eligible for such reduction.

(h) TREATMENT OF AFDC AND SSI RECIPIENTS.—

(1) NO APPLICATION REQUIRED.—AFDC and SSI families may not be required to submit an application under this section.

(2) NOTICE REQUIREMENT FOR SSI RECIPIENTS.—The Secretary shall notify each State, in a manner specified by the Secretary of the identity

(and period of eligibility under the SSI program) of each SSI recipient, unless such a recipient elects (in a manner specified by the Secretary) not to accept the reduction in cost sharing or premium discounts under this part.

(i) RULES.—The Secretary shall issue rules related to the application procedure, confirmation and verification of eligibility, ensuring due process in enforcement of penalties for inaccurate information, and other issues related to the implmentation of cost sharing reductions, premium discounts and reductions in liability under this subpart.

SEC. 1283. END-OF-YEAR RECONCILIATION.

(a) IN GENERAL.—In the case of a family whose application for a premium discount or reduction of liability for a year has been approved before the end of the year under this subpart, the family shall, subject to subsection (c), file with the State an income reconciliation statement to verify the family's adjusted income or wage-adjusted income, as appropriate, for the previous year. Such a statement shall contain such information as the Secretary shall require. Each State shall coordinate the submission of such statements with the notice and payment of family payments due under section 1237.

(b) RECONCILIATION OF PREMIUM DISCOUNT AND LIABILITY ASSISTANCE BASED ON ACTUAL INCOME.—

Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to a family, the State shall compute the amount of premium discount or reduction in liability that should have been provided under section 6104 or section 6113 with respect for the family for the year involved. If the amount of such discount or liability reduction computed is—

(1) greater than the amount that has been provided, the family is liable to pay (directly or through an increase in future family share of premiums or other payments) a total amount equal to the amount of the excess payment, or

(2) less than the amount that has been provided, the State shall pay to the family (directly or through a reduction in future family share of premiums or other payments) a total amount equal to the amount of the deficit.

(c) NO RECONCILIATION FOR AFDC AND SSI FAMILIES; NO RECONCILIATION FOR COST SHARING REDUCTIONS.—No reconciliation statement is required under this section—

(1) with respect to cost sharing reductions provided under section 1281, or

(2) for a family that only claims a premium discount or liability reduction under this subpart on the basis of being an AFDC or SSI family.

(d) DISQUALIFICATION FOR FAILURE TO FILE.—In the case of any family that is required to file a statement under this section in a year and that fails to file such a statement by the deadline specified, members of the family shall not be eligible for premium reductions under section 6104 or reductions in liability under section 6113 until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the family establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

(e) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under subsection (a) is subject to the same liabilities as are provided under section 1282 for a misrepresentation of material fact described in such section.

(f) NOTICE OF REQUIREMENT.—Each State shall provide for written notice, at the end of each year, of the requirement of this section to each family which had received premium discount or reduction in liability under this subpart in any month during the preceding year and to which such requirement applies.

(g) TRANSMITTAL OF INFORMATION; VERIFICATION.—

(1) IN GENERAL.—Each participating State shall transmit annually to the Secretary such information relating to the income of families for the previous year as the Secretary may require to verify such income under this subpart.

(2) VERIFICATION.—Each participating State may use such information as it has available to it, including information made available to the State under section 6103(l)(7)(D)(x) of the Internal Revenue Code of 1986, in verifying income of families with applications filed under this subpart. The Secretary of the Treasury may, consistent with section 6103 of the Internal Revenue Code of 1986, permit return information to be disclosed and used by a participating State in verifying such income but only in accordance with such section.

(h) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of any cost sharing reduction provided under this subpart.

SEC. 1284. ELIGIBILITY ERROR RATES.

Each State shall make eligibility determinations for premium discounts, liability reductions, and cost sharing reductions under sections 6104 and 6123, section 6113,

and section 1281, respectively, in a manner that maintains the error rates below an applicable maximum permissible error rate specified by the Secretary (or the Secretary of Labor with respect to section 6123). In specifying such a rate, the Secretary shall take into account maximum permissible error rates recognized by the Federal Government under comparable State-administered programs.

Subtitle D—Consumer Purchasing Cooperatives

PART 1—GENERAL REQUIREMENTS

SEC. 1301. DESIGNATION AND ORGANIZATION OF COOPERATIVES.

(a) DESIGNATION OF COOPERATIVES.—A State shall certify consumer purchasing cooperatives (in this Act referred to as ''cooperatives'') in accordance with this part. Each cooperative shall be chartered under State law and operated as a not-for-profit corporation.

(b) BOARD OF DIRECTORS.—Each cooperative shall be governed by a Board of Directors to be composed in equal numbers of representatives of community-rated employers, eligible employees, and eligible individuals.

(c) MEMBERSHIP.—A cooperative shall accept all eligible employers and eligible individuals residing within the area served by the cooperative as members if such employers, employees or individuals request such membership.

Members of a cooperative shall have voting rights to select Board members consistent with rules established by the State.

(d) DUTIES OF COOPERATIVES.—Each cooperative shall—

(1) enter into agreements with health plans under section 1302;

(2) enter into agreements with community-rated employers;

(3) enroll eligible individuals in health plans;

(4) make payments to health plans on behalf of community-rated employers and eligible individuals;

(5) provide for coordination with other cooperatives;

(6) provide information on health plans, in accordance with section 1205; and

(7) carry out other functions provided for under this title.

(e) LIMITATION ON ACTIVITIES.—A cooperative shall not—

(1) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

(2) perform any activity (including certification or enforcement) relating to compliance of health plans with the requirements of this Act;

(3) assume insurance risk; or

(4) perform other activities identified by the State as being inconsistent with the performance of its duties under this Act.

(f) RULES OF CONSTRUCTION.—

(1) SINGLE ORGANIZATION SERVING MULTIPLE HEALTH CARE COVERAGE AREA.—Nothing in this section shall be construed as preventing a single not-for-profit corporation from being the cooperative for more than one health care coverage area.

(2) MULTIPLE COOPERATIVES.—Noting in this section shall be construed to prevent a State from designating or establishing more than one cooperative in a health care coverage area.

(3) VOLUNTARY PARTICIPATION.—Nothing in this section shall be construed as requiring any individual or community-rated employer to purchase a health plan exclusively through a cooperative.

SEC. 1302. AGREEMENTS WITH HEALTH PLANS.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (2)(A) of subsection (c)—

(A) each cooperative for a health care coverage area shall enter into an agreement under this section with each certified community-rated health plan and each health plan of the Department of Veterans Affairs and Uniformed Health Services Plan that serves residents of the health care coverage area; and

(B) a cooperative may not refuse to enter into such an agreement with a health plan which is certified by a State as offering coverage in the health care coverage area, nor may a community-rated health plan refuse to enter into an agreement with a cooperative in accordance with section 1522.

(2) COMMUNITY-RATED PREMIUM.—Except as provided in paragraph (2)(B) of subsection (c), a cooperative shall offer plans at the community-rate (as defined in section 6000(a)(3)) filed by the plan.

(3) TERMINATION OF AGREEMENT.—The State shall establish a process for the termination of agreements entered into under this section and a process for appealing such termination under this paragraph. In accordance with rules established by the State—

(A) a cooperative may terminate an agreement with a health plan if the health plan's certification for the health care coverage area involved is terminated or if the health plan fails to fulfill the requirements of the agreement; and

(B) a health plan may appeal the termination of an agreement with a cooperative under this paragraph to the State in accordance with rules and procedures established by the State.

(b) RECEIPT OF GROSS PREMIUMS.—

(1) IN GENERAL.—Under an agreement between a cooperative and a health plan, payment of premiums shall be made directly to the cooperative in accordance with rules promulgated by the Board.

(2) FORWARDING OF PREMIUMS.—Under an agreement between a health plan and a cooperative, the cooperative shall forward to each health plan in which an eligible individual has been enrolled the amounts collected on the behalf of enrollees in such plans.

(c) NEGOTIATING COOPERATIVES.—

(1) IN GENERAL.—A State may designate a cooperative as a ''negotiating cooperative'' if such co-

operative is the sole State-certified cooperative in a health care coverage area.

(2) AUTHORITIES AND RESPONSIBILITIES OF NEGOTIATING COOPERATIVES.—

(A) IN GENERAL.—Negotiating cooperatives may exclude plans from the plans offered to cooperative members if such cooperatives offer at least three plans, including at least one fee-for-service plan.

(B) PREMIUMS.—A health plan may, through negotiations with a negotiating cooperative, offer to individuals enrolled through such cooperative a premium that is less than the community-rated premium, but in no case shall a plan bid a premium to a negotiating cooperative that is higher than the filed per-capita community-rated bid (described in section 6000(a)(1)).

SEC. 1303. AGREEMENTS WITH COMMUNITY-RATED EMPLOYERS.

(a) IN GENERAL.—Cooperatives for each health care coverage area shall offer to enter into an agreement under this section with each community-rated employer that employs individuals in the area and that desires to join the cooperative. Each arrangement between a community-

rated employer and a cooperative shall include provisions consistent with the requirements of this subtitle.

(b) ELECTION OF ENROLLMENT.—Qualified employees of a community-rated employer may elect to enroll in a plan offered through the cooperative with which the employer has entered into an agreement, through a cooperative sponsored by the FEHBP or directly with a health plan selected by the employer (if such plan is not offered by the cooperative selected by the employer). Qualified employees not residing in the health care coverage area served by the cooperative selected by the employer shall enroll in a health plan consistent with rules promulgated by the Board. The cooperative selected by the employer shall be responsible for forwarding premium payments to the appropriate plan or cooperative for each qualified employee.

(c) FORWARDING INFORMATION ON ELIGIBLE EMPLOYEES.—Under an agreement between an employer and a cooperative, the employer must forward to the appropriate cooperative such information as may be required by the Secretary or the Board.

SEC. 1304. ENROLLING INDIVIDUALS IN HEALTH PLANS THROUGH A COOPERATIVE.

(a) IN GENERAL.—Each cooperative shall offer community-rate eligible individuals the opportunity to enroll

in any health plan which has an agreement with the cooperative for the health care coverage area in which the individual resides.

(b) ENROLLMENT PROCESS.—Each cooperative shall establish an enrollment process in accordance with rules established by the Board, including a process for enrolling those qualified employees of a community-rated employer who elect not to participate in the cooperative with which the employer has entered into an agreement.

(c) ENROLLMENT FEES.—The Board shall promulgate rules regarding payment of cooperative fees by employees exercising an election under section 1303(b).

SEC. 1305. COOPERATIVE FEE.

(a) IN GENERAL.—Each cooperative shall charge members a uniform membership fee to cover the cost of activities undertaken by the cooperative (including all administrative costs incurred by the cooperative).

(b) DISCLOSURE.—Each cooperative shall, prior to the time of enrollment, publish the membership fee of such cooperative. Such fees shall be calculated and identified as a separate charge from the premium charged by the health plans offered by the cooperative. A comparison of fees charged by each cooperative in a health care coverage area shall be incorporated into the plan brochure described in section 1205.

(c) MULTIPLE COOPERATIVES.—In health care coverage areas in which States have certified multiple cooperatives, such cooperatives may compete for members on the basis of the fees described in this section.

SEC. 1306. COORDINATION AMONG COOPERATIVES.

The State shall establish rules consistent with this section for coordination among cooperatives with respect to enrollment, payment of premiums, and provision of out-of-area benefits and services.

SEC. 1307. THIRD-PARTY CONTRACTING TO PERFORM DUTIES.

(a) IN GENERAL.—Each cooperative may contract with qualified, independent third parties for any service necessary to carry out the powers and duties of the cooperative pursuant to the requirements established under this section.

(b) RESTRICTION ON PERSONS ELIGIBLE FOR THIRD-PARTY CONTRACT.—No person may act, directly or through an affiliated company, both as a health plan serving the cooperative and as an independent third party contractor as described in subsection (a) within a given health care coverage area.

PART 2—ACCESS TO HEALTH PLANS SPONSORED BY FEHBP

SEC. 1321. DESIGNATION OF FEHBP AS A CONSUMER PURCHASING COOPERATIVE.

(a) IN GENERAL.—The Federal Employees Health Benefits Program (FEHBP) shall serve as a consumer purchasing cooperative in each health care coverage area designated by each State. The responsibilities and authorities provided to the FEHBP under this part shall be carried out by the Federal Office of Personnel Management.

(b) RESPONSIBILITIES AND AUTHORITIES OF FEHBP-SPONSORED COOPERATIVES.—

(1) EXEMPTION FROM COOPERATIVE ORGANIZATIONAL REQUIREMENTS.—The organizational requirements specified in part 1 with respect to State certification (under section 1301(a)), governance (under section 1301(b)), and restrictions on the authority of cooperatives to negotiate with health plans (under section 1302(a)), shall not apply to a cooperative sponsored by the FEHBP.

(2) GENERAL RESPONSIBILITIES AND AUTHORITIES.—A cooperative sponsored by the FEHBP shall undertake all the duties and retain all the privileges specified in part 1, including section 1302 (regarding requirements of plans to contract with, and not undersell, cooperatives).

(c) SATISFACTION OF STATE REQUIREMENT TO CERTIFY A COOPERATIVE.—Compliance with the requirements of this part with respect to the establishment of a cooperative sponsored by the FEHBP shall satisfy a State's requirement to certify at least one consumer purchasing cooperative under section 1201(6).

(d) REQUIREMENT OF OPM.—The Federal Office of Personnel Management is hereby authorized to take such actions as are appropriate to fulfill its responsibilities under this part.

SEC. 1322. SPECIAL RULES FOR FEHBP SUPPLEMENTAL PLANS.

(a) FEHBP SUPPLEMENTAL PLANS.—

(1) DEVELOPMENT.—The Office of Personnel Management shall develop FEHBP supplemental health benefit policies. The Office of Personnel Management shall meet and confer with representatives of Federal employees regarding the supplemental health benefit policies and the cost sharing policies to be offered (including premium contributions, if any, to be made by the Federal Government with respect to such policies for Federal employees and annuitants) through a process to be established by the National Partnership Council.

(2) OFFERING.—The Federal Government shall offer FEHBP supplemental health benefit policies developed in accordance with paragraph (1) and cost sharing policies as provided in section 1523 to Federal employees, annuitants, and any other community rate eligible individual (as defined in section 1902(9)).

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

(1) ANNUITANT.—The term ''annuitant'' means an ''annuitant'' as defined by section 8901 of title 5, United States Code.

(2) FEHBP.—The term ''FEHBP'' means the health insurance program under chapter 89 of title 5, United States Code.

(3) FEDERAL EMPLOYEE.—The term ''Federal employee'' means an ''employee'' as defined by section 8901 of title 5, United States Code.

Subtitle E—Employer Purchasers

PART 1—DEFINITIONS AND RESPONSIBILITIES OF EMPLOYER PURCHASERS

SEC. 1401. DEFINITIONS.

(a) LARGE GROUP PURCHASER DEFINED.—In this Act, the term ''large group purchaser'' means—

(1) an employer that—

(A) is a current large employer (as defined in subsection (e)(2)),

(B) is a dual choice employer (as defined in subsection (e)(4)) that has elected to become a large employer, and

(C) is not an excluded employer described in subsection (b)(2); or

(2) an eligible purchaser (described in subsection (b) if—

(A) the sponsor elects, in a form and manner specified by the Secretary of Labor consistent with this subpart, to be treated as a large group purchaser under this title and such election has not been terminated under section 1403; and

(B) the purchaser has filed with the Secretary of Labor a document describing how the sponsor shall carry out activities as such a large group purchaser consistent with part 2.

(b) ELIGIBLE LARGE GROUP PURCHASER.—

(1) IN GENERAL.—In this subpart, each of the following is an eligible large group purchaser:

(A) NEW LARGE EMPLOYER.—An employer that—

(i) is a new large employer (as defined in subsection (e)(2)) as of the date of an election under subsection (a)(1), and

(ii) is not an excluded employer described in paragraph (2).

(B) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.—A plan sponsor described in section 3(16)(B)(iii) of Employee Retirement Income Security Act of 1974, but only with respect to a group health plan that is a multiemployer plan (as defined in subsection (e)(3)) maintained by the sponsor and only if—

(i) such plan offered health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, such plan covers more than 1,000 full-time employees in the United States, or the plan is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 1,000 employees.

(2) EXCLUDED EMPLOYERS.—For purposes of this section, any of the following are excluded employers described in this paragraph:

(A) An employer whose primary business is employee leasing.

(B) The Federal government (other than the United States Postal Service).

(c) INDIVIDUALS ELIGIBLE TO ENROLL IN EXPERIENCE-RATED PLANS.—For purposes of part 1 of subtitle A, subject to subsection (d)—

(1) FULL-TIME EMPLOYEES OF LARGE EMPLOYERS.—Each eligible individual who is a full-time employee (as defined in section 1901(b)(2)(C)) of—

(A) a current large employer, or

(B) a new large employer that has an election in effect as a large group purchaser,

is eligible to enroll in an experience-rated plan offered by such purchaser.

(2) MULTIEMPLOYER PURCHASERS.—

(A) PARTICIPANTS.—Each participant and beneficiary (as defined in subparagraph (B)) under a multiemployer plan, with respect to which an eligible purchaser of the plan described in subsection (b)(1)(B) has an election in effect as a large group purchaser, is eligible

to enroll in an experience-rated plan offered by such purchaser.

(B) PARTICIPANT AND BENEFICIARY DEFINED.—In subparagraph (A), the terms ''participant'' and ''beneficiary'' have the meaning given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(3) INELIGIBLE TO ENROLL IN COMMUNITY-RATED PLAN.—Except as provided in section 1013, an experience-rated individual is not eligible to enroll under a community-rated plan.

(d) EXCLUSION OF CERTAIN INDIVIDUALS.—In accordance with rules of the Board, the following individuals shall not be treated as experience-rated individuals:

(1) AFDC recipients.

(2) SSI recipients.

(3) Individuals who are described in section 1004(b) (relating to veterans, military personnel, and Indians) and who elect an applicable health plan described in such section.

(4) Employees who are part-time, seasonal or temporary workers (as defined by the Board), other than such workers who are treated as experience-rated individuals pursuant to a collective bargaining agreement (as defined by the Secretary of Labor).

(5) Electing migrant and seasonal agricultural workers (described in section 1005(b)(4)).

(e) ADDITIONAL DEFINITIONS.—As used in this subtitle:

(1) GROUP HEALTH PLAN.—The term ''group health plan'' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

(2) LARGE EMPLOYER.—The term ''large employer'' means an employer with more than 1000 full-time employees in the United States. Such term includes the United States Postal Service. A large group purchaser shall offer a choice of health plans to qualified employees in accordance with section 1403 and meet the enrollment requirements described in such section.

(3) SMALL EMPLOYER.—The term ''small employer'' means an employer with 500 or less full-time employees. A small employer shall offer a choice of health plan to qualified employees in ac-

cordance with section 1403 and meet the enrollment requirements described in such section. A small employer under this subtitle is a community-rated employer described in title I and title VI of this Act.

(4) DUAL CHOICE EMPLOYER.—

(A) IN GENERAL.—The term ''dual choice employer'' means an employer with more than 500 but less than 1000 full-time employees.

(B) ELECTION.—A dual choice employer may elect to be considered as either a small employer or a large employer for purposes of this Act. The status of the employer as a small employer or a large employer after such an election shall remain in effect for a period of not less than 3 years. A dual choice employer electing to be a large employer shall not be eligible for discounts under title VI.

(5) EMPLOYER SPONSORED HEALTH PLAN.—The term ''employer sponsored health plan'' means a group health plan with an enrollment of at least 500 individuals that is established and maintained by a large employer. The health plan may be operated as a fee-for-service plan (as described in section 1211(b)(2)(A)) or as a network plan (as described in section 1514(c)(4)). The employer shall retain the

insurance risk and meet requirements specified by the Secretary of Labor for such plans in accordance with section 1406. The Secretary shall ensure that employer sponsored health plans meet the requirements of this paragraph.

(6) MULTIEMPLOYER PLAN.—The term ''multiemployer plan'' has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

SEC. 1402. ELECTION OF LARGE GROUP PURCHASERS.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Labor shall promulgate regulations for the election of new large employers and multiemployer plans as large group purchasers and for the termination of such elections of multiemployer plans.

(b) DUAL CHOICE EMPLOYERS.—If the number of full-time employees of a dual choice employer changes during the coverage year such that the employer has fewer than 500 or more than 1000 employees, the status of such employer shall be retained only throughout that year. The employer shall notify the Secretary of Labor of change in employer status in such a manner as the Secretary shall prescribe.

SEC. 1403. EMPLOYEE ENROLLMENT REQUIREMENTS.

(a) ESTABLISHMENT OF EMPLOYER ENROLLMENT FUNCTION.—

(1) IN GENERAL.—Each employer shall make available enrollment in at least three health plans, one of which shall be a fee-for-service plan, to each eligible employee of such employer.

(2) ASSURANCE OF ENROLLMENT.—Each employer shall ensure that each eligible individual is enrolled in a health plan and receives continuous coverage pursuant to regulations promulgated by the Secretary of Labor and consistent with the appropriate provisions of subtitle F. The methods and procedures prescribed in such regulations shall ensure the enrollment of such individuals at the time such individuals first become eligible individuals with respect to the employer.

(3) INFORMATION.—The Secretary shall promulgate regulations regarding the provision of information to employees by employers to effectuate enrollment under this section.

(4) CONSTRUCTION.—Nothing in this section shall be construed to prevent an employer from complying with this subsection through the offering of plans provided by a single carrier.

(5) SMALL EMPLOYERS.—Each small employer shall offer, at the age-adjusted community rate in the area, at least three State-certified health plans, one of which shall be a fee-for-service plan, and shall join a consumer purchasing cooperative. A small employer may satisfy the requirement that it offer at least three health plans by joining a consumer purchasing cooperative.

(b) FORWARDING OF ENROLLMENT INFORMATION.—

(1) INFORMATION REGARDING PLANS.—An employer must provide each employee of such employer (including any part-time or seasonal employee) with information regarding all qualified health plans offered in the health care coverage area in which the employer is located and, if the employee resides in another health care coverage area, information regarding how to obtain information on qualified health plans offered to residents of such other health care coverage area.

(2) INFORMATION REGARDING EMPLOYEES.—An employer must forward the name and address (and any other necessary identifying information specified by the Secretary) of each eligible employee—

(A) to the qualified health plan in which such employee is enrolled, or

(B) to the cooperative (if any) through which such enrollment is made.

(c) PAYROLL DEDUCTION.—The employer, upon authorization by the employee, shall provide for the deduction, from the employee's wages or other compensation, of the premium amount due (less any employer contribution) to the plan or purchasing cooperative in accordance with section 6209. This subsection shall only apply to plans and purchasing cooperatives made available by the employer.

(d) NO REQUIREMENT TO ENROLL IN EMPLOYER-PROVIDED PLAN.—An eligible employee of a community-rated employer may elect not to enroll in a health plan offered by an employer under this section. In addition to such plans, such an employee may enroll in a health plan offered through a purchasing cooperative of the employers choosing, in an association health plan (as described in section 1508) or through a plan offered by the Federal Employees Health Benefits Program.

SEC. 1404. RESPONSIBILITIES AND AUTHORITY OF EMPLOYER PURCHASERS.

(a) SELECTION OF PLANS BY MAJORITY OF EMPLOYEES.—Each employer shall make the selections of health

plans under this subsection on an annual basis. In making each such selection, a employer shall comply with any selection made by at least 50 percent of the eligible employees of the employer. The Secretary of Labor shall prescribe rules which shall govern the manner in which employees may make such a selection.

(b) SPECIFIC REQUIREMENTS OF LARGER GROUP PURCHASERS.—

(1) CONTRACTS WITH PLANS.—Each large group purchaser may—

(A) negotiate with a State-certified health plan to enter into a contract with the plan for the enrollment of such individuals under the plan; or

(B) offer to individuals an appropriate employer sponsored health plan (as defined in section 1401(e)(5));

or offer a combination of the plans described in this paragraph.

(2) TERMS OF CONTRACTS WITH STATE-CERTIFIED HEALTH PLANS.—Contracts under this section between a large group purchaser and a State-certified health plan may contain such provisions (not inconsistent with the requirements of this title) as the large group purchaser and plan may provide,

except that in no case does such contract remove the obligation of the large group purchaser to provide for health benefits to large group purchaser eligible individuals consistent with this part.

(3) PLAN AND INFORMATION REQUIREMENTS.—

(A) IN GENERAL.—A large group purchaser shall provide a written submission to the Secretary of Labor (in such form as the Secretary may require) detaining how the large group purchaser will carry out its activities under this part.

(B) ANNUAL INFORMATION.—An employer group purchaser shall provide to the Secretary of Labor each year, in such form and manner as the Secretary may require, such information as the Secretary may require in order to monitor the compliance of the purchaser with the requirements of this part.

(4) MANAGEMENT OF FUNDS.—

(A) MANAGEMENT OF FUNDS.—The management of funds by an large group purchaser shall be subject to the applicable fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act

of 1974, together with the applicable enforcement provisions of part 5 of subtitle B of title I of such Act.

(B) MANAGEMENT OF FINANCES AND RECORDS; ACCOUNTING SYSTEM.—Each large group purchaser shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

(c) LARGE GROUP PURCHASER TRANSITION.—Each large group purchaser must provide coverage—

(1) as of the first day of any month in which an individual first becomes a large group sponsor eligible individual, and

(2) through the end of the month in the case of a large group sponsor eligible individual who loses such eligibility during the month unless covered under paragraph (1).

(d) EMPLOYEE SHARE.—The premiums charged by a large group purchaser to an employee for enrollment in a plan offered by such a purchaser (not taking into account any employer premium payment under section 6131) shall vary only by class of family enrollment (as specified under section 6131) and by geographic area. The Secretary of Labor shall promulgate regulations regarding

the designation of geographic area by large group purchasers. Such regulations shall provide for such exceptions to the requirements under this section with respect to a sponsor described in section 1401(b)(1)(B), as may be appropriate.

SEC. 1405. DEVELOPMENT OF LARGE EMPLOYER GROUP PURCHASERS.

(a) IN GENERAL.—Nothing in this title shall be construed as prohibiting 2 or more large employers from forming a purchasing group with respect to the employees of such employer or employers. Such entities shall comply with the requirements applicable to health plans offered by large group purchasers under this subtitle.

(b) NO USE OF INDIVIDUAL AND COMMUNITY-RATED EMPLOYER PURCHASING COOPERATIVES.—A large employer shall be ineligible to purchase health insurance through an individual and community-rated employer purchasing cooperative.

SEC. 1406. TIMING AND TERMINATION OF EMPLOYER ELECTIONS.

(a) REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary of Labor shall promulgate regulations for employer elections.

(b) ELECTIVE TERMINATION.—A large group sponsor (other than a large employer) may terminate an elec-

tion under this part by filing with the National Health Board and the Secretary of Labor a notice of intent to terminate.

(c) EFFECTIVE DATE OF TERMINATION.—In the case of a termination of an election under this section, in accordance with rules established by the Secretary of Labor—

(1) subject to section 6022(a)(1), the termination shall take effect as of the effective date of enrollments in experience-rated plans made during the next open enrollment period (as provided in section 1403), and

(2) the enrollment of eligible individuals in experience-rated plans of the sponsor shall be terminated as of such date and such individuals shall be enrolled in other applicable health plans effective on such date.

(d) NOTICE TO BOARD.—If an election with respect to a large group sponsor is terminated pursuant to subsection (b), the Secretary of Labor shall notify the National Health Board of the termination of the election.

PART 2—REQUIREMENTS FOR HEALTH PLANS OFFERED BY LARGE GROUP PURCHASERS

SEC. 1411. ESTABLISHMENT OF STANDARDS APPLICABLE TO EMPLOYER SPONSORED PLANS.

(a) IN GENERAL.—The Secretary of Labor shall develop and publish standards applicable to employer sponsored plans (as defined in section 1401(e)(5)) offered by large group purchasers relating to the requirements described in subsection (b). The Secretary shall develop and publish such standards by not later than the date that is 6 months after the date of enactment of this Act. Such standards shall be the certified health plan standards applicable to employer sponsored plans under this part.

(b) REQUIREMENTS SPECIFIED.—

(1) IN GENERAL.—The requirements referred to in subsection (a) are applicable plan requirements specified in subtitle F.

(2) OTHER REQUIREMENTS.—The standards referred to in subsection (a) shall include standards—

(A) relating to financial solvency, reserve and guaranty fund requirements, as the Secretary of Labor shall specify, except that such standards shall be consistent with the applicable rules under part 4 of title I of the Employee Retirement Income Security Act of 1974;

(B) relating to the payments of premiums; and

(C) relating to claims grievance procedures, in accordance with subtitle C of title V.

SEC. 1412. CORRECTIVE ACTIONS FOR HEALTH PLANS OFFERED BY LARGE EMPLOYERS.

(a) IN GENERAL.—The plan sponsor of each large employer plan shall determine semiannually whether the requirements of this part are met. In any case in which the plan sponsor determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary of Labor makes such a determination and so notifies the plan sponsor, the plan sponsor shall, within 90 days after making such determination or receiving such notification, notify such Secretary (in such form and manner as such Secretary may prescribe by regulation) of a description of the corrective actions (if any) that the plan sponsor has taken or plans to take in response to such recommendations. The plan sponsor shall thereafter report to such Secretary, in such form and frequency as such Secretary may specify to the plan sponsor, regarding corrective action taken by the plan sponsor until such requirements are met. Such Secretary may make a determination that a large employer plan has ceased to be a large employer plan only if such Secretary is satisfied that the nec-

essary corrective action cannot reasonably be expected to occur on a timely basis necessary to avoid failure to provide benefits for which the plan is obligated.

(b) DISQUALIFIED OR TERMINATION OF PLAN.—

(1) IN GENERAL.—In any case in which the plan sponsor of a large employer plan determines that there is reason to believe that the plan will cease to be a large employer sponsored health plan or will terminate, the plan sponsor shall so inform the Secretary of Labor, shall develop a plan for winding up the affairs of the plan in connection with such disqualification or termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and shall submit such plan in writing to such Secretary. Actions required under this subparagraph shall be taken in such form and manner as may be prescribed in regulations jointly prescribed by such Secretary.

(2) ACTIONS REQUIRED IN CONNECTION WITH DISQUALIFICATION OR TERMINATION.—

(A) IN GENERAL.—In any case in which—

(i) the Secretary of Labor has been notified under paragraph (1) of a failure of a large employer sponsored health plan to meet the requirements of this part and has

not been notified by the plan sponsor that corrective action has restored compliance with such requirements, and

(ii) such Secretary determines that the continuing failure to meet such requirements can be reasonably expected to result in a continuing failure to pay benefits for which the plan is obligated,

the plan sponsor and the large employer shall comply with the requirements of subparagraph (B) or (C), as applicable.

(B) ACTIONS BY PLAN SPONSOR.—Upon a determination by the Secretary of Labor under subparagraph (A)(ii), the plan sponsor shall, at the direction of such Secretary, terminate the plan and, in the course of the termination, take such actions as such Secretary may require as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the plan is obligated.

(C) ACTIONS BY LARGE EMPLOYER.—Upon a determination by the Secretary of Labor under subparagraph (A)(ii), the large

employer shall provide for such contingency coverage for all eligible employees of the employer in accordance with regulations which shall be prescribed by such Secretary. Such regulations may provide for temporary coverage of such employees under a plan provided by a purchasing group in the appropriate area, a plan provided under chapter 89 of title 5, United States Code, or other appropriate means established in such regulations.

SEC. 1413. DISCLOSURE AND RESERVE REQUIREMENTS FOR LARGE EMPLOYER PURCHASER HEALTH PLANS.

(a) IN GENERAL.—The Secretary of Labor shall ensure that each large group purchaser health plan which is an employer sponsored health plan maintains plan assets in trust as provided in section 403 of the Employee Retirement Income Security Act of 1974—

(1) without any exemption under section 403(b)(4) of such Act, and

(2) in amounts which the Secretary determines are sufficient to provide at any time for payment to health care providers of all outstanding balances owed by the plan at such time and consistent with standards for State certified health plans.

The requirements of the preceding sentence may be met through letters of credit, bonds, or other appropriate security to the extent provided in regulations of the Secretary.

(b) DISCLOSURE.—Each employer sponsored health plan shall notify the Secretary at such time as the financial reserve requirements of this section are not being met. The Secretary may assess a civil money penalty of not more than $100,000 against any large group purchaser for any failure to provide such notification in such form and manner and within such time periods as the Secretary may prescribe by regulation.

SEC. 1414. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT LARGE EMPLOYER PURCHASED HEALTH PLANS.

(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary of Labor determines that a large employer sponsored health plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of the Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the

court. The court shall appoint the Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the enrolled individuals or health care providers or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the large group purchaser Health Plan Insolvency Fund. The trusteeship of the Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

(b) POWERS AS TRUSTEE.—The Secretary of Labor, upon appointment as trustee under subsection (a), shall have the power—

(1) to do any act authorized by the plan, this Act, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

(4) to do such other acts as the Secretary determines to be necessary to continue operation of the

plan without increasing the potential liability of the large group purchaser Health Plan Insolvency Fund, if such acts may be done under the provisions of the plan,

(5) to require the large group purchaser, the plan administrator, any contributing employer, and any employee organization representing covered individuals to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

(6) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

(7) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

(8) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

(9) to terminate the plan and liquidate the plan assets in accordance with applicable provisions of this Act and other provisions of law, to restore the plan to the responsibility of the large group purchaser, or to continue the trusteeship,

(10) to provide for the enrollment of individuals covered under the plan in an appropriate health plan, and

(11) to do such other acts as may be necessary to comply with this Act or any order of the court and to protect the interests of enrolled individuals and health care providers.

(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

(1) the plan administrator,

(2) each enrolled individual,

(3) each employer who may be liable for contributions to the plan, and

(4) each employee organization which, for purposes of collective bargaining, represents enrolled individuals.

(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this Act or part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or as may be otherwise ordered by the court, the Secretary of Labor, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United

States Code, and shall have the duties of a fiduciary for purposes of such part 4.

(e) OTHER PROCEEDINGS.—An application by the Secretary of Labor under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) JURISDICTION OF COURT.—

(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this subsection, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this subsection, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary of Labor as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the large group

purchaser, or property of such plan or purchaser, and any other suit against any receiver, conservator, or trustee of the plan, the purchaser, or property of the plan or purchaser. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the large group purchaser or any other suit against the plan or the purchaser.

(2) VENUE.—An action under this subsection may be brought in the judicial district where the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) PERSONNEL.—In accordance with regulations of the Secretary of Labor, the Secretary shall appoint, retain, and reasonably compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

Subtitle F—Health Plans

SEC. 1500. HEALTH PLAN DEFINED.

(a) IN GENERAL.—In this Act, the term ''health plan'' means a plan that provides the comprehensive bene-

fit package and meets the requirements of this Act applicable to health plans.

(b) STATE-CERTIFIED HEALTH PLAN.—In this Act, the term ''State-certified health plan'' means a health plan that has been certified by a State under section 1504 (or, in the case in which the Board is exercising certification authority under this title, that has been certified by the Board).

(c) DOMICILIARY STATE.—For purposes this section, the State which has certified a cooperative is the State in which the cooperative is domiciled.

PART 1—REQUIREMENTS FOR HEALTH PLANS

SEC. 1501. CERTIFIED HEALTH PLAN.

(a) IN GENERAL.—To be certified under this title a health plan must meet the applicable standards under section 1503 for a certified health plan.

(b) SPECIAL RULES FOR LARGE GROUP PURCHASERS.—Employer sponsored health plans offered by large group purchasers shall meet applicable standards in accordance with subtitle E.

(c) CONSTRUCTION.—Whenever in this title a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or health plan sponsor of the plan in relation to that plan.

SEC. 1502. APPLICATION OF REQUIREMENTS.

No plan shall be treated under this Act as a health plan—

(1) unless the plan is an employer sponsored health plan or a State-certified plan; or

(2) on and after the effective date of a finding by the applicable regulatory authority that the plan has failed to comply with such applicable requirements.

SEC. 1503. ESTABLISHMENT OF STANDARDS.

In order for a health plan to be eligible to be certified as a health plan by a State, the health plan shall meet the requirements of this Act, as described in regulations promulgated by the Board or the Secretary, including standards requiring that the plan shall—

(1) provide for the effective delivery of covered services throughout each designated service area for which it is certified;

(2) provide for coverage of the comprehensive benefits package described in subtitle B;

(3) provide for the collection and reporting of data;

(4) not discriminate in enrollment or benefits;

(5) establish community-rated premiums for the comprehensive benefits;

(6) meet financial solvency and financial management standards promulgated by the Board;

(7) provide for effective grievance procedures;

(8) demonstrate an ability to ensure that enrollees have adequate access to providers of health care;

(9) meet information, disclosure and marketing requirements;

(10) meet requirements for open enrollment, availability, and renewability;

(11) meet requirements with respect to rural and underserved areas;

(12) meet requirements with respect to participation in a payment adjustment program;

(13) meet quality standards;

(14) enter into agreements with cooperatives; and

(15) meet other applicable requirements of this Act pursuant to the Board or to regulations promulgated by the Secretary.

SEC. 1504. CERTIFICATION AND REVOCATION OF HEALTH PLAN CERTIFICATION.

(a) CERTIFICATION.—A participating State shall—

(1) certify each health plan, review the continued compliance of each plan with the certification requirements and recertify each plan not less fre-

quently than once during every 3-year period if the State determines that the plan continues to meet the criteria for certification, including demonstrating that the policies of the plan have not discriminated on the basis of any of the categories described in section 1914; and

(2) review enrollee disenrollment from health plans in order to determine whether there is a pattern of disenrollment that does not reflect the distribution of such plans' reenrolling members with respect to age, income, health condition, prior utilization of health services, place of residence and other potential risk characteristics.

Evidence of any of the disenrollment patterns described in paragraph (2) may be cause for the denial of a certification or for the application of one or more interim sanctions described in section 1505.

(b) REVOCATION.—The State may revoke a plan's certification as a certified health plan for any health care coverage area or refuse to recertify a plan only upon a determination by the State that the health plan no longer meets the requirements of this section, pursuant to procedures established by the Board.

SEC. 1505. MONITORING.

A participating State shall monitor the performance of each State-certified health plan to ensure that it continues to meet the criteria for certification. If during such monitoring the State determined that a health plan fails to deliver care of adequate quality, either with respect to the overall enrollment population or the vulnerable population, fails to meet applicable standards relating to financial solvency and stability, or fails to meet any other criteria for certification or recertification, the State shall impose sanctions on the plan. Such sanctions may include fines and the limitation or prohibition of further enrollment until such time as the plan develops and complies with a corrective action plan.

SEC. 1506. ASSOCIATION HEALTH PLANS.

(a) APPLICATION.—This section shall apply to any association health plan that is in operation on June 1, 1994 and that meets the requirements for being considered an multiple employer welfare arrangement under section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)).

(b) APPLICATION OF STANDARDS.—An association health plan shall meet the requirements of a State-certified community-rated health plan.

(c) REQUIREMENTS.—The sponsoring entity of the association health plan—

(1) shall be organized and maintained in good faith, with appropriate bylaws that specifically state the purpose, as a trade association, industry association, professional association, chamber of commerce, a religious organization, or a public entity association and that the entity has been established and maintained for substantial purposes other than to provide the health care required under this section; and

(2) is and has been in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years and receives the active support of its membership.

(d) TREATMENT OF EXISTING ENTITIES.—Any arrangement that, as of June 1, 1994, has been in effect for not less than 18 months and with respect to which there is a pending application with the State insurance commissioner for a certificate of operation as a health plan, shall be treated for purposes of this subtitle as a qualified health plan (if such plan otherwise meets the requirements of this Act) unless the State can demonstrate that—

(1) fraudulent or material misrepresentations have been made by the sponsor in the application;

(2) the plan that is the subject of the application, on its face, fails to meet the requirements for a complete application; or

(3) a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operations.

(e) TREATMENT OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

(1) MEWAs.—The Secretary of Labor shall promulgate regulations that prohibit the insuring of employees under a multiple employer welfare arrangement as defined under section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)) unless the arrangement meets the standards for an association health plan under subtitle F or is certified by a State or a consumer purchasing cooperative in accordance with subtitle D.

(2) REPEAL OF ERISA PROVISIONS.—

(A) Paragraph (40) of section 3 of such Act (29 U.S.C. 1002(40)) is repealed.

(B) Paragraph 6 of section 514(b) of such Act (29 U.S.C. 1144(b)(6)) is repealed.

SEC. 1507. SPECIFIED STANDARD BENEFITS; SUPPLEMENTAL BENEFITS AND COST-SHARING POLICIES.

(a) STANDARD BENEFITS AND OTHER REQUIREMENTS.—A State shall not accept the certification of a health plan as a certified health plan unless the plan provides the comprehensive benefits package required under this Act.

(b) TREATMENT OF SUPPLEMENTARY HEALTH BENEFITS.—

(1) IN GENERAL.—Subsection (a) shall not be construed as preventing a health plan, carrier, or insurer from offering (in a manner that is separate from the offering of health plans) supplemental insurance policies, pursuant to the State certification plan and regulations promulgated by the Board.

(2) NO DUPLICATIVE HEALTH BENEFITS.—A health plan or any other carrier or insurer may not offer any policy for supplementary health benefits under paragraph (1) that duplicates the comprehensive benefits or is linked in any manner to the plan's comprehensive benefits package.

(3) REGULATION OF SUPPLEMENTAL PLANS.—The Secretary shall provide appropriate rules for the regulation of supplemental benefit policies and plans,

including rules providing for the guaranteed issue and the community rating of supplemental policies.

(c) TREATMENT OF COST-SHARING POLICIES.—

(1) RULES FOR OFFERING OF POLICIES.—A cost sharing policy may be offered to an individual only if—

(A) the policy is offered by the certified health plan in which the individual is enrolled;

(B) the certified health plan offers the policy to all individuals enrolled in the plan;

(C) the plan offers each such individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage (in accordance with standards established by the Board); and

(D) the policy is offered only during the annual open enrollment period for community-rated health plans (described in section 1516).

(2) PROHIBITION OF COVERAGE OF COPAYMENTS.—Each cost sharing policy may not provide any benefits relating to any copayments established under subtitle B.

(3) EQUIVALENT COVERAGE FOR ALL SERVICES.—Each cost sharing policy must provide coverage for items and services in the comprehensive

benefit package to the same extent as the policy provides coverage for all items and services in the package.

(4) REQUIREMENTS FOR PRICING.—

(A) IN GENERAL.—The price of any cost sharing policy shall—

(i) be the same for each individual to whom the policy is offered;

(ii) take into account any expected increase in utilization resulting from the purchase of the policy by individuals enrolled in the community-rated health plan; and

(iii) not result in a loss-ratio of less than 90 percent.

(B) LOSS-RATIO DEFINED.—In subparagraph (A)(iii), a ''loss-ratio'' is the ratio of the premium returned to the consumer in payout relative to the total premium collected.

SEC. 1508. COLLECTION, PROVISION OF STANDARDIZED INFORMATION, AND CONFIDENTIALITY.

Each health plan must provide information required in accordance with subtitles A and B of title V.

SEC. 1509. PROHIBITION OF DISCRIMINATION.

(a) IN GENERAL.—Each health plan shall comply with the antidiscrimination requirements of section 1914.

(b) ANTIDISCRIMINATION.—

(1) IN GENERAL.—No health plan may discriminate on the basis of—

(A) the method through which a family seeks enrollment under the plan; or

(B) the provider's status as a member of a health care profession for the purposes of selecting among providers of health services for participation in a provider network, provided that the State authorizes members of that profession to render the services in question and that such services are covered in the comprehensive benefits package described in subtitle B.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(B) shall be construed as requiring any health plan to—

(A) include in a network any individual provider;

(B) establish any defined ratio of different categories of health professionals;

(C) maintain any specific reimbursement methodology other than that which is established in other provisions of this Act; and

(D) establish any specific utilization review or internal quality standards other than that required in other provisions of this Act.

SEC. 1510. QUALITY ASSURANCE STANDARDS.

(a) IN GENERAL.—Each health plan shall comply with the plan performance standards in accordance with subtitle A of title V. Each health plan shall establish procedures, including ongoing quality improvement procedures, to ensure that the health care services provided to enrollees under the plan will be provided under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice and the quality standards established under subtitle A of title V.

(b) INTERNAL QUALITY ASSURANCE PROGRAM.—Each health plan shall establish, and communicate to its enrollees and its providers, an ongoing internal program, including periodic reporting, to monitor and evaluate the quality and cost effectiveness of its health care services, pursuant to standards established by the National Quality Council.

SEC. 1511. COMMUNITY-RATING.

(a) IN GENERAL.—The Secretary shall promulgate regulations for community rating as modified by age. Such regulations pertaining to adjustments in the community

rate for age shall terminate on December 31, 1998, except that the Board at any time may make a recommendation to Congress to maintain a form of modified community rating during the transition.

(b) MARKETING FEES.—Notwithstanding this section, a health plan may impose a marketing fee for individuals enrolling in a plan through an agent. Such fees shall be a uniform percentage of the premium established under section 6102(a)(1). In no case shall a plan impose a marketing fee for individuals enrolled through a cooperative or through a direct enrollment process established pursuant to section 1660.

SEC. 1512. FINANCIAL SOLVENCY REQUIREMENTS AND CONSUMER PROTECTION AGAINST PROVIDER CLAIMS.

(a) SOLVENCY PROTECTION.—Each health plan shall meet financial solvency requirements to assure protection of enrollees with respect to potential insolvency. Health plans must provide a financial plan and meet capital requirements established by the Board under section 1651. Health plans may utilize reinsurance, provide risk sharing, and other appropriate measures established by the Board.

(b) PROTECTION AGAINST PROVIDER CLAIMS.—In the case of a failure of a health plan to make payments with respect to the comprehensive benefits for any reason,

an individual who is enrolled under the plan is not liable to any health care provider with respect to the provision of health services within such set of benefits for payments in excess of the amount for which the enrollee would have been liable if the plan were to have made payments in a timely manner.

SEC. 1513. GRIEVANCE MECHANISMS.

A health plan shall establish grievance procedures that enrollees may utilize in pursuing complaints in accordance with subtitle C of title V.

SEC. 1514. ACCESS TO CARE.

(a) POINT-OF-SERVICE OPTION.—Each health plan that is a low-cost sharing plan (as described in section 1131) shall offer enrollees the opportunity to obtain coverage for out-of-network items and services, except that such point-of-service option must be offered, and priced separately from the benefits offered through the plan's network. A health plan providing coverage to an enrollee for out-of-network items and services may charge an alternative premium and require alternative cost-sharing to take into account such coverage, consistent with regulations promulgated by the Secretary.

(b) TREATMENT OF COST-SHARING.—Each health plan, in providing benefits in the comprehensive benefit package shall include in its payments to providers such

additional reimbursement as may be necessary to reflect cost sharing reductions to which individuals are entitled under section 1281.

(c) DEFINITIONS.—

(1) IN-NETWORK ITEMS AND SERVICES.—For purposes of this Act, the term ''in-network'', when used with respect to items or services described in this subtitle, means items or services provided to an individual enrolled under a health plan by a health care provider who is a member of a provider network of the plan (as defined in paragraph (3)).

(2) OUT-OF-NETWORK ITEMS AND SERVICES.—For purposes of this Act, the term ''out-of network'', when used with respect to items or services described in this subtitle, means items or services provided to an individual enrolled under a health plan by a health care provider who is not a member of a provider network of the plan (as defined in paragraph (3)).

(3) PROVIDER NETWORK DEFINED.—A ''provider network'' means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services in the comprehensive benefit package to individuals enrolled in the plan, or

have an agreement to provide services on a fee-for-service basis.

(4) NETWORK PLAN DEFINED.—For purposes of this Act, a ''network plan'' means a health plan that utilizes a provider network described in paragraph (3) and that meets the requirements of section 1523(c).

(d) RELATION TO DETENTION.—A health plan is not required to provide any reimbursement to any detention facility for services performed in that facility for detainees in the facility.

SEC. 1515. INFORMATION AND MARKETING STANDARDS.

(a) IN GENERAL.—Each health plan shall provide information in accordance with sections 1205 and 1603(e), other applicable information requirements of this Act and rules promulgated by the Board.

(b) MARKETING METHODS; ADVERTISING MATERIALS.—A health plan may utilize direct marketing, agency, or other arrangements to distribute health plan information, subject to applicable State fair marketing practices laws and standards established by the State, including standards to prevent selective marketing. All advertising, promotional materials, and other communications with health plan members and the general public must be factually accurate and responsive to the needs of served

populations. A health plan may not distribute marketing materials to an area smaller than the entire designated service area of the plan.

(c) PAYMENT OF AGENT COMMISSIONS.—A health plan—

(1) may pay a commission or other remuneration to an agent or broker in marketing the plan to individuals or groups, but

(2) may not vary such remuneration based, directly or indirectly, on the anticipated or actual claims experience associated with the group or individuals to which the plan was sold.

(d) MATERIALS IN APPROPRIATE LANGUAGES.—In the case of a health care coverage area that includes a significant number or proportion of residents with limited English proficiency, the State shall provide all materials under this Act at an appropriate reading level and in the native languages of such residents, as appropriate.

SEC. 1516. ENROLLMENT; AVAILABILITY, AND RENEWABILITY.

(a) ENROLLMENT REQUIREMENTS.—Each health plan shall establish an enrollment process consistent with this paragraph. To be certified as a health plan, the plan shall accept the enrollment of every eligible individual who seeks such enrollment (including individuals enrolling di-

rectly with the plan or through a cooperative) and comply with all rules and procedures regarding enrollment established by the State and by the Board. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics, such as occupation or affiliation with any person or entity, or those characteristics described in section 1914.

(b) NO LIMITS ON COVERAGE; NO PRE-EXISTING CONDITION LIMITS.—A health plan may not—

(1) terminate, restrict, or limit coverage for the comprehensive benefit package in any portion of the plan's service area, except as provided in this section;

(2) cancel coverage for any community rate eligible individual until that individual is enrolled in another applicable health plan;

(3) exclude any eligible individual from coverage because of existing medical conditions or genetic predisposition to medical conditions;

(4) impose waiting periods before coverage begins; or

(5) impose a rider that serves to exclude coverage of particular eligible individuals.

(c) RENEWABILITY; LIMITATION ON TERMINATION.—Coverage of eligible individuals, except as pro-

vided in this section, under a health plan in a health care coverage area shall be renewed at the option of such eligible individuals, and coverage may not be terminated except after notice and in accordance with subsection (g).

(d) CAPACITY LIMITATIONS.—

(1) IN GENERAL.—With the approval of the applicable regulatory authority, a health plan may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability. If such a limitation is imposed, the limitation may not be imposed on a basis referred to in subsection (a).

(2) RESTRICTIONS.—If such a limitation is imposed—

(A) the plan may only enroll individuals under the plan consistent with priorities established by the State consistent with paragraph (3); and

(B) the plan may not discriminate based on the method through which a family seeks enrollment under the plan.

(3) STATE OVERSIGHT.—Each State shall, in accordance with rules promulgated by the Board, establish procedures and methods to assure equal opportunity of enrollment for all families, regardless of

when during the open enrollment period or the method by which the enrollment has been sought.

(e) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan which is a network plan as defined in section 1514(c)(4) may deny enrollment under the plan to an eligible individual who is located outside a service area of the plan, but only if such denial is applied uniformly.

(2) SERVICE AREAS.—The State shall establish standards, consistent with guidelines promulgated by the Secretary, for the designation by network plans of service areas in order to prevent discrimination in violation of section 1914.

(f) TERMINATION OF PLANS.—A health plan may elect not to renew or make available a health plan in a health care coverage area, or not to utilize a particular type of delivery system in a health care coverage area, but only if the health plan—

(1) elects not to renew all of its health plans in such health care coverage area or not to use the delivery system in such health care coverage area; and

(2) provides notice to the State and each individual covered under the plan of such termination at

1 least 180 days before the date of expiration of either
2 the plan or use of the delivery system.
3 In such case, a health plan may not provide for the issu-
4 ance of any health plan in such health care coverage area,
5 or to utilize such delivery system in that health care cov-
6 erage area during a 5-year period beginning on the date
7 of the termination of the last plan not so renewed. For
8 purposes of this paragraph the term ''delivery system''
9 means an open-network, closed network, or nonnetwork
10 health care delivery system.

11 **SEC. 1517. ADMINISTRATIVE PROVISIONS.**

12 (a) CAPABILITY.—Each health plan shall dem-
13 onstrate to the certifying authority the capability to ad-
14 minister the plan.
15 (b) UTILIZATION MANAGEMENT.—Each health plan
16 shall demonstrate to the certifying authority, through
17 written management procedures, an appropriate utiliza-
18 tion management process. The Secretary shall establish
19 guidelines under this subsection for utilization manage-
20 ment.

21 **SEC. 1518. INFORMATION REGARDING A PATIENT'S RIGHT**
22 **TO SELF-DETERMINATION IN HEALTH CARE**
23 **SERVICES.**

24 Each health plan shall provide written information to
25 each individual enrolling in such plan of such individual's

right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives (as defined in section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3))), and the written policies of the qualified health plan with respect to such right.

SEC. 1519. RURAL AND MEDICALLY UNDERSERVED AREAS.

(a) IN GENERAL.—If, in accordance with appropriate rules established by the Secretary, a State determines that there is inadequate access in the provision of health services by health plans in any area of a State, the State may authorize—

(1) a health plan to be the only health plan in the area; or

(2) two or more health plans to take joint action to develop and implement a program.

(b) MEDICALLY UNDERSERVED AREA DEFINED.—For purposes of this subtitle the term ''medically underserved area'' means an urban or rural area designated by the Board as an area with a shortage of health professionals or of health services or facilities.

SEC. 1520. PAYMENT ADJUSTMENTS.

Each health plan shall participate in any risk adjustment, reinsurance, or other premium adjustment program

implemented by the State in accordance with section 1641. Provisions of this section concerning risk adjustment and reinsurance shall not apply to health plans offered by large group purchasers.

SEC. 1521. PREEMPTION OF CERTAIN STATE LAWS RELATING TO HEALTH PLANS.

(a) LAWS RESTRICTING PLANS OTHER THAN FEE-FOR-SERVICE PLANS.—Except as may otherwise be provided in this section, no State law shall apply to any services provided under a health plan that is not a fee-for-service plan (or a fee-for-service component of a plan) if such law has the effect of prohibiting or otherwise restricting plans from—

(1) limiting the number and type of health care providers who participate in the plan;

(2) requiring enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan;

(3) requiring enrollees to obtain a referral for treatment by a specialized physician or health institution;

(4) establishing different payment rates for participating providers and providers outside the plan;

(5) creating incentives to encourage the use of participating providers; or

(6) requiring the use of single-source suppliers for pharmacy, non-serviced medical equipment, and other health products and services.

(b) PREEMPTION OF STATE CORPORATE PRACTICE ACTS.—Any State law related to the corporate practice of medicine and to provider ownership of health plans or other providers shall not apply to arrangements between health plans that are not fee-for-service plans and their participating providers.

SEC. 1522. CONTRACTS WITH CONSUMER PURCHASING COOPERATIVES.

(a) CONTRACTS WITH COOPERATIVES.—A certified health plan provided by a carrier shall enter into contracts with each cooperative in the designated service area served by the plan seeking such a contract.

(b) PRICING.—No health plan shall offer a rate to a cooperative that is more than the filed per-capita community rate (as described in section 6000(a)(1)).

SEC. 1523. HEALTH PLAN ARRANGEMENTS WITH PROVIDERS.

(a) PROVIDER VERIFICATION.—Plans shall ensure that all health care providers reimbursed by the plan are authorized under State law to provide applicable services. Each health plan shall—

(1) verify the credentials of practitioners and facilities;

(2) ensure that all providers participating in the plan meet applicable State licensing and certification standards;

(3) ensure that each health care provider participating in the plan annually discloses information regarding operations, ownership, finances, and workforce necessary to evaluate the providers compliance with this Act;

(4) oversee the quality and performance of participating providers, consistent with section 1510; and

(5) investigate and resolve consumer complaints against participating providers.

(b) REQUIREMENTS FOR NONNETWORK PLANS.—Each health plan must enter into such agreements or have such other arrangements as may be necessary with an appropriate mix, number, and distribution of qualified health professionals to ensure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled in the plan.

(c) REQUIREMENTS FOR NETWORK PLANS.—A health plan that requires coinsurance for an out-of-net-

work item or service shall comply with the following requirements:

(1) AGREEMENTS.—Each health plan must enter into such agreements or have such other arrangements as may be necessary with an appropriate mix, number, and distribution of qualified health professionals to ensure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled in the plan.

(2) GATEKEEPER.—With respect to each health plan that utilizes a gatekeeper or similar process to approve health care services prior to or following the provision of such services, such gatekeepers shall include specialists or a care coordinator from an interdisciplinary team if medically necessary or appropriate given the nature, severity, or complexity of each patient's chronic disease, disorder, or other health condition.

(3) CONTINUED CARE.—Each health plan shall develop a process to ensure the access of enrollees to—

(A) obstetrician-gynecologists for medically necessary or appropriate primary care without gatekeeper approval prior to each visit, and

(B) relevant specialists for the continued care of patient-enrollees with chronic diseases, disorders, or health conditions without gatekeeper approval prior to each visit, when the continued care is medically indicated.

(4) ELIGIBLE CENTERS OF SPECIALIZED TREATMENT EXPERTISE.—

(A) IN GENERAL.—Each health plan shall provide access through agreements (as defined in subparagraph (B)) to eligible centers of specialized treatment expertise (as defined in subparagraphs (C) and (D)), including centers outside the health care coverage area or State, to ensure that enrollees receive the specialized treatment expertise of such centers when medically indicated. For children such specialized treatment expertise shall specifically be in pediatrics. A health plan shall be deemed to be in accordance with this paragraph if the agreement of such plan provides that, with respect to health conditions within the specialized treatment expertise of the center involved, the plan will, at the enrollees request—

(i) refer medical cases involving such conditions to such center;

(ii) inform plan members of the availability of referral care; and

(iii) establish an appeal mechanism in which plan participants may challenge denials of referrals to such center or may request that their specialized care be provided at an alternative center as described in subparagraph (E).

(B) AGREEMENTS.—An agreement between a health plan and a center of specialized treatment expertise shall—

(i) be a written provider participation agreement with the center; or

(ii) be a written agreement under which the plan shall make payment to the center such that services provided will be reimbursable at the plan's normal rate for equivalent services or, with respect to a plan that does not pay providers on a fee-for-service basis, based on payment methodologies and rates used under the applicable methodology and rates or the most closely applicable Medicare payment methodologies under such program as the Secretary may specify in regulations.

(C) SPECIALIZED TREATMENT EXPERTISE.—For purposes of this subtitle, the term ''specialized treatment expertise'', with respect to the treatment of a health condition by an eligible center, means expertise in diagnosing and treating unusual diseases or conditions, diagnosing and treating diseases or conditions which are unusually difficult to diagnose or treat, and providing other specialized health care.

(D) ELIGIBLE CENTERS.—Eligible centers under this paragraph shall be designated to diagnose and provide care for patients with specified categories of conditions and diseases. Such centers may include academic health centers and teaching hospitals, and other designated centers and systems of advanced care that meet strict objective criteria established by the Secretary including—

(i) specialized credentials for caring for patients with the specified categories of conditions and diseases;

(ii) staff with experience in caring for a significant number of patients with the

specified categories of conditions and diseases; and

(iii) excellent measured outcomes in the diagnosis and treatment of patients with the specified categories of conditions and diseases.

(E) ACCESS TO ALTERNATIVE CENTERS.—

(i) IN GENERAL.—Patients in need of specialized treatment expertise may request that specialized care be provided at an alternative center. As used in this subparagraph, the term ''alternative center'' means a center of specialized treatment expertise with which the health plan of the patient does not have a written agreement as described in subparagraph (B). Plans shall have a procedure for making decisions regarding such requests and have an appeals process for patients who are refused coverage at an alternative center for specialized treatment.

(ii) REIMBURSEMENT.—Care provided at an alternative center shall be reimbursed by the health plan at the plan's normal rate for equivalent services or, with

respect to a plan that does not pay providers on a fee-for-service basis, based on payment methodologies and rates used under the applicable methodology and rates or the most closely applicable Medicare payment methodologies under such program as the Secretary may specify in regulations.

(F) LIMITATION.—A State may not establish rules or policies that require or encourage health plans to give preference to centers of specialized treatment expertise within the State or within the health care coverage area. A health plan shall not prohibit an academic health center, teaching hospital, or other center for specialized care with which it contracts from contracting with one or more other plans.

(d) EMERGENCY AND URGENT CARE SERVICES.—

(1) IN GENERAL.—Each health plan must cover emergency and urgent care services provided to enrollees, without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and in the case of

emergency services without regard to prior authorization.

(2) PAYMENT AMOUNTS.—In the case of emergency and urgent care provided to an enrollee outside of a health plan's service area, the payment amounts of the plan shall be based on the applicable fee schedule described in subsection (e).

(e) APPLICATION OF FEE SCHEDULE.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), each qualified health plan that provides for payment for services on a fee-for-service basis and has not established an agreement or contractual arrangement with providers specifying a basis for payment shall make such payment to such providers under a fee schedule established by the plan.

(2) RULE OF CONSTRUCTION.—Nothing in the paragraph (1) shall be construed to prevent a health plan from providing for a different basis or level of payment than the fee schedule established under such paragraph as part of a contractual agreement with participating providers under the plan.

(3) REDUCTION FOR PROVIDERS VOLUNTARILY REDUCING CHARGES.—If a provider under a health plan voluntarily agrees to reduce the amount charged to an individual enrolled under the plan, the

plan shall reduce the amount otherwise determined under the fee schedule applicable under paragraph (1) by the proportion of the reduction in such amount charged.

(4) REDUCTION FOR NONCOMPLYING PLAN.—Each community-rated health plan that is a noncomplying plan shall provide for reductions in payments under the fee schedule to providers that are not participating providers in accordance with section 6012(b).

(f) PROHIBITION AGAINST BALANCE BILLING; REQUIREMENT OF DIRECT BILLING.—

(1) PROHIBITION OF BALANCE BILLING.—A provider may not charge or collect from an enrollee a fee in excess of the applicable payment amount under the applicable fee schedule under subsection (e), and the health plan and its enrollees are not legally responsible for payment of any amount in excess of such applicable payment amount for items and services covered under the comprehensive benefits package.

(2) DIRECT BILLING.—

(A) IN GENERAL.—A provider may not charge or collect from an enrollee amounts that are payable by the health plan (including any

cost sharing reduction assistance payable by the plan) and shall submit charges to such plan in accordance with any applicable requirements of subtitle B of title V (relating to health information systems).

(B) PROHIBITION.—An individual or entity that performs ancillary health services, such as clinical laboratory services or other services as defined by the Secretary, may not present or cause to be presented, a claim, bill, or demand for payment to any person other than the individual receiving such services, or to the health plan of the individual, except that the Secretary may by regulation establish appropriate exceptions to the requirement of this subparagraph.

(3) COVERAGE UNDER AGREEMENTS WITH PLANS.—The agreements or other arrangements entered into under section 1514(c)(2) between a health plan and the health care providers providing the comprehensive benefit package to individuals enrolled with the plan shall prohibit a provider from engaging in balance billing described in paragraph (1).

(4) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to—

(A) require or force an individual to receive health care solely through the individual's health plan; or

(B) prohibit any individual from privately contracting with any health care provider and paying for the treatment or service provided by such provider on a cash basis or any other basis as agreed to between the individual and the provider.

(g) IMPOSITION OF PARTICIPATING PROVIDER ASSESSMENT IN CASE OF A NONCOMPLYING PLAN.—Each community-rated health plan shall provide that if the plan is a noncomplying plan for a year under section 6012, payments to participating providers shall be reduced by the applicable network reduction percentage under such section.

(h) PROVIDERS OUTSIDE AREA.—A State may not limit the ability of any plan to contract with a provider of health services located outside of the geographic boundaries of a health care coverage area or the State, so long as the provider is authorized under State law to provide such services.

SEC. 1524. HEALTH SECURITY CARDS.

Each health plan shall issue a health security card to each individual enrolled in such plan in accordance with

subtitle B of title V and regulations promulgated by the Board.

SEC. 1525. UTILIZATION MANAGEMENT PROTOCOLS AND PHYSICIAN INCENTIVE PLANS.

(a) REQUIRING CONSUMER DISCLOSURE.—Each health plan shall disclose to enrollees (and prospective enrollees) and providers the protocols and financial incentives used by the plan, including utilization management protocols and physician incentive plans (as defined in subsection (b)), for controlling utilization and costs.

(b) UTILIZATION MANAGEMENT.—Each health plan shall provide that all treatment assessment and placement decisions, or review of such decisions, shall be made by personnel—

(1) licensed, certified or otherwise credentialed by the State in the field for which the assessment or treatment is sought; and

(2) qualified to review utilization of the specific treatment delivered.

(c) PHYSICIAN INCENTIVE PLAN DEFINED.—As used in this section, the term ''physician incentive plan'' means any compensation arrangement between a health plan, a utilization management organization or other organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services

provided with respect to individuals enrolled with the organization.

(d) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—A health plan, or any provider or group of providers with whom the health plan contracts, may not operate a physician incentive plan (as defined in subsection (c)) unless the following requirements are complied with:

(1) The physician incentive plan provides that no specific payment may be made directly or indirectly under the plan to a physician or physician group or utilization management organization as an inducement to reduce or limit medically necessary or appropriate services provided to individuals enrolled with the organization.

(2) If the health plan places a physician or physician group at financial risk for services not provided by the physician or physician group, the physician incentive plan shall provide stop-loss protection for the physician or physician group that is adequate and appropriate, based on standards developed by the Board that take into account the number of physicians placed at such financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group.

(3) The health plan and any physician or physician group with whom the health plan contracts shall provide the Board with descriptive information regarding the physician incentive plan, sufficient to permit the Board to determine whether the plan is in compliance with the requirements of this subsection.

PART 2—REQUIREMENTS RELATING TO ESSENTIAL COMMUNITY PROVIDERS

SEC. 1531. HEALTH PLAN REQUIREMENT.

(a) IN GENERAL.—Each health plan shall, with respect to each electing essential community provider (as defined in subsection (d), other than a provider of school health services) located within the plan's service area, either—

(1) enter into a written provider participation agreement (described in subsection (b)) with the provider, or

(2) enter into a written agreement under which the plan shall make payment to the provider in accordance with subsection (c).

(b) PARTICIPATION AGREEMENT.—A participation agreement between a health plan and an electing essential community provider under this subsection shall provide that the health plan agrees to treat the provider in accord-

ance with terms and conditions at least as favorable as those that are applicable to other providers participating in the health plan with respect to each of the following:

(1) The scope of services for which payment is made by the plan to the provider.

(2) The rate of payment for covered care and services.

(3) The availability of financial incentives to participating providers.

(4) Limitations on financial risk provided to other participating providers.

(5) Assignment of enrollees to participating providers.

(6) Access by the provider's patients to providers in medical specialties or subspecialties participating in the plan.

(c) PAYMENTS FOR PROVIDERS WITHOUT PARTICIPATION AGREEMENTS.—

(1) IN GENERAL.—Payment in accordance with this subsection is payment based, as elected by the electing essential community provider, either—

(A) on the fee schedule developed by the State; or

(B) on payment methodologies and rates used under the applicable Medicare payment

methodology and rates (or the most closely applicable methodology under such program as the Secretary of Health and Human Services specifies in regulations).

(2) SPECIAL RULE FOR FEDERALLY QUALIFIED HEALTH CENTERS.—With respect to each federally qualified health center (as such term is defined in section 1861(aa) of the Social Security Act) that is an essential community provider, a health plan shall make payments based on the reasonable cost rates applicable under section 1833(a)(3) of the Social Security Act, except that the federally qualified health center may accept other payment amounts.

(3) NO APPLICATION OF GATE-KEEPER LIMITATIONS.—Payment in accordance with this subsection may be subject to utilization review, but may not be subject to otherwise applicable gate-keeper requirements under the plan.

(d) ELECTION.—

(1) IN GENERAL.—In this part, the term ''electing essential community provider'' means, with respect to a health plan, an essential community provider that elects this subpart to apply to the health plan.

(2) FORM OF ELECTION.—An election under this subsection shall be made in a form and manner specified by the Secretary, and shall include notice to the health plan involved. Such an election may be made annually with respect to a health plan, except that the plan and provider may agree to make such an election on a more frequent basis.

(e) SPECIAL RULE FOR PROVIDERS OF SCHOOL HEALTH SERVICES.—A health plan shall pay, to each provider of school health services located in the plan's service area an amount determined by the Secretary for such services furnished to enrollees of the plan.

SEC. 1532. RECOMMENDATION ON CONTINUATION OF REQUIREMENT.

(a) STUDIES.—In order to prepare recommendations under subsection (b), the Secretary shall conduct studies regarding essential community providers, including studies that assess—

(1) the definition of essential community provider,

(2) the sufficiency of the funding levels for providers, including the special rule for federally qualified health centers under section 1531(c)(2), for both covered and uncovered benefits under this Act,

(3) the effects of contracting requirements relating to such providers on such providers, health plans, and enrollees,

(4) the impact of the payment rules for such providers, and

(5) the impact of national health reform on such providers.

(b) RECOMMENDATIONS TO CONGRESS.—The Secretary shall submit to Congress, by not later than March 1, 2001, specific recommendations respecting whether, and to what extent, section 1531 should continue to apply to some or all essential community providers. Such recommendations may include a description of the particular types of such providers and circumstances under which such section should continue to apply.

Subtitle G—Federal Responsibilities

PART 1—NATIONAL HEALTH BOARD

Subpart A—Establishment of National Health Board

SEC. 1601. CREATION OF NATIONAL HEALTH BOARD; MEMBERSHIP.

(a) IN GENERAL.—There is hereby created in the Executive Branch a National Health Board.

(b) COMPOSITION.—The Board is composed of 9 members appointed by the President, by and with the advice and consent of the Senate.

(c) CHAIR.—The President shall designate one of the members as chair. The chair serves a term concurrent with that of the President. The chair may serve a maximum of 3 terms. The chair shall serve as the chief executive officer of the Board.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (4), the term of each member of the Board, except the chair, is 4 years and begins when the term of the predecessor of that member ends.

(2) INITIAL TERMS.—The initial terms of the members of the Board (other than the chair) first taking office after the date of the enactment of this Act, shall expire as designated by the President, three at the end of one year, three at the end of two years, and three at the end of three years.

(3) REAPPOINTMENT.—A member (other than the chair) may be reappointed for one additional term.

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

(e) VACANCIES.—

(1) IN GENERAL.—Whenever a vacancy shall occur, other than by expiration of term, a successor shall be appointed by the President, by and with the consent of the Senate, to fill such vacancy, and is appointed for the remainder of the term of the predecessor.

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

(3) ACTING CHAIR.—The Board may designate a Member to act as chair during any period in which there is no chair designated by the President.

(f) MEETINGS; QUORUM.—

(1) MEETINGS.—At meetings of the Board the chair shall preside, and in the absence of the chair, the Board shall elect a member to act as chair pro tempore.

(2) QUORUM.—Four members of the Board shall constitute a quorum thereof.

SEC. 1602. QUALIFICATIONS OF BOARD MEMBERS.

(a) CITIZENSHIP.—Each member of the Board shall be a citizen of the United States.

(b) BASIS OF SELECTION.—Board members will be selected on the basis of their experience and expertise in relevant subjects, including the practice of medicine, nursing, or other clinical practices, health care financing and delivery, state health systems, consumer protection, business, law, and delivery of care to vulnerable populations, including children, individuals with disabilities, and individuals in rural and urban underserved areas.

(c) EXCLUSIVE EMPLOYMENT.—During the term of appointment, Board members shall serve as employees of the Federal Government and shall hold no other employment.

(d) PROHIBITION OF CONFLICT OF INTEREST.—A member of the Board may not have a pecuniary interest in or hold an official relation to any health care plan, health care provider, insurance company, pharmaceutical company, medical equipment company, or other affected industry. Before entering upon the duties as a member of the Board, the member shall certify under oath compliance with this requirement.

(e) POST-EMPLOYMENT RESTRICTIONS.—After leaving the Board, former members are subject to post-employment restrictions applicable to comparable Federal employees.

(f) COMPENSATION OF BOARD MEMBERS.—Each member of the Board (other than the chair) shall receive an annual salary at the annual rate payable from time to time for level IV of the Executive Schedule. The chair of the Board, during the period of service as chair, shall receive an annual salary at the annual rate payable from time to time for level III of the Executive Schedule.

SEC. 1603. GENERAL DUTIES AND RESPONSIBILITIES.

(a) COMPREHENSIVE BENEFIT PACKAGE.—

(1) INTERPRETATION.—The Board shall interpret the comprehensive benefit package, adjust the delivery of preventive services under section 1153, and take such steps as may be necessary to assure that the comprehensive benefit package is available on a uniform national basis to all eligible individuals.

(2) FISCAL ANALYSIS BY NATIONAL HEALTH BOARD.—

(A) IN GENERAL.—Not later than 6 months prior to the effective date of this Act, the National Health Board, in cooperation with the Congressional Budget Office, shall undertake and conclude a fiscal analysis of—

(i) the cost of the comprehensive benefits package under section 1101;

(ii) the ability of the health care system's cost containment mechanisms, as defined in this Act, to control health care spending and Federal health expenditures based on current economic projections; and

(iii) the impact of new health care financial obligations under this Act on the Federal budget deficit, in current economic terms, and the source of any projected spending increases, including those described in clauses (i) and (ii), provider reimbursement rates, and administrative expenses.

(B) SUBMISSION OR REPORT.—The Board shall prepare and submit a preliminary analysis under this paragraph not later than January 1, 1997, and submit a final report not later than July 1, 1997, and July 1 of each year thereafter.

(C) REQUIREMENT OF REPORT.—In a report submitted under this paragraph, the Board shall specify the source and amount of any Federal budget deficit increases in order that Congress may more adequately assess other sources of funding or spending reductions that may be

appropriate to maintain the benefit package without adjustments.

(D) REPORT.—Based on the fiscal analysis contained in a report under this paragraph, if the Board concludes that the Federal government's obligation to contribute to the health care system (through the provision of subsidies to employers and families) will result in previously unprojected increases in the Federal budget deficit, the Board shall report and make corrective recommendations to the President and the Congress.

(3) REPORT AND RECOMMENDATIONS.—

(A) IN GENERAL.—If determined to be necessary by the Board, in consultation with the Congressional Budget Office, to prevent significant Federal deficit increases attributable to the provisions of this Act (or subsequent amendments to this Act), the Board shall include in the reports under paragraph (2)(B), adjustments in specific aspects of the comprehensive benefits package (such as scope of benefits, co-payments, deductibles, and phase-in's for additional benefits) to achieve savings

consistent with the findings in a report under paragraph (2).

(B) NO BOARD ADJUSTMENTS.—If the report of the Board under paragraph (2) contains no adjustments in the benefit package, the benefit package described in section 1101 shall become effective, except that the President may take action under section 9100(e)(4) as the President determines appropriate.

(C) BOARD ADJUSTMENTS.—If the report of the Board under paragraph (2) contains adjustments in the benefit package, the adjustments shall apply unless a joint resolution disapproving the adjustments is passed by Congress within 45 legislative days of the date of the submission of the report. The provisions of section 6006(d) shall apply to Congressional consideration of a joint resolution considered under this paragraph.

(D) AUTHORITY OF PRESIDENT.—The requirements of this section shall not be limited in any way by section 9100(e)(4) or any other provision of this Act.

(4) SCOPE OF RECOMMENDATIONS.—The Board may make adjustments in the services covered

under the benefit package, including any periodicity tables; copayment, deductible, and out-of-pocket requirements; and phase-in schedules for additional health benefits. The Board may not require co-payments for preventive health services, but may reclassify services described in section 1101 as preventive services.

(5) RECOMMENDATIONS.—The Board may recommend to the President and the Congress appropriate revisions to such package. Such recommendations may reflect changes in technology, health care needs, health care costs, and methods of service delivery.

(b) ADMINISTRATION OF COST CONTAINMENT PROVISIONS.—The Board shall oversee the cost containment requirements of subtitle A of title VI and certify compliance with such requirements.

(c) COVERAGE AND FAMILIES.—The Board shall develop and implement standards relating to the eligibility of individuals for coverage in applicable health plans under subtitle A of title I and may provide such additional exceptions and special rules relating to the treatment of family members under section 1012 as the Board finds appropriate.

(d) QUALITY MANAGEMENT AND IMPROVEMENT.—The Board shall establish and have ultimate responsibility for a performance-based system of quality management and improvement as required by section 5001.

(e) INFORMATION SYSTEM AND INFORMATION RELATED FUNCTIONS.—

(1) IN GENERAL.—The Board shall—

(A) develop and implement standards to establish a national health information system to measure quality as required by section 5101;

(B) provide model format and content requirements for summary plan descriptions; and

(C) provide model format and content requirements for comparative plan brochures under section 1205.

(2) INFORMATION RELATED FUNCTIONS.—

(A) DESIGNATION.—The Board shall provide for the use of entities in the national health data network to perform information related functions under this section with respect to employers, States, contracting entities, and consumer purchasing cooperatives.

(B) FUNCTIONS.—The functions referred to in subparagraph (A) shall include—

(i) receipt of information submitted by employers under section 1702,

(ii) from the information received, transmittal to States, and

(iii) such other functions as the Board specifies.

(f) PARTICIPATING STATE REQUIREMENTS.—Consistent with the provisions of subtitle C, the Board shall—

(1) establish requirements for participating States,

(2) monitor State compliance with those requirements,

(3) provide technical assistance, and

in a manner that ensures access to the comprehensive benefit package for all eligible individuals.

(g) DEVELOPMENT OF PREMIUM CLASS FACTORS.—The Board shall establish premium class factors under subpart D of this part.

(h) DEVELOPMENT OF REINSURANCE AND RISK-ADJUSTMENT METHODOLOGY.—The Board shall develop a methodology for the reinsurance and risk-adjustment of premium payments to community-rated health plans in accordance with subpart E of this part.

(i) FINANCIAL REQUIREMENTS.—The Board shall establish minimum capital requirements and requirements

for guaranty funds and financial reporting and auditing standards under subpart F of this part.

(j) STANDARDS FOR HEALTH PLAN GRIEVANCE PROCEDURES.—The Board shall establish standards for health plan grievance procedures that are used by enrollees in pursuing complaints.

(k) NATIONAL OPEN ENROLLMENT PERIODS.—The Board shall specify those periods which shall include a national, uniform open enrollment period, in which eligible individuals may change the applicable health plan in which they enrolled.

(l) FIDUCIARY REQUIREMENTS.—The Board shall, in consultation with the Secretary of Labor, develop and promulgate fiduciary requirements for the management of funds by States, plans, cooperatives, and employers.

SEC. 1604. ANNUAL REPORT.

(a) IN GENERAL.—The Board shall prepare and send to the President and Congress an annual report addressing the overall implementation of the new health care system.

(b) MATTERS TO BE INCLUDED.—The Board shall include in each annual report under this section the following:

(1) Information on Federal and State implementation.

(2) Data related to quality improvement.

(3) Recommendations or changes in the administration, regulation and laws related to health care and coverage.

(4) A full account of all actions taken during the previous year.

SEC. 1605. POWERS.

(a) STAFF; CONTRACT AUTHORITY.—The Board shall have authority, subject to the provisions of the civil-service laws and chapter 51 and subchapter III of chapter 53 of title 5, United States Code, to appoint such officers and employees as are necessary to carry out its functions. To the extent provided in advance in appropriations Acts, the Board may contract with any person (including an agency of the Federal Government) for studies and analysis as required to execute its functions. Any employee of the Executive Branch may be detailed to the Board to assist the Board in carrying out its duties.

(b) ESTABLISHMENT OF ADVISORY COMMITTEES.—The Board may establish advisory committees, including committees to advise the Board on the health care needs of disadvantaged and vulnerable populations, including children and individuals with physical, cognitive and other mental disabilities.

(c) ACCESS TO INFORMATION.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out its functions, to the extent such information is otherwise available to a department or agency of the United States. Upon request of the chair, the head of that department or agency shall furnish that information to the Board.

(d) DELEGATION OF AUTHORITY.—Except as otherwise provided in this Act, the Board may delegate any function to such officers and employees as the Board may designate and may authorize such successive redelegations of such functions with the Board as the Board deems to be necessary or appropriate. No delegation of functions by the Board shall relieve the Board of responsibility for the administration of such functions.

(e) RULEMAKING.—The National Health Board is authorized to establish such rules as may be necessary to carry out this Act.

SEC. 1606. FUNDING.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Board such sums as may be necessary for fiscal years 1994, 1995, 1996, 1997, and 1998.

(b) SUBMISSION OF BUDGET.—Under the procedures of chapter 11 of title 31, United States Code, the budget

for the Board for a fiscal year shall be reviewed by the Director of the Office of Management and Budget and submitted to the Congress as part of the President's submission of the Budget of the United States for the fiscal year.

Subpart B—Responsibilities Relating to Review and Approval of State Systems

SEC. 1611. FEDERAL REVIEW AND ACTION ON STATE SYSTEMS.

(a) APPROVAL OF STATE SYSTEMS BY NATIONAL BOARD.—

(1) IN GENERAL.—The National Health Board shall approve a State health care system for which a document is submitted under section 1200(b) unless the Board finds that the system (as set forth in the document) does not (or will not) provide for the State meeting the responsibilities for participating States under this Act.

(2) REGULATIONS.—The Board shall issue regulations, not later than July 1, 1995, prescribing the requirements for State health care systems under subtitle C, except that in the case of a document submitted under section 1200(b) before the date of issuance of such regulations, the Board shall take

action on such document notwithstanding the fact that such regulations have not been issued.

(3) NO APPROVAL PERMITTED FOR YEARS PRIOR TO 1996.—The Board may not approve a State health care system under this subpart for any year prior to 1996.

(b) REVIEW OF COMPLETENESS OF DOCUMENTS.—

(1) IN GENERAL.—If a State submits a document under subsection (a)(1), the Board shall notify the State, not later than 7 working days after the date of submission, whether or not the document is complete and provides the Board with sufficient information to approve or disapprove the document.

(2) ADDITIONAL INFORMATION ON INCOMPLETE DOCUMENT.—If the Board notifies a State that the State's document is not complete, the State shall be provided such additional period (not to exceed 45 days) as the Board may by regulation establish in which to submit such additional information as the Board may require. Not later than 7 working days after the State submits the additional information, the Board shall notify the State respecting the completeness of the document.

(c) ACTION ON COMPLETED DOCUMENTS.—

(1) IN GENERAL.—The Board shall make a determination (and notify the State) on whether the State's document provides for implementation of a State system that meets the applicable requirements of subtitle C—

(A) in the case of a State that did not require the additional period described in subsection (b)(2) to file a complete document, not later than 90 days after notifying a State under subsection (b) that the State's document is complete, or

(B) in the case of a State that required the additional period described in subsection (b)(2) to file a complete document, not later than 90 days after notifying a State under subsection (b) that the State's document is complete.

(2) REVIEW OF COVERAGE AREA.—The Board shall review State designation of health care coverage area boundaries to determine whether such boundaries comply with sections 1202 and 1914, and in particular, the requirements of such sections concerning non-discrimination in the establishment of coverage area boundaries.

(3) PLANS DEEMED APPROVED.—If the Board does not meet the applicable deadline for making a

determination and providing notice under paragraph (1) with respect to a State's document, the Board shall be deemed to have approved the State's document for purposes of this Act.

(d) OPPORTUNITY TO RESPOND TO REJECTED DOCUMENT.—

(1) IN GENERAL.—If (within the applicable deadline under subsection (c)(1)) the Board notifies a State that its document does not provide for implementation of a State system that meets the applicable requirements of subtitle C, the Board shall provide the State with a period of 30 days in which to submit such additional information and assurances as the Board may require.

(2) DEADLINE FOR RESPONSE.—Not later than 30 days after receiving such additional information and assurances, the Board shall make a determination (and notify the State) on whether the State's document provides for implementation of a State system that meets the applicable requirements of subtitle C.

(3) PLAN DEEMED APPROVED.—If the Board does not meet the deadline established under paragraph (2) with respect to a State, the Board shall

be deemed to have approved the State's document for purposes of this Act.

(e) APPROVAL OF PREVIOUSLY TERMINATED STATES.—If the Board has approved a State system under this part for a year but subsequently terminated the approval of the system under section 1612(b)(2), the Board shall approve the system for a succeeding year if the State—

(1) demonstrates to the satisfaction of the Board that the failure that formed the basis for the termination no longer exists, and

(2) provides reasonable assurances that the types of actions (or inactions) which formed the basis for such termination will not recur.

(f) REVISIONS TO STATE SYSTEM.—

(1) SUBMISSION.—A State may revise a system approved for a year under this section, except that such revision shall not take effect unless the State has submitted to the Board a document describing such revision and the Board has approved such revision.

(2) ACTIONS ON AMENDMENTS.—Not later than 60 days after a document is submitted under paragraph (1), the Board shall make a determination (and notify the State) on whether the implementa-

tion of the State system, as proposed to be revised, meets the applicable requirements of subtitle C. If the Board fails to meet the requirement of the preceding sentence, the Board shall be deemed to have approved the implementation of the State system as proposed to be revised.

(3) REJECTION OF AMENDMENTS.—Subsection (d) shall apply to an amendment submitted under this subsection in the same manner as it applies to a completed document submitted under subsection (b).

(g) NOTIFICATION OF NON-PARTICIPATING STATES.—If a State fails to submit a document for a State system by the deadline referred to in section 1200, or such a document is not approved under subsection (c), the Board shall immediately notify the Secretary of Health and Human Services of the State's failure for purposes of applying subpart C in that State.

SEC. 1612. FAILURE OF PARTICIPATING STATES TO MEET CONDITIONS FOR COMPLIANCE.

(a) IN GENERAL.—In the case of a participating State, if the Board determines that the operation of the State system under subtitle C fails to meet the applicable requirements of this Act, sanctions shall apply against the State in accordance with subsection (b).

(b) TYPE OF SANCTION APPLICABLE.—The sanctions applicable under this part are as follows:

(1) If the Board determines that the State's failure does not substantially jeopardize the ability of eligible individuals in the State to obtain coverage for the comprehensive benefit package the Board shall notify the Secretary who shall reduce payment with respect to the State in accordance with section 1613.

(2) If the Board determines that the failure substantially jeopardizes the ability of eligible individuals in the State to obtain coverage for the comprehensive benefit package—

(A) the Board shall terminate its approval of the State system; and

(B) the Board shall notify the Secretary of Health and Human Services, who shall assume the responsibilities described in section 1622.

(c) TERMINATION OF SANCTION.—

(1) COMPLIANCE BY STATE.—A State against which a sanction is imposed may submit information at any time to the Board to demonstrate that the failure that led to the imposition of the sanction has been corrected.

(2) TERMINATION OF SANCTION.—If the Board determines that the failure that led to the imposition of a sanction has been corrected in the case of the sanction described in subsection (b)(1)(A), the Board shall notify the Secretary of Health and Human Services.

(d) PROTECTION OF ACCESS TO BENEFITS.—The Board and the Secretary of Health and Human Services shall exercise authority to take actions under this section with respect to a State only in a manner that assures the continuous coverage of eligible individuals enrolled in community-rated health plans.

SEC. 1613. REDUCTION IN PAYMENTS FOR HEALTH PROGRAMS BY SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Upon receiving notice from the Board under section 1612(b)(1)(B), the Secretary of Health and Human Services shall reduce the amount of any of the payments described in subsection (b) that would otherwise be made to individuals and entities in the State by such amount as the Secretary determines to be appropriate.

(b) PAYMENTS DESCRIBED.—The payments described in this subsection are as follows:

(1) Payments to academic health centers in the State under subtitle B of title III.

(2) Payments to individuals and entities in the State for health research activities under section 301 and title IV of the Public Health Service Act.

(3) Payments to hospitals in the State under part 4 of subtitle E of title III (relating to payments to hospitals serving vulnerable populations)

SEC. 1614. REVIEW OF FEDERAL DETERMINATIONS.

Any State affected by a determination by the Board under this subpart may appeal such determination in accordance with section 5231.

SEC. 1615. FEDERAL SUPPORT FOR STATE IMPLEMENTATION.

(a) PLANNING GRANTS.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall make available to each State a planning grant to assist a State in the development of a health care system to become a participating State under subtitle C.

(2) FORMULA.—The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $50,000,000 in each of fiscal years 1995 and 1996 for grants under this subsection.

(b) GRANTS FOR START-UP SUPPORT.—

(1) IN GENERAL.—The Secretary shall make available to States, upon their enacting enabling legislation to become participating States, grants to assist in the establishment of consumer purchasing cooperatives.

(2) FORMULA.—The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) STATE MATCHING FUNDS REQUIRED.—Funds are payable to a State under this subsection only if the State provides assurances, satisfactory to the Secretary, that amounts of State funds (at least equal to the amount made available under this subsection) are expended for the purposes described in paragraph (1).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $313,000,000 for fiscal year 1996, $625,000,000 for fiscal year 1997, and $313,000,000 for fiscal year 1998 for grants under this subsection.

Subpart C—Responsibilities in Absence of State Systems

SEC. 1621. APPLICATION OF SUBPART.

(a) INITIAL APPLICATION.—This subpart shall apply with respect to a State as of January 1, 1998, unless—

(1) the State submits a document for a State system under section 1611(a)(1) by July 1, 1997, and

(2) the Board determines under section 1611 that such system meets the requirements of part 1 of subtitle C.

(b) TERMINATION OF APPROVAL OF SYSTEM OF PARTICIPATING STATE.—In the case of a participating State for which the Board terminates approval of the State system under section 1612(b)(2), this subpart shall apply with respect to the State as of such date as is appropriate to assure the continuity of coverage for the comprehensive benefit package for eligible individuals in the State.

SEC. 1622. FEDERAL ASSUMPTION OF RESPONSIBILITIES IN NON-PARTICIPATING STATES.

(a) NOTICE.—When the Board determines that this subpart will apply to a State for a calendar year, the Board shall notify the Secretary of Health and Human Services.

(b) ESTABLISHMENT OF COMMUNITY-RATING SYSTEM.—Upon receiving notice under subsection (a), the

Secretary shall take such steps as are necessary to ensure that the comprehensive benefit package is provided to eligible individuals in the State during the year.

(c) ESTABLISHMENT OF GUARANTY FUND.—

(1) ESTABLISHMENT.—The Secretary must ensure that there is a guaranty fund that meets the requirements established by the Board under section 1652, in order to provide financial protection to health care providers and others in the case of a failure of a community-rated health plan under a health care system established and operated by the Secretary under this section.

(2) ASSESSMENTS TO PROVIDE GUARANTY FUNDS.—In the case of a failure of one or more community-rated health plans, the Secretary may require each community-rated health plan to pay an assessment to the Secretary in an amount not to exceed 2 percent of the premiums of such plans paid by or on behalf of community rate eligible individuals during a year for so long as necessary to generate sufficient revenue to cover any outstanding claims against the failed plan.

SEC. 1623. IMPOSITION OF SURCHARGE ON PREMIUMS UNDER FEDERALLY-OPERATED SYSTEM.

(a) IN GENERAL.—If this subpart applies to a State for a calendar year, the premiums charged by community-rated health plans in the State shall be equal to premiums that would otherwise be charged, increased by 15 percent. Such 15 percent increase shall be used to reimburse the Secretary for any administrative or other expenses incurred as a result of establishing and operating the system.

(b) TREATMENT OF SURCHARGE AS PART OF PREMIUM.—For purposes of determining the compliance of a State for which this subpart applies in a year with the requirements for budgeting under subtitle A of title VI for the year, the 15 percent increase described in subsection (a) shall be treated as part of the premium for payment to a State.

SEC. 1624. RETURN TO STATE OPERATION.

(a) APPLICATION PROCESS.—After the establishment and operation of a system by the Secretary in a State under section 1622, the State may at any time apply to the Board for the approval of a State system in accordance with the procedures described in section 1611.

(b) TIMING.—If the Board approves the system of a State for which the Secretary has operated during a year, the Secretary shall terminate the operation of the system,

and the State shall establish and operate its approved system, as of January 1 of the first year beginning after the Board approves the State system. The termination of the Secretary's system and the operation of the State's system shall be conducted in a manner that assures the continuous coverage of eligible individuals in the State under community-rated health plans.

Subpart D—Establishment of Class Factors for Charging Premiums

SEC. 1631. PREMIUM CLASS FACTORS.

(a) IN GENERAL.—For each class of family enrollment (as specified in section 1011(c)), for purposes of title VI, the Board shall establish a premium class factor that reflects, subject to subsection (b), the relative actuarial value of the comprehensive benefit package of the class of family enrollment compared to such value of such package for individual enrollment.

(b) CONDITIONS.—In establishing such factors, the factor for the class of individual enrollment shall be 1 and the factor for the couple-only class of family enrollment shall be 2.

Subpart E—Risk Adjustment and Reinsurance Methodology for Payment of Plans

SEC. 1641. DEVELOPMENT OF A RISK ADJUSTMENT AND REINSURANCE METHODOLOGY.

(a) DEVELOPMENT.—

(1) INITIAL DEVELOPMENT.—Not later than April 1, 1995, the Board shall develop a risk adjustment and reinsurance methodology in accordance with this subpart.

(2) IMPROVEMENTS.—The Board shall make such improvements in such methodology as may be appropriate to achieve the purposes described in subsection (b)(1).

(b) RISK ADJUSTMENT METHODOLOGY.—

(1) PURPOSES.—Such risk adjustment methodology shall provide for the adjustment of payments to community-rated health plans for the purposes of—

(A) assuring that payments to such plans reflect the expected relative utilization and expenditures for such services by each plan's enrollees compared to the average utilization and expenditures for community rate eligible individuals, and

(B) protecting health plans that enroll a disproportionate share of community rate eligi-

ble individuals with respect to whom expected utilization of health care services (included in the comprehensive benefit package) and expected health care expenditures for such services are greater than the average level of such utilization and expenditures for community rate eligible individuals.

(2) FACTORS TO BE CONSIDERED.—In developing such risk adjustment methodology, the Board shall take into account the following factors:

(A) Demographic characteristics.

(B) Health status, including prior use of health services.

(C) Geographic area of residence.

(D) Socio-economic status.

(E) Subject to paragraph (5), (i) the proportion of enrollees who are SSI recipients and (ii) the proportion of enrollees who are AFDC recipients.

(F) Any other factors determined by the Board to be material to the purposes described in paragraph (1).

(3) ZERO SUM.—The risk adjustment methodology shall assure that the total payments to health plans after application of the methodology are the

same as the amount of payments that would have been made without application of the methodology.

(4) TREATMENT OF SSI/AFDC ADJUSTMENT.—The Board is not required to apply the factor described in clause (i) or (ii) of paragraph (2)(E) if the Board determines that the application of the other risk adjustment factors described in paragraph (2) is sufficient to adjust premiums to take into account the enrollment in plans of AFDC recipients and SSI recipients.

(5) SPECIAL CONSIDERATION FOR MENTAL ILLNESS AND MENTAL RETARDATION.—In developing the methodology under this section, the Board shall give consideration to the unique problems of adjusting payments to health plans with respect to individuals with mental illness and mental retardation.

(6) SPECIAL CONSIDERATION FOR VETERANS, MILITARY, AND INDIAN HEALTH PLANS.—In developing the methodology under this section, the Board shall give consideration to the special enrollment and funding provisions relating to plans described in section 1004(b).

(7) ADJUSTMENT TO ACCOUNT FOR USE OF ESTIMATES.—If the total payments made to all community-rated health plans in a year under section

1239 exceeds, or is less than, the total of such payments estimated by the State in the application of the methodology under this subsection, because of a difference between—

(A) the State's estimate of the distribution of enrolled families in different risk categories (assumed in the application of risk factors under this subsection in making payments to community-rated health plans), and

(B) the actual distribution of such enrolled families in such categories,

the methodology under this subsection shall provide for an adjustment in the application of such methodology in the second succeeding year in a manner that would reduce, or increase, respectively, by the amount of such excess (or deficit) the total of such payments made to all such plans.

(c) MANDATORY REINSURANCE.—

(1) IN GENERAL.—The methodology developed under this section shall include a system of mandatory reinsurance as a component of the risk adjustment methodology.

(2) REQUIREMENT IN CERTAIN CASES.—The Board shall reduce or eliminate such a system of reinsurance at such time as the Board determines that

an adequate prospective payment adjustment for health status has been developed and is ready for implementation.

(3) REINSURANCE SYSTEM.—The Board, in developing the methodology for a mandatory reinsurance system under this subsection, shall—

(A) provide for health plans to make payments to state-established reinsurance programs for the purpose of eliminating incentives for plans to discriminate against individuals on the basis of their expected utilization of health services; and

(B) specify the manner of creation, structure, and operation of the system in each State, including—

(i) the manner (which may be prospective or retrospective) in which health plans make payments to the system, and

(ii) the type and level of reinsurance coverage provided by the system.

(d) CONFIDENTIALITY OF INFORMATION.—The methodology shall be developed in a manner consistent with privacy standards promulgated under section 5120(a). In developing such standards, the Board shall take into account any potential need of States for certain

individually identifiable health information in order to carry out risk-adjustment and reinsurance activities under this Act, but only to the minimum extent necessary to carry out such activities and with protections provided to minimize the identification of the individuals to whom the information relates.

(e) STATE EXPERIMENTATION.—The Board is authorized to undertake experimentation with alternative reinsurance and risk adjustments methods in one or more different States, with the approval of the States adopting such experiments, to determine the most appropriate method to be used on a national basis.

(f) STATE-SPECIFIC ADJUSTERS.—States may, with the approval of the Board, add such risk adjusters to the national risk adjustment and reinsurance methodology that reflect State specific patters of disease or population characteristics.

SEC. 1642. INCENTIVES TO ENROLL DISADVANTAGED GROUPS.

The Board shall establish standards under which States may provide (under section 1203) for an additional adjustment in the risk-adjustment methodology developed under section 1641 in order to provide a financial incentive for community-rated health plans to enroll individuals

who are members of disadvantaged groups or populations vulnerable to discrimination due to their health status.

SEC. 1643. RESEARCH AND DEMONSTRATIONS.

The Secretary shall conduct and support research and demonstration projects to develop and improve, on a continuing basis, the risk adjustment and reinsurance methodology under this subpart.

SEC. 1644. TECHNICAL ASSISTANCE TO STATES.

The Board shall provide technical assistance to States in implementing the methodology developed under this subpart.

Subpart F—Responsibilities for Financial Requirements

SEC. 1651. CAPITAL STANDARDS FOR COMMUNITY-RATED PLANS.

(a) IN GENERAL.—The Board shall establish, in consultation with the States, minimum capital requirements for carriers, for purposes of section 1512.

(b) $500,000 MINIMUM.—Subject to subsection (c), under such requirements there shall be not less than $500,000 of capital maintained for each carrier.

(c) ADDITIONAL CAPITAL REQUIREMENTS.—The Board shall establish standards that provide for additional capital. The amount of such additional capital required

shall reflect factors likely to affect the financial stability of a carrier, including the following:

(1) Projected plan enrollment and number of providers participating in plans of the carrier.

(2) Market share and strength of competition.

(3) Extent and nature of risk-sharing with participating providers and the financial stability of risk-sharing providers.

(4) Prior performance of the carrier, risk history, and liquidity of assets.

(d) COMMUNITY- AND PROVIDER-BASED PLANS.—

(1) IN GENERAL.—States shall consider alternative financial instruments and methods for community- and provider-based plans (as defined in paragraph (2)) to meet the capital and solvency standards developed in accordance with this section. Provisions made for such plans shall ensure the fiscal integrity and financial solvency of such plans.

(2) ELIGIBLE PLANS.—Plans eligible for special consideration by States must be public or not-for-profit entities that are owned, or in which a majority share of the plan's investment is held by—

(A) health care providers who practice in the plan;

(B) individuals who live in the area, or not-for-profit organizations located in the area serviced by the plan;

(C) a combination of individuals and organizations described in subparagraphs (A) and (B); or

(D) organizations located outside the service area which provide for control over local operations by individuals described in subparagraphs (A) or (B).

(e) DEVELOPMENT OF STANDARDS BY NAIC.—The Board may request the National Association of Insurance Commissioners to develop model standards for the additional capital requirements described in subsection (c) and to present such standards to the Board not later than July 1, 1995. The Board may accept such standards as the standards to be applied under subsection (c) or modify the standards in any manner it finds appropriate.

SEC. 1652. STANDARD FOR GUARANTY FUNDS.

(a) IN GENERAL.—In consultation with the States, the Board shall establish standards for guaranty funds established by States.

(b) GUARANTY FUND STANDARDS.—The standards established under subsection (a) for a guaranty fund shall include the following:

(1) Each fund must have a method to generate sufficient resources to pay health providers and others in the case of a failure of a health plan in order to meet obligations with respect to—

(A) services rendered by the health plan for the comprehensive benefit package, including any supplemental coverage for cost sharing provided by the health plan, and

(B) services rendered prior to health plan insolvency and services to patients after the insolvency but prior to their enrollment in other health plans.

(2) The fund is liable for all claims against the plan by health care providers with respect to their provision of items and services covered under the comprehensive benefit package to enrollees of the failed plan. Such claims, in full, shall take priority over all other claims. The fund also is liable, to the extent and in the manner provided in accordance with rules established by the Board, for other claims, including other claims of such providers and the claims of contractors, employees, governments, or any other claimants.

(3) The fund stands as a creditor for any payments owed the plan to the extent of the payments made by the fund for obligations of the plan.

(4) The fund has authority to borrow against future assessments in order to meet the obligations of failed plans participating in the fund.

Subpart G—Open Enrollment

SEC. 1660. PERIODS OF AUTHORIZED CHANGES IN ENROLLMENT.

(a) ANNUAL OPEN ENROLLMENT PERIOD.—

(1) IN GENERAL.—For purposes of section 1211 and section 1502(a)(1), in order to encourage periodic family choice in the selection of health plans, the National Health Board shall specify a uniform, national annual open enrollment period during which all eligible individuals are permitted the opportunity to change enrollment among the health plans offered to them under this Act.

(2) EFFECTIVENESS OF CHANGE OF ENROLLMENT.—Except as the National Health Board may provide, changes in enrollment during an annual open enrollment period under paragraph (1) shall take effect as of the first date of the following year.

(b) ADDITIONAL PERIODS OF AUTHORIZED CHANGES IN ENROLLMENT.—The National Health Board also shall specify—

(1) such other periods and occurrences (including the insolvency of carriers or large group purchasers, changes in residence, and appropriate changes in employment) for which an individual is authorized to change enrollment in health plans, and

(2) when such change of enrollment becomes effective.

(c) DIRECT ENROLLMENT.—

(1) IN GENERAL.—The Board shall establish methods and procedures for the direct enrollment of individuals in the health plans of their choice.

(2) ENROLLMENT PROCESSES.—The Board shall provide standards for State to ensure the broad availability of enrollment forms, including direct enrollment through the mail, and other such processes as the Board may designate.

(3) NO MARKETING FEE.—Individuals enrolling in plans through the processes described in paragraph (2) shall be eligible for the community-rated premium (described in section 6000) filed by the health plan selected by the individual, without incurring a marketing fee, a surcharge or any other pay-

ment that represents an addition to the community-rated premium, whether such charge is imposed by the health plan, an agent of the plan, or any other entity.

(d) DISENROLLMENT FOR CAUSE.—

(1) IN GENERAL.—In addition to the annual open enrollment period held under subsection (a), the Board shall establish procedures by which eligible individuals enrolled in a plan may disenroll from the plan for good cause (as defined by Board) at any time during a year and enroll in another plan. Such procedures shall be implemented by participating States in a manner that ensures continuity of coverage for the comprehensive benefit package for such individuals during the year.

(2) DISENROLLMENT FOR CAUSE.—

(A) IN GENERAL.—In addition to the periods of authorized change in enrollment under paragraph (1), the National Health Board shall define good cause and establish procedures under which eligible individuals enrolled in a health plan provided by a carrier may disenroll from the plan for good cause at any time during a year and enroll in another applicable health plan.

(B) ASSURING CONTINUITY OF COVERAGE.—The procedures under this paragraph shall be implemented in a manner that ensures continuity of coverage for the comprehensive benefit package for individuals changing enrollment during the year.

(C) ADDITIONAL REMEDIES.—The Board may provide rules under which an individual who changes enrollment from a plan for good cause due to a pattern of underservice under a plan, the carrier providing the health plan is liable, to the subsequent health plan in which the individual is enrolled, for excess costs (as identified in accordance with such rules) during a reasonable period of the anticipated duration of enrollment with the original health plan.

(e) CHANGE OF ENROLLMENT.—In this section and subtitle E, the term ''change of enrollment'' includes, with respect to an individual—

(1) a change in the health plan in which the individual is enrolled,

(2) a change in the type of family enrollment, and

(3) the enrollment of the individual at the time the individual first becomes an eligible individual.

(f) PROVIDER-BASED ENROLLMENT MECHANISMS.—The Board shall promulgate rules regarding the establishment by States of provider-based enrollment mechanisms for individuals seeking care who are not enrolled in a health plan. Such rules shall include provisions requiring health plans to pay providers for care delivered to individuals prior to the individual's enrollment in the plan.

(g) COORDINATION OF ENROLLMENT ACTIVITIES.—Each State shall coordinate its activities, including plan enrollment and disenrollment activities, with other States in a manner specified by the National Health Board that ensures continuous, nonduplicative coverage of community-rated and experience-rated individuals in health plans and that minimizes administrative procedures and paperwork.

SEC. 1661. DISTRIBUTION OF COMPARATIVE INFORMATION.

The Board shall specify a period of time prior to open enrollment during which States must provide for the distribution to community-rate eligible individuals enrollment materials and comparative information on health plans.

PART 2—RESPONSIBILITIES OF DEPARTMENT OF HEALTH AND HUMAN SERVICES

Subpart A—General Responsibilities

SEC. 1671. GENERAL RESPONSIBILITIES OF SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Except as otherwise specifically provided under this Act (or with respect to administration of provisions in the Internal Revenue Code of 1986 or in the Employee Retirement Income Security Act of 1974), the Secretary of Health and Human Services shall administer and implement all of the provisions of this Act, except those duties delegated to the National Health Board, any other executive agency, or to any State.

(b) FINANCIAL MANAGEMENT STANDARDS.—The Secretary, in consultation with the Secretaries of Labor and the Treasury, shall establish, for purposes of section 1512, standards relating to the management of finances, maintenance of records, accounting practices, auditing procedures, and financial reporting for States, consumer purchasing cooperatives and health plans. Such standards shall take into account current Federal laws and regulations relating to fiduciary responsibilities and financial management of funds.

(c) AUDITING STATE PERFORMANCE.—The Secretary shall perform periodic financial and other audits of States to assure that such States are carrying out their

1 responsibilities under this Act consistent with this Act.
2 Such audits shall include audits of State performance in
3 the areas of—
4 (1) assuring enrollment of all community rate
5 eligible individuals in health plans,
6 (2) management of premium and cost sharing
7 discounts and reductions provided;
8 (3) financial management (including the finan-
9 cial activities of cooperatives and State-designated
10 contracting entities); and
11 (4) assuring enforcement of the antidiscrimina-
12 tion provisions of this Act.
13 (d) STANDARDS FOR UTILIZATION MANAGEMENT
14 PROGRAMS.—
15 (1) IN GENERAL.—Not later than 12 months
16 after the date of enactment of this Act, the Sec-
17 retary, in consultation with interested parties which
18 may include one or more accrediting organizations,
19 shall promulgate uniform Federal standards for uti-
20 lization management programs, to include the activi-
21 ties described in section 1210(b).
22 (2) COMPLIANCE.—States shall ensure compli-
23 ance with the Federal standards established under
24 paragraph (1), consistent with their role in certify-
25 ing health plans.

(3) REVIEW AND UPDATE.—The Secretary shall periodically review and update utilization management standards to reflect appropriate policies and practices in health care delivery.

SEC. 1672. MEDICAL TECHNOLOGY IMPACT STUDY.

(a) ASSESSMENT OF THE COMPREHENSIVE IMPACT OF MEDICAL TECHNOLOGIES.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Agency for Health Care Policy and Research (hereafter referred to in this section as the ''Administrator''), shall undertake an interdisciplinary study (to be known as the ''Medical Technology Impact Study'') to assess the overall economic costs, economic benefits, and effect on patient outcomes of medical technologies used in treating each of a list of target diseases and conditions. The Secretary shall submit the report of the Administrator to Congress (in accordance with subsection (c)) concerning the results of the study and may provide any recommendations determined to be necessary to ensure the availability, access, and appropriate use of medical technologies to improve the quality of health care in the United States.

(2) PURPOSE.—The purpose of the study under paragraph (1) is to assess the impact of old, new

and emerging medical technologies on health care costs, social costs, and patient outcomes, and to identify the factors, including government and private payor reimbursement policies, that impede or encourage innovation that improves patient outcomes. Congress intends that the study complement the technology assessment, outcomes research, and guideline development activities authorized under title IX of the Public Health Service Act by providing a comprehensive context for understanding the economic and social factors related to the development and use of medical technologies.

(3) DEFINITIONS.—As used in this section:

(A) ECONOMIC BENEFITS.—The term economic benefits may include, based on available data—

(i) reductions in the economic costs of disease;

(ii) increases in employment attributable to the medical technology industry;

(iii) increases in Federal and State tax revenues attributable to the medical technology industry and its employees;

(iv) improvements in the balance of trade deficit attributable to the medical technology industry; and

(v) other benefits that are determined by the Advisory Committee to be relevant to assessing the impact of medical technology.

(B) ECONOMIC COSTS.—The term ''economic costs'' may include, based on available data—

(i) the financial costs to the health care system of diagnosing and treating disease, including the costs of nontreatment and palliative care;

(ii) the financial costs to employers resulting from worker illness, including the costs of productivity losses and worker absenteeism;

(iii) the financial costs to families resulting from illness of a family member, including costs associated with loss of income, hiring of caretakers, and long term and hospice care;

(iv) the financial costs to government of illness, including reductions in income

tax revenues attributable to worker illness and worker related injuries and increases in transfer payments, including unemployment, disability, welfare, and survivor benefit payments, made to individuals and families on account of illness; and

(v) other costs that are determined by the Advisory Committee to be relevant to assessing the impact of medical technology.

(C) PATIENT OUTCOMES.—The term ''patient outcomes'' may include—

(i) changes in clinical outcomes, including stabilization of patients with progressive disease or health conditions, resulting from the use of safe and effective medical technology in prevention, diagnosis, or treatment;

(ii) changes in mortality, morbidity, and health service use, including stabilization of patients with progressive diseases;

(iii) changes in quality of life, including ability to perform activities of daily living, ability to return to work, relief from discomfort or pain, alleviation of fatigue,

and improved mental functioning and well-being; and

(iv) other outcomes that are determined by the advisory committee to be relevant to assessing the impact of medical technology.

(D) MEDICAL TECHNOLOGIES.—The term ''medical technologies'' includes drugs, biologics (including vaccines), medical devices, drug delivery systems, and surgical services and other procedures for preventing, diagnosing, and treating diseases or health conditions.

(E) MEDICAL TECHNOLOGY INDUSTRY.—The term ''medical technology industry'' includes the biotechnology, pharmaceutical, and medical device industries, and such other industries that invent, develop, or market medical technologies.

(b) ADVISORY COMMITTEE.—

(1) IN GENERAL.—The Administrator shall establish an Advisory Committee to assist the Agency in preparing the reports required under subsection (c). Except as provided in paragraph (3), no member of the advisory committee shall be an employee of the Federal Government.

(2) MEMBERSHIP.—The Advisory Committee shall be balanced in its representation of interested parties and shall be composed of at least two individuals appointed by the President of the Institute of Medicine and two individuals from each of the following categories:

(A) Experts in medical technology assessment.

(B) Experts in objective measures of improved patient outcomes, such as clinical outcomes, mortality, morbidity, and health service use.

(C) Experts in subjective measures of improved patient outcomes, such as quality of life.

(D) Experts in quantifying the economic costs of disease to the health care system, including public and private payers.

(E) Experts in quantifying the economic impact of the medical technology industry.

(F) Experts in health statistics and epidemiology.

(G) Physicians and other health care providers.

(H) Officers or employees of health plans and other health care payers.

(I) Experts in the ethical implications of health care.

(J) Experts in private sector financial market investment in the medical technology industry.

(K) Consumers and members of patient advocacy groups.

(L) Health professional organizations.

(M) Officers or employees of biotechnology companies.

(N) Officers or employees of medical device companies.

(O) Officers or employees of pharmaceutical companies.

(3) EX OFFICIO.—The following individuals or their designees shall serve as ex officio members of the Advisory Committee:

(A) The Director of the National Institutes of Health.

(B) The Commissioner of Food and Drugs.

(C) The Director of the Centers for Disease Control and Prevention.

(D) The Administrator of the Health Care Financing Administration.

(E) The Under Secretary of Commerce for Technology.

(F) The Director of the Congressional Office of Technology Assessment.

(c) INTERDISCIPLINARY STUDY AND REPORT.—

(1) IN GENERAL.—The Administrator, in consultation with the Advisory Committee established under subsection (b), shall determine which diseases or conditions should be studied in the Medical Technology Impact Study. In carrying out the medical technology assessment required under this subsection, the Administrator shall consider various factors, including those outlined in section 904(b)(2) of the Public Health Service Act and government and private payor reimbursement policies that impede or encourage innovation that improves patient outcomes. The diseases or conditions studied in such Study shall be those considered to be high priority according to the following criteria:

(A) Aggregate economic costs to the United States.

(B) Overall importance to public heath.

(C) Potential for improvements in patient outcomes.

(D) Significant changes expected in management of the condition.

(E) Other criteria identified by the Advisory Committee.

(2) DESIGN.—The Administrator, in consultation with the Advisory Committee established under subsection (b), and the Institute of Medicine pursuant to paragraph (3), shall develop a design, based on the list of target diseases and conditions, for undertaking the Medical Technology Impact Study.

(3) CONTRACT.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to enter into a contract to review the Study design and report to the Administrator concerning any recommendations for revising such design, in the interest of assuring that it reflects the best available scientific methodologies.

(4) PUBLICATION.—The Administrator shall publish the study design and list of target diseases and conditions, the recommendations of the Institute of Medicine, and the response of the Administrator to such recommendations in the Federal Register for a 60-day period for public comment. Any such comments shall be considered by the Administrator in

completing the proposed study design for submission to the Secretary.

(5) DESIGN REPORT.—The Secretary shall report to Congress concerning the proposed design of the Medical Technology Impact Study, together with recommendations for appropriations necessary to carry out the Study.

(6) GRANTS AND CONTRACTS.—Beginning in the first fiscal year for which Congress appropriates funds consistent with paragraph (5), and ending on September 30 of that year, the Administrator shall enter into grants and contracts with appropriate entities to conduct any investigations and analyses that may be required to carry out the design of the Medical Technology Impact Study.

(7) REPORT ON FINDINGS.—The Administrator, in consultation with the Advisory Committee, shall develop a draft comprehensive report concerning the findings of the Study, shall make copies of the draft report available to the public and publish a notice in the Federal Register providing for a 60-day period of public comment. Any such comments shall be considered by the Administrator in completing and submitting the final report to the Secretary.

(8) FINAL REPORT.—Not later than 3 years after the date of enactment of this section, the Secretary shall submit the report of the Administrator to Congress, and may include any recommendations determined necessary to assure the availability, access and appropriate use of medical technologies to improve the quality of health care in the United States.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 1673. ASSISTANCE WITH FAMILY COLLECTIONS.

The Secretary shall provide States with such technical and other assistance as may promote the efficient collection of other amounts owed by families under this Act. Such assistance may include the assessment of civil monetary penalties, not to exceed $5,000 or three times the amount of the liability owed, whichever is greater, in the case of repeated failure to pay (as specified in rules of the Secretary).

SEC. 1674. ADVISORY OPINIONS.

(a) IN GENERAL.—Community- and provider-based plans and individuals and organizations seeking to establish such plans shall be eligible to receive advisory opinions from appropriate Federal entities, including opinions con-

cerning whether their arrangement complies with Federal self-referral, fraud and abuse, and anti-trust laws.

(b) REGULATIONS.—The Secretary shall issue regulations setting forth the procedures for obtaining advisory opinions described in subsection (a).

(c) TIMING OF OPINIONS.—Advisory opinions shall be issued not later than 90 days after receipt of a request for such opinions from a plan.

(d) FEES.—Applicants shall pay a fee, the amount of which to be determined by the Secretary, to cover the costs of providing the opinion.

SEC. 1675. REPORTS.

(a) DENTAL CARE.—The Secretary shall undertake studies to determine—

(1) the costs of providing—

(A) preventive dental care to all adults;

(B) restorative dental care to all adults; and

(C) preventive dental care to adults with developmental, cognitive, and other mental disabilities; and

(2) the best oral health care practice and the cost or savings of providing such care prior to 2001.

The Secretary shall report to the National Health

Board and the Congress not later than September 1, 1995 concerning such study.

(b) IN VITRO FERTILIZATION.—The Secretary shall undertake a study to determine the costs of providing coverage for in vitro fertilization in the comprehensive benefits package. The Secretary shall report to the National Health Board and the Congress not later than September 1, 1995 concerning such study.

Subpart B—Certification of Essential Community Providers

SEC. 1681. CERTIFICATION.

For purposes of this Act, the Secretary shall certify as an ''essential community provider'' any health care provider or organization that—

(1) is within any of the categories of providers and organizations specified in section 1682(a), or

(2) meets the standards for certification under section 1683(a).

SEC. 1682. CATEGORIES OF PROVIDERS AUTOMATICALLY CERTIFIED.

(a) IN GENERAL.—The categories of providers and organizations, including subrecipients, specified in this subsection are as follows:

(1) Covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42

U.S.C. 256b(a)(4)), except that subsections (a)(4)(L)(iii) and (a)(7) of such section shall not apply.

(2) School health services centers under title III of this Act.

(3)(A) Nonprofit hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act, except that subsection (a)(4)(L)(iii) of such section shall not apply.

(B) Nonprofit hospitals with a minimum of 200 beds, located in urban areas where—

(i) the cumulative total of its services provided to individuals who are entitled to benefits under title XVIII of the Social Security Act or under a State plan under title XIX of such Act equals a minimum of 65 percent; and

(ii) a minimum of 20 percent of its services are provided to individuals eligible for assistance under such title XIX;

(C) A Medicare dependent small rural hospital under section 1886(d)(8)(iii) of the Social Security Act.

(D) Children's hospitals meeting comparable criteria determined appropriate by the Secretary.

(4) Public and private, nonprofit mental health and substance abuse providers receiving funds under title V or XIX of the Public Health Service Act.

(5) Runaway homeless youth centers or transitional living programs for homeless youth providing health services under the Runaway Homeless Youth Act of 1974 (42 U.S.C. 5701 et seq.).

(6) Public or nonprofit maternal and child health providers that receive funding under title V of the Social Security Act.

(7) Rural health clinics as defined under section 1861(aa)(2) of the Social Security Act.

(b) STUDY OF FEDERALLY CERTIFIED RURAL HEALTH CLINICS.—The Secretary shall conduct an evaluation of the Rural Health Clinics program as defined in section 1861(aa)(2) of the Social Security Act to examine the causes of the growth in the program and the characteristics of providers certified as rural health clinics and the characteristics of the population served by rural health clinics to ensure that the program meets the needs of rural underserved communities. The Secretary shall report the findings of such evaluation, together with any recommended changes in the rural health clinics program, to the Congress not later than January 1, 1996.

SEC. 1683. STANDARDS FOR ADDITIONAL PROVIDERS.

(a) STANDARDS.—The Secretary shall publish standards for the certification of additional categories of health care providers and organizations as essential community providers, including the categories described in subsection (b). Such a health care provider or organization shall not be certified unless the Secretary determines, under such standards, that health plans operating in the area served by the applicant would not otherwise be able to assure adequate access to items and services included in the comprehensive benefit package if such a provider was not so certified.

(b) CATEGORIES TO BE INCLUDED.—The categories described in this subsection are as follows:

(1) CERTAIN HEALTH PROFESSIONALS.—A health professional who—

(A) for at least 20 hours per week—

(i) is located in an area (or areas) designated as a health professional shortage area (under section 332 of the Public Health Service Act) or serves a population (or populations) designated as a medically underserved population (under section 330 of the Public Health Service Act); or

(ii)(I) is located or provides services in a neighborhood or community whose residents are at risk of underservice; and

(II) is available to patients at such location on evenings and weekends; and

(B) if the health professional is a physician—

(i) is licensed to practice in the jurisdiction; and

(ii) is either—

(I) granted privileges to practice at one or more hospitals; or

(II) has a consultation and referral arrangement with one or more physicians who are granted privileges to practice at one or more hospitals.

(2) INSTITUTIONAL PROVIDERS.—Public and private nonprofit hospitals and other public and nonprofit institutional health care providers, including family planning clinics, located in health professional shortage areas (as defined under section 332 of the Public Health Service Act) or providing health services to medically underserved populations (as defined under title III of this Act).

(3) OTHER PROVIDERS.—Other public and private nonprofit agencies and organizations that—

(A) are located in such an area or providing health services to such a population, and

(B) provide health care and services essential to residents of such an area or such populations.

SEC. 1684. CERTIFICATION PROCESS; REVIEW; TERMINATION OF CERTIFICATIONS.

(a) CERTIFICATION PROCESS.—

(1) PUBLICATION OF PROCEDURES.—The Secretary shall publish, not later than 6 months after the date of the enactment of this Act, the procedures to be used by health care professionals, providers, agencies, and organizations seeking certification under this subpart, including the form and manner in which an application for such certification is to be made.

(2) TIMELY DETERMINATION.—The Secretary shall make a determination upon such an application not later than 60 days (or 15 days in the case of a certification for an entity described in section 1682) after the date the complete application has been submitted. The determination on an application for certification of an entity described in section

1682 shall only involve the verification that the entity is an entity described in such section.

(b) REVIEW OF CERTIFICATIONS.—The Secretary shall periodically review whether professionals, providers, agencies, and organizations certified under this subpart continue to meet the requirements for such certification.

(c) TERMINATION OR DENIAL OF CERTIFICATION.—

(1) PRELIMINARY FINDING.—If the Secretary preliminarily finds that an entity seeking certification under this section does not meet the requirements for such certification or such an entity certified under this subpart fails to continue to meet the requirements for such certification, the Secretary shall notify the entity of such preliminary finding and permit the entity an opportunity, under subtitle C of title V, to rebut such findings.

(2) FINAL DETERMINATION.—If, after such opportunity, the Secretary continues to find that such an entity continues to fail to meet such requirements, the Secretary shall terminate the certification and shall notify the entity, the State, large group purchasers, of such termination and the effective date of the termination.

SEC. 1685. NOTIFICATION OF PARTICIPATING STATES.

(a) IN GENERAL.—Not less often than annually the Secretary shall notify each participating State of essential community providers that have been certified under this subpart.

(b) CONTENTS.—Such notice shall include sufficient information to permit each State to notify health plans of the identity of each entity certified as an essential community provider, including—

(1) the location of the provider within each plan's service area,

(2) the health services furnished by the provider, and

(3) other information necessary for health plans to carry out part 3 of subtitle E.

SEC. 1686. DEFINITIONS.

As used in subpart:

(1) SUBRECIPIENT.—The term ''subrecipient'' means, with respect to a recipient of a grant under a particular authority, an entity that—

(A) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

(B) meets the requirements established to be a recipient of such a grant.

(2) HEALTH PROFESSIONAL.—The term ''health professional'' means a physician, nurse, nurse practitioner, certified nurse midwife, physician assistant, psychologist, dentist, pharmacist, chiropractor, clinical social worker, and other health care professional recognized by the Secretary.

(3) CHILDREN'S HOSPITAL.—The term ''children's hospital'' means those hospitals whose inpatients are certified by the Secretary or the State to be predominantly under the age of 18.

Subpart C—Workplace Wellness Programs

SEC. 1687. WORKPLACE WELLNESS PROGRAM.

(a) IN GENERAL.—The Secretary shall perform responsibilities required under this Act with respect to the development of certification criteria and other duties required under this Act relating to workplace wellness programs.

(b) APPLICATION OF SECTION.—Employers maintaining qualified worksite health promotion programs meeting the requirements of subsection (d) shall be entitled to the worksite health promotion rebate specified in subsection (c).

(c) WORKSITE HEALTH PROMOTION REBATE.—Employers maintaining a qualified worksite health promotion programs shall be paid a rebate by the State in an amount

determined using the methodology developed by the Secretary.

(d) REQUIREMENTS FOR QUALIFIED WORKSITE HEALTH PROMOTION PROGRAMS.—

(1) ESTABLISHMENT OF LEVELS.—The Secretary shall establish not less than two levels of qualified worksite health promotion programs and determine the program elements (or combination of program elements) necessary for an employer to qualify at each level. In establishing such levels, the Secretary shall take into consideration the special characteristics of small businesses (as defined in section 6123(c)) and incorporate provisions providing small businesses the opportunity to qualify at all levels.

(2) PROGRAM ELEMENTS.—Program elements that the Secretary should consider for inclusion in qualified worksite health promotion programs are the following:

(A) Education, screening, counseling, follow-up, treatment or referral programs to reduce lifestyle and other modifiable risk factors such as cholesterol, inactivity, nutrition and weight management, HIV, sexually transmitted diseases, cancer prevention, or smoking.

(B) Education, screening, counseling, follow-up, monitoring or referral for chronic health risks or problems such as high blood pressure or diabetes.

(C) Promotion of exercise and fitness through education or the provision of exercise facilities at the worksite, adjoining the worksite, or at a proximate location with transportation provided from the worksite.

(D) Employee assistance programs that provide counseling and assistance with respect to other areas of personal concern that may adversely affect job performance such as substance abuse, stress or parenting.

(E) Workplace health and safety education and prevention programs that go beyond those required by law.

(F) Prenatal counseling and education.

(G) Consumer education regarding health care services including programs on the development of living wills.

(3) MINIMUM PARTICIPATION RATES.—The Secretary shall have the authority to establish minimum employee participation rates as a condition of

employer qualification under a qualified worksite health promotion program.

(4) GUIDELINES.—The Secretary shall develop guidelines to ensure that employers who sponsor qualified worksite health promotion program do not discriminate among employees as to either eligibility for participation or program benefits.

(5) APPLICATION.—The Secretary shall develop an application form and supporting material to be used by employers to certify that they qualify for one of the worksite health promotion program levels established by the Secretary.

SEC. 1688. WELLNESS DISCOUNT METHODOLOGY.

(a) REQUIREMENT.—The Secretary shall develop a methodology consistent with subsection (b) in order to ensure that—

(1) families entitled to a wellness discount by virtue of employment of a family member by an employer maintaining a qualified worksite health promotion program under section 1687(d) receive a credit toward their family share of premium (as defined in section 6101(b)(1)) equal to the wellness discount specified by the plan in which the family elects to enroll; and

(2) employers maintaining qualified programs receive a rebate annually, based on the average worksite health promotion discount in the health care coverage area, weighted by the enrollment of employees of all employers offering certified wellness programs in the area.

(b) METHODOLOGY.—The methodology developed by the Secretary under subsection (a) shall—

(1) ensure that each family enrolled in a community-rated plan that offers a wellness discount receives the discount provided by the plan chosen by the family regardless of whether the family has enrolled in the plan through a consumer purchasing cooperative directly or through the plan, or through some other means;

(2) ensure that a separate rebate is computed for each worksite health promotion program level established by the Secretary under section 1687; and

(3) ensure that any wellness discount offered by health plans are not taken into account in the Board's determination of plan and area compliance with the per-capita premium targets described in subtitle A of title VI of this Act.

PART 3—SPECIFIC RESPONSIBILITIES OF SECRETARY OF LABOR

SEC. 1691. RESPONSIBILITIES OF SECRETARY OF LABOR.

(a) IN GENERAL.—The Secretary of Labor is responsible—

(1) under subtitle E, for the enforcement of requirements applicable to community-rated employers (including requirements relating to payment of premiums) and the administration of large group purchasers;

(2) under subtitle E, with respect to elections by eligible purchasers to become large group purchasers and the termination of such elections;

(3) for the temporary assumption of the operation of self-insured employer sponsored health plans that are insolvent;

(4) for carrying out any other responsibilities assigned to the Secretary under this Act; and

(5) for administering title I of the Employee Retirement Income Security Act of 1974 as it relates to group health plans maintained by large group purchasers.

(b) AGREEMENTS WITH STATES.—The Secretary of Labor may enter into agreements with States in order to enforce responsibilities of employers and large group purchasers, and requirements of employer sponsored health

plans, under subtitle B of title I of the Employee Retirement Income Security Act of 1974.

(c) CONSULTATION WITH BOARD.—In carrying out activities under this Act with respect to large group purchasers, employer sponsored health plans, and employers, the Secretary of Labor shall consult with the National Health Board.

(d) STUDY ON SEASONAL WORKERS.—Not later than 6 months after the date of enactment of this Act, the Secretary of Labor, in consultation with the Secretary and such other Federal departments and experts as determined appropriate, shall prepare and submit to the appropriate committees of Congress, a report concerning the impact of requiring employers of seasonal workers to make premium contributions for such workers. The report shall analyze and make recommendations concerning the fiscal and administrative (including paperwork) burdens on employers, employees, and health plans.

(e) EMPLOYER-RELATED REQUIREMENTS.—

(1) IN GENERAL.—The Secretary of Labor, in consultation with the Secretary, shall be responsible for assuring that employers—

(A) make payments of any employer premiums (and withhold and make payment of the family share of premiums with respect to quali-

fying employees) and provide discounts to employees as required under this Act, including auditing of collection activities with respect to such payments,

(B) submit timely reports as required under this Act, and

(C) otherwise comply with requirements imposed on employers under this Act.

(2) AUDIT AND SIMILAR AUTHORITIES.—The Secretary of Labor—

(A) may carry out such audits (directly or through contract) and such investigations of employers and States, consumer purchasing cooperatives and large group purchasers,

(B) may exercise such authorities under section 504 of Employee Retirement Income Security Act of 1974 (in relation to activities under this Act),

(C) may, with the permission of the Board, provide (through contract or otherwise) for such collection activities (in relation to amounts owed to States, consumer purchasing cooperatives and large group purchasers, and for the benefit of such States, consumer purchasing cooperatives and large group purchasers), and

(D) may impose such civil penalties under section 6210,

as may be necessary to carry out such Secretary's responsibilities under this section.

(3) AUDITING OF EMPLOYER PAYMENTS.—

(A) IN GENERAL.—Each State is responsible for auditing the records of community-rated employers to assure that employer payments (including the payment of amounts withheld) were made in the appropriate amount as provided under subpart A of part 2 of subtitle B of title VI.

(B) EMPLOYERS WITH EMPLOYEES RESIDING IN DIFFERENT COMMUNITY-RATING AREAS.—In the case of a community-rated employer which has employees who reside in more than one community-rating area, the Secretary of Labor, in consultation with the Secretary, shall establish a process for the coordination of State auditing activities among the States involved.

(C) APPEAL.—In the case of an audit conducted by a State on an employer under this paragraph, an employer or other State that is aggrieved by the determination in the audit is

entitled to review of such audit by the Secretary of Labor in a manner to be provided by such Secretary.

(f) AUTHORITY.—The Secretary of Labor is authorized to issue such regulations as may be necessary to carry out section 1704 and responsibilities of the Secretary under this Act (including under title XI).

SEC. 1692. ASSISTANCE WITH EMPLOYER COLLECTIONS.

The Secretary of Labor shall provide States with such technical and other assistance as may promote the efficient collection of all amounts owed under this Act by employers. Such assistance may include the assessment of civil monetary penalties, not to exceed $5,000 or three times the amount of the liability owed, whichever is greater, in the case of repeated failure to pay (as specified in rules of the Secretary of Labor).

SEC. 1693. PENALTIES FOR FAILURE OF LARGE EMPLOYERS TO MEET REQUIREMENTS.

(a) IN GENERAL.—If the Secretary of Labor finds that a large group purchaser has failed substantially to meet the applicable requirements of subtitle E, the Secretary shall impose a civil money penalty of not to exceed $10,000 for each such violation.

(b) EXCESS INCREASE IN PREMIUM EQUIVALENT.—If the Secretary of Labor finds that a large group pur-

chaser that is a large employer is in violation of the requirements of section 6022 (relating to prohibition against excess increase in premium expenditures), the Secretary shall require that the purchaser enter into contracts with all carriers providing community-rated plans in community-rating areas in which their experience-rated individuals reside, under which the purchaser—

(1) makes payment to the carriers based on an appropriate community rate (determined by the Secretary of Labor based on the final filed per capita premium rate, subject to appropriate risk adjustment and not subject to any employer discount), and

(2) makes payments to the State of an amount provided under section 6124.

SEC. 1694. APPLICABILITY OF ERISA ENFORCEMENT MECHANISMS FOR ENFORCEMENT OF CERTAIN REQUIREMENTS.

The provisions of sections 502 (relating to civil enforcement), 504 (relating to investigative authority) and 506 (relating to criminal enforcement) of the Employee Retirement Income Security Act of 1974 shall apply to enforcement by the Secretary of Labor of the applicable requirements for large group purchasers in the same manner and to same extent as such provisions apply to enforcement of title I of such Act.

PART 4—COLLECTIVE BARGAINING DISPUTE RESOLUTION

SEC. 1695. FINDINGS AND PURPOSE.

(a) FINDING.—Congress finds that—

(1) consistent with the intention of this Act to eliminate waste and inefficiency in the health care industry, it is important to avoid costly and disruptive labor disputes; and

(2) such disputes are particularly likely to take place during the period of transition to a restructured health care delivery system because of disruptions to established employment relationships resulting from that restructuring.

(b) PURPOSE.—It is the purpose of this part to expand the role of the Federal Mediation and Conciliation Service, acting through the Boards of Inquiry provided for in limited terms under section 8(g) of the National Labor Relations Act (29 U.S.C. 158(g)) and section 213 of the Labor Management Relations Act of 1947 (29 U.S.C. 183), to avoid labor disputes by providing for public fact finding in contract negotiations.

SEC. 1696. APPLICATION LIMITED TO TRANSITION PERIOD.

The provisions of this part are intended to avoid costly and disruptive labor disputes during the period of transition to a restructured health care delivery system, and

shall be repealed effective upon the end of calendar year 2000.

SEC. 1697. REQUEST FOR APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—A health care entity (as defined in section 3082(a)) or a labor organization that has been lawfully certified or recognized as the representative of the employees of a health care entity for the purpose of engaging in collective bargaining concerning wages, hours and other terms and conditions of employment, may request that the Director of the Federal Mediation and Conciliation Service (hereafter referred to in this part as the ''Director'') appoint an impartial Health Care Board of Inquiry to investigate the issues involved in a collective bargaining dispute between the entity and the labor organization.

(b) TIME FOR REQUEST.—Such request may be made no earlier than 60 days after notice of the existence of a contract dispute has been provided to—

(1) the Federal Mediation and Conciliation Service in accordance with clause (A) or (B) of the last sentence of section 8(d) of the Labor Management Relations Act (29 U.S.C. 158(d)); or

(2) where the health care entity is otherwise exempt from coverage under such Act, any comparable

State or territorial agency established to mediate and conciliate disputes to which notice is required to be given under applicable State law.

SEC. 1698. APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—Except as provided in subsection (b), the Director shall appoint a Health Care Board of Inquiry not later than 10 days after receipt of a request under section 1696. Each such Board shall be composed of such number of individuals as the Director may deem desirable. No member appointed under this section shall have any interest or involvement in the health care institutions or the employee organizations involved in the dispute.

(b) LIMITATION.—With respect to the appointment of a Health Care Board of Inquiry under paragraph (1), if the Director determines that—

(1) the health care entity is—

(A) otherwise exempt from coverage under the Labor Management Relations Act, as amended (29 U.S.C. 141 et seq.); and

(B) subject to State laws containing procedures for the resolution of impasses in collective bargaining that are comparable to those that would be followed by a Board of Inquiry under this section; or

(2) the parties involved have agreed to procedures for the resolution of the impasse in collective bargaining that are comparable to those that would be followed by a Board of Inquiry;

the Director may refuse the request for the appointment of such a Board.

SEC. 1699. PUBLIC FACTFINDING.

A Health Care Board of Inquiry appointed under this part shall investigate the issues involved in the dispute and make a written report thereon to the parties and to the Director within 30 days after the establishment of such a Board. The written report shall contain the findings of fact together with the Board's recommendations for settling the dispute, with the objective of achieving a prompt, peaceful and just settlement of the dispute. The Board shall arrange for publication of such report within the community served by the health care entity involved.

SEC. 1699A. COMPENSATION OF MEMBERS OF BOARDS OF INQUIRY.

(a) EMPLOYEES IF FEDERAL GOVERNMENT.—Members of any board established under this part who are otherwise employed by the Federal Government shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by such members in carrying out its duties under this section.

(b) OTHER MEMBERS.—Members of any board established under this section who are not subject to subsection (a) shall receive compensation at a rate prescribed by the Director but not to exceed the daily rate prescribed for GS–128 of the General Schedule under section 5332 of title 5, United States Code, including travel for each day they are engaged in the performance of their duties under this section and shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by them in carrying out their duties under this part.

SEC. 1699B. MAINTENANCE OF STATUS QUO.

After the establishment of a board under section 1697, and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time the parties began their bargaining in the case of an initial beginning negotiation, except by agreement, shall be made by the parties to the controversy.

Subtitle H—Miscellaneous Employer Requirements

SEC. 1701. AUDITING OF RECORDS.

Each community-rated employer shall maintain such records, and provide the State for the area in which the employer maintains the principal place of employment (as

specified by the Secretary of Labor) with access to such records, as may be necessary to verify and audit the information reported under this subtitle.

SEC. 1702. PROHIBITION OF CERTAIN EMPLOYER DISCRIMINATION.

No employer may discriminate with respect to an employee on the basis of the family status of the employee or on the basis of the class of family enrollment selected with respect to the employee.

SEC. 1703. EVASION OF OBLIGATIONS.

It shall be unlawful for any employer or other person to discharge, fine, suspend, expel, discipline, discriminate or otherwise take adverse action against any employee if a purpose of such action is to interfere with the employee's attainment of status as a qualifying employee, as a full time employee, or as a part-time employee, or if a purpose of such action is to evade or avoid any obligation under this Act.

SEC. 1704. PROHIBITION ON SELF-FUNDING OF COST SHARING BENEFITS.

(a) PROHIBITION.—A community-rated employer (and an experience-rated employer with respect to employees who are community rate eligible individuals) may provide benefits to employees that consist of the benefits included in a cost sharing policy (as defined in section

1507(c)) only through a contribution toward the purchase of a cost sharing policy which is funded primarily through insurance.

(b) INDIVIDUAL AND EMPLOYER RESPONSIBILITIES.—In the case of an individual who resides in a single-payer State and an employer with respect to employees who reside in such a State, the responsibilities of such individual and employer under such system shall supersede the obligations of the individual and employer under this subtitle.

SEC. 1705. EMPLOYER RETIREE OBLIGATION.

(a) IN GENERAL.—If an employer was providing, as of October 1, 1993, a threshold payment (specified in subsection (c)) for a person who was a qualifying retired beneficiary (as defined in subsection (b)) as of such date, the employer shall pay, to or on behalf of that beneficiary for each month beginning with January 1998, an amount that is not less than the amount specified in subsection (d), but only if and for so long as the person remains a qualifying retired beneficiary.

(b) QUALIFYING RETIRED BENEFICIARY.—In this section, the term ''qualifying retired beneficiary'' means a person who is an eligible retiree or qualified spouse or child (as such terms are defined in subsections (b) and (c) of section 6114).

(c) THRESHOLD PAYMENT.—The term ''threshold payment'' means, for an employer with respect to a health benefit plan providing coverage to a qualifying retired beneficiary, a payment—

(1) for coverage of any item or service described in section 1101, and

(2) the amount of which is at least 20 percent of the amount of the premium (or premium equivalent) for such coverage with respect to the beneficiary (and dependents).

(d) AMOUNT.—The amount specified in this subsection is 20 percent of the weighted average premium for the health care coverage area in which the beneficiary resides and for the applicable class of family enrollment.

(e) NATURE OF OBLIGATION.—The requirement of this section shall be in addition to any other requirement imposed on an employer under this Act or otherwise.

(f) PROTECTION OF COLLECTIVE BARGAINING RIGHTS.—Nothing in this Act (including this section) shall be construed as affecting collective bargaining rights or rights under collective bargaining agreements.

SEC. 1706. RULES GOVERNING LITIGATION INVOLVING RETIREE HEALTH BENEFITS.

(a) MAINTENANCE OF BENEFITS.—

(1) IN GENERAL.—If—

(A) retiree health benefits or plan or plan sponsor payments in connection with such benefits are to be or have been terminated or reduced under an employee welfare benefit plan; and

(B) an action is brought by any participant or beneficiary to enjoin or otherwise modify such termination or reduction,

the court without requirement of any additional showing shall promptly order the plan and plan sponsor to maintain the retiree health benefits and payments at the level in effect immediately before the termination or reduction while the action is pending in any court. No security or other undertaking shall be required of any participant or beneficiary as a condition for issuance of such relief. An order requiring such maintenance of benefits may be refused or dissolved only upon determination by the court, on the basis of clear and convincing evidence, that the action is clearly without merit.

(2) MODIFICATIONS.—Nothing in this section shall preclude a court from modifying the obligation of a plan or plan sponsor to the extent retiree benefits are otherwise being paid under section 6208.

(b) BURDEN OF PROOF.—In addition to the relief authorized in subsection (a) or otherwise available, if, in any action described in subsection (a), the terms of the employee welfare benefit plan summary plan description or other materials distributed to employees at the time of a participant's retirement or disability are silent or are ambiguous, either on their face or after consideration of extrinsic evidence, as to whether retiree health benefits and payments may be terminated or reduced for a participant and his or her beneficiaries after the participant's retirement or disability, then the benefits and payments shall not be terminated or reduced for the participant and his or her beneficiaries unless the plan or plan sponsor establishes by a preponderance of the evidence that the summary plan description and other materials about retiree benefits—

(1) were distributed to the participant at least 90 days in advance of retirement or disability;

(2) did not promise retiree health benefits for the lifetime of the participant and his or her spouse; and

(3) clearly and specifically disclosed that the plan allowed such termination or reduction as to the participant after the time of his or her retirement or disability.

The disclosure described in paragraph (3) must have been made prominently and in language which can be understood by the average plan participant.

(c) REPRESENTATION.—Notwithstanding any other provision of law, an employee representative of any retired employee or the employee's spouse or dependents may—

(1) bring an action described in this section on behalf of such employee, spouse, or dependents; or

(2) appear in such an action on behalf of such employee, spouse or dependents.

(d) RETIREE HEALTH BENEFITS.—For the purposes of this section, the term ''retiree health benefits'' means health benefits (including coverage) which are provided to—

(1) retired or disabled employees who, immediately before the termination or reduction, are entitled to receive such benefits upon retirement or becoming disabled; and

(2) their spouses and dependents.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to actions relating to terminations or reductions of retiree health benefits which are pending or brought, on or after July 20, 1993.

SEC. 1707. PARTICIPATION IN FEHBP.

(a) IN GENERAL.—A qualifying employee of an American employer (as defined in section 3121(h) of the Internal Revenue Code of 1986) who is employed by such an employer outside the United States may elect to purchase coverage through designated health plans participating in FEHBP.

(b) VOLUNTARY PARTICIPATION.—Participation by an employee described in subsection (a) shall be at the discretion of such employee, and employer payments on behalf of such employee shall be voluntary.

(c) REGULATIONS.—The National Health Board, in consultation with the Office of Personnel Management, shall issue regulations governing the provision and reimbursement of items and services included in the comprehensive benefit package, premium payments by employers and employees, and the establishment of separate risk pools for Federal and non-Federal employees abroad.

SEC. 1708. ENFORCEMENT.

In the case of a person that violates a requirement of this subtitle, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual.

Subtitle I—General Definitions; Miscellaneous Provisions

PART 1—GENERAL DEFINITIONS

SEC. 1901. DEFINITIONS RELATING TO EMPLOYMENT AND INCOME.

(a) IN GENERAL.—Except as otherwise specifically provided, in this Act the following definitions and rules apply:

(1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND WAGES DEFINED.—Except as provided in this section—

(A) the terms ''wages'' and ''employment'' have the meanings given such terms under section 3121 of the Internal Revenue Code of 1986,

(B) the term ''employee'' has the meaning given such term under section 3121 of such Code, subject to the provisions of chapter 25 of such Code, and

(C) the term ''employer'' has the same meaning as the term ''employer'' as used in such section 3121.

(2) EXCEPTIONS.—For purposes of paragraph (1)—

(A) EMPLOYMENT.—

(i) EMPLOYMENT INCLUDED.—Paragraphs (1), (2), (5), (7) (other than clauses (i) through (iv) of subparagraph (C) and clauses (i) through (v) of subparagraph (F)), (8), (9), (10), (11), (13), (15), (18), and (19) of section 3121(b) of the Internal Revenue Code of 1986 shall not apply.

(ii) EXCLUSION OF INMATES AS EMPLOYEES.—Employment shall not include services performed in a penal institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(B) WAGES.—

(i) IN GENERAL.—Paragraph (1) of section 3121(a) of the Internal Revenue Code of 1986 shall not apply.

(ii) TIPS NOT INCLUDED.—The term ''wages'' does not include cash tips.

(C) EXCLUSION OF CERTAIN FOREIGN EMPLOYMENT.—The term ''employee'' does not include an individual with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States.

(3) AGGREGATION RULES FOR EMPLOYERS.—For purposes of this Act—

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) under regulations of the Secretary of Labor, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under subparagraph (B) shall be based on principles similar to the principles which apply to taxable organizations under subparagraph (A).

(4) EMPLOYER PREMIUM.—The term ''employer premium'' refers to the premium established and imposed under part 2 of subtitle B of title VI.

(b) QUALIFYING EMPLOYEE; FULL-TIME EMPLOYMENT.—

(1) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—In this Act, the term ''qualifying employee'' means, with respect to

an employer for a month, an employee (other than a covered child, as defined in subparagraph (C)) who is employed by the employer for at least 40 hours (as determined under paragraph (3)) in the month, subject to the limitation set forth in subparagraph (D).

(B) NO SPECIAL TREATMENT OF MEDICARE BENEFICIARIES, SSI RECIPIENTS, AFDC RECIPIENTS, AND OTHERS.—Subparagraph (A) shall apply regardless of whether or not the employee is a medicare-eligible individual, an SSI recipient, an AFDC recipient, an individual described in section 1004(b), an eligible individual or is authorized to be so employed.

(C) COVERED CHILD DEFINED.—In subparagraph (A), the term ''covered child'' means an eligible individual who is a child and is enrolled under a health plan as a family member described in section 1011(b)(2)(B).

(D) QUALIFYING EMPLOYEES.—As used in this Act—

(i) the term qualifying employee shall not include, with respect to an employer for a month, an employee of a nonelecting

small employer (as defined in section 6220);

(ii) the term ''nonqualifying employee'' means, with respect to an employer for a month, an employee (who otherwise would be a qualifying employee) of a nonelecting small employer;

(iii) the term ''qualifying employee'' shall not include, with respect to an employer for a month, a part-time employee during the first month (four-week period) of such employee's employment; and

(iv) the term ''qualifying employee'' shall include, with respect to an employer for a month, a part-time employee beginning with the second month of such employee's employment.

(2) FULL-TIME EQUIVALENT EMPLOYEES; PART-TIME EMPLOYEES.—

(A) IN GENERAL.—For purposes of this Act, a qualifying employee who is employed by an employer—

(i) for at least 120 hours in a month, is counted as 1 full-time equivalent em-

ployee for the month and shall be deemed to be employed on a full-time basis, or

(ii) for at least 40 hours, but less than 120 hours, in a month, is counted as a fraction of a full-time equivalent employee in the month equal to the full-time employment ratio (as defined in subparagraph (B)) for the employee and shall be deemed to be employed on a part-time basis.

(B) FULL-TIME EMPLOYMENT RATIO DEFINED.—For purposes of this Act, the term ''full-time employment ratio'' means, with respect to a qualifying employee of an employer in a month, the lesser of 1 or the ratio of—

(i) the number of hours of employment such employee is employed by such employer for the month (as determined under paragraph (3)), to

(ii) 120 hours.

(C) FULL-TIME EMPLOYEE.—For purposes of this Act, the term ''full-time employee'' means, with respect to an employer, an employee who is employed on a full-time basis (as specified in subparagraph (A)) by the employer.

(D) PART-TIME EMPLOYEE.—For purposes of this Act, the term ''part-time employee'' means, with respect to an employer, an employee who is employed on a part-time basis (as specified in subparagraph (A)) by the employer.

(E) CONSIDERATION OF INDUSTRY PRACTICE.—As provided under rules established by the Board, an employee who is not described in subparagraph (C) or (D) shall be considered to be employed on a full-time or part-time basis by an employer (and to be a full-time or part-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into account the structure or nature of employment in the industry, represents full or part-time employment in that industry.

(F) INSTITUTIONS OF HIGHER EDUCATION.—Notwithstanding any other provision in this section—

(i)(I) employees of an Institution of higher education (as defined in section 1201(a) of the Higher Education Act of 1965), or of an elementary or secondary

school (as defined in section 1471 of the Elementary and Secondary Education Act of 1965), who are exempt under section 13 of the Fair Labor Standards Act, shall be deemed to be full-time employees if they work the hours that constitute full-time employment as defined at such institution;

(II) part-time employment shall be considered proportional to such hours for full-time employees; and

(III) part-time employees who work at least one-third of the hours that constitute full-time employment as defined at such institution shall be eligible for proportional employer premium contributions; and

(ii) regular employees of institutions of higher education or elementary and secondary schools who are not paid during the summer months or other periods of the year, but are assured employment at the end of such periods, shall be eligible for year-round employer premium contributions if such individuals are not eligible to collect unemployment compensation for the periods for which they would receive health

care premium contributions from the employer covered by this subsection.

(3) HOURS OF EMPLOYMENT.—

(A) IN GENERAL.—For purposes of this Act, the Board shall specify the method for computing hours of employment for employees of an employer consistent with this paragraph. The Board shall take into account rules used for purposes of applying the Fair Labor Standards Act.

(B) HOURLY WAGE EARNERS.—In the case of an individual who receives compensation (in the form of hourly wages or compensation) for the performance of services, the individual is considered to be ''employed'' by an employer for an hour if compensation is payable with respect to that hour of employment, without regard to whether or not the employee is actually performing services during such hours.

(4) TREATMENT OF SALARIED EMPLOYEES AND EMPLOYEES PAID ON CONTINGENT OR BONUS ARRANGEMENTS.—In the case of an employee who receives compensation on a salaried basis or on the basis of a commission (or other contingent or bonus basis), rather than an hourly wage, the Board shall

establish rules for the conversion of the compensation to hours of employment, taking into account the minimum monthly compensation levels for workers employed on a full-time basis under the Fair Labor Standards Act and other factors the Board considers relevant.

(c) DEFINITIONS RELATING TO SELF-EMPLOYMENT.—In this Act:

(1) NET EARNINGS FROM SELF-EMPLOYMENT.—The term ''net earnings from self-employment'' has the meaning given such term under section 1402(a) of the Internal Revenue Code of 1986.

(2) SELF-EMPLOYED INDIVIDUAL.—The term ''self-employed individual'' means, for a year, an individual who has net earnings from self-employment for the year.

SEC. 1902. OTHER GENERAL DEFINITIONS.

Except as otherwise specifically provided, in this Act the following definitions apply:

(1) AFDC FAMILY.—The term ''AFDC family'' means a family composed entirely of one or more AFDC recipients.

(2) AFDC RECIPIENT.—The term ''AFDC recipient'' means, for a month, an individual who is receiving aid or assistance under any plan of the

State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

(3) APPLICABLE HEALTH PLAN.—The term ''applicable health plan'' means, with respect to an eligible individual, the health plan specified pursuant to section 1004 and part 2 of subtitle A.

(4) CARRIER.—The term ''carrier'' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of Internal Revenue Code of 1986), a health maintenance organization, or other entity licensed or certified by the State to provide health insurance or health benefits. The Board may issue regulations that provide for affiliated carriers to be treated as a single carrier where appropriate under this Act.

(5) CASE MANAGEMENT.—The term ''case management'' means services that assist individuals in gaining access to needed medical, social, educational, and other services.

(6) CITIZEN OF ANOTHER COUNTRY LEGALLY RESIDING IN THE UNITED STATES.—The term ''citi-

zen of another country legally residing in the United States'' means any of the following:

(A) An alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act).

(B) An alien granted work authorization by the Immigration and Naturalization Service.

(C) An alien permanently residing in the United States under color of law, including (but not limited to) any of the following:

(i) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(ii) An alien who is granted asylum under section 208 of such Act.

(iii) An alien whose deportation is withheld under section 243(h) of such Act.

(iv) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(v) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended vol-

untary departure, temporary protected status, or deferred enforced departure.

(vi) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(vii) An alien within such other classification of aliens permanently residing under color of law for purposes of this Act only as the National Health Board may establish by regulation. Such regulation shall include categories of such aliens who are included in regulations as in effect on the date of the enactment of this Act under title XIX of the Social Security Act and other categories within a public health priority.

(7) COMBINATION COST SHARING PLAN.—The term ''combination cost sharing plan'' means a health plan that provides combination cost sharing schedule (consistent with section 1134).

(8) COMMUNITY-RATED EMPLOYER.—The term ''community-rated employer'' means, with respect to an employee, an employer that is not an experience-rated employer with respect to such employee.

(9) COMMUNITY-RATED PLAN.—The term ''community-rated plan'' means a health plan certified by a State under section 1503 that is provided to community-rated individuals.

(10) COMMUNITY RATE ELIGIBLE INDIVIDUAL.—The term ''community rate eligible individual'' means an eligible individual with respect to whom a community-rated plan is an applicable health plan.

(11) COMPREHENSIVE BENEFIT PACKAGE.—The term ''comprehensive benefit package'' means the package of health benefits provided under subtitle B.

(12) CONSUMER PRICE INDEX; CPI.—The terms ''consumer price index'' and ''CPI'' mean the Consumer Price Index for all urban consumers (U.S. city average), as published by the Bureau of Labor Statistics.

(13) COST SHARING POLICY.—The term ''cost sharing policy'' means a health insurance policy or health benefit plan offered to an community rate eli-

gible individual which provides coverage for deductibles, coinsurance, and copayments imposed as part of the comprehensive benefit package under subtitle B, whether imposed under a higher cost sharing plan or with respect to out-of-network providers.

(14) COVERED WAGES DEFINED.—In this section, the term ''covered wages'' means wages paid an employee of an employer during a month in which the employee was a qualifying employee of the employer.

(15) DIAGNOSABLE MENTAL DISORDER AND DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The terms ''diagnosable mental disorder'' and ''diagnosable substance abuse disorder'' mean a disorder that—

(A) is listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised or a revised version of such manual (except V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment);

(B) is the equivalent of a disorder described in subparagraph (A), but is listed in the International Classification of Diseases, 9th Re-

vision, Clinical Modification, Third Edition or a revised version of such text; or

(C) is listed in any authoritative text specifying diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board.

(16) DISABLED SSI RECIPIENT.—The term ''disabled SSI recipient'' means an individual who—

(A) is an SSI recipient, and

(B) has been determined to be disabled for purposes of the supplemental security income program (under title XVI of the Social Security Act).

(17) ESSENTIAL COMMUNITY PROVIDER.—The term ''essential community provider'' means an entity certified as such a provider under subpart B of part 2 of subtitle F.

(18) EXPERIENCE-RATED EMPLOYER.—The term ''experience-rated employer'' means—

(A) a large employer that is a large group purchaser, and

(B) another employer that participates in a experience-rated plan sponsored by a large group purchaser described in paragraph (6) or (7) of section 1401.

(19) EXEMPT INDIVIDUAL.—The term ''exempt individual'' means an individual that has been granted an exemption from paying Social Security Taxes under section 1402(g) of the Internal Revenue Code of 1986, or an individual who would be eligible for an exemption under such section if the individual were self-employed.

(20) EXPERIENCE-RATED INDIVIDUAL.—The term ''experience-rated individual'' means, with respect to a large group purchaser, an eligible individual with respect to whom an experience-rated plan sponsored by the purchaser is the applicable health plan.

(21) EXPERIENCE-RATED PLAN.—The term ''experience-rated plan'' means either—

(A) an employer sponsored health plan (as defined in section 1401(e)(5)) offered by a large group purchaser, or

(B) an insured health plan offered by a carrier to a large group purchaser.

(22) FEE-FOR-SERVICE PLAN.—The term ''fee-for-service plan'' means a health plan described in section 1211(b)(2)(A).

(23) FIRST YEAR.—The term ''first year'' means, with respect to—

(A) a State that is a participating State in a year before 1998, the year in which the State first is a participating State, or

(B) any other State, 1998.

(24) HEALTH CARE COVERAGE AREA.—The term ''health care coverage area'' means an area specified by a State under section 1202.

(25) HEALTH PLAN SPONSOR.—The term ''health plan sponsor'' means—

(A) with respect to a community-rated plan, the carrier providing the plan,

(B) with respect to an insured experience-rated plan, the carrier providing the plan, and

(C) with respect to a self-funded experience-rated plan, the large group purchaser providing the plan.

(26) HIGHER COST SHARING PLAN.—The term ''higher cost sharing plan'' means a health plan that provides a higher cost sharing schedule (consistent with section 1133).

(27) HOSPITAL.—The term ''hospital'' has the meaning given such term in section 1861(e) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1005(b)(1), a facility of the uniformed services under title 10, United States Code, that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e);

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1005(b)(2), a facility operated by the Department of Veterans Affairs that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e); and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1005(b)(3), a facility operated by the Indian Health Service that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e).

(28) INPATIENT HOSPITAL SERVICES.—The term ''inpatient hospital services'' means items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided to an inpatient of a hospital. The National Health Board shall specify those health professional services described in section 1103 that shall be treated as inpatient hospital services when provided to an inpatient of a hospital.

(29) LONG-TERM NONIMMIGRANT.—The term ''long-term nonimmigrant'' means a nonimmigrant described in subparagraph (E), (H), (I), (J), (K), (L), (M), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act or an alien within such other classification of nonimmigrant as the National Health Board may establish by regulation.

(30) LOWER COST SHARING PLAN.—The term ''lower cost sharing plan'' means a health plan that provides a lower cost sharing schedule (consistent with section 1132).

(31) MEDICARE PROGRAM.—The term ''medicare program'' means the health insurance program under title XVIII of the Social Security Act.

(32) MEDICARE-ELIGIBLE INDIVIDUAL.—The term ''medicare-eligible individual'' means, subject to section 1012(a), an individual who is entitled to benefits under part A of the medicare program.

(33) MEDICATIONS MANAGEMENT.—

(A) IN GENERAL.—The term ''medications management'' refers to the prescription, use, monitoring, and review of medication for treatment of a mental disorder or pharmacotherapy for the treatment of a substance abuse disorder, including no more than minimal medical psychotherapy or counseling.

(B) VISIT.—For purposes of medications management, the term ''visit'' means one week of treatment.

(34) MOVE.—The term ''move'' means, respect to an individual, a change of residence of the individual from one health care coverage area to another health care coverage area.

(35) NATIONAL HEALTH BOARD; BOARD.—The terms ''National Health Board'' and ''Board'' mean the National Health Board created under section 1601.

(36) NON-QUALIFYING EMPLOYEE.—The term ''non-qualifying employee'' means, with respect to an

employer for a month, an employee (who otherwise would be a qualifying employee) of a nonelecting small employer.

(37) PARTICIPATING PROVIDER.—The term ''participating provider'' means, with respect to a health plan, a provider of health care services who is a member of a provider network of the plan.

(38) PLACED FOR ADOPTION.—The term ''placed for adoption'' in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of the adoption of such child.

(39) POVERTY LEVEL.—

(A) IN GENERAL.—The term ''applicable poverty level'' means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved (as determined under subparagraph (B)) for 1994 adjusted by the percentage increase or decrease described in subparagraph (C) for the year involved.

(B) FAMILY SIZE.—In applying the applicable poverty level to—

(i) an individual enrollment, the family size is deemed to be one person;

(ii) a couple-only enrollment, the family size is deemed to be two persons;

(iii) a single parent enrollment, the family size is deemed to be three persons; or

(iv) a dual parent enrollment, the family size is deemed to be four persons.

(C) PERCENTAGE ADJUSTMENT.—The percentage increase or decrease described in this subparagraph for a year is the percentage increase or decrease by which the average CPI for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 1993.

(D) ROUNDING.—Any adjustment made under subparagraph (A) for a year shall be rounded to the nearest multiple of $100.

(40) PRISONER.—The term ''prisoner'' means, as specified by the Board, an eligible individual during a period of imprisonment under Federal, State, or local authority after conviction as an adult.

(41) PSYCHIATRIC HOSPITAL.—The term ''psychiatric hospital'' has the meaning given such term in section 1861(f) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1005(b)(1), a facility of the uniformed services under title 10, United States Code, that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital;

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1005(b)(2), a facility operated by the Department of Veterans Affairs that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital; and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1005(b)(3), a facility operated by the Indian Health Service that is engaged in providing services to inpa-

tients that are equivalent to the services provided by a psychiatric hospital.

(42) REHABILITATION FACILITY.—The term ''rehabilitation facility'' means an institution (or a distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness, injury, disorder or other health condition. An entity qualifying as a hospital for purposes of section 1102 may also qualify as a rehabilitation facility for purposes of section 1110.

(43) RESIDE.—

(A) An individual is considered to reside in the location in which the individual maintains a primary residence (as established under rules of the National Health Board).

(B) Under such rules and subject to section 1516, in the case of an individual who maintains more than one residence, the primary residence of the individual shall be determined taking into account the proportion of time spent at each residence.

(C) In the case of a couple only one spouse of which is a qualifying employee, except as the

Board may provide, the residence of the employee shall be the residence of the couple.

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

(45) SELF-FUNDED PLAN.—The term ''self-funded plan'' means (as defined in regulations of the Secretary of Labor) a health plan provided by a large group purchaser and which is not provided by or through a carrier.

(46) SEXUAL ORIENTATION.—The term ''sexual orientation'' means homosexual, bisexual, or heterosexual orientation, real or perceived, as manifested by identity, acts, statements, or associations.

(47) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' means an institution (or a distinct part of an institution) which is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care; or

(B) rehabilitation services to residents for rehabilitation from illness, injury, disorder or other health condition.

(48) SSI FAMILY.—The term ''SSI family'' means a family composed entirely of one or more SSI recipients.

(49) SSI RECIPIENT.—The term ''SSI recipient'' means, for a month, an individual—

(A) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

(B) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66 for the month, or

(C) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month.

(50) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(51) STATE MEDICAID PLAN.—The term ''State medicaid plan'' means a plan of medical assistance of a State approved under title XIX of the Social Security Act.

(52) SUPPLEMENTAL HEALTH BENEFIT POLICY.—

(A) IN GENERAL.—The term ''supplemental health benefit policy'' means a health insurance policy or health benefit plan offered to a community rate eligible individual which provides—

(i) coverage for services and items not included in the comprehensive benefit package, or

(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope provided under this title,

or both.

(B) EXCLUSIONS.—Such term does not include the following:

(i) A cost sharing policy.

(ii) A long-term care insurance policy.

(iii) Insurance that limits benefits with respect to specific diseases (or conditions).

(iv) Hospital or nursing home indemnity insurance.

(v) A medicare supplemental policy (as defined in section 1882(g) of the Social Security Act).

(vi) Insurance with respect to accidents.

(53) UNITED STATES.—The term ''United States'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.

SEC. 1903. REFERENCE TO CERTAIN TERMS.

In any provision in this Act (other than this I, subtitle J of title III, title VI, and subtitle E of title VIII), including any amendment made by such a provision of this Act—

(1) any reference to a ''corporate alliance employer'' is deemed a reference to an ''experience-rated employer'';

(2) any reference to a ''corporate alliance'' is deemed a reference either to an ''experience-rated employer'' or a ''large group purchaser'', as specified by the Board;

(3) any reference to a ''corporate alliance eligible individual'' is deemed a reference to an ''experience-rated individual'';

(4) any reference to a ''regional alliance'' is deemed a reference either to a contracting entity, a State, or a consumer purchasing cooperative, as specified by the Board;

(5) any reference to an ''alliance area'' is deemed a reference to a ''community-rating area'';

(6) any reference to a ''regional alliance eligible individual'' is deemed a reference to a ''community-rated individual'';

(7) any reference to an ''alliance eligible individual'' is deemed a reference to a ''community-rated individual'' and to an ''experience rated individual'';

(8) any reference to a ''regional alliance health plan'' is deemed a reference to a ''community-rated plan'';

(9) any reference to a ''corporate alliance health plan'' is deemed a reference to an ''experience-rated plan''; and

(10) any reference to a ''health plan'' is deemed a reference either to a health plan or a carrier, as specified by the Board.

PART 2—MISCELLANEOUS PROVISIONS

SEC. 1911. USE OF INTERIM, FINAL REGULATIONS.

In order to permit the timely implementation of the provisions of this Act, the National Health Board, the Sec-

retary of Health and Human Services, the Secretary of Labor are each authorized to issue regulations under this Act on an interim basis that become final on the date of publication, subject to change based on subsequent public comment.

SEC. 1912. NEUTRALITY CONCERNING UNION ORGANIZING.

Amounts appropriated to carry out this Act may not be utilized to assist, promote or deter union organizing.

SEC. 1913. SOCIAL SECURITY ACT REFERENCES.

Except as may otherwise be provided, any reference in this title, or in title V or VI, to a provision of the Social Security Act shall be to that provision of the Social Security Act as in effect on the date of the enactment of this Act.

SEC. 1914. ANTIDISCRIMINATION.

(a) IN GENERAL.—Neither the National Health Board nor any State, health plan, consumer purchasing cooperative, large group purchaser, employer, or other entity subject to this Act shall directly or through contractual arrangements—

(1) deny or limit access to or the availability of health care services, or otherwise discriminate in connection with the provision of health care services; or

(2) limit, segregate or classify an individual in any way which would deprive or tend to deprive such individual of health care services, or otherwise adversely affect his or her access to health care services;

on the basis of race, national origin, sex, religion, language, income, age, sexual orientation, disability, health status, or anticipated need for health services.

(b) DEFINITION.—As used in this section, the term ''in connection with the provision of health care services'' includes, but is not limited to—

(1) establishing the boundaries for health care coverage areas under section 1202 and for premium areas, enrolling persons in a health care plan or marketing a health care plan, and selecting providers or setting the terms or conditions under which providers participate in a health care plan or provider network; and

(2) determining the scope of services provided by a health care plan, and providing such services and determining the site or location of health care facilities.

(c) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and

Human Services shall issue regulations to carry out this section.

(d) EFFECT ON OTHER LAWS. Nothing in this Act shall be construed to limit the scope of, or the availability of relief under, any other Federal or State law prohibiting discrimination or providing relief therefore.

(e) BENEFITS.—Nothing in this Act shall be construed to require or prohibit the provision of benefits to an employee for the benefit of his or her same-sex partner.

(f) OUTREACH UNAFFECTED.—Nothing in this section shall be construed to prevent a person from engaging in activities to encourage the enrollment of community rated individuals residing in underserved areas.

SEC. 1915. COVERAGE OF BENEFITS UNDER HEALTH SECURITY ACT.

(a) DAVIS-BACON ACT.—Subsection (b)(2) of the first section of the Davis Bacon Act (40 U.S.C. 276a(b)(2)) is amended in the matter following subparagraph (B) by inserting after ''local law'' the following: ''(other than benefits provided pursuant to the Health Security Act)''.

(b) SERVICE CONTRACT ACT OF 1965.—The second sentence of section 2(a)(2) of the Service Contract Act of 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after

''local law'' the following: ''(other than benefits provided pursuant to the Health Security Act)''.

SEC. 1916. GOVERNMENT REQUIRED DATA.

The set of data referred to in section 5114(a)(5) shall include data on—

(1) enrollment and disenrollment in health plans;

(2) clinical encounters and other items and services provided by health care providers;

(3) administrative, operational and financial aspects regarding composition, transactions and activities of participating States, health plans, health care providers, employers and individuals that are necessary to determine compliance with this Act or an Act amended by this Act;

(4) terms of agreement between health plans and the health care providers who are members of provider networks of the plans;

(5) payment of benefits in cases in which benefits may be payable under a health plan and any other insurance policy or health program;

(6) utilization management by health plans and health care providers;

(7) the information collected and reported by the Board or disseminated by other individuals or

entities as part of the National Quality Management Program under subtitle A;

(8) health care and payment grievances and the resolutions of such grievances; and

(9) any other fact that may be necessary to determine whether a health plan or a health care provider has complied with a Federal statute pertaining to fraud or misrepresentation in the provision or purchasing of health care or in the submission of a claim for benefits or payment under a health plan.

SEC. 1917. SENSE OF THE COMMITTEE CONCERNING FUNDING SOURCES.

(a) FINANCING.—It is the sense of the Committee on Labor and Human Resources of the Senate that when the Health Security Act is enacted it should include the following sources of financing not within the jurisdiction of the Committee:

(1) The net savings and revenues included in S.1757, the Health Security Act which are outside the jurisdiction of the Committee.

(2) The extension to all employers that are not community-rated employers the 1 percent payroll assessment applied to corporate alliances under S.1757, the Health Security Act.

(3) An increase in the cigarette tax of 75 cents per pack in excess of the amount specified in S.1757, the Health Security Act.

(4) A phased-in 1 percent premium assessment equal to the additional amount provided for biomedical research under title III of this Act.

(b) RESEARCH AND DEVELOPMENT TAX CREDIT.—It is the sense of the Committee on Labor and Human Resources of the Senate that when health reform legislation is enacted it should include the following provision not within the jurisdiction of the Committee:

(1) The permanent extension of the research and development tax credit.

SEC. 1918. SENSE OF THE COMMITTEE CONCERNING MEDICAL SAVINGS ACCOUNTS.

It is the sense of the Committee on Labor and Human Resources of the Senate that provisions encouraging the establishment of medical savings accounts be included in any health reform bill passed by the Senate, in conjunction with a comprehensive benefit package described in subtitle B of this title.

TITLE II—LONG-TERM CARE

PART 1—STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

SUBPART A—HOME AND COMMUNITY-BASED SERVICES

Sec. 2101. State programs for home and community-based services for individuals with disabilities.

Sec. 2102. State plans.
Sec. 2103. Individuals with disabilities defined.
Sec. 2104. Home and community-based services covered under State plan.
Sec. 2105. Cost sharing.
Sec. 2106. Quality assurance and safeguards.
Sec. 2107. Advisory groups.
Sec. 2108. Payments to States.
Sec. 2109. Total Federal budget; allotments to States.
Sec. 2110. Federal evaluations.

SUBPART B—STATE PROGRAMS FOR EXTENDED SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Sec. 2111. State programs for extended services for children with special health care needs.
Sec. 2112. Extended services covered under the State plan.
Sec. 2213. Children eligible for services.
Sec. 2114. Application and administration.
Sec. 2115. Cost-sharing.
Sec. 2116. Program evaluation.
Sec. 2117. Total Federal budget and Federal allotment to States.

PART 2—LONG-TERM CARE INSURANCE IMPROVEMENT AND ACCOUNTABILITY

Sec. 2201. Short title.
Sec. 2202. Establishment of Federal standards for long-term care insurance.

PART 3—LIFE CARE

Sec. 2301. Short title.
Sec. 2302. Life care: public insurance program for nursing home care.
Sec. 2303. Sense of the Committee concerning PACE (Program of All-Inclusive Care for the Elderly).

PART 1—STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

Subpart A—Home and Community-Based Services

SEC. 2101. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Each State that has a plan for the home and community-based services to individuals with disabilities submitted to and approved by the Sec-

retary under section 2102(b) is entitled to payment in accordance with section 2108.

(b) ENTITLEMENT TO SERVICES.—Nothing in this part shall be construed to create a right to services for individuals or a requirement that a State with an approved plan expend the entire amount of funds to which it is entitled under this subtitle, except that nothing in this subtitle shall be construed to restrict or modify an individual's right under existing Federal or State law to enforce the obligations of States entered into pursuant to this Act.

(c) DESIGNATION OF AGENCY.—Not later than 6 months after the date of enactment of this Act, the Secretary shall designate an agency responsible for program administration under this subtitle.

SEC. 2102. STATE PLANS.

(a) PLAN REQUIREMENTS.—In order to be approved under subsection (b), a State plan for home and community-based services for individuals with disabilities must meet the following requirements:

(1) ELIGIBILITY.—

(A) IN GENERAL.—Within the amounts provided by the State (and under section 2108) for such plan, the plan shall provide that services under the plan will be available to individ-

uals with disabilities (as defined in section 2103(a)) in the State.

(B) INITIAL SCREENING.—The plan shall provide a process for the initial screening of individuals who appear to have some reasonable likelihood of being an individual with disabilities. Any such process shall require the provision of assistance to individuals who wish to apply but whose disability limits their ability to do so. Except as provided in subparagraph (C), the initial screening, as well as the determination of disability (as defined under section 2103(b)(1)) and the comprehensive assessment and individualized plan of care (as defined under section 2104(b)(1)(A) and (B)) and 2104(b)(2) (A) and (B) shall be provided by public or private nonprofit agencies that—

(i) do not provide home and community-based services covered under the State plan, with the exception of care management services;

(ii) do not provide nursing facility services; and

(iii) do not have a direct or indirect ownership or control interest in an entity

that provides home and community-based services or nursing facility services.

(C) SCREENING AGENCY EXCEPTIONS.—The provisions of subparagraph (B)(i), (ii) and (iii) shall not apply to providers of residential care. The State agency may elect to waive the provisions of subparagraph (B)(i), (ii), and (iii) in areas of the State in which there is an insufficiency of available service providers.

(D) RESTRICTIONS.—The plan may not limit the eligibility of individuals with disabilities based on—

(i) income,

(ii) age,

(iii) geography,

(iv) nature, severity, or category of disability,

(v) residential setting (other than an institutional setting), or

(vi) other grounds specified by the Secretary;

except that during the initial phase-in period the Secretary may permit a State to limit eligibility based on level of disability or geography

(if the State assures a balance between urban and rural areas).

(E) CONTINUATION OF SERVICES.—The plan must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under the State medicaid plan as of the date of the enactment of this Act, the State will continue to make available (either under this plan, under the State medicaid plan, or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

(2) SERVICES.—

(A) NEEDS ASSESSMENT.—Not later than the end of the second year of implementation, the plan or its amendments shall include the results of a statewide assessment of the needs of individuals with disabilities, in a format required by the Secretary. The needs assessment shall include demographic data concerning the number of individuals within each category of

disability described in this Act, and the services available to meet the needs of such individuals.

(B) SPECIFICATION.—Consistent with section 2104, the plan shall specify—

(i) the services made available under the plan,

(ii) the extent and manner in which such services are allocated and made available to individuals with disabilities, and

(iii) the manner in which services under the plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

(C) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disability, the availability of informal care. Any individual care plan that includes informal care shall be required to verify the availability of the informal care.

(D) ALLOCATION.—The State plan—

(i) shall specify how it will allocate services under the plan, during and after

the 7-fiscal-year phase-in period beginning with fiscal year 1996, among covered individuals with disabilities,

(ii) shall attempt to meet the needs of individuals with a variety of disabilities and, within the limits of available funding, be sufficient in amount, duration, and scope to provide a substantial assistance in living independently,

(iii) shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions,

(iv) shall demonstrate that services are allocated equitably, in accordance with the needs assessment required under subparagraph (A), and

(v) shall ensure that—

(I) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the

plan, under the State medicaid plan, or under both, is not less than,

(II) the proportion of the population of the State that represents individuals who are low-income individuals.

(E) LIMITATION ON LICENSURE OR CERTIFICATION.—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(F) CONSUMER CHOICE.—To the extent feasible, the State shall follow the choice of an individual with disabilities (or that individual's designated representative who may be a family member) regarding which covered services to receive and the providers who will provide such services.

(3) COST SHARING.—The plan shall impose cost sharing with respect to covered services only in accordance with section 2105.

(4) TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.—The plan shall specify—

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers, except that the plan—

(i) may not limit such benefits to services provided by registered nurses or licensed practical nurses; and

(ii) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

(B) any requirements for participation applicable to each type of service provider.

(5) BUDGET.—The plan shall specify how the State will manage Federal and State funds available under the plan for each fiscal year during the period beginning with fiscal year 1996 and ending with fiscal year 2003 and for each 5-fiscal-year periods thereafter to serve all categories of individuals with disabilities and meet the requirements of this subsection. If the Secretary makes an adjustment under section 2109(a)(5)(C) for a year, each State shall update the specifications under this paragraph to reflect the impact of such an adjustment.

(6) PROVIDER REIMBURSEMENT.—

(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of payment for consumer-directed services, including the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax and health care coverage provisions.

(B) PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set payment rates for—

(i) agency administered services furnished under the plan; and

(ii) consumer-directed services furnished under the plan, including cash payments or vouchers to individuals with disabilities, except that such payments shall be adequate to cover amounts required under the applicable employment tax provisions of the Internal Revenue Code of

1986 (as added or amended by title VII of the Health Security Act) and the health care coverage provisions under this Act.

(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted or provided for under section 2105 as payment in full for services furnished under the plan.

(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 2106.

(8) ADVISORY GROUP.—The State plan shall—

(A) assure the establishment and maintenance of an advisory group under section 2107(b), and

(B) include the documentation prepared by the group under section 2107(b)(4).

(9) ADMINISTRATION AND ACCESS.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) INFORMATION AND ASSISTANCE CENTER.—The plan shall provide for a single point of access to information about the system for individuals with disabilities. The plan may designate separate entry points for individuals under the age of 22, for individuals age 65 years and older, or for other appropriate classification of individuals.

(C) COORDINATION.—The plan shall specify how it will—

(i) integrate services provided under the plan, including eligibility prescreening, service coordination, and referrals for individuals with disabilities who are ineligible for services under this part, with the State medicaid plan, titles V and XX of the Social Security Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or assistance targeted to individuals with disabilities, and

(ii) coordinate with health plans.

(D) ADMINISTRATIVE EXPENDITURES.—The plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs, except that, in fiscal years 1996 through 2002, administrative expenditures for the design, development, and installation of mechanical claims processing systems, information retrieval, and infrastructure development may exceed the limit described in this subparagraph by not more than an additional 10 percent of total expenditures. Quality assurance activities shall not be included as administrative costs. The Secretary shall have the authority to waive the administrative limit.

(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this part, including the processing of claims under the plan, and

(B) such data and information as the Secretary may require in a uniform format as specified by the Secretary.

(11) USE OF STATE FUNDS FOR MATCHING.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this part.

(12) HEALTH CARE WORKER REDEPLOYMENT REQUIREMENT.—The plan provides for compliance with the requirement of section 3083(a).

(13) TERMINOLOGY.—The plan shall adhere to uniform definitions of terms, as specified by the Secretary.

(b) APPROVAL OF PLANS.—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after a public comment period of not less than 30 days, and

(2) meets the requirements of subsection (a).

The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before January 1, 1996, shall be effective as of January 1, 1996). In order to budget funds allotted under this part, the Secretary may establish a deadline for the submission of such

a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year. Any significant changes to the State plan shall be submitted to the Secretary in the form of plan amendments and shall be subject to approval by the Secretary.

(c) MONITORING.—The Secretary shall annually monitor the compliance of State plans with the requirements of this subtitle according to specified performance standards. States that fail to comply with such requirements may be subject to the withholding of Federal funds for services or administration until such time as compliance is achieved.

(d) TECHNICAL ASSISTANCE.—The Secretary shall ensure the availability of ongoing technical assistance to States under this section. Such assistance shall include serving as a clearinghouse for information regarding successful practices in providing long-term care services.

(e) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this part on a timely basis.

SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.

(a) IN GENERAL.—In this part, the term ''individual with disabilities'' means any individual within one or more of the following 4 categories of individuals:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—Except as provided in section 2103(a)(4) an individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living (as defined in subsection (c)), and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 90 days.

(2) INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either severe cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living,

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activi-

ties) of daily living related to cognitive or mental impairment as the Secretary specifies, or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

(C) who is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 90 days.

Not later than 2 years after the date of enactment of this Act, the Secretary shall make recommendations regarding the most appropriate duration of disability under this paragraph.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) YOUNG CHILDREN WITH SEVERE DISABILITIES.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the stand-

ards established under paragraphs (1), (2), or (3), and

(B) is expected to have such a disability or condition and require such services over a period of at least 90 days.

(b) DETERMINATION.—

(1) IN GENERAL.—In formulating eligibility criteria under subsection (a), the Secretary shall establish criteria for assessing the functional level of disability among all categories of individuals with disabilities that are comparable in severity, regardless of the age or the nature of the disabling condition of the individual. The determination of whether an individual is an individual with disabilities shall be made, by persons or entities specified under the State plan, using a uniform protocol consisting of an initial screening and preliminary assessment specified by the Secretary. A State may not impose cost sharing with respect to the preliminary assessment. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 2104(b) or for other purposes. The State shall establish a fair hearing process for appeals of such determinations.

(2) INDIVIDUALS WITH COMPARABLE DISABILITIES.—Not more than 2 percent of a State's allotment for services under this part may be expended for the provision of services to individuals with severe disabilities that are comparable in severity to the criteria described in subsection (a), but who fail to meet the criteria described in any single category.

(3) PERIODIC REASSESSMENT.—The determination that an individual is an individual with disabilities shall be considered to be effective under the State plan for a period of not more than 6 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(c) REASSESSMENTS.—The Secretary shall reassess the validity of the eligibility criteria described in subsection (a) as new knowledge regarding the assessments of functional disabilities becomes available. The Secretary shall report to the Committee on Labor and Human Resources of the Senate and the Committee on Energy and Commerce of the House of Representatives on its findings

not later than 5 years after the date of enactment of this Act.

(d) ACTIVITY OF DAILY LIVING DEFINED.—In this part, the term ''activity of daily living'' means any of the following: eating, toileting, dressing, bathing, and transferring.

SEC. 2104. HOME AND COMMUNITY-BASED SERVICES COVERED UNDER STATE PLAN.

(a) SPECIFICATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the State plan under this part shall specify—

(A) the home and community-based services available under the plan to individuals with disabilities (or to such categories of such individuals), and

(B) any limits with respect to such services, except that within the limits of available funding, such services shall be sufficient in amount, duration, and scope to provide substantial assistance in living independently.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Subject to subsection (e)(1)(B), such services may be delivered in an individual's home, a

range of community residential arrangements, or outside the home.

(b) REQUIREMENT FOR CARE MANAGEMENT.—

(1) IN GENERAL.—The State shall make available to each category of individual with disabilities care management services that at a minimum include—

(A) a comprehensive assessment of the individual's need for home and community-based services (regardless of whether all needed services are available under the plan),

(B) an individualized plan of care based on such assessment,

(C) services consistent with such plan of care,

(D) arrangements for the provision of such services, and

(E) monitoring of the delivery of services.

(2) HOME AND COMMUNITY-BASED SERVICES.—The State shall provide for home and community-based services to an individual with disabilities only if—

(A) a comprehensive assessment of the individual's need for home and community-based services (regardless of whether all needed serv-

ices are available under the plan) has been made,

(B) an individualized plan of care based on such assessment is developed, and

(C) such services are provided consistent with such plan of care.

The Secretary shall develop a uniform comprehensive assessment tool that shall be used by the States under subparagraph (A). Alternative comprehensive assessment tools may be used by the States only with the approval of the Secretary. The Secretary shall provide guidance to the States with regard to the appropriate qualifications for individuals who conduct comprehensive assessments.

(3) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under paragraphs (1)(B) and (2)(B) for an individual with disabilities shall—

(A) be developed by qualified individuals (specified under the State plan),

(B) be developed and implemented in close consultation with the individual or the individual's designated representative,

(C) be approved by the individual (or the individual's designated representative), and

(D) be reviewed and updated not less often than every 6 months.

(4) PLAN OF CARE.—The plan of care under paragraphs (1)(B) and (2)(B) shall—

(A) specify which services specified under the individual plan will be provided under the State plan under this part,

(B) identify (to the extent possible) how the individual will be provided any services specified under the plan of care and not provided under the State plan, and

(C) specify how the provision of services to the individual under the plan will be coordinated with the provision of other health care services to the individual.

The State shall make reasonable efforts to identify and arrange for services described in subparagraph (B). Nothing in this subsection shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(c) MANDATORY COVERAGE OF PERSONAL ASSISTANCE SERVICES.—The State plan shall include, in the array of services made available to each category of individuals with disabilities, both agency-administered and

consumer-directed personal assistance services (as defined in subsection (g)).

(d) ADDITIONAL SERVICES.—

(1) TYPES OF SERVICES.—Subject to subsection (e), services available under a State plan under this part shall include any (or all) of the following:

(A) Homemaker and chore assistance.

(B) Home modifications.

(C) Respite services.

(D) Assistive devices, as defined in the Technology Related Assistance for Individuals with Disabilities Act.

(E) Adult day services.

(F) Habilitation and rehabilitation.

(G) Supported employment.

(H) Home health services.

(I) Transportation.

(J) Any other care or assistive services (approved by the Secretary) that the State determines will help individuals with disabilities to remain in their homes and communities.

(2) CRITERIA FOR SELECTION OF SERVICES.—The State plan shall specify—

(A) the methods and standards used to select the types, and the amount, duration, and

scope, of services to be covered under the plan and to be available to each category of individuals with disabilities, and

(B) how the types, and the amount, duration, and scope, of services specified, within the limits of available funding, provide substantial assistance in living independently to individuals within each of the 4 categories of individuals with disabilities.

Not later than the date on which the plan is fully phased-in, the State shall ensure that a full array of services is available to meet the needs of individuals with disabilities.

(e) EXCLUSIONS AND LIMITATIONS.—A State plan may not provide for coverage of—

(1) room and board,

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary, or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(f) PAYMENT FOR SERVICES.—A State plan may provide for the use of—

(1) vouchers,

(2) cash payments directly to individuals with disabilities,

(3) capitation payments to health plans, and

(4) payment to providers,

to pay for covered services.

(g) PERSONAL ASSISTANCE SERVICES.—

(1) IN GENERAL.—In this section, the term ''personal assistance services'' means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living and for people with primarily mental, cognitive or sensory impairments such instrumental activities of daily living as deemed necessary or appropriate, whether agency-administered or consumer-directed (as defined in paragraph (2)). Such services shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions,

(2) CONSUMER-DIRECTED.—In this part:

(A) IN GENERAL.—The term ''consumer-directed'' means, with reference to personal assistance services or the provider of such serv-

ices, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) STATE RESPONSIBILITIES.—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) RIGHT OF CONSUMERS.—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including man-

age, train, schedule, and verify services provided) the work of a home care provider.

(3) AGENCY ADMINISTERED.—The term ''agency-administered'' means, with respect to such services, services that are not consumer-directed.

SEC. 2105. COST SHARING.

(a) NO COST SHARING FOR POOREST.—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (c)) less than 150 percent of the official poverty level (referred to in section 1902(30)) applicable to a family of the size involved (determined without regard to section 1902(30)(B)).

(b) SLIDING SCALE FOR REMAINDER.—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied);

(2) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of such official poverty line (as so applied); and

(3) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such official poverty line (as so applied).

(c) RECOMMENDATION OF THE SECRETARY.—The Secretary shall make recommendations to the States as to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the cost-sharing provisions of section 2105 could jeopardize their ability to take advantage of the services offered under this Act. The Secretary shall establish a methodology for reducing the cost-sharing burden for individuals with exceptionally high out-of-pocket costs under this Act.

(d) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) MINIMUM REQUIREMENTS FOR PROVIDERS.—

(1) IN GENERAL.—Providers of home and community-based services under this subtitle must, as a condition of participation under this subtitle, meet such requirements for quality assurance and safeguards as shall be established by the Secretary

under this section. Such requirements will include at a minimum:

(A) QUALITY ASSURANCE.—Not later than January 1, 1995, the Secretary shall promulgate regulations specifying how the States will ensure and monitor the quality of services, including—

(i) safeguarding the health and safety of individuals with disabilities, including the use of periodic surveys of providers;

(ii) the minimum standards for agency providers, including certification, and how such standards will be enforced;

(iii) the minimum competency requirements, including education and training requirements, for agency provider employees who provide direct services under this part and how the competency of such employees will be enforced;

(iv) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services;

(v) participation in quality assurance activities; and

(vi) the role of existing State consumer protection and advocacy resources, particularly the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

(B) SAFEGUARDS.—Not later than January 1, 1995, the Secretary shall promulgate regulations providing the following:

(i) CONFIDENTIALITY.—The regulations shall provide safeguards which restrict the use of disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan (including performance reviews under this section).

(ii) SAFEGUARDS AGAINST ABUSE.—The regulations shall provide safeguards against physical, emotional, or financial

abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payment or vouchers given directly to individuals with disabilities.

(2) NO DELEGATION TO STATES.—The Secretary's authority under this subsection shall not be delegated to States.

(3) NO PREVENTION OF MORE STRINGENT REQUIREMENTS BY STATES .—Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements established by the Secretary under this subsection.

(b) FEDERAL STANDARDS.—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) Random home visits for a specified percentage of cases.

(3) The mandatory reporting of abuse, neglect, or exploitation.

(4) The establishment of a formal client grievance mechanism, including a fair hearing process.

(5) State licensure or certification for agency providers that offer home health services.

(6) Minimum training requirements for agency-directed home care workers.

(7) The development of a registry of provider agencies or home care workers against whom any complaints have been sustained, which shall be available to the public.

(8) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(9) Surveys of client satisfaction.

(10) State optional training programs for informal caregivers.

(c) FUNDING.—A State that is entitled to a payment in accordance with section 2108 shall receive a separate allocation that may be expended only for client advocacy activities. The State may use such funds to augment the budgets of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) or may establish a separate and independent agency to administer a new program designed to advocate for client rights.

(d) FUNCTIONS.—

(1) IN GENERAL.—A client advocacy office established under this section shall—

(A) identify, investigate, and resolve complaints that—

(i) are made by, or on behalf of, clients; and

(ii) relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the clients (including the welfare and rights of the clients with respect to the appointment and activities of guardians and representative payees), of—

(I) providers, or representatives of providers, of long-term care services;

(II) public agencies; or

(III) health and social service agencies;

(B) provide services to assist the clients in protecting the health, safety, welfare, and rights of the clients;

(C) inform the clients about means of obtaining services provided by providers or agen-

cies described in subparagraph (A)(ii) or services described in subparagraph (B);

(D) ensure that the clients have regular and timely access to the services provided through the office and that the clients and complainants receive timely responses from representatives of the office to complaints; and

(E) represent the interests of the clients before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the clients with regard to the provisions of this title and related concerns under this Act.

(2) CONTRACTS AND ARRANGEMENTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the State agency may establish and operate the office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(B) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.—The State agency may not enter into the contract or other arrangement described in subparagraph (A) with an agency or organization that is responsible

for licensing, certifying, or providing long-term care services in the State.

(e) SAFEGUARDS.—

(1) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan (including performance reviews under section 2602).

(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities). All providers of services shall be required to register with the State agency.

(f) ISSUANCE OF REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall issue regulations implementing the quality provisions of this section.

SEC. 2107. ADVISORY GROUPS.

(a) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group, to advise the Secretary

and States on all aspects of the program under this part.

(2) COMPOSITION.—The group shall be composed of individuals with disabilities and their representatives, providers, Federal and State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives.

(b) STATE ADVISORY GROUPS.—

(1) IN GENERAL.—Each State plan shall provide for the establishment and maintenance of an advisory group to advise the State on all aspects of the State plan under this part.

(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representatives, providers, State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives. The members of the advisory group shall be selected from the those nominated as described in section 2107(b)(3).

(3) SELECTION OF MEMBERS.—Each State shall establish a process whereby all residents of the

State, including individuals with disabilities and their representatives, shall be given the opportunity to nominate members to the advisory group.

(4) PARTICULAR CONCERNS.—Each advisory group shall—

(A) before the State plan is developed, advise the State on guiding principles and values, policy directions, and specific components of the plan,

(B) meet regularly with State officials involved in developing the plan, during the development phase, to review and comment on all aspects of the plan,

(C) participate in the public hearings to help assure that public comments are addressed to the extent practicable,

(D) report to the Governor and make available to the public any differences between the group's recommendations and the plan,

(E) report to the Governor and make available to the public specifically the degree to which the plan is consumer-directed, and

(F) meet regularly with officials of the designated State agency (or agencies) to provide

advice on all aspects of implementation and evaluation of the plan.

SEC. 2108. PAYMENTS TO STATES.

(a) IN GENERAL.—Subject to section 2102(a)(9)(D) (relating to limitation on payment for administrative costs), the Secretary, in accordance with the Cash Management Improvement Act, shall authorize payment to each State with a plan approved under this part, for each quarter (beginning on or after January 1, 1996), from its allotment under section 2109(b), an amount equal to—

(1) the Federal matching percentage (as defined in subsection (b)) of amount demonstrated by State claims to have been expended during the quarter for home and community-based services under the plan for individuals with disabilities; plus

(2) an amount equal to 90 percent of the amount demonstrated by the State to have been expended during the quarter for quality assurance activities under the plan; plus

(3) an amount equal to 90 percent of amount expended during the quarter under the plan for activities (including preliminary screening) relating to determination of eligibility and performance of needs assessment; plus

(4) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2003, 75 percent) of the amount expended during the quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

(5) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2003, the Federal matching percentage) of the amount expended during the quarter for infrastructure development, as defined by the Secretary; plus

(6) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan; plus

(7) an amount equal to .5 percent of the State's total allotment for client advocacy activities described in section 2106(c).

(b) FEDERAL MATCHING PERCENTAGE.—

(1) IN GENERAL.—In subsection (a), the term ''Federal matching percentage'' means, with respect to a State, the reference percentage specified in paragraph (2) increased by 17.5 percentage points, except that the Federal matching percentage shall in

no case be less than 67.5 percent or more than 95 percent.

(2) REFERENCE PERCENTAGE.—

(A) IN GENERAL.—The reference percentage specified in this paragraph is 100 percent less the State percentage specified in subparagraph (B), except that—

(i) the percentage under this paragraph shall in no case be less than 50 percent or more than 83 percent, and

(ii) the percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 percent.

(B) STATE PERCENTAGE.—The State percentage specified in this subparagraph is that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii.

(c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of the total sum to be expended in such quarter, and such other information as the Secretary may find necessary.

(2) From the allotment available therefore, the Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

(d) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act .

SEC. 2109. APPROPRIATION; ALLOTMENTS TO STATES.

(a) APPROPRIATION.—

(1) FISCAL YEARS 1996 THROUGH 2003.—Subject to paragraph (5)(C), for purposes of this part, the appropriation authorized under this part for each of fiscal years 1996 through 2003 is the following:

(A) For fiscal year 1996, $3,900,000,000.

(B) For fiscal year 1997, $6,800,000,000.

(C) For fiscal year 1998, $9,600,000,000.

(D) For fiscal year 1999, $12,900,000,000.

(E) For fiscal year 2000, $16,400,000,000.

(F) For fiscal year 2001, $23,400,000,000.

(G) For fiscal year 2002, $31,100,000,000.

(H) For fiscal year 2003, $33,600,000,000.

(2) SUBSEQUENT FISCAL YEARS.—For purposes of this part, the total Federal budget for State plans under this part for each fiscal year after fiscal year 2003 is the total Federal budget under this subsection for the preceding fiscal year multiplied by—

(A) a factor (described in paragraph (3)) reflecting the change in the CPI for the fiscal year, and

(B) a factor (described in paragraph (4)) reflecting the change in the number of individuals with disabilities for the fiscal year.

(3) CPI INCREASE FACTOR.—For purposes of paragraph (2)(A), the factor described in this paragraph for a fiscal year is the ratio of—

(A) the annual average index of the consumer price index for the preceding fiscal year, to—

(B) such index, as so measured, for the second preceding fiscal year.

(4) DISABLED POPULATION FACTOR.—For purposes of paragraph (2)(B), the factor described in this paragraph for a fiscal year is 100 percent plus (or minus) the percentage increase (or decrease) change in the disabled population of the United States (as determined for purposes of the most recent update under subsection (b)(3)(D)).

(5) ADDITIONAL FUNDS DUE TO MEDICAID OFFSETS.—

(A) IN GENERAL.—Each participating State must provide the Secretary with informa-

tion concerning offsets and reductions in the medicaid program resulting from home and community-based services provided disabled individuals under this part, that would have been paid for such individuals under the State medicaid plan but for the provision of similar services under the program under this part. At the time a State first submits its plan under this title and before each subsequent fiscal year (through fiscal year 2003), the State also must provide the Secretary with such budgetary information (for each fiscal year through fiscal year 2003), as the Secretary determines to be necessary to carry out this paragraph.

(B) REPORTS.—Each State with a program under this part shall submit such reports to the Secretary as the Secretary may require in order to monitor compliance with subparagraph (A). The Secretary shall specify the format of such reports and establish uniform data reporting elements.

(C) ADJUSTMENTS TO FEDERAL BUDGET.—

(i) IN GENERAL.—For each fiscal year (beginning with fiscal year 1996 and end-

ing with fiscal year 2003) and based on a review of information submitted under subparagraph (A), the Secretary shall determine the amount by which the total Federal budget under subsection (a) will increase. The amount of such increase for a fiscal year shall be limited to the reduction in Federal expenditures of medical assistance (as determined by Secretary) that would have been made under title XIX of the Social Security Act for home and community based services for disabled individuals but for the provision of similar services under the program under this part.

(ii) ANNUAL PUBLICATION.—The Secretary shall publish before the beginning of such fiscal year, the revised total Federal budget under this subsection for such fiscal year (and succeeding fiscal years before fiscal year 2003).

(D) NO DUPLICATE PAYMENT.—No payment may be made to a State under this section for any services to the extent that the State received payment for such services under section

1903(a) of the Social Security Act or title I of this Act.

(E) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring States to determine eligibility for medical assistance under the State medicaid plan on behalf of individuals receiving assistance under this part.

(b) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall allot to each State for each fiscal year an amount that bears the same ratio to the total Federal budget for the fiscal year (specified under paragraph (1) or (2) of subsection (a)) as the State allotment factor (under paragraph (2) for the State for the fiscal year) bears to the sum of such factors for all States for that fiscal year. One-half of one percent of the allotment provided under this paragraph shall be used exclusively for client advocacy activities.

(2) STATE ALLOTMENT FACTOR.—

(A) IN GENERAL.—For each State for each fiscal year, the Secretary shall compute a State allotment factor equal to the sum of—

(i) the base allotment factor (specified in subparagraph (B)), and

(ii) the low income allotment factor (specified in subparagraph (C)),

for the State for the fiscal year.

(B) BASE ALLOTMENT FACTOR.—The base allotment factor, specified in this subparagraph, for a State for a fiscal year is equal to the product of the following:

(i) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in the State (determined under paragraph (3)) for the fiscal year.

(ii) 80 PERCENT OF THE NATIONAL PER CAPITA BUDGET.—80 percent of the national average per capita budget amount (determined under paragraph (4)) for the fiscal year.

(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

(iv) FEDERAL MATCHING RATE.—The Federal matching rate (determined under section 2108(b)) for the fiscal year.

(C) LOW INCOME ALLOTMENT FACTOR.—The low income allotment factor, specified in

this subparagraph, for a State for a fiscal year is equal to the product of the following:

(i) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in the State (determined under paragraph (3)) for the fiscal year.

(ii) 10 PERCENT OF THE NATIONAL PER CAPITA BUDGET.—10 percent of the national average per capita budget amount (determined under paragraph (4)) for the fiscal year.

(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

(iv) FEDERAL MATCHING RATE.—The Federal matching rate (determined under section 2108(b)) for the fiscal year.

(v) LOW INCOME INDEX.—The low income index (determined under paragraph (6)) for the State for the preceding fiscal year.

(3) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities

in a State for a fiscal year shall be determined as follows:

(A) BASE.—The Secretary shall determine the number of individuals in the State by age, sex, and income category, based on the 1990 decennial census, adjusted (as appropriate) by the March 1994 current population survey.

(B) DISABILITY PREVALENCE LEVEL BY POPULATION CATEGORY.—The Secretary shall determine, for each such age, sex, and income category, the national average proportion of the population of such category that represents individuals with disabilities. The Secretary may conduct periodic surveys in order to determine such proportions.

(C) BASE DISABLED POPULATION IN A STATE.—The number of individuals with disabilities in a State in 1994 is equal to the sum of the products, for such each age, sex, and income category, of—

(i) the population of individuals in the State in the category (determined under subparagraph (A)), and

(ii) the national average proportion for such category (determined under subparagraph (B)).

(D) UPDATE.—The Secretary shall determine the number of individuals with disabilities in a State in a fiscal year equal to the number determined under subparagraph (C) for the State increased (or decreased) by the percentage increase (or decrease) in the disabled population of the State as determined under the current population survey from 1994 to the year before the fiscal year involved.

(4) NATIONAL PER CAPITA BUDGET AMOUNT.—The national average per capita budget amount, for a fiscal year, is—

(A) the total Federal budget specified under subsection (a) for the fiscal year; divided by

(B) the sum, for the fiscal year, of the numbers of individuals with disabilities (determined under paragraph (3)) for all the States for the fiscal year.

(5) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor, for a State for a fiscal year, is equal to the ratio of—

(A) the average hourly wages for service workers (other than household or protective services) in the State, to

(B) the national average hourly wages for service workers (other than household or protective services).

The hourly wages shall be determined under this paragraph based on data from the most recent decennial census for which such data are available.

(6) LOW INCOME INDEX.—The low income index for each State for a fiscal year is the ratio, determined for the preceding fiscal year, of—

(A) the percentage of the State's population that has income below 150 percent of the poverty level, to

(B) the percentage of the population of the United States that has income below 150 percent of the poverty level.

Such percentages shall be based on data from the most recent decennial census for which such data are available, adjusted by data from the most recent current population survey as determined appropriate by the Secretary.

(c) CARRY-OVER.—With respect to fiscal years 1996 through 2003, a State shall be permitted to carry-over not

more than 25 percent of the allotment of such State for expenditures in the subsequent year.

(d) STATE ENTITLEMENT.—This part constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

SEC. 2110. FEDERAL EVALUATIONS.

Not later than December 31, 2000, December 31, 2003, and each December 31 thereafter, the Secretary shall provide to Congress analytical reports that evaluate—

(1) the extent to which individuals with low incomes and disabilities are equitably served;

(2) the adequacy and equity of service plans to individuals with similar levels of disability across States;

(3) the comparability of program participation across States, described by level and type of disability; and

(4) the ability of service providers to sufficiently meet the demand for services.

Not later than 18 months after the date of enactment of this Act, the Secretary shall report to Congress concerning the feasibility of providing reimbursement under

health plans and other payers of health services for full geriatric assessment, when recommended by a physician.

Subpart B—State Programs for Extended Services for Children With Special Health Care Needs

SEC. 2111. STATE PROGRAMS FOR EXTENDED SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

(a) PURPOSE.—The purpose of this subpart is to provide financial assistance to the States to assist each State in developing and implementing, or expanding and enhancing, a family-centered, culturally competent, community-centered, comprehensive statewide system of extended services and benefits for children with special health care needs.

(b) PAYMENT.—Each State that has a plan for the provision of extended services for children with special health care needs submitted to and approved by the Secretary under section 2114 is entitled to payment subject to section 2117. Approval of a plan shall be contingent upon adequacy of funding and fulfillment of criteria established and published by the Secretary.

SEC. 2112. EXTENDED SERVICES COVERED UNDER THE STATE PLAN.

(a) SPECIFICATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the State plan under this subpart shall specify—

(A) the extended services available under the plan to eligible children, and

(B) any limits with respect to such services.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Subject to subsection (e)(1)(B), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(b) REQUIREMENT FOR NEEDS ASSESSMENT AND PLAN OF CARE.—

(1) IN GENERAL.—The State plan shall provide for extended services to an eligible child only if—

(A) a comprehensive assessment of the child's need for home and community-based services (regardless of whether all needed services are available under the plan) has been made,

(B) an individualized plan of care based on such assessment is developed, and

(C) such services are provided consistent with such plan of care.

(2) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under paragraph (1)(B) for an eligible child shall—

(A) be developed by qualified individuals (specified under the State plan),

(B) be developed and implemented in close consultation with the child's designated representative and the child where appropriate,

(C) be approved by the child's designated representative and the child where appropriate, and

(D) be reviewed and updated not less often than every 6 months.

(3) PLAN OF CARE.—The plan of care under paragraph (1)(B) shall—

(A) specify which services specified under the individual plan will be provided under the State plan under this part,

(B) identify (to the extent possible) how the child will be provided any services specified under the plan of care and not provided under the State plan, and

(C) specify how the provision of services to the child under the plan will be coordinated

with the provision of other health care services to the child.

The State shall make reasonable efforts to identify and arrange for services described in subparagraph (B). Nothing in this subsection shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(c) EXTENDED SERVICES COVERED UNDER THE STATE PLAN.—

(1) IN GENERAL.—The State plan shall include the following extended services:

(A) Developmentally appropriate personal assistance services that are family centered and provided in a culturally competent manner, and which meet the standards of 2104(g).

(B) Care management.

(C) Homemaker and chore assistance.

(D) Home modifications.

(E) Respite services.

(F) Assistive technology devices and assistive technology services as defined in the Technology Related Assistance for Individuals with Disabilities Act.

(G) Habilitation and rehabilitation.

(H) Home health services.

(I) Transportation.

(J) Any other care or assistive services (approved by the Secretary) that the State determines will help maximize a child's ability to function independently, appropriately, and effectively in an age-appropriate manner, or will facilitate the caregiver's ability to care for the child outside of an institution.

(2) CRITERIA FOR SELECTION OF SERVICES.—The State plan shall specify—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of services to be covered under the plan and to be available to eligible children, and

(B) how the types, and the amount, duration, and scope, of services specified meet the needs of eligible children.

(d) NO INDIVIDUAL ENTITLEMENT.—Nothing in this section shall be construed to create an entitlement for eligible children.

(e) EXCLUSIONS AND LIMITATIONS.—

(1) IN GENERAL.—A State plan may not provide for coverage of—

(A) room and board,

(B) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary, or

(C) items and services for which the child may receive payment under title I or title IV of this Act.

(f) PAYMENT FOR SERVICES.—A State plan may provide for the use of—

(1) vouchers,

(2) cash payments directly to a child's designated representative,

(3) capitation payments to health plans, and

(4) payment to providers,

to pay for covered services.

SEC. 2113. CHILDREN ELIGIBLE FOR SERVICES.

(a) ELIGIBILITY CRITERIA.—

(1) IN GENERAL.—Children with special health care needs shall be eligible for extended services and benefits under this subpart.

(2) CHILD WITH SPECIAL HEALTH CARE NEEDS.—As used in this subpart, the term ''child with special health care needs'' means an individual between the ages of birth to 21 years who—

(A) is not eligible for medical assistance under title IV of this Act;

(B) has a significant functional limitation under paragraph (3); and

(C) is in need of extended services under paragraph (4).

(3) SIGNIFICANT FUNCTIONAL LIMITATION.—

(A) IN GENERAL.—As used in this subpart, the term ''significant functional limitation'' means—

(i) in the case of an individual 6 years of age or older, a significant physical or mental impairment as defined pursuant to State policy to the extent that such policy is established without regard to type of disability; and

(ii) in the case of infants and young children, birth to age 5, inclusive, a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in a disability if services are not provided.

(B) PRESUMPTIVE SIGNIFICANT FUNCTIONAL LIMITATION.—An individual who has a disability or who is blind pursuant to the eligi-

bility requirements of title XVI of the Social Security Act (42 U.S.C. 1381 et seq.) shall be considered to have—

(i) in the case of an individual 6 years of age or older, a significant physical or mental impairment as defined pursuant to State policy to the extent that such policy is established without regard to type of disability; and

(ii) in the case of infants and young children, birth to age 5, inclusive, a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in a disability if services are not provided.

(4) CHILD IN NEED OF EXTENDED SERVICES.—As used in this subpart, the term ''child in need of extended services'' means an individual between the ages of birth to 21 years of age who requires services identified in section 2112(c) in order to maximize or restore function, or prevent or limit disability.

SEC. 2114. APPLICATION AND ADMINISTRATION.

(a) APPLICATION FOR STATE PARTICIPATION.—

(1) IN GENERAL.—A State desiring a grant under this subpart shall submit an application, as an addendum to the State application under section 2102, identifying in the State plan—

(A) the population to be served under this subpart;

(B) the manner in which funds made available would be utilized, and the services to be provided;

(C) how the State will define individuals qualified to develop individualized pediatric plans of care as defined in section 2112(b)(3); and

(D) how the State will assure that the range of services available under section 2112 will also be available to individuals with disabilities under the age of 21 who are eligible for services under subpart A to the maximum extent possible consistent with funds available to carry out subpart A; and

(E) any other information the Secretary may require.

(2) EVALUATION OF PROGRAM.—An applicant under this section shall agree to provide an evaluation of the effectiveness, including cost effectiveness

when measurable, of offering the benefits and services under the State plan to children with special health care needs.

(b) NUMBER OF PROGRAMS.—

(1) REQUEST FOR APPLICATIONS.—The Secretary shall publish a request for applications under this section not later than 1 year after the date of the enactment of this Act.

(2) MAXIMUM NUMBER OF GRANTS.—The Secretary shall make grants available under this subpart for the maximum number of State programs, in accordance with the current funding level in section 2117, that is compatible with services and benefits to be offered under section 2112 for eligible children with special health care needs residing in such State.

(3) FORMULA.—The provisions of subsection (b)(2) shall remain in effect through fiscal year 2003, at which time the Secretary shall establish a formula by which to distribute funds under this subpart, in accordance with section 2117, to all States that have a plan approved in accordance with section 2111 to provide the benefits described in section 2112.

(c) ADMINISTRATION.—

(1) STATE AGENCY.—The State shall designate a State agency or designee to administer (or to supervise the administration of) the program under this subpart.

(2) COORDINATION.—The State agency or designee shall specify how the agency or designee will coordinate its activities with health plans and other service providers, and with the agency administering subpart A.

(3) REQUIREMENT FOR COORDINATION OF CARE.—The State program under this subpart shall provide for coordinated services and benefits as described in section 2112 to a family with children with special health care needs integrating services whenever possible in accordance with section 2102(a)(9)(C).

SEC. 2115. COST-SHARING.

(a) NO COST SHARING FOR POOREST.—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (c)) less than 150 percent of the official poverty level (referred to in section 1902(38)(A)) applicable to a family of the size involved (determined without regard to section 1902(38)(B)).

(b) SLIDING SCALE FOR REMAINDER.—The State plan shall impose cost sharing in the form of coinsurance

(based on the amount paid under the State plan for a service)—

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied);

(2) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of such official poverty line (as so applied); and

(3) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such official poverty line (as so applied).

(c) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. In making these income determinations, the State shall at a minimum comply with standards established by the Secretary. Such standards shall include a uniform Federal definition of income and shall allow deductions from income for disability-related expenses not covered under other titles of this Act as promulgated by the Secretary.

(d) RECOMMENDATION FOR REDUCTIONS.—The Secretary shall make recommendations to the States as how

to reduce cost-sharing based on income standards established under subsection (c) for individuals with extraordinary out of pocket costs for whom the cost-sharing provisions of section 2115 could jeopardize their ability to take advantage of the services offered under this Act.

(e) REQUEST FOR PAYMENT PLAN.—If copayments under subsection (b) for services utilized by the child pursuant to section 2112(b)(1) exceed 10 percent of the child's income or the income of their designated representative—

(1) the child or child's designated representative may request that the State provide a payment schedule for these amounts that shall not exceed 10 percent of monthly income, and

(2) States may accept such requests from individuals and provide payment plans without interest or finance charges.

SEC. 2116. PROGRAM EVALUATION.

The Secretary shall evaluate the programs under this subpart, and shall submit to Congress interim reports detailing the utilization, cost, and cost efficiency of the programs.

SEC. 2117. TOTAL FEDERAL BUDGET AND FEDERAL ALLOTMENT TO STATES.

(a) TOTAL FEDERAL BUDGET.—The amount available to carry out State plans under this subpart shall be an amount equal to the total of a 2 percent set-aside from the amounts for each fiscal year beginning in fiscal year 1996 pursuant to section 2109.

(b) FEDERAL MATCHING PERCENTAGE.—States shall contribute to the program an amount consistent with the requirements in section 2108(b)(1).

(c) REMAINING FUNDS.—Funds remaining under subsection (a) at the end of each fiscal year shall be made available to States under section 2108 for the following fiscal year.

PART 2—LONG-TERM CARE INSURANCE IMPROVEMENT AND ACCOUNTABILITY

SEC. 2201. SHORT TITLE.

This part may be cited as the ''Long-Term Care Insurance Improvement and Accountability Act''.

SEC. 2202. ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE.

The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE XXVII—LONG-TERM CARE

"PART 1—LONG-TERM CARE INSURANCE STANDARDS

"Subpart A—Promulgation of Standards and Model Benefits

"SEC. 2701. STANDARDS.

''(a) APPLICATION OF STANDARDS.—

''(1) NAIC.—

''(A) IN GENERAL.—The Secretary shall request that the National Association of Insurance Commissioners (hereafter in this part referred to as the 'NAIC')—

''(i) develop specific standards that incorporate the requirements of this part; and

''(ii) report to the Secretary concerning such standards.

''(B) APPLICATION.—If, within 12 months after the date of the enactment of this part, the NAIC develops the model standards under subparagraph (A)(i), the Secretary shall have 60 days in which to determine whether such standards implement the requirements of this part. If such standards are approved by the Secretary,

they shall be the standards that apply as provided in this part.

''(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this part and such standards shall apply as provided for in this part.

''(3) RELATION TO STATE LAW.—Nothing in this part shall be construed as preventing a State from applying standards that provide greater protection to policyholders of long-term care insurance policies than the standards promulgated under this part, except that such State standards may not be inconsistent or in conflict with any of the requirements of this part.

''(b) DEADLINE FOR APPLICATION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is—

''(A) the date the State adopts the standards established under subsection (a)(1); or

''(B) the date that is 1 year after the first day of the first regular legislative session that

begins after the date such standards are first established under subsection (a)(2);

whichever is earlier.

''(2) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

''(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

''(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

''(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

''(1) minimum Federal standards for long-term care insurance consistent with the provisions of this part;

''(2) standards for the enhanced protection of consumers with long-term care insurance; and

''(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program.

''(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall, after consultation with representatives of carriers, consumer groups, and providers of long-term care services—

''(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

''(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

''(3) recommend appropriate standards for the regulation of the insurance aspects of supported housing arrangements; and

''(4) perform such other activities as determined appropriate by the Secretary.

"Subpart B—Establishment and Implementation of Long-Term Care Insurance Policy Standards

"SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.

''(a) IN GENERAL.—

''(1) REGULATORY PROGRAM.—No long-term care policy (as defined in section (2721)) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2701(b) unless—

''(A) the Secretary determines that the State has established a regulatory program that—

''(i) provides for the application and enforcement of the standards established under section 2701(a); and

''(ii) complies with the requirements of subsection (b);

by the date specified in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

''(B) if the State has not established such a program, or if the State's regulatory program

has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2701(a) by the date specified in section 2701(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

''(2) REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary shall review regulatory programs described in paragraph (1)(A) at least biannually to determine if they continue to provide for the application and enforcement of the standards and procedures established under section 2701(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such

standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2701 for carriers, agents, or associations or its subsidiary in the State plans in the State.

''(b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

''(1) ENFORCEMENT.—The enforcement under the program—

''(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

''(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

''(2) PROCESS.—The enforcement process under each State regulatory program shall provide for—

''(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

''(B) responding to such complaints within 90 days;

''(C) the investigation of—

''(i) those complaints which have a reasonable probability of validity, and

''(ii) such other alleged violations of the standards as the program finds appropriate; and

''(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2718) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

''(3) PRIVATE ACTIONS.—An individual may commence a civil action in an appropriate State or United States district court to enforce the provisions of this title and may be awarded appropriate relief and reasonable attorney's fees.

''(4) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

"(A) IN GENERAL.—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

"(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

"(5) PROCESS FOR APPROVAL OF PREMIUMS.—

"(A) IN GENERAL.—Each State regulatory program shall—

"(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

"(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

"(B) CONDITIONS FOR APPROVAL.—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

''(i) includes a description of the assumptions that justify the increase, including a financial report on expenditures;

''(ii) contains such information as may be required under the Standards; and

''(iii) is made available to the public.

''(C) APPLICATION.—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

''(D) EXCEPTION.—Subparagraph (C) shall not apply to—

''(i) group conversion policies;

''(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

''(iii) group policies where the function of the employer is limited solely to col-

lecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

''(6) ANNUAL REPORTS.—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

''(7) ACCESS TO OTHER INFORMATION.—The State regulatory program must provide for consumer access to actuarial memoranda, including financial information, provided under paragraph (4).

''(8) DEFAULT.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

''(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

"(1) IN GENERAL.—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

"(2) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

"(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this part;

"(B) for responding on a timely basis to such complaints; and

"(C) for the investigation of—

"(i) those complaints that have a reasonable probability of validity; and

"(ii) such other alleged violations of the requirements of this part as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

"(3) HEARINGS.—

"(A) IN GENERAL.—Prior to imposing an order described in paragraph (4) against a car-

rier, agent, or association or its subsidiary under this section for a violation of the requirements of this part, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

''(B) CONDUCT OF HEARING.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

''(C) AUTHORITY IN HEARINGS.—In conducting hearings under this paragraph—

''(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

''(ii) administrative law judges, may, if necessary, compel by subpoena the at-

tendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

''(D) ISSUANCE OF ORDERS.—If an administrative law judge determines in a hearing under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this part, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

''(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

"(A) IN GENERAL.—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

"(i) shall require the agent, association or its subsidiary, or a carrier—

"(I) to cease and desist from such violations; and

"(II) to pay a civil penalty in an amount not to exceed $15,000 in the case of each agent, and not to exceed $25,000 for each association or its subsidiary or a carrier for each such violation; and

"(ii) may require the agent, association or its subsidiary, or a carrier to take such other remedial action as is appropriate.

"(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or association or its subsidiary establishes to the satisfaction of the Secretary that—

"(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

''(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

''(C) WAIVER BY SECRETARY.—In the case of a violation under this part that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

''(D) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

"(E) JUDICIAL REVIEW.—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

"(F) ENFORCEMENT OF ORDERS.—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"SEC. 2712. REGULATION OF SALES PRACTICES.

"(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

"(1) IN GENERAL.—Each agent (as defined in section 2733) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

"(2) POLICY REPLACEMENT FORM.—With respect to any person who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

"(3) PROHIBITED PRACTICES.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

"(A) TWISTING.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

"(B) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-

term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

''(C) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

''(D) OTHERS.—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

''(b) FINANCIAL STANDARDS.—The NAIC shall develop recommended financial minimum standards (including both income and asset criteria) for the purpose of advising individuals as to the costs and amounts of insurance needed when considering the purchase of a long-term care insurance policy.

''(c) PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

"(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

"(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

"(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

"(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

"(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term 'service-benefit long-term care insurance policy' means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

"(e) PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.—A carrier may not sell or issue a

long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

''(f) PROVISION OF OUTLINE OF COVERAGE.—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy without providing to every individual purchaser or potential purchaser (or representative) an outline of coverage that complies with the standards established under section 2701(a).

''(g) PENALTIES.—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed $15,000 for each such violation. Any association or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and in addition, is subject to a civil money penalty of not to exceed $25,000 for each violation. Nothing in this subsection shall be construed as preempting or otherwise limiting the penalties that may

be imposed by a State for conduct that violates this section.

''(h) AGENT TRAINING AND CERTIFICATION REQUIREMENTS.—The NAIC, shall establish requirements for long-term care insurance agent training and certification that—

''(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

''(2) specify procedures for certifying and recertifying agents who have completed such training and who are as qualified to sell or offer for sale long-term care insurance policies.

"SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

''(a) REFUND OF PREMIUMS.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

1 ''(b) MAILING OF POLICY.—If an application for a
2 long-term care insurance policy (or for a certificate under
3 a group long-term care insurance policy) is approved, the
4 carrier shall provide every individual applicant the policy
5 (or certificate) of insurance and outline of coverage not
6 later than 30 days after the date of the approval.

7 ''(c) INFORMATION ON DENIALS OF CLAIMS.—If a
8 claim under a long-term care insurance policy is denied,
9 the carrier shall, within 15 days of the date of a written
10 request by the policyholder or certificate holder (or rep-
11 resentative)—

12 ''(1) provide a written explanation of the rea-
13 sons for the denial;

14 ''(2) make available all medical and patient
15 records directly relating to such denial; and

16 ''(3) provide a written explanation of the man-
17 ner in which to appeal the denial.

18 Except as provided in subsection (e) of section 2715, no
19 claim under such a policy may be denied on the basis of
20 a failure to disclose a condition at the time of issuance
21 of the policy if the application for the policy failed to re-
22 quest information respecting the condition.

23 ''(d) REPORTING OF INFORMATION.—A carrier that
24 issues one or more long-term care insurance policies shall
25 periodically (not less often than annually) report, in a

form and in a manner determined by the NAIC, to the Commissioner, superintendent or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

''(1) the long-term care insurance policies of the carrier that are in force;

''(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

''(3) the lapse rate, replacement rate, and rescission rates by policy;

''(4) the names of that 10 percent of its agents that—

''(A) have the greatest lapse and replacement rate; and

''(B) have produced at least $50,000 of long-term care insurance sales in the previous year; and

''(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

Information required under this subsection shall be reported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), there shall be included (but reported separately) data con-

cerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

''(e) STANDARDS ON COMPENSATION FOR SALE OF POLICIES.—

''(1) IN GENERAL.—A carrier that issues one or more long-term care insurance policies may provide a commission or other compensation to an agent or other representative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year, or if the first year commission or other compensation to be paid does not exceed 50 percent of the premium paid on the first year policy, until the NAIC promulgates mandatory standards concerning compensation for the sale of such policies.

''(2) SUBSEQUENT YEARS.—The commission or other compensation provided for the sale of long-term care insurance policies in years subsequent to the first year of the policy shall be the same as that

provided in the second subsequent year and shall be provided for no fewer than 5 subsequent years.

''(3) LIMITATION.—No carrier shall provide compensation to its agents for the sale of a long-term care insurance policy and no agent shall receive compensation greater than the renewal compensation payable by the replacing carrier on renewal policies if an existing policy is replaced.

''(4) COMPENSATION DEFINED.—As used in this subsection, the term 'compensation' includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including but not limited to deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

"SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIC FOR CANCELLATION OF POLICIES.

''(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

''(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

''(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals

with a basis for continuation or conversion in accordance with this subsection.

''(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

''(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

''(A) whose coverage under the group policy would otherwise be terminated for any reason; and

''(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

''(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

''(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

''(c) STANDARDS FOR ISSUANCE.—

''(1) IN GENERAL.—

''(A) GUARANTEE.—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan,

if such individual meets the minimum medical underwriting requirements of such policy.

''(B) PREMIUM FOR CONVERTED POLICY.—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

''(2) UPGRADE FOR CURRENT POLICIES.—The NAIC shall establish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

''(3) RATE STABILIZATION.—The NAIC shall establish standards for premium rate stabilization.

''(d) EFFECT OF INCAPACITATION.—

''(1) IN GENERAL.—

"(A) PROHIBITION.—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

"(B) REINSTATEMENT.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

"(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

"(A) the period of such nonpayment is in excess of 30 days; and

''(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

''SEC. 2715. BENEFIT STANDARDS.

''(a) USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2701(a)—

''(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers; and

''(2) use a uniform format for presenting the outline of coverage under such a policy;

as prescribed under guidelines issued by the NAIC and periodically updated.

''(b) DISCLOSURE.—

''(1) OUTLINE OF COVERAGE.—

"(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage to each individual policyholder under such policy that meets the applicable standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

"(B) CONTENTS.—The outline of coverage for each long-term care insurance policy shall include at least the following:

"(i) A description of the benefits and coverage under the policy.

"(ii) A statement of the exclusions, reductions, and limitations contained in the policy.

"(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

''(iv) Consumer protection information, including the manner in which to file a claim and to register complaints.

''(v) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall substantially and accurately reflect the contents of the policy or the master policy.

''(vi) A description of the terms, specified in section 2717, under which a policy or certificate may be returned and premium refunded.

''(vii) Information on—

''(I) national average costs for nursing facility and home health care and information (in graphic form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs; and

''(II) other public and private long-term care insurance products and long-term care programs where made available by the Federal Government or by a State government.

''(viii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

''(2) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

''(A) a description of the principal benefits and coverage provided in the policy;

''(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

''(C) a statement that the group master policy determines governing contractual provisions.

''(3) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

''(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

''(B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and

''(C) any exclusions, reductions, and limitations on benefits of long-term care.

''(4) ADDITIONAL INFORMATION.—The NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.

''(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

''(1) IN GENERAL.—A long-term care insurance policy may not condition or limit eligibility—

''(A) for benefits for a type of services to the need for or receipt of any other services;

''(B) for any benefit on the medical necessity for such benefit;

''(C) for benefits furnished by licensed or certified providers in compliance with conditions

which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or

''(D) for residential care (if covered under the policy) only—

''(i) to care provided in facilities which provide a higher level of care; or

''(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

''(2) HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

''(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

''(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker, except

that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC;

''(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

''(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services, adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

''(3) NURSING FACILITY SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2715(a)(1)) in the State.

''(4) PER DIEM POLICIES.—

"(A) DEFINITION.—For purposes of this part, the term 'per diem long-term care insurance policy' means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

"(B) LIMITATION.—No per diem long-term care insurance policy (or certificate) may condition, limit or otherwise exclude benefit payments based on the receipt of any type services from any type providers of long-term care service providers.

"(d) PROHIBITION OF DISCRIMINATION.—A long-term care insurance policy may not treat benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment differently from an individual having a functional impairment for which benefits may be made available.

1 ''(e) LIMITATION ON USE OF PREEXISTING CONDI-
2 TION LIMITS.—
3 ''(1) INITIAL ISSUANCE.—
4 ''(A) IN GENERAL.—Subject to subpara-
5 graph (B), a long-term care insurance policy
6 may not exclude or condition benefits based on
7 a medical condition for which the policyholder
8 received treatment or was otherwise diagnosed
9 before the issuance of the policy.
10 ''(B) 6-MONTH LIMIT.—
11 ''(i) IN GENERAL.—No long-term care
12 insurance policy or certificate issued under
13 this part shall utilize a definition of 'pre-
14 existing condition' that is more restrictive
15 than the following: The term 'preexisting
16 condition' means a condition for which
17 medical advice or treatment was rec-
18 ommended by, or received from a provider
19 of health care services, within 6 months
20 preceding the effective date of coverage of
21 an insured individual.
22 ''(ii) PROHIBITION ON EXCLUSION OF
23 COVERAGE.—No long-term care insurance
24 policy or certificate may exclude coverage
25 for a loss or confinement that is the result

of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

''(2) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

''(f) ELIGIBILITY FOR BENEFITS.—

''(1) LONG-TERM CARE POLICIES.—Each long-term care insurance policy shall—

''(A) describe the level of benefits available under the policy; and

''(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

''(2) FUNCTIONAL ASSESSMENT.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her functional or cog-

nitive abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term 'control' means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing at least 10 percent of the voting securities of another person.

''(3) CLAIMS REVIEW.—Except as provided in paragraph (1), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

''(4) APPEALS PROCESS.—

''(A) IN GENERAL.—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards

established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the policyholder's functional assessment, conducted under paragraph (2).

''(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's functional or cognitive abilities.

''(C) CONDUCT.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

''(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

''(ii) by an entity that provides services to the policyholder or certificate holder

for which benefits are available under the long-term care insurance policy; or

''(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

''(5) STANDARD ASSESSMENTS.—Not later than 2 years after the date of enactment of this part, the advisory committee established under section 2701(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

''(g) INFLATION PROTECTION.—

''(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one following:

''(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

''(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

''(i) the existing policy benefit; and

''(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

''(C) With respect to service benefit policies, the policy covers a specified percentage of

the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

''(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

''(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this part:

''(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

''(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

''(4) CONTINUATION OF PROTECTION.—Inflation protection benefit increases under this subsection under a policy that contains such protection

shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

''(5) CONSTANT PREMIUM.—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

''(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

"SEC. 2716. NONFORFEITURE.

''(a) IN GENERAL.—Each long-term care insurance policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period (specified under the standards under section 2701(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the NAIC.

''(b) ESTABLISHMENT OF STANDARDS.—The standards under section 2701(a) shall provide that the percentage or amount of benefits under subsection (a) must increase based upon the policyholder's equity in the policy.

"SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

''(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or intentional misrepresentation relating to the issuance of the policy unless notice of such fraud or misrepresentation is provided within a time period to be determined by the NAIC.

''(b) RIGHT TO RETURN.—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

"SEC. 2718. CIVIL MONEY PENALTY.

''(a) CARRIER.—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2713(a);

''(2) fails to transmit a policy in accordance with section 2713(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

''(4) provides a commission or compensation in violation of section 2713(e);

''(5) fails to provide an outline of coverage in violation of section 2715(b)(1); or

''(6) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

''(b) AGENTS.—Any agent that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2713(a);

''(2) fails to transmit a policy in accordance with section 2713(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

''(4) fails to provide an outline of coverage in violation of section 2715(b)(1); or

''(5) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

''(c) EFFECT ON STATE LAW.—Nothing in this section shall be construed as preempting or otherwise limiting the penalties that may be imposed by a State for the types of conduct described in this section.

"Subpart C—Long-Term Care Insurance Policies, Definition and Endorsements

"SEC. 2721. LONG-TERM CARE INSURANCE POLICY DEFINED.

''(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

''(1) group and individual annuities and life insurance policies, riders or certificates that provide

directly, or that supplement long-term care insurance; and

''(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(b) ISSUANCE.—Long-term care insurance policies may be issued by—

''(1) carriers;

''(2) fraternal benefit societies;

''(3) nonprofit health, hospital, and medical service corporations;

''(4) prepaid health plans;

''(5) health maintenance organizations; or

''(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

''(c) POLICIES EXCLUDED.—The term 'long-term care insurance policy' shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health cov-

erage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

''(d) APPLICATIONS.—Notwithstanding any other provision of this part, this part shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

"SEC. 2722. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

''Not later than 1 year after the date of enactment of this part the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

''(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

''(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

''(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

''(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

''(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.''.

PART 3—LIFE CARE

SEC. 2301. SHORT TITLE.

This part may be cited as the ''Life Care Act''.

SEC. 2302. LIFE CARE: PUBLIC INSURANCE PROGRAM FOR NURSING HOME CARE.

Title XXVII of the Public Health Service Act (as added by section 2301) is amended by adding at the end thereof the following new part:

"PART 2—LIFE CARE: PUBLIC INSURANCE PROGRAM FOR NURSING HOME CARE

"SEC. 2741. ESTABLISHMENT OF VOLUNTARY LONG-TERM CARE INSURANCE PROGRAM.

''The Secretary shall establish a voluntary insurance program for individuals 35 years of age and over to cover the nursing home stays of such individuals. The Secretary shall establish a process for enrollment in the Life Care program.

"SEC. 2742. BENEFITS.

''(a) IN GENERAL.—

''(1) ELIGIBILITY FOR COVERAGE.—Subject to subsection (c), an individual who meets the eligibility criteria prescribed in section 2743 shall be eligible under the program established under this part for coverage for necessary services described in subsection (b) (in the amounts described in subsection (c)) that are provided to the individual by a nursing facility while the individual is an inpatient of the facility.

''(2) NONFORFEITURE.—The Secretary shall establish standards to ensure the nonforfeiture of benefits for which premiums have been paid.

''(b) TYPES.—Coverage may be provided under this part for—

''(1) nursing care provided by or under the supervision of a registered professional nurse;

''(2) physical, occupational, or speech therapy furnished by a facility or by others under arrangements with a facility;

''(3) medical social work services;

''(4) drug, biological, supply, appliance, and equipment for use in the facility, that is ordinarily furnished by the facility for the care and treatment of an inpatient;

''(5) such other services necessary to the functioning of a patient, including personal care and assistance with activities of daily living, as are generally provided by a nursing home facility; and

''(6) with respect to the initial 6 months of covered residence in a nursing facility, such room and board costs as are not covered by beneficiary copayment.

''(c) COVERAGE AMOUNT.—

''(1) IN GENERAL.—The amount of coverage provided with respect to an eligible individual for the services described in subsection (b) shall, based on an election made by the individual, not exceed $30,000, $60,000, or $90,000 over the lifetime of the eligible individual. Such amounts shall be ad-

justed by the Secretary to reflect increases in the Consumer Price Index.

''(2) ASSET PROTECTION.—An eligible individual shall be entitled to the asset protection provided under section 2748.

''(d) PAYMENT.—Amounts provided under this part with respect to an eligible individual for the services described in subsection (b) shall be paid from the general fund of the Treasury of the United States.

''(e) RESIDENTIAL CARE FACILITIES.—The Secretary shall consider the feasibility of making payments under this part for services delivered in residential care facilities. Not later than 2 years after the date of enactment of this Act, the Secretary shall report its findings to the Congress with respect to the feasibility of making such payments.

"SEC. 2743. ELIGIBILITY.

''(a) IN GENERAL.—An individual shall be eligible for benefits under this part if—

''(1) the individual—

''(A) is a legal resident of the United States and has elected coverage under subsection (c); and

''(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2747)—

''(i)(I) to require hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living; or

''(II) to require hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies; or

''(III) to display symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; or

''(IV) has achieved a score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, that indicates either severe cognitive impairment or severe mental impairment, or both; and

"(ii) to require such assistance, supervision, or cueing over a period of at least 90 days; and

"(2)(A) the individual has filed an application for such benefits, and is in need of, benefits covered under this part; or

"(B) the legal guardian of the individual has filed an application on behalf of an individual who is in need of benefits covered under this part; or

"(C) the representative of an individual who is cognitively impaired and who is in need of benefits covered under this part has filed an application on behalf of the individual.

"(b) CURRENT INDIVIDUALS.—An individual who is in a hospital or nursing home on the date of the enrollment of the individual in the program established under this part shall be ineligible for coverage under this section until the individual's first spell of illness beginning after such date.

"(c) ELECTION OF COVERAGE.—

"(1) IN GENERAL.—Subject to this subsection, an individual shall have the option to purchase coverage under this part when the individual is 35 years of age, 45 years of age, 55 years of age, or 65 years of age.

"(2) INITIAL YEAR.—During the 1-year period beginning on the date on which final regulations that implement this part are issued, an individual who is 35 years of age or older shall be eligible to purchase insurance under this part, except that such an individual shall not be eligible to purchase such insurance—

"(A) while confined to a hospital or nursing home;

"(B) within the 6-month period after the individual's confinement in a nursing home; or

"(C) within the 90-day period after the individual's confinement in a hospital.

Individuals described in the matter preceding subparagraph (A) shall become eligible to receive benefits under this part on the expiration of the 3-year period beginning on the date such individuals purchase insurance under this part.

"(3) EXTENSION BEYOND INITIAL YEAR.—If an individual is confined to a nursing home or hospital during a period that extends beyond the first year after the effective date of this part, an individual shall be eligible to enroll in the program established by this part during the 60-day period beginning after the individual's spell of illness.

"(4) SUBSEQUENT YEARS.—During years subsequent to the 1-year period referred to in paragraph (2), an individual shall be eligible to purchase insurance under this part within 6 months of the 35th, 45th, 55th or 65th birthday of the individual.

"(5) ACTIVATION OF BENEFITS.—To receive coverage under the insurance program established by this part, an individual shall have purchased such coverage not later than 1 month prior to admission to a nursing facility, unless the reason for the need of services is a result of an accident or stroke subsequent to the date that such individual enrolled for coverage under this part.

"(d) PUBLIC EDUCATION.—In the 12 months preceding the initial enrollment period, the Secretary shall, either directly or through grants and contracts, conduct a public service and education campaign designed to inform potentially eligible individuals as to the nature of the benefits and the limited enrollment period. In conducting such campaigns the Secretary shall make information available to individuals through the open enrollment process for obtaining health care benefits under this Act.

"SEC. 2744. PREMIUM RATES.

"(a) IN GENERAL.—The Secretary shall determine one premium rate for individuals electing to purchase cov-

erage under this part at age 35 (or between the ages of 35 and 44 during the initial enrollment period), a separate rate for those individuals who elect coverage at age 45 (or between the ages of 45 and 54 during the initial enrollment period), a separate rate for those individuals who elect such coverage at age 55 (or between that ages of 55 and 64 during the initial enrollment period), and a separate rate for those individuals who elect such coverage at age 65 (or at age 65 and over during the initial enrollment period). During the initial enrollment period, the Secretary shall establish actuarily fair, age-rated premiums for persons age 65 and over.

''(b) REVISION.—The Secretary shall revise premium rates annually to increase such rates to reflect the amount of the increase in the cost of living adjustment with respect to benefits under title II of the Social Security Act.

''(c) RATES.—In developing premium rates under the program established under this part, the Secretary shall establish rates that are expected to cover 100 percent of the reimbursement amount provided under this part for nursing home stays for those individuals enrolled in the program.

''(d) WAIVER.—An individual electing to purchase coverage under this part shall not be required to pay pre-

miums during any period in which such individual is receiving benefits under this part.

''(e) PAYMENT.—Premiums shall be paid under this section into the general fund of the Treasury of the United States.

"SEC. 2745. QUALIFIED SERVICE PROVIDERS.

''(a) IN GENERAL.—To be considered as a covered nursing home service under this part, such service must have been provided by a qualified service provider.

''(b) TYPES.—A provider shall be considered a qualified service provider under this part if the provider is a nursing facility that is certified by the State and meets the requirements of this part and any other standards established by the Secretary by regulation for the safe and efficient provision of services covered under this part.

"SEC. 2746. REIMBURSEMENT.

''(a) AMOUNT.—Monthly reimbursement for nursing facility services under this part shall equal 65 percent (or during the initial 6 months of coverage, 80 percent) of the amount the Secretary determines to be reasonable and appropriate to cover the cost of care provided under this part.

''(b) PROSPECTIVE PAYMENT.—To the extent feasible, the Secretary shall establish a prospective payment mechanism for payment for nursing home services under

this part that takes into account the expected resource utilization of individual patients based on their degree of disability, the methodology recommended for reimbursement of skilled nursing facilities under title XVIII of the Social Security Act, and other factors determining service requirements.

''(c) ROOM AND BOARD PAYMENT.—An individual receiving benefits under this program shall be responsible for the payment of an amount for room and board that is equal to—

''(1) with respect to the initial 6 months of residence in a nursing facility, 20 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this part; and

''(2) with respect to subsequent periods of residence, 35 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this part. Payments under subsection (a) and (c) shall be considered payment in full for services received under this section.

''(d) PRIORITY PAYERS.—Notwithstanding any other provision of this part, reimbursement for nursing facility services provided under this part to an individual shall, to the extent available, be made under the Medicare program, under Department of Veterans Affairs' programs,

or under private insurance policies prior to reimbursement under this part.

"SEC. 2747. LONG-TERM CARE SCREENING AGENCY.

''(a) ESTABLISHMENT.—The Secretary shall contract with entities to act as Long-Term Care Screening Agencies (hereafter referred to in this part as the 'Screening Agency') for each designated area of a State. It shall be the responsibility of such agency to assess the eligibility of individuals residing in the geographic jurisdiction of the Agency, for services provided under this part according to the requirements of this part and regulations prescribed by the Secretary. In entering into such contracts, the Secretary shall give preference to State governmental entities and private nonprofit agencies.

''(b) ELIGIBILITY.—The Screening Agency shall determine the eligibility of an individual under this part based on the results of a preliminary telephone interview or written questionnaire (completed by the applicant, by the caregiver of the applicant, or by the legal guardian or representative of the applicant) that shall be validated through the use of a screening tool administered in person to each applicant determined eligible through initial telephone or written questionnaire interviews not later than 15 days from the date on which such individual initially applied for services under this part.

"(c) QUESTIONNAIRES AND SCREENING TOOLS.—

"(1) IN GENERAL.—The Secretary shall establish a telephone or written questionnaire and a screening tool to be used by the Screening Agency to determine the eligibility of an individual for services under this part consistent with requirements of this part and the standards established by the Secretary by regulation.

"(2) QUESTIONNAIRES.—The questionnaire shall include questions about the functional impairment and mental status of an individual and other criteria that the Secretary shall prescribe by regulation.

"(3) SCREENING TOOLS.—The screening tool should measure functional impairment caused by physical or cognitive conditions as well as information concerning cognition disability, behavioral problems (such as wandering or abusive and aggressive behavior), and any other criteria that the Secretary shall prescribe by regulation. The screening tool shall be administered in person.

"(d) NOTIFICATION.—Not later than 15 days after the date on which an individual initially applied for services under this part (by telephone or written questionnaire), the Screening Agency shall notify such individual

that such individual is not eligible for benefits, or that such individuals must schedule an in-person screening to determine final eligibility for benefits under this part. The Screening Agency shall notify such individual of its final decision not later than 2 working days after the in-person screening.

''(e) IN-PERSON SCREENING.—An individual (or the legal guardian or representative of such individual) whose application for benefits under this part is denied on the basis of information provided through a telephone or written questionnaire, shall be notified of such individual's right to an in-person screening by a nurse or appropriate health care professionals.

''(f) APPEALS.—The Secretary shall establish a mechanism for hearings and appeals in cases in which individuals contest the eligibility findings of the Screening Agency.

''(g) PAYMENT.—

''(1) PAYMENT FOR SCREENING.—The Screening Agency may require payment from individuals only in accordance with standards established by the Secretary.

''(2) NO PAYMENT FOR POOREST.—The Screening Agency may not require payment for individuals

with incomes of less than 150 percent of the official poverty line.

"SEC. 2748. ASSET PROTECTION.

''Notwithstanding any other provision of law, the assets an eligible individual may retain and be determined eligible for nursing facility benefits, including payments of room and board under this part, under State Medicaid programs (in accordance with section 1902(a)(10)) shall be increased by the amount of coverage ($30,000, $60,000, or $90,000) elected under section 2742.

"SEC. 2749. RELATION TO PRIVATE INSURANCE.

''(a) IN GENERAL.—Except as provided in subsection (b), an insurer may not offer a long-term care insurance policy to an individual who has purchased coverage under this part if the coverage under such policy duplicates the coverage provided under this part.

''(b) DEVELOPMENT OF STANDARD PACKAGES.—The Secretary shall develop standard long-term care insurance benefits packages that insurers may offer to insured individuals under this part. Such packages shall provide coverage for benefits that compliment, but do not duplicate, those covered under this part.

"SEC. 2750. DEFINITIONS.

''As used in this part:

''(1) NURSING FACILITY.—The term 'nursing facility' means—

''(A) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act); or

''(B) a facility that is a nursing facility (as defined in section 1919(a) of such Act) which meets the requirements of section 1819(b)(4)(C) of such Act (relating to nursing care).

''(2) SPELL OF ILLNESS.—The term 'spell of illness' means a period of consecutive days beginning with the first day on which an individual is furnished services as an inpatient in a hospital or nursing facility and ending with the close of the first 6 consecutive months thereafter during which the individual is no longer an inpatient of a nursing facility, or 90 days after the individual is no longer an inpatient in a hospital.

"SEC. 2751. REPORTS.

''(a) IN GENERAL.—Prior to the promulgation of regulations implementing this title, the Secretary shall report to Congress on—

''(1) the actuarially-sound premium rates to be used in the implementation of this Act, including

whether the premiums will cover 100 percent of the benefits paid out, and whether Federal funds will be required to support the payment of benefits;

''(2) an assessment of the impact of such premium rates on the affordability of coverage under this Act;

''(3) a projected enrollment of individuals by age category; and

''(4) an estimate of current and projected enrollment of individuals, by age category in coverage under private long-term care insurance.

''(b) LIFE CARE REPORT.—Not later than 2 years after the promulgation of regulations implementing this title, the Secretary shall report to Congress on the following aspects of the Life Care Act:

''(1) The current and projected premium rates.

''(2) The current and projected enrollment of individuals, by age category and an estimate of current and projected enrollment of individuals by age category in private long-term care insurance.

''(3) The projected use of benefits and the impact of use on premium rates.

''(4) An assessment of the impact of projected premium rates on the affordability of coverage under this Act.

"(c) RECOMMENDATIONS.—The Secretary shall make recommendations to Congress regarding necessary revisions to the Life Care Act as a result of the findings provided in the reports submitted under this section.".

SEC. 2303. SENSE OF THE COMMITTEE CONCERNING PACE (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY).

(a) FINDINGS.—The Committee on Labor and Human Resources of the Senate finds that—

(1) a serious shortcoming in the Nation's current health care delivery system is its ability to integrate acute and long-term care services;

(2) the pioneering efforts of the On Lok program in San Francisco, which has been replicated as PACE (Program of All-inclusive Care for the Elderly), provides a comprehensive range of acute and long-term care services to frail, nursing home eligible individuals, allowing them to avoid unwanted institutionalization;

(3) two of the current PACE sites are located in East Boston, Massachusetts and Columbia, South Carolina;

(4) these programs have done a remarkable job in keeping elderly, low-income, severely disabled indi-

viduals in their homes and have proven to be both popular and cost-effective;

(5) payments to PACE providers are capitated and, therefore, require waivers of Medicare and Medicaid rules; and

(6) at the present time, only 15 PACE sites are authorized.

(b) SENSE OF THE COMMITTEE.—It is the sense of the Committee on Labor and Human Resources of the Senate that—

(1) the number of PACE sites should be expanded substantially; and

(2) the Committee on Finance of the Senate, which has jurisdiction over Medicare and Medicaid, should take action on this critical issue to allow a greater number of individuals with disabilities to take advantage of a successful model for integrated service delivery.

TITLE III—PUBLIC HEALTH INITIATIVES

Subtitle A—Workforce Priorities Under Federal Payments

PART 1—INSTITUTIONAL COSTS OF GRADUATE MEDICAL EDUCATION; WORKFORCE PRIORITIES

SUBPART A—NATIONAL COUNCIL REGARDING WORKFORCE PRIORITIES

Sec. 3001. National council on graduate medical education.

SUBPART B—AUTHORIZED POSITIONS IN SPECIALTY TRAINING

Sec. 3011. Cooperation regarding approved physician training programs.

Sec. 3012. Annual authorization of number of specialty positions; requirements regarding primary health care.
Sec. 3013. Allocations among specialities and programs.

SUBPART C—COSTS OF GRADUATE MEDICAL EDUCATION

CHAPTER 1—OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

Sec. 3031. Federal formula payments to qualified entities for the costs of the operation of approved physician training programs.
Sec. 3032. Application for payments.
Sec. 3033. Availability of funds for payments; annual amount of payments.

CHAPTER 2—MEDICAL SCHOOL FUND ACCOUNT

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Sec. 3052. Request for payments.
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Sec. 3061. Transitional payments to institutions.

PART 2—INSTITUTIONAL COSTS OF GRADUATE NURSING EDUCATION; WORKFORCE PRIORITIES

Sec. 3071. Authorized graduate nurse training positions; institutional costs.
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PART 3—RELATED PROGRAMS

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Sec. 3312. Grants to States for core functions of public health.
Sec. 3313. Submission of information.
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Subtitle A—Workforce Priorities Under Federal Payments

PART 1—INSTITUTIONAL COSTS OF GRADUATE MEDICAL EDUCATION; WORKFORCE PRIORITIES

Subpart A—National Council Regarding Workforce Priorities

SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—There is established within the Department of Health and Human Services a council to be known as the National Council on Graduate Medical Education.

(b) DUTIES.—The Secretary shall carry out subpart B acting through the National Council.

(c) COMPOSITION.—

(1) IN GENERAL.—The membership of the National Council shall include between 12 and 18 individuals who are appointed to the Council from among individuals who are not officers or employees of the United States. Such individuals shall be appointed by the Secretary, and shall include individuals from each of the following categories:

(A) Consumers of health care services, at least one of whom resides in a rural area.

(B) Physicians who are faculty members of medical schools.

(C) Physicians in private practice who are not physicians described in subparagraph (B).

(D) Officers or employees of regional and corporate health alliances.

(E) Officers or employees of health care plans that participate in such alliances.

(F) Executives of teaching hospitals.

(G) Nurses.

(H) Primary care physicians, at least one of whom practices in a rural area.

(I) Such other individuals as the Secretary determines to be appropriate.

(2) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the National Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary or other Federal officers who are appointed by the President with the advice and consent of the Senate.

(d) CHAIR.—The Secretary shall, from among members of the National Council appointed under subsection

(c)(1), designate an individual to serve as the Chair of the Council.

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

(1) The term ''academic health center'' means an entity defined in section 3051(c)(1).

(2) The term ''medical school'' means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as defined in such section).

(3) The term ''National Council'' means the council established in subsection (a).

Subpart B—Authorized Positions in Specialty Training

SEC. 3011. COOPERATION REGARDING APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—With respect to an approved physician training program in a medical specialty, a funding agreement with a qualified applicant for payments under section 3031 for a calendar year is that the qualified applicant will ensure that the number of individuals enrolled in the program in the subsequent academic year is in accordance with this subpart.

(b) DEFINITIONS.—

(1) APPROVED PROGRAM.—For purposes of this subtitle:

(A) The term ''approved physician training program'', with respect to the medical speciality involved, means a residency or other post-graduate program that trains physicians and meets the following conditions:

(i) Participation in the program may be counted toward certification in the medical specialty.

(ii) The program is accredited by the Accreditation Council on Graduate Medical Education, or approved by the Council on Postgraduate Training of the American Osteopathic Association.

(B) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A) that provides health services in an ambulatory setting, without regard to whether the program provides inpatient hospital services.

(C) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A), whether operated by academic health centers, teaching hospitals, multispecialty group practices, ambula-

tory care providers, prepaid health plans, or other entities.

(D) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A) that provides fellowship training in family medicine, general internal medicine or general pediatrics, and provides training for a faculty position in family medicine, general medicine or general pediatrics.

(2) QUALIFIED APPLICANT; SUBPART DEFINITION.—For purposes of this subpart, the term ''qualified applicant'', with respect to an academic year, means an entity that trains individuals in an approved physician program that receives payments under subpart C for the calendar year in which the academic year begins.

(3) OTHER DEFINITIONS.—For purposes of this subtitle:

(A)(i) The term ''academic year'' means the 1-year period beginning on July 1. The academic year beginning July 1, 1993, is academic year 1993–94.

(ii) With respect to the funding agreement described in subsection (a), the term ''subse-

quent academic year'' means the academic year beginning July 1 of the calendar year for which payments are to be made under the agreement.

(B) The term ''funding agreement'', with respect to payments under section 3031 to a qualified applicant, means that the Secretary may make the payments only if the qualified applicant makes the agreement involved.

(C) The term ''medical specialty'' includes all medical, surgical, and other physician specialties and subspecialties.

SEC. 3012. ANNUAL AUTHORIZATION OF NUMBER OF SPECIALTY POSITIONS; REQUIREMENTS REGARDING PRIMARY HEALTH CARE.

(a) ANNUAL AUTHORIZATION OF NUMBER OF POSITIONS.—In the case of each medical specialty, the National Council shall, pursuant to section 3011, designate for each academic year the number of individuals nationwide who are authorized to be enrolled in eligible programs. The preceding sentence is subject to subsection (c)(2).

(b) PRIMARY HEALTH CARE.—

(1) IN GENERAL.—Subject to paragraph (2), in carrying out subsection (a) for an academic year, the National Council shall ensure that, of the class of

training participants entering eligible programs for academic year 2000–2001 or any subsequent academic year, the percentage of such class that completes eligible programs in primary health care is not less than 55 percent (without regard to the academic year in which the members of the class complete the programs).

(2) RULE OF CONSTRUCTION.—The requirement of paragraph (1) regarding a percentage applies in the aggregate to training participants entering eligible programs for the academic year involved, and not individually to any eligible program.

(c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

(1) DESIGNATION PERIODS.—For each medical specialty, the National Council shall make the annual designations under subsection (a) for periods of 3 academic years.

(2) INITIAL PERIOD.—The first designation period established by the National Council after the date of the enactment of this Act shall be the academic years 2000–2001 through 2002–03.

(d) CERTAIN CONSIDERATIONS IN DESIGNATING ANNUAL NUMBERS.—

(1) IN GENERAL.—Factors considered by the National Council in designating the annual number

of specialty positions for an academic year for a medical specialty shall include the extent to which there is a need for additional practitioners in the speciality, as indicated by the following:

(A) The characteristics of diseases, disorders, or health conditions treated, including—

(i) the incidence and prevalence (in the general population and in various other populations) of the diseases, disorders, or other health conditions with which the specialty is concerned;

(ii) the intensity of care required for each of these diseases, disorders, or health conditions;

(iii) the relevant training received and experience attained by primary care and specialist physicians in caring for each of these diseases, disorders, or health conditions; and

(iv) when sufficient data becomes available, the extent to which individuals with certain diseases, disorders, or health conditions have better health outcomes when treated by health specialists than by primary care physicians.

(B) The number of physicians who will be practicing in the specialty in the academic year.

(C) The number of physicians who will be practicing in the specialty at the end of the 5-year period beginning on the first day of the academic year.

(2) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In designating the annual number of specialty positions for an academic year for a medical specialty, the National Council shall consider the recommendations of organizations representing physicians in the specialty, organizations representing academic medicine, and the recommendations of organizations representing consumers of the services of such physicians.

(3) TOTAL OF RESPECTIVE ANNUAL NUMBERS.—

(A) For academic year 2000–2001 and subsequent academic years, the National Council shall ensure that the total of the respective annual numbers designated under subsection (a) for an academic year is a total that—

(i) bears a relationship to the number of individuals who graduated from medical

schools in the United States in the preceding academic year; and

(ii) is consistent with the purposes of this subpart.

(B) For each of the academic years 2000–2001 through 2004–05, the total determined under subparagraph (A) shall be reduced by a percentage determined by the National Council.

(e) INTERIM VOLUNTARY TARGETS.—

(1) ESTABLISHMENT.—Not later than July 1, 1996, the National Council shall establish targets with respect to the aggregate number of individuals enrolled in approved physician training programs for each specialty to be achieved by the year 2000.

(2) VOLUNTARY COMPLIANCE.—Specialties that meet and continue to be in compliance with the aggregate targets established under paragraph (1), as determined by the National Council, shall not be subject to the mandatory allocation system described in section 3013.

(3) MEASURE OF COMPLIANCE.—To be considered in compliance with the targets under paragraph (2), a specialty shall demonstrate, not later than July 1, 1998, that the number of individuals enrolled in approved physician training programs of

the specialty is not less than the number of individuals enrolled in such programs as of July 1, 1994, increased or decreased, as the case may be, by 45 percent of the difference between such enrollment and the target enrollment established under paragraph (1) and, not later than January 1, 2000, have increased or decreased by 90 percent of such difference, and, by January 1, 2001, are deemed by the National Council to be in compliance with the target.

(4) LOSS OF COMPLIANCE.—The National Council may, at any time, determine that a specialty is not in compliance with the targets established under paragraph (1) and initiate, with respect to that specialty, the system of mandatory allocations described under section 3013.

(f) STUDY.—Not later than January 1, 2005, the Secretary shall arrange for the completion, by the Institute of Medicine or other similar entity, of an independent study concerning the effect of medical workforce regulation and planning. The results of such study together with recommendations concerning the appropriateness of modifying or eliminating workforce regulations shall be compiled in a report and transmitted by the Secretary to the President and the Congress.

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

(1) The term ''annual number of specialty positions'', with respect to a medical specialty, means the number designated by the National Council under subsection (a) for eligible programs for the academic year involved.

(2) The term ''designation period'' means a 3-year period under subsection (c)(1) for which designations under subsection (a) are made by the National Council.

(3) The term ''primary health care'' means the following medical specialties: Family medicine, general internal medicine, general pediatrics, geriatric medicine, obstetrics and gynecology, and medical specialties (including psychiatry), if any, that have been designated to be medical shortage specialties or protected medical specialties by the Council on Graduate Medical Education, or other similar physician advisory body authorized by Congress to provide an ongoing assessment of physician workforce trends, and identify needs and be advisory to the Secretary, the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of

Representatives. Only those participants in programs with a significant primary care training emphasis will be considered to have completed an eligible program in primary care for the purposes of subsection (b)(1). Determination of meeting the definition of a ''significant primary care training emphasis'' will be made by the National Board.

(4) The term ''specialty position'' means a position as a training participant.

(5) The term ''training participant'' means an individual who is enrolled in an approved physician training program.

SEC. 3013. ALLOCATIONS AMONG SPECIALITIES AND PROGRAMS.

(a) IN GENERAL.—For each academic year, the National Council shall for each medical specialty make allocations among eligible programs of the annual number of specialty positions that the Council has designated for such year. The preceding sentence is subject to subsection (b)(3).

(b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

(1) IN GENERAL.—For each medical specialty, the National Council shall make the annual allocations under subsection (a) for periods of 3 academic years.

(2) ADVANCE NOTICE TO PROGRAMS.—With respect to the first academic year of an allocation period established by the National Council, the National Council shall, not later than July 1 of the preceding academic year, notify each eligible program of the allocations made for the program for each of the academic years of the period.

(3) INITIAL PERIOD.—The first allocation period established by the National Council after the date of the enactment of this Act shall be the academic years 2000–2001 through 2002–03.

(c) CERTAIN CONSIDERATIONS.—

(1) GEOGRAPHIC AREAS; QUALITY OF PROGRAMS.—In making allocations under subsection (a) for eligible programs of the various geographic areas, the National Council shall include among the factors considered the historical distribution among the areas of approved physician training programs, and the quality of such programs.

(2) UNDERREPRESENTATION OF MINORITY GROUPS AND WOMEN.—In making an allocation under subsection (a) for an eligible program, the National Council shall include among the factors considered the following:

(A) The extent to which the population of training participants in the program includes training participants who are members of racial or ethnic minority groups and women.

(B) With respect to a racial or ethnic group or women represented among the training participants, the extent to which the group is underrepresented in the field of medicine generally and in the various medical specialities.

(3) UNDERSERVED RURAL AND INNER-CITY COMMUNITIES.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the extent to which the population of training participants in the program includes training participants who have resided in rural or inner-city communities and the proportion of past participants in the program who are practicing in rural or inner-city communities.

(4) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the recommendations of organizations representing physicians in the medical specialties, the recommendations of organizations representing academic medicine and the recommendations of organi-

zations representing consumers of the services of such physicians.

(d) DEFINITIONS.—For purposes of this subtitle, the term ''allocation period'' means a 3-year period under subsection (b)(1) for which allocations under subsection (a) are made by the National Council.

CHAPTER 1—OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

SEC. 3031. FEDERAL FORMULA PAYMENTS TO QUALIFIED ENTITIES FOR THE COSTS OF THE OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—In the case of a qualified entity that in accordance with section 3032 submits to the Secretary an application for calendar year 1996 or any subsequent calendar year, the Secretary shall make payments for such year to the qualified entity for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3033, and may administer the payments as a contract, grant, or cooperative agreement.

(b) PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.—The purpose of payments under subsection (a) is to assist a qualified applicant with the costs of operation of an approved physician training

program. A funding agreement for such payments is that the qualified applicant involved will expend the payments only for such purpose.

(c) QUALIFIED APPLICANT; SUBPART DEFINITION.—

(1) IN GENERAL.—For purposes of this subpart, the term ''qualified applicant'', with respect to the calendar year involved, means an entity—

(A) that trains individuals in approved physician training programs;

(B) that submits to the Secretary an application for such year in accordance with section 3032; and

(C) if the entity has an approved physician training program in primary health care, that rotates individuals enrolled in the program to health centers or other community programs in underserved urban or rural areas.

(2) ENTITIES INCLUDED.—The term ''qualified applicant'' may include a teaching hospital, medical school, group practice, an entity representing two or more parties engaged in a formal association, a community health center or another entity operating an approved physician training program.

(d) TREATMENT OF PODIATRIC AND DENTAL RESIDENCY PROGRAMS.—For the purposes of chapters 1 and

3 of subpart C, an approved physician training program includes training programs approved by the Commission on Dental Accreditation or the Council of Podiatric Medical Education of the American Podiatric Medical Association. This subsection shall not apply for purposes of subpart B.

SEC. 3032. APPLICATION FOR PAYMENTS.

(a) IN GENERAL.—

(1) IN GENERAL.—For purposes of section 3031(a), an application for payments under such section for a calendar year is in accordance with this section if—

(A) the eligible entity involved submits the application not later than the date specified by the Secretary;

(B) the application demonstrates that the condition described in subsection (b) is met with respect to the program;

(C) the application contains each funding agreement described in this part and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(D) the application is in such form, is made in such manner, and contains such agree-

ments, assurances, and information as the Secretary determines to be necessary to carry out this part.

(2) CERTAIN ENTITIES.—If an applicant under paragraph (1) is an entity representing two or more parties—

(A) the application shall contain a written agreement, signed by all participants, in which all of the participants agree as to the manner in which the payments will be allocated; and

(B) the applicant shall agree to submit additional documentation, if requested by the National Council, that demonstrates that the funds are distributed in the manner agreed upon by all participants.

(b) CERTAIN CONDITIONS.—An eligible entity meets the condition described in this subsection for receiving payments under section 3031 for a calendar year if—

(1) the entity agrees to use such funds only to support an approved physician training program;

(2) with respect to—

(A) a specialty for which programs have received allocations under section 3013, the entity agrees that funds will only be used to support approved training programs for which the

number of specialists in training is consistent with the allotment under section 3013; and

(B) a specialty for which a voluntary program has received allocations under section 3012(e), the entity agrees that funds will only be used to support approved training programs for which the number of specialists in training is consistent with the targets under section 3012(e); and

(3) the application of the entity contains a written agreement, signed by all participants, in which all participants agree to the manner in which the payments will be allocated; and

(4) the entity agrees to submit additional documentation, if requested by the National Council, that demonstrates that the funds will be distributed in a manner agreed upon by all participants.

SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) ANNUAL HEALTH PROFESSIONS WORKFORCE ACCOUNT.—Subject to paragraph (2), the amount available for a calendar year for making payments under sections 3031 and 3061 (constituting an account to be known as the annual health professions workforce account) is the following, as applicable to the calendar year:

(1) In the case of calendar year 1996, $3,200,000,000.

(2) In the case of calendar year 1997, $3,550,000,000.

(3) In the case of calendar year 1998, $4,800,000,000.

(4) In the case of each of the calendar years 1999 and 2000, $5,800,000,000.

(5) In the case of each subsequent calendar year, the amount specified in paragraph (4) increased by the product of such amount and the general health care inflation factor for such year (as defined in subsection (d)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE ENTITIES.—

(1) IN GENERAL.—Payment amounts with respect to any physician training program under this section shall be equal to the product of the number of full time equivalent training participants in the program, and the per resident amount for the training program.

(2) PER RESIDENT AMOUNT.—The per resident amount for a training program shall be equal to—

(A) with respect to—

(i) the first calendar years during which the program is in operation, 90 percent;

(ii) the second calendar years during which the program is in operation, 80 percent;

(iii) the third calendar years during which the program is in operation, 70 percent;

(iv) the fourth calendar years during which the program is in operation, 60 percent; and

(v) the fifth and subsequent calendar years during which the program is in operation, 50 percent;

of the all payer hospital per resident cost; and

(B) with respect to—

(i) the first calendar years during which the program is in operation, 10 percent;

(ii) the second calendar years during which the program is in operation, 20 percent;

(iii) the third calendar years during which the program is in operation, 30 percent;

(iv) the fourth calendar years during which the program is in operation, 40 percent; and

(v) the fifth and subsequent calendar years during which the program is in operation, 50 percent;

of the geographically adjusted national average per resident amount.

(3) ADJUSTMENT FACTOR.—Payments under this section shall be subject to an adjustment factor, as determined by the Secretary, so that total payments in any year will not exceed the amounts specified in section 3033(a) and as provided in section 3033(c).

(4) ADDITIONAL PROVISIONS REGARDING NATIONAL AVERAGE COST.—

(A) The Secretary shall in accordance with paragraph (1)(B) determine, for academic year 1992–93, an amount equal to the national average described in such paragraph with respect to training a participant in an approved physician training program in the medical specialty in-

volved. The national average applicable under such paragraph for a calendar year for such programs is, subject to subparagraph (B), the amount determined under the preceding sentence increased by the amount necessary to offset the effects of inflation occurring since academic year 1992–93, as determined through use of the consumer price index.

(B) The national average determined under subparagraph (A) and applicable to a calendar year shall, in the case of the eligible entity involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

(5) FUNDING LEVEL AND ALLOCATION METHOD.—Not later than January 1, 1998, the Secretary shall complete a study to determine the effect of the funding level and allocation method described in subsection (a) and paragraphs (1) and (2) of this subsection on the operation of training programs and shall compile the findings and recommendations derived from such study in a report to be submitted to the President and the Congress.

(c) LIMITATION.—If, subject to subsection (a)(2), the annual health professions workforce account available for

a calendar year is insufficient for providing each eligible entity with the amount of payments determined under subsection (b) for the entity for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under section 3031 for such year equals the total of such account.

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

(1) The term ''annual health professions workforce account'' means the account established pursuant to subsection (a)(1).

(2) The term ''consumer price index'' has the meaning given such term in section 1902(11).

(3) The term ''general health care inflation factor'', with respect to a year, has the meaning given such term in section 6001(a)(3) for such year.

CHAPTER 2—MEDICAL SCHOOL FUND ACCOUNT

SEC. 3041. FEDERAL PAYMENTS TO THE MEDICAL SCHOOL FUND.

(a) IN GENERAL.—In the case of an eligible medical school that in accordance with section 3042 submits to the Secretary an application for academic year 1996, or any subsequent academic year, the Secretary shall make payments for such year to the school for the purpose speci-

fied in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3043, and shall administer the payments as a grant.

(b) PAYMENTS FOR THE MEDICAL SCHOOL FUND.—The purpose specified in this subsection is to assist an eligible medical school with the direct costs of academic programs, including the education of medical students (especially in ambulatory and preventive medicine), graduate students in biomedical sciences, and otherwise unfunded faculty research. A funding agreement for such payments is that the medical school involved will expend the payments only for direct expenses determined as allowable by the Secretary.

(c) ELIGIBLE MEDICAL SCHOOL; SUBPART DEFINITION.—For purposes of this subpart, the term ''eligible medical school'' with respect to the academic year involved, means an approved medical school that submits to the Secretary an application for such year in accordance with section 3043.

SEC. 3042. APPLICATION FOR PAYMENTS.

For purposes of section 3041(a), an application for payments under such section for an academic year is in accordance with this section if—

(1) the dean (or appropriate presiding official) of the eligible medical school submits the application not later than the date specified by the Secretary;

(2) the application contains each funding agreement described in this subpart and provides such assurances of compliance with the agreements as the Secretary may require; and

(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

SEC. 3043. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) ANNUAL MEDICAL SCHOOL FUND ACCOUNT.—Subject to section 3043, the amount available for an academic year for making payments under section 3041 (constituting an account to be known as the annual medical school fund account) shall be the following, as applicable to the academic year:

(1) In the case of academic year 1996, $200,000,000.

(2) In the case of academic year 1997, $300,000,000.

(3) In the case of academic year 1998, $400,000,000.

(4) In the case of academic year 1999, $500,000,000.

(5) In the case of academic year 2000, $600,000,000.

(6) In the case of each subsequent calendar year, the amount specified in paragraph (5) increased by the product of such amount and the general health care inflation factor (as defined in subsection (d)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE PROGRAMS.—Subject to the annual medical school fund account available for an academic year, the amount of payment required under section 3041 to be made to an eligible medical school for the academic year is an amount equal to the sum of—

(1) the product of ¾ of the fund account available and the proportion of full-time equivalent students at the eligible medical school in academic year 1993–1994 compared to all full-time equivalent students enrolled in eligible medical schools nationwide in academic year 1993–1994; and

(2) the product of ¼ of the fund account available and the proportion of research conducted by the faculty at the eligible medical school compared to all

research conducted by the faculty at all eligible medical schools nationwide.

The Secretary shall establish a method for measuring faculty research contributions.

(c) STUDIES.—

(1) FUNDING LEVEL AND ALLOCATION METHOD.—Not later than January 1, 1998, the Secretary shall arrange for an independent study and report to be completed, by the Institute of Medicine or other similar entity, concerning the amount of and allocation method for medical school funding. Such report shall be submitted to the President and the Congress and shall include findings and recommendation as to the appropriateness of modifying funding levels or allocation.

(2) Not later than January 1, 2000, the Secretary shall arrange for an independent study and report to be completed, by the Institute of Medicine or other similar entity, concerning the impact of health reform on undergraduate and graduate medical education. Such report shall be submitted to the President and the Congress and shall include appropriate findings and recommendations.

(d) DEFINITIONS.—As used in this subtitle:

(1) The term ''annual medical school fund account'' means the account established under subsection (a).

(2) The term ''general health care inflation factor'' with respect to a year, has the meaning given such term in section 6001(a)(3) for such year.

CHAPTER 3—ACADEMIC HEALTH CENTERS

SEC. 3051. FEDERAL FORMULA PAYMENTS TO ACADEMIC HEALTH CENTERS.

(a) IN GENERAL.—In the case of a qualified academic health center or qualified teaching hospital that in accordance with section 3052 submits to the Secretary a written request for calendar year 1996 or any subsequent calendar year, the Secretary shall make payments for such year to the center or hospital for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3053, and may administer the payments as a contract, grant, or cooperative agreement.

(b) PAYMENTS FOR COSTS ATTRIBUTABLE TO ACADEMIC NATURE OF INSTITUTIONS.—The purpose of payments under subsection (a) is to assist eligible institutions with costs that are not routinely incurred by other entities in providing health services, but are incurred by such insti-

tutions in providing health services by virtue of the academic nature of such institutions. Such costs include—

(1) with respect to productivity in the provision of health services, costs resulting from the reduced rate of productivity of faculty due to teaching responsibilities;

(2) the uncompensated costs of clinical research; and

(3) exceptional costs associated with the treatment of health conditions with respect to which an eligible institution has specialized expertise (including treatment of rare diseases, treatment of unusually severe conditions, and providing other specialized health care).

(c) DEFINITIONS.—

(1) ACADEMIC HEALTH CENTER.—For purposes of this subtitle, the term ''academic health center'' means an entity that operates a teaching hospital that carries out an approved physician training program.

(2) TEACHING HOSPITAL.—For purposes of this subtitle, the term ''teaching hospital'' means a hospital that operates an approved physician training program (as defined in section 3011(b) or section 3031(d)).

(3) QUALIFIED CENTER OR HOSPITAL.—For purposes of this subtitle:

(A) The term ''qualified academic health center'' means an academic health center that operates a teaching hospital.

(B) The term ''qualified teaching hospital'' means any teaching hospital other than a teaching hospital that is operated by an academic health center.

(4) ELIGIBLE INSTITUTION.—For purposes of this subtitle, the term ''eligible institution'', with respect to a calendar year, means a qualified academic health center, or a qualified teaching hospital, that submits to the Secretary a written request in accordance with section 3052.

SEC. 3052. REQUEST FOR PAYMENTS.

(a) IN GENERAL.—For purposes of section 3051, a written request for payments under such section is in accordance with this section if the qualified academic health center or qualified teaching hospital involved submits the request not later than the date specified by the Secretary; the request is accompanied by each funding agreement described in this part; and the request is in such form, is made in such manner, and contains such agreements, as-

surances, and information as the Secretary determines to be necessary to carry out this part.

(b) CONTINUED STATUS AS ACADEMIC HEALTH CENTER.—A funding agreement for payments under section 3051 is that the qualified academic health center or qualified teaching hospital involved will maintain status as such a center or hospital, respectively. For purposes of this subtitle, the term ''funding agreement'', with respect to payments under section 3051 to such a center or hospital, means that the Secretary may make the payments only if the center or hospital makes the agreement involved.

SEC. 3053. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) ANNUAL ACADEMIC HEALTH CENTER ACCOUNT.—The amount available for a calendar year for making payments under section 3051 (constituting an account to be known as the annual academic health center account) is the following, as applicable to the calendar year:

(1) In the case of calendar year 1996, $6,280,000,000.

(2) In the case of calendar year 1997, $7,250,000,000.

(3) In the case of calendar year 1998, $8,220,000,000.

(4) In the case of calendar year 1999, $9,400,000,000.

(5) In the case of calendar year 2000, $10,640,000,000.

(6) In the case of each subsequent calendar year, the amount specified in paragraph (5) increased by the product of such amount and the general health care inflation factor (as defined in subsection (d)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE INSTITUTIONS.—

(1) FORMULA.—The amount of payments required in section 3051 to be made to an eligible institution for a calendar year is an amount equal to the product of—

(A) the annual academic health center account available for the calendar year; and

(B) the percentage constituted by the ratio of—

(i) the product of—

(I) the sum, for all discharges of individuals, of the amounts otherwise

paid on behalf of such individuals; and

(II) an adjustment factor equal to 1.200 multiplied by (((1 + r) to the nth power) - 1), where ''r'' equals the ratio of the hospital's full-time equivalent interns and residents to beds and ''n'' equals .405; and

(ii) the sum of the respective amounts determined under clause (i) for eligible institutions.

(2) ADJUSTMENT FACTOR.—Payments under this section shall be subject to an adjustment factor, as determined by the Secretary, so that total payments in any year will not exceed the amounts specified in section 3033(a) and as provided in section 3033(c).

(c) REPORT REGARDING MODIFICATIONS IN FORMULA.—Not later than July 1, 2000, the Secretary shall submit to the Congress a report containing any recommendations of the Secretary for the modification of the program of formula payments described in this chapter. In preparing such report the Secretary shall consider—

(1) the costs described in subsection (b) incurred by academic health centers;

(2) the adequacy of the formula payments established in this chapter to cover such costs, taking into account any additional revenues to cover such costs paid by other payers, including private health plans;

(3) the importance to the maintenance of a quality national health care system of academic health centers in providing for the training of health professionals, in conducting clinical research, and in providing innovative, technically advanced care; and

(4) the overall impact of the reformed health care system on the ability of academic health centers to perform such functions.

(d) DEFINITION.—For purposes of this subtitle:

(1) The term ''annual academic health center account'' means the account established pursuant to subsection (a).

(2) The term ''general health care inflation factor'', with respect to a year, has the meaning given such term in section 6001(a)(3) for such year.

Subpart D—General Provisions

SEC. 3055. DEFINITIONS.

For purposes of this subtitle:

(1) The term ''academic year'' has the meaning given such term in section 3011(b).

(2) The term ''allocation period'' has the meaning given such term in section 3013(d).

(3) The term ''annual health professions workforce account'' has the meaning given such term in section 3033(d).

(4) The term ''annual number of specialty positions'' has the meaning given such term in section 3012(e).

(5) The term ''approved physician training program'' has the meaning given such term in section 3011(b).

(6) The term ''consumer price index'' has the meaning given such term in section 3033(d).

(7) The term ''designation period'' has the meaning given such term in section 3012(e).

(8) The term ''eligible entity'' has the meaning given such term in section 3011(b), in the case of subpart B; and has the meaning given such term in section 3031(c), in the case of subpart C.

(9) The term ''funding agreement'' has the meaning given such term in section 3011(b).

(10) The term ''general health care inflation factor'' has the meaning given such term in section 3033(d).

(11) The term ''medical school'' has the meaning given such term in section 3001(e).

(12) The term ''medical specialty'' has the meaning given such term in section 3011(b).

(13) The term ''National Council'' has the meaning given such term in section 3001(e).

(14) The term ''primary health care'' has the meaning given such term in section 3012(e).

(15) The term ''specialty position'' has the meaning given such term in section 3012(e).

(16) The term ''training participant'' has the meaning given such term in section 3012(e).

Subpart E—Transitional Provisions

SEC. 3061. TRANSITIONAL PAYMENTS TO INSTITUTIONS.

(a) PAYMENTS REGARDING EFFECTS OF SUBPART B ALLOCATIONS.—For each of the four calendar years specified in subsection (b)(2), in the case of an eligible entity that submits to the Secretary an application for such year in accordance with subsection (d), the Secretary shall make payments for the year to the entity for the purpose specified in subsection (c). The Secretary shall make the payments in an amount determined in accordance with subsection (e), and may administer the payments as a contract, grant, or cooperative agreement.

(b) ELIGIBLE ENTITIES LOSING SPECIALTY POSITIONS; RELEVANT YEARS REGARDING PAYMENTS.—

(1) ELIGIBLE ENTITIES LOSING SPECIALTY POSITIONS.—The Secretary may make payments under subsection (a) to an eligible entity only if, with respect to the calendar year involved, the entity meets the following conditions:

(A) The entity operates or operated in the year preceding the initiation of transitional payments one or more programs that—

(i) are or were at the time they terminated approved physician training programs; and

(ii) are or were at the time they terminated receiving payments under section 3031 for such year.

(B) The aggregate number of speciality positions in such programs (in the medical specialities with respect to which such payments are made) is below the aggregate number of such positions at the entity for academic year 1993–94 as a result of allocations under subpart B, or as a result of voluntary changes under section 3012(e) prior to January 1, 2000.

(2) RELEVANT YEARS.—The Secretary may make payments under subsection (a) to an eligible entity only for the first four calendar years after the initial calendar year for which the entity meets the conditions described in paragraph (1).

(3) ELIGIBLE ENTITY.—For purposes of this section, the term ''eligible entity'' means an entity that submits to the Secretary an application in accordance with subsection (d).

(c) PURPOSE OF PAYMENTS.—The purpose of payments under subsection (a) is to assist an eligible entity with the costs of operation. A funding agreement for such payments is that the entity involved will expend the payments only for such purpose.

(d) APPLICATION FOR PAYMENTS.—For purposes of subsection (a), an application for payments under such subsection is in accordance with this subsection if—

(1) the eligible entity involved submits the application not later than the date specified by the Secretary;

(2) the application demonstrates that the entity meets the conditions described in subsection (b)(1) and that the entity has cooperated with the approved physician training programs of the entity in meeting the condition described in section 3032(b);

(3) the application contains each funding agreement described in this subpart and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

(e) AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—Subject to the annual health professions workforce account available for the calendar year involved, the amount of payments required in subsection (a) to be made to an eligible entity for such year is the product of the amount determined under paragraph (2) and the applicable percentage specified in paragraph (3).

(2) NUMBER OF SPECIALTY POSITIONS LOST.—For purposes of paragraph (1), the amount determined under this paragraph for an eligible entity for the calendar year involved is the product of—

(A) an amount equal to the aggregate number of full-time equivalent specialty positions lost; and

(B) the amount that would be received under section 3033 for each speciality position lost.

(3) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage for a calendar year is the following, as applicable to such year:

(A) For the first calendar year after calendar year 1995 for which the eligible entity involved meets the conditions described in subsection (b)(1), 100 percent.

(B) For the second such year, 75 percent.

(C) For the third such year, 50 percent.

(D) For the fourth such year, 25 percent.

(4) DETERMINATION OF SPECIALTY POSITIONS LOST.—

(A) For purposes of this subsection, the aggregate number of specialty positions lost, with respect to a calendar year, is the difference between—

(i) the aggregate number of specialty positions described in subparagraph (B) that are estimated for the eligible entity involved for the academic year beginning in such calendar year; and

(ii) the aggregate number of such specialty positions at the entity for academic year 1993–94.

(B) For purposes of subparagraph (A), the specialty positions described in this subparagraph are specialty positions in the medical specialities with respect to which payments under section 3031 are made to the approved physician training programs of the eligible entities involved.

(5) ADDITIONAL PROVISION REGARDING NATIONAL AVERAGE SALARY.—

(A) The Secretary shall determine, for academic year 1992–93, an amount equal to the national average described in paragraph (2)(B). The national average applicable under such paragraph for a calendar year is, subject to subparagraph (B), the amount determined under the preceding sentence increased by an amount necessary to offset the effects of inflation occurring since academic year 1992–93, as determined through use of the consumer price index.

(B) The national average determined under subparagraph (A) and applicable to a cal-

endar year shall, in the case of the eligible entity involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

PART 2—INSTITUTIONAL COSTS OF GRADUATE NURSING EDUCATION; WORKFORCE PRIORITIES

SEC. 3071. AUTHORIZED GRADUATE NURSE TRAINING POSITIONS; INSTITUTIONAL COSTS.

(a) PROGRAM REGARDING GRADUATE NURSE TRAINING PROGRAMS.—The Secretary shall, in accordance with this part, carry out a program with respect to graduate nurse training programs that is equivalent to the program carried out under part 1 with respect to approved physician training programs.

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

(1) The term ''graduate nurse training programs'' means programs for advanced nurse education, programs for education as nurse practitioners, programs for education as nurse midwives, programs for education as nurse anesthetists, and such other programs for training in clinical nurse specialties as are determined by the Secretary to require advanced education.

(2) The term ''graduate nurse training position'' means a position as an individual who is enrolled in a graduate nurse training program.

(3) The term ''programs for advanced nurse education'' means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 821 of the Public Health Service Act.

(4) The term ''programs for education as nurse practitioners'' means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as a nurse practitioners.

(5) The term ''programs for education as nurse midwives'' means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as nurse midwives.

(6) The term ''programs for education as nurse anesthetists'' means programs meeting the conditions to be programs for which awards of grants may be made under section 831 of the Public Health Service Act for education as nurse anesthetists.

SEC. 3072. APPLICABILITY OF PART 1 PROVISIONS.

(a) IN GENERAL.—The provisions of part 1 apply to the program carried out under section 3071 to the same extent and in the same manner as such provisions apply to the program carried out under part 1, subject to the subsequent provisions of this section. Section 3061 does not apply for purposes of the preceding sentence.

(b) NATIONAL COUNCIL.—With respect to section 3001 as applied to this part, the council shall be known as the National Council on Graduate Nurse Education (in this part referred to as the ''National Council''). The provisions of section 851 of the Public Health Service Act regarding the composition of the council under such section apply to the composition of the National Council to the same extent and in the same manner as such provisions apply to the council under such section 851.

(c) ALLOCATION OF GRADUATE NURSE TRAINING POSITIONS; FORMULA PAYMENTS FOR OPERATING COSTS.—With respect to subparts B and C of part 1 as applied to this part—

(1) the funding agreement described in section 3011 is to be made by graduate nurse training programs;

(2) the applicable accrediting bodies described in section 3011 for graduate nurse training pro-

grams are the National League of Nursing and others determined to be appropriate by the Secretary;

(3) designations under section 3012 and allocations under section 3013 apply to graduate nurse training positions; and

(4) payments under section 3031 are to be made to graduate nurse training programs, subject to the requirements for such payments.

SEC. 3073. FUNDING.

(a) IN GENERAL.—With respect to section 3033 as applied to this part, the provisions of this section apply.

(b) ANNUAL GRADUATE NURSE TRAINING ACCOUNT.—The amount available for each of the calendar years 1996 through 2000 for making payments pursuant to section 3072(c)(4) to graduate nurse training programs (constituting an account to be known as the annual graduate nurse training account) is $200,000,000.

PART 3—RELATED PROGRAMS

Subpart A—Workforce Development

SEC. 3081. PROGRAMS OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—

(1) FUNDING.—For purposes of carrying out the programs described in this section, there is authorized to be appropriated $100,000,000 for each

of the fiscal years 1995 and 1996, and $150,000,000 for each of the fiscal years 1997 through 2000 (in addition to amounts that may otherwise be authorized to be appropriated for carrying out the programs).

(2) ADMINISTRATION.—The programs described in this section and carried out with amounts made available under subsection (a) shall be carried out by the Secretary of Health and Human Services.

(b) PRIMARY CARE PHYSICIAN AND PHYSICIAN ASSISTANT TRAINING.—For purposes of subsection (a), the programs described in this section include programs to support projects to train additional numbers of primary care physicians and physician assistants, including projects to enhance community-based generalist training for medical students, residents, and practicing physicians; to retrain mid-career physicians previously certified in a nonprimary care medical specialty; to expand the supply of physicians with special training to serve in rural and inner-city medically underserved areas; to support expansion of service-linked educational networks that train a range of primary care providers in community settings; to provide for training in managed care, cost-effective practice management, and continuous quality improvement; to provide interdisciplinary training for medical stu-

dents, residents or practicing physicians, and dental students, residents, and dental hygienists, to deliver primary care to individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age; and to develop additional information on primary care workforce issues as required to meet future needs in health care.

(c) TRAINING OF UNDERREPRESENTED RACIAL AND ETHNIC MINORITIES AND DISADVANTAGED PERSONS.—For purposes of subsection (a), the programs described in this section include a program to support projects to increase the number of racial and ethnic underrepresented minority and disadvantaged persons in medicine, osteopathy, dentistry, advanced practice nursing, public health, psychology, and other health professions, including projects to provide continuing financial assistance for such persons entering health professions training programs; for financial assistance for facility renovation or construction; to increase support for recruitment and retention of such persons in the health professions; to maintain efforts to foster interest in health careers among such persons at the preprofessional level; and to increase the number of racial and ethnic minority health professions faculty at programs that have a significant number of underrepresented racial and ethnic minorities.

(d) EXPANDING RURAL HEALTH CAREER OPPORTUNITIES AND RETENTION EFFORTS.—

(1) IN GENERAL.—For purposes of subsection (a), the programs described in this section include programs to support projects to increase the number of individuals living in rural, underserved communities who enter the fields of medicine, osteopathy, dentistry, advanced practice nursing, public health, psychology, and other health professions, and to encourage the retention of such health care professionals in rural, underserved communities.

(2) RURAL HEALTH CAREER TRAINING.—Projects to increase the number of individuals recruited from rural, underserved areas include projects—

(A) to provide continuing financial assistance for such persons entering health professions education and training programs;

(B) to increase efforts to foster interest in health careers among such persons at the preprofessional level;

(C) to foster the development of training curricula appropriate to rural health care settings; and

(D) to increase support for recruitment of such persons in the health professions.

(3) RETENTION OF RURAL HEALTH CARE PROVIDERS.—Projects to encourage the retention of individuals providing health care in rural, underserved areas include projects—

(A) to establish State and regional locum tenans programs in rural health care settings so that substitute health care providers are available when permanent staff is absent from the health care setting;

(B) to implement programs to foster interdisciplinary team approaches to rural health training and practice; and

(C) to develop state-of-the-art network telecommunications and telemedicine systems to link rural health professionals to other health care providers and academic health care centers.

(e) NURSE TRAINING.—For purposes of subsection (a), the programs described in this section include a program to support projects to support midlevel provider training and address priority nursing workforce needs, including projects to train additional nurse practitioners and nurse midwives; to support baccalaureate-level nurse

training programs providing preparation for careers in teaching, community health service, and specialized clinical care; to train additional nurse clinicians and nurse anesthetists; to support interdisciplinary school-based community nursing programs; and to promote research on nursing workforce issues.

(f) INAPPROPRIATE PRACTICE BARRIERS; FULL UTILIZATION OF SKILLS.—For purposes of subsection (a), the programs described in this section include a program—

(1) to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants, and to otherwise support efforts to remove inappropriate barriers to practice by such nurses and such physician assistants; and

(2) to promote the full utilization of the professional education and clinical skills of advanced practice nurses and physician assistants.

(g) ADVISORY BOARD ON HEALTH CARE WORKFORCE DEVELOPMENT.—

(1) IN GENERAL.—The Secretary shall establish an Advisory Board known as the National Advisory Board on Health Care Workforce Development to advise, consult with, and make recommendations to

the Secretary and to the Secretary of Labor on matters relating to—

(A) health care worker supply and its adequacy to assure proper health care delivery system staffing in both rural and urban areas; and

(B) the impact of this Act, and of related changes in law regarding health care, on health care workers and the needs of such workers, including needs regarding education, training, and other career development matters.

(2) COMPOSITION.—The Board established under paragraph (1) shall be composed of the following members with expertise in health care workforce issues appointed by the Secretary in consultation with the Secretary of Labor:

(A) Five representatives of labor organizations representing health care workers.

(B) Five representatives of health institutions.

(C) Two representatives from health care education organizations.

(D) Two representatives from consumer organizations.

(3) ASSISTANCE.—The Secretary shall provide the Board with such administrative assistance as

may be necessary for the Board to carry out this subsection.

(h) OTHER PROGRAMS.—For purposes of subsection (a), the programs described in this section include a program to train health professionals and administrators in managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.

(i) RELATIONSHIP TO EXISTING PROGRAMS.—This section may be carried out through programs established in title VII or VIII of the Public Health Service Act, as appropriate and as consistent with the purposes of such programs.

(j) MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES.—Title VII of the Public Health Service Act is amended by inserting after section 778, the following new section:

"SEC. 779. MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES.

''(a) IN GENERAL.—The Secretary may make grants and enter into contracts with university affiliated programs, schools of medicine, and schools of dentistry to assist in meeting the costs of such programs or schools to—

''(1) improve the interdisciplinary training of primary care physicians and dentists in the health

care services needs of individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age;

''(2) develop, evaluate, and disseminate curricula relating to the health care service needs of individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those individuals who are more than 18 years of age;

''(3) support the training and retraining of faculty to provide such instruction; and

''(4) support continuing education of health professionals who provide health care services and support to individuals with mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated, $10,000,000 for each of the fiscal years 1995 through 2000.''.

SEC. 3082. PROGRAMS OF THE SECRETARY OF LABOR.

(a) IN GENERAL.—

(1) FUNDING.—For purposes of carrying out the programs described in this section, and for car-

rying out section 3083, there is authorized to be appropriated $200,000,000 for fiscal year 1994 and each subsequent fiscal year (in addition to amounts that may otherwise be authorized to be appropriated for carrying out the programs).

(2) ADMINISTRATION.—The programs described in this section and carried out with amounts made available under subsection (a) shall be carried out by the Secretary of Labor (in this section referred to as the ''Secretary'').

(b) RETRAINING PROGRAMS; ADVANCED CAREER POSITIONS; WORKFORCE ADJUSTMENT PROGRAMS.—

(1) IN GENERAL.—For purposes of subsection (a), the programs described in this section are the following:

(A) A program for skills upgrading and occupational retraining (including retraining health care workers for more advanced positions as technicians, nurses, and physician assistants), and for quality and workforce improvement.

(B) A demonstration program to assist workers in health care institutions in obtaining advanced career positions.

(C) A program to develop and operate health care and health insurance industry worker job banks in local employment services agencies or one-stop career centers, subject to the following:

(i) Such job banks shall be available to all health care providers in the community involved.

(ii) Such job banks shall begin operation not later than 90 days after the date of the enactment of this Act.

(iii)(I) With respect to each affected community, the local employment service agency or one-stop career center serving such community shall be allocated not less than one counselor whose responsibility it shall be to develop and operate health and insurance industry worker job banks. Where the impact of health care industry restructuring in the affected community is such that the functions required under this clause cannot be adequately provided by one counselor, additional counselors shall be allocated to carry out such functions.

(II) Such counselor shall solicit job openings from local health care industry employers, maintain frequent contacts with these and other employers, and monitor and update all job listings appropriate for displaced health care and health insurance industry workers seeking employment.

(III) The local employment service agency or one-stop career center shall provide directly, or facilitate the provision of, labor exchange services to displaced health care and insurance industry workers, including assessment, counseling, testing, job-search assistance, job referral and placement, and referral to training and educational programs, where appropriate.

(IV) The Secretary of Labor shall develop performance goals for the effective performance of such job banks with respect to the number and quality of jobs listed, the degree of participation by employers in the affected community, and success in placement of job bank users in jobs listed, taking into account specific geographic,

economic and labor market characteristics of the community served.

(D) A program to provide for joint labor-management decision-making in the health care sector on workplace matters related to the restructuring of the health care delivery system provided for in this Act.

(E) A program to collect data regarding the adequacy of the supply of health care workers by occupation and sector of the health industry in light of existing and projected demand for such workers.

(F)(i) A program to encourage the adoption and utilization of high performance, high quality health care delivery systems, including employee participation committees and employee team systems that will contribute to more effective health care by increasing the role and the area of independent decisionmaking of health care workers.

(ii) For purposes of this subparagraph, the term ''employee participation committees'' means committees of workers independently selected by and from a facility's nonmanagerial workforce, or selected by unions where collective

bargaining agreements are in effect, and which operate independently without employer interference and consult with management on issues of efficiency, productivity, and quality of care, except that an employee participation committee established under and operating in conformity with this subparagraph shall not be considered a labor organization within the meaning of section 2(5) of the National Labor Relations Act or a representative within the meaning of section 1, sixth, of the Railway Labor Act.

(2) USE OF FUNDS.—Amounts made available under subsection (a) for carrying out this section may be expended for program support, faculty development, trainee support, workforce analysis, and dissemination of information, as necessary to produce required performance outcomes.

(c) CERTAIN REQUIREMENTS FOR PROGRAMS.—In carrying out the programs described in subsection (b), the Secretary shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Explicit, clearly defined skill requirements developed for all the positions and projections of the number of openings for each position.

(2) Opportunities for internal career movement.

(3) Opportunities to work while training or completing an educational program.

(4) Evaluation and dissemination.

(5) Training opportunities in several forms, as appropriate.

(d) ADMINISTRATIVE REQUIREMENTS.—In carrying out the programs described in subsection (b), the Secretary shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Joint labor-management implementation and administration.

(2) Discussion with employees as to training needs for career advancement.

(3) Commitment to a policy of internal hirings and promotion.

(4) Provision of support services.

(5) Consultations with employers and with organized labor.

SEC. 3083. REQUIREMENT FOR CERTAIN PROGRAMS REGARDING REDEPLOYMENT OF HEALTH CARE WORKERS.

(a) STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.—With respect to the plan required in section 2102(a) (for State programs for home and community-

based services for individuals with disabilities under part 1 of subtitle B of title II), the plan shall, in addition to requirements under such part, provide for the following:

(1) Before initiating the process of implementing the State program under such plan, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(2) Negotiations under paragraph (1) will address the following:

(A) The impact of the implementation of the program upon the workforce.

(B) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the program.

(3) The plan will provide evidence that there has been compliance with paragraphs (1) and (2), including a description of the results of the negotiations.

(b) PLAN FOR INTEGRATION OF MENTAL HEALTH SYSTEMS.—With respect to the plan required in section 3511(a) (relating to the integration of the mental health and substance abuse services of a State and its political subdivisions with the mental health and substance abuse services included in the comprehensive benefit package

under title I), the plan shall, in addition to requirements under such section, provide for the following:

(1) Before initiating the process of implementing the integration of such services, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(2) Negotiations under paragraph (1) will address the following:

(A) The impact of the proposed changes upon the workforce.

(B) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the proposed changes.

(3) The plan will provide evidence that there has been compliance with paragraphs (1) and (2), including a description of the results of the negotiations.

Subpart B—Transitional Provisions for Workforce Stability

SEC. 3091. APPLICATION.

(a) LIMITATION TO TRANSITION PERIOD.—The provisions of this subpart are intended to minimize, to the extent possible, disruptions in established employment relationships during the period of transition to a restruc-

tured health care delivery system, and shall terminate December 31, 2000.

(b) HEALTH CARE ENTITIES COVERED BY SUBPART.—The provisions of this subpart, including references to displacing employers, hiring employers, successors and contractors, apply only to health care entities that employ more than 25 individuals.

SEC. 3092. DEFINITIONS.

(a) HEALTH CARE ENTITY.—As used in this subpart, the term ''health care entity'' includes individuals, sole proprietorships, partnerships, associations, business trusts, corporations, governmental institutions, and public agencies (including state governments and political subdivisions thereof) that—

(1) provide health care services under title I (including nonmandatory health care services under title I) or under the amendments made or programs referred to in titles IV and VIII; or

(2) provide necessary related services, including administrative, food service, janitorial or maintenance services, to an entity that provides health care services (as described in subparagraph (1));

except that an entity that solely manufactures or provides goods or equipment to a health care entity shall not be considered a health care entity.

(b) AFFILIATED ENTERPRISE.—As used in this subpart, the term ''affiliated enterprise'' means a health care entity that, together with the displacing employer, is considered a single employer as defined under 414 of the Internal Revenue Code of 1986.

(c) PREFERENCE ELIGIBLE EMPLOYEE.—As used in this subpart, the term ''preference eligible employee'' means an employee who—

(1) has been employed for in excess of 1 year by a health care entity; and

(2) has been displaced by or has received notice of an impending displacement by such entity.

(d) DISPLACEMENT.—As used in this subpart, the term ''displacement'' includes a layoff, termination, significant cutback in paid work hours, or other loss of employment, except that a discharge for just cause shall not constitute a displacement within the meaning of this paragraph.

SEC. 3093. OBLIGATIONS OF DISPLACING EMPLOYER AND AFFILIATED ENTERPRISES IN EVENT OF DISPLACEMENT.

(a) NOTICE.—A health care entity which displaces a preference eligible employee shall provide such employee with—

(1) written notice, no later than the date of displacement, of employment rights under this subpart, including employment rights with respect to affiliated enterprises of the displacing employer; and

(2) notice of any existing or subsequent vacancies with the displacing employer or an affiliated enterprise, which notice may be given by posting of such vacancies wherever notices to applicants for employment are customarily posted, by listing such vacancies with the local employment services agency, or in such other manner as the Secretary of Labor, by regulation, may hereafter specify.

Any such vacancy shall remain open for applications by preference eligible employees for not less than 14 calendar days from the date on which the initial notice is provided.

(b) HIRING PREFERENCE.—

(1) IN GENERAL.—A qualified preference eligible employee who applies during the notice period described in subsection (a)(2) for a vacant position with the displacing employer or an affiliated enterprise, which position is in the employee's occupational specialty and is located in the same State or Standard Metropolitan Statistical Area in which the employee was employed prior to the displacement, shall be given the right to accept or decline the posi-

tion before the employer may offer the position to a nonpreference eligible employee.

(2) MULTIPLE APPLICATIONS.—When considering applications from more than one qualified preference eligible employee, the hiring health care entity shall have discretion as to which of such employees will be offered the position.

(3) EMPLOYMENT QUALIFICATIONS.—Nothing in this subsection shall be construed to prohibit the hiring health care entity from establishing reasonable employment qualifications for a vacancy to which this subpart applies, except that employees who performed essentially the same work prior to their displacement shall be deemed presumptively qualified for comparable positions.

(c) TERMINATION OF PREFERENCE ELIGIBILITY.—A displaced employee's preference eligibility shall terminate—

(1) at such time as the displaced employee obtains substantially equivalent employment with the displacing employer; or

(2) if the employee does not obtain such employment—

(A) with respect to health care entities other than the displacing employer, 2 years after the date of the displacement; or

(B) with respect to the displacing employer, upon the termination of this subpart pursuant to section 3081(a).

SEC. 3094. EMPLOYMENT WITH SUCCESSORS.

A health care entity that succeeds another health care entity through merger, consolidation, acquisition, contract, or other similar manner shall provide employees of the previous health care entity who would otherwise be displaced the right to continued employment in the job positions held by such employees prior thereto, unless the employer can establish that such positions no longer exist.

SEC. 3095. COLLECTIVE BARGAINING OBLIGATIONS DURING TRANSITION PERIOD.

(a) CONTINUATION OF PREVIOUSLY RECOGNIZED BARGAINING REPRESENTATIVES AND AGREEMENTS.—If a majority of the employees in an appropriate bargaining unit consists of employees who were previously covered by a bargaining agreement or represented by an exclusive representative with respect to terms and conditions of employment, and there has not been a substantial change in the operations performed by the employees in that unit, the employer shall recognize such representative as the ex-

clusive representative for the unit and shall assume the bargaining agreement, except that where application of this subsection would result in the recognition of more than one bargaining representative for a single unit, the question concerning which representative shall be recognized as the exclusive representative for the unit shall be resolved in accordance with applicable Federal or State law.

(b) JOINT EMPLOYER STATUS.—If employees of a contractor are assigned on a regular basis to perform work on the premises of a contracting entity and the tasks performed by these employees are functionally integrated with the operations of the contracting entity on whose premises such employees work, both the contractor and the contracting entity shall be considered joint employers of the employees with respect to work performed on those premises for purposes of determining compliance with labor relations laws. Employees of such joint employers may not be excluded from a bargaining unit within either entity on the basis of such joint employer status.

SEC. 3096. GENERAL PROVISIONS.

(a) REGULATIONS.—Not later than 120 days after the date of enactment of this Act, the Secretary shall promulgate regulations to implement the requirements of section 3093.

(b) OTHER LAWS.—The standards and requirements of this subpart shall not preempt or excuse noncompliance with any other applicable Federal or State law, regulation or municipal ordinance that establishes additional notice and preference standards or requirements concerning employee dislocation, employee representation, or collective bargaining.

(c) RULES OF CONSTRUCTION.—Nothing in this subpart shall be construed—

(1) to excuse or otherwise limit the obligation of an employer to comply with any collective bargaining agreement or any employment benefit plan that provides rights to employees in addition to those provided under this subpart; or

(2) to require an employer to recognize or bargain with a labor organization in violation of State law.

(d) ENFORCEMENT.—Unless otherwise specifically provided in this subpart, the enforcement provisions of section 107 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2617) shall apply with respect to the enforcement of the individual rights, including notice requirements, provided under section 3093. The collective bargaining and contractual rights provided under sections 3094 and 3095 shall be enforced through administrative

and judicial procedures otherwise provided under Federal or State law with respect to such rights.

Subtitle B—Academic Health Centers

SEC. 3131. DISCRETIONARY GRANTS REGARDING ACCESS TO CENTERS.

(a) RURAL INFORMATION AND REFERRAL SYSTEMS.—The Secretary may make grants to eligible centers for the establishment and operation of information and referral systems to provide the services of such centers to rural health plans.

(b) OTHER PURPOSES REGARDING URBAN AND RURAL AREAS.—The Secretary may make grants to community- and provider-based health plans under section 1651(d) to carry out activities (other than activities carried out under subsection (a)) for the purpose of providing the services of eligible centers to residents of rural or urban communities who otherwise would not have adequate access to such services.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriate, $3,000,000 for fiscal year 1995, $4,000,000 for fiscal year 1996, and $5,000,000 for each of the fiscal years 1997 through 2000.

Subtitle C—Health Research Initiatives

PART 1—PROGRAMS FOR CERTAIN AGENCIES

SEC. 3201. BIOMEDICAL AND BEHAVIORAL RESEARCH.

(a) FINDINGS.—Congress finds the following:

(1) Nearly 4 of 5 peer reviewed research projects deemed worthy of funding by the National Institutes of Health are not funded.

(2) Less than 2 percent of the nearly one trillion dollars our Nation spends on health care is devoted to health research, while the defense industry spends 15 percent of its budget on research.

(3) Public opinion surveys have shown that Americans want more Federal resources put into health research and support by having a portion of their health insurance premiums set aside for this purpose.

(4) Ample evidence exists to demonstrate that health research has improved the quality of health care in the United States. Advances such as the development of vaccines, the cure of many childhood cancers, drugs that effectively treat a host of diseases and disorders, a process to protect our Nation's blood supply from the HIV virus, progress against cardiovasculor disease including heart attack

and stroke, and new strategies for the early detection and treatment of diseases such as colon, breast, and prostate cancer clearly demonstrates the benefits of health research.

(5) Among the most effective methods to control health care costs are the prevention of intentional and unintentional injury and the prevention and cure of disease and disability, thus, health research which holds the promise of prevention of intentional and unintentional injury and cure and prevention of disease and disability is a critical component of any comprehensive health care reform plan.

(6) The state of our Nation's research facilities at the National Institutes of Health and at universities is deteriorating significantly. Renovation and repair of these facilities are badly needed to maintain and improve the quality of research.

(7) Because the Omnibus Budget Reconciliation Act of 1993 freezes discretionary spending for the next 5 years, the Nation's investment in health research through the National Institutes of Health is likely to decline in real terms unless corrective legislative action is taken.

(8) A health research fund is needed to maintain our Nation's commitment to health research

and to increase the percentage of approved projects which receive funding at the National Institutes of Health to at least 33 percent.

(9) Private sector investment in research and development has been responsible for the vast majority of new developments in pharmaceuticals, medical devices, biotechnology and other health care innovations. Over 90 percent of the most prescribed drugs in the United States were discovered by the research-based pharmaceutical industry.

(10) United States industry is the preeminent world leader in the research, development and delivery of innovative therapies that improve the quality of care for people throughout the world.

(11) Global health care budgets may constrict private sector investment in research and development. Further, they may be inconsistent with the goal of developing promising new cost effective treatment therapies.

(b) AVAILABILITY OF FUNDS.—

(1) IN GENERAL.—With respect to each calendar year, the Secretary shall pay, from funds in the Treasury not otherwise appropriated, for activities under this section in an amount equal to 0.25 percent in 1996, 0.50 percent in 1997, 0.75 percent

in 1998, and 1.0 percent in 1999 and subsequent years, of all private premiums required to be paid under this Act.

(2) For purposes of this subsection, the term ''private health premiums'' means all premium related payments made by employers, individuals, and families for coverage under this Act.

(c) PURPOSES FOR EXPENDITURES.—Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 404F. EXPENDITURES FOR HEALTH RESEARCH.

''(a) IN GENERAL.—From amounts made available under section 3201 of the Health Security Act, the Secretary shall distribute—

''(1) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

''(A) for carrying out the responsibilities of the Office of the Director, in including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Alternative Medicine and the Office of Rare Diseases Research; and

''(B) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

''(2) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

''(3) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV with respect to health information communications; and

''(4) the remainder of such amounts during any fiscal year to member institutes of the National Institutes of Health and Centers in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

''(b) PLANS OF ALLOCATION.—The amounts transferred under subsection (a) shall be allocated by the Director of NIH or the various directors of the institutes and

centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.''.

SEC. 3202. HEALTH SERVICES RESEARCH.

Section 902 of the Public Health Service Act (42 U.S.C. 299a), as amended by section 2(b) of Public Law 102–410 (106 Stat. 2094), is amended by adding at the end the following subsection:

''(f) RESEARCH ON HEALTH CARE REFORM.—

''(1) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support research on the reform of the health care system of the United States, as directed by the National Board.

''(2) PRIORITIES.—In carrying out paragraph (1), the Administrator shall give priority to the following:

''(A) Conducting and supporting research on the appropriateness and effectiveness of alternative clinical strategies (including community-based programs and preventive services), the quality and outcomes of care, and administrative simplification.

''(B) Conducting and supporting research on the appropriateness and effectiveness of al-

ternative community-based and clinical strategies including integrating preventive services into primary care, the effectiveness of preventive counseling and health education, and the efficacy and cost-effectiveness of clinical preventive services.

''(C) Conducting and supporting research on consumer choice and information resources; the effects of health care reform on health delivery systems; workplace injury and illness prevention; intentional and unintentional injury prevention; methods for risk adjustment; factors influencing access to health care for vulnerable populations, including children, persons with low-income, persons with disabilities, or individuals with chronic or complex health conditions, and primary care.

''(D) The development of clinical practice guidelines consistent with section 913, the dissemination of such guidelines consistent with section 903, and the assessment of the effectiveness of such guidelines.''.

PART 2—FUNDING FOR PROGRAM

SEC. 3211. AUTHORIZATIONS OF APPROPRIATIONS.

(a) HEALTH SERVICES RESEARCH.—For the purpose of carrying out activities pursuant to the amendments made by section 3202, there are authorized to be appropriated $150,000,000 for fiscal year 1995, $400,000,000 for fiscal year 1996, $500,000,000 for fiscal year 1997, and $600,000,000 for each of the fiscal years 1998 through 2000.

(b) RELATION TO OTHER FUNDS.—The authorization of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purposes described in such subsection.

(c) TRIGGER AND RELEASE OF MONIES.—No expenditure shall be made pursuant to section 3201(c) during any fiscal year in which the annual amount appropriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year. With respect to amounts available for expenditure pursuant to section 3201(c) which, as a result of the application of this subsection remain unexpended, such amounts shall be obligated by the Secretary of Health and Human Services under the public health initiative under subtitle H.

Subtitle D—Core Functions of Public Health Programs; National Initiatives Regarding Preventive Health

PART 1—FUNDING

SEC. 3301. AUTHORIZATIONS OF APPROPRIATIONS.

(a) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For the purpose of carrying out part 2, there are authorized to be appropriated $150,000,000 for fiscal year 1995, $225,000,000 for fiscal year 1996, $325,000,000 for fiscal year 1997, $425,000,000 for fiscal year 1998, $500,000,000 for fiscal year 1999, and $625,000,000 for fiscal year 2000.

(b) NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION.—For the purpose of carrying out part 3, there are authorized to be appropriated $125,000,000 for each of the fiscal years 1996 through 1998, and $150,000,000 for each of the fiscal years 1999 and 2000.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsections (a) and (b) are in addition to any other authorizations of appropriations that are available for the purposes described in such subsections.

PART 2—CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS

SEC. 3311. PURPOSES.

Subject to the subsequent provisions of this subtitle, the purposes of this part are to strengthen the capacity of State and local public health agencies to carry out the following functions:

(1) To monitor and protect the health of communities against communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products, and poor quality health care.

(2) To identify and control outbreaks of infectious disease and patterns of chronic disease and injury.

(3) To inform and educate health care consumers and providers about their roles in preventing injury, preventing and controlling disease and the appropriate use of medical services.

(4) To develop and test new prevention and public health control interventions.

(5) To integrate and coordinate the prevention programs and services of health plans, community-based providers, local health departments, State health departments, health alliances, and other sectors of State and local government that affect

health, including education, labor, transportation, welfare, criminal justice, environment, agriculture, and housing.

(6) To conduct research on the effectiveness and cost-effectiveness of public health programs.

SEC. 3312. GRANTS TO STATES FOR CORE FUNCTIONS OF PUBLIC HEALTH.

(a) IN GENERAL.—The Secretary shall make grants to States that submit applications as prescribed in section 3313 in an amount which bears the same ratio to the available amounts for that fiscal year as the amounts provided by the Secretary under the provisions of law listed in section 1902(2) of the Public Health Service Act to the State for fiscal year 1981 bear to the total amount appropriated for such provisions of law for fiscal year 1981.

(b) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For purposes of subsection (a), the functions described in this subsection are, subject to subsection (c), as follows:

(1)(A) Data collection, activities related to population health (including the population of individuals ineligible for the comprehensive benefit package) measurement and outcomes monitoring, including the acquisition and installation of hardware and software, personnel training and technical assistance

to operate and support automated and integrated information systems, the regular collection and analysis of public health data, vital statistics, and personal health services data and analysis for planning and needs assessment purposes of data collected from health plans through the information system under title V of this Act.

(B) Data measures under this paragraph must include an ethnic identifier on all forms. To the extent feasible, ethnic identifiers should be classified by ethnic sub-group populations. Access to data must be ensured for research organizations and data clearinghouses. Population health measurement and outcome monitoring should focus on health status differentials between racial, and ethnic groups, by subpopulation, and gender differences.

(2) Activities to protect the environment and to assure the safety of housing, workplaces, food and water, including the following activities:

(A) Monitoring and improving the overall public health quality and safety of communities.

(B) Assessing exposure to high lead levels and water contamination.

(C) Providing support for poison control centers.

(D) Monitoring sewage and solid waste disposal, radiation exposure, radon exposure, and noise levels.

(E) Abatement of lead-related hazards.

(F) Assuring recreation, home and worker safety.

(G) Public information and education programs that help to reduce intentional and unintentional injuries, including training parents and children on use of safety devices.

(H) Enforcing public health safety and sanitary codes.

(I) Other activities relating to promoting the public health of communities.

(3) Investigation and control of adverse health conditions, including improvements in emergency treatment preparedness, injury prevention, cooperative activities to reduce violence levels in homes and communities, activities to control the outbreak of disease, exposure related conditions and other threats to the health status of individuals.

(4) Public information and education programs to reduce risks to health such as use of tobacco, alcohol and other drugs, sexual activities that increase the risk to HIV transmission and sexually transmit-

ted diseases, domestic violence, poor diet, physical inactivity, and low childhood immunization levels.

(5) Accountability and quality assurance activities, including monitoring the quality of personal health services furnished by health plans and providers of medical and health services in a manner consistent with the overall quality of care monitoring activities undertaken under title V, and monitoring communities' overall access to health services.

(6) Provision of public health laboratory services to complement private clinical laboratory services and that screen for diseases and conditions such as metabolic diseases in newborns, provide toxicology assessments of blood lead levels and other environmental toxins, diagnose sexually transmitted diseases, tuberculosis and other diseases requiring partner notification, test for infectious and food-borne diseases, and monitor the safety of water and food supplies.

(7) Training and education to assure provision of care by all health professionals, with special emphasis placed on the training of public health professions including epidemiologists, biostatisticians, health educators, public health administrators, sanitarians and laboratory technicians.

(8) Leadership, policy development and administration activities, including needs assessment, the setting of public health standards, the development of community public health policies, and the development of community public health coalitions.

(c) RESTRICTIONS ON USE OF GRANT.—

(1) IN GENERAL.—A funding agreement for a grant under subsection (a) for a State is that the grant will not be expended—

(A) to provide inpatient services;

(B) to make cash payments to intended recipients of health services;

(C) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(D) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(E) to provide financial assistance to any entity other than a public or nonprofit private entity.

(2) LIMITATION ON ADMINISTRATIVE EXPENSES.—A funding agreement for a grant under subsection (a) is that the State involved will not ex-

pend more than 10 percent of the grant for administrative expenses with respect to the grant.

(d) MAINTENANCE OF EFFORT.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of non-Federal amounts for core health functions at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant.

SEC. 3313. SUBMISSION OF INFORMATION.

The Secretary may make a grant under section 3312 only if the State involved submits to the Secretary the following information:

(1) A description of existing deficiencies in the State's public health system (at the State level and the local level), using standards of sufficiency developed by the Secretary.

(2) A description of health status measures to be improved within the State (at the State level and the local level) through expanded public health functions.

(3) Measurable outcomes and process objectives for improving health status and core health functions for which the grant is to be expended.

(4) Information regarding each such function, which—

(A) identifies the amount of State and local funding expended on each such function for the fiscal year preceding the fiscal year for which the grant is sought; and

(B) provides a detailed description of how additional Federal funding will improve each such function by both the State and local public health agencies.

(5) A description of the core health functions to be carried out at the local level, and a specification for each such function of—

(A) the communities in which the function will be carried out; and

(B) the amount of the grant to be expended for the function in each community so specified.

SEC. 3314. REPORTS.

A funding agreement for a grant under section 3312 is that the States involved will, not later than the date specified by the Secretary, submit to the Secretary a report describing—

(1) the purposes for which the grant was expended; and

(2) describing the extent of progress made by the State in achieving measurable outcomes and process objectives described in section 3313(3).

SEC. 3315. APPLICATION FOR GRANT.

The Secretary may make a grant under section 3312 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 3314, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

SEC. 3316. ALLOCATIONS FOR CERTAIN ACTIVITIES.

Of the amounts made available under section 3301 for a fiscal year for carrying out this part, the Secretary may reserve not more than 5 percent for carrying out the following activities:

(1) Technical assistance with respect to planning, development, and operation of core health functions carried out under section 3312, including provision of biostatistical and epidemiological expertise and provision of laboratory expertise.

(2) Development and operation of a national information network among State and local health agencies.

(3) Program monitoring and evaluation of core health functions carried out under section 3312.

(4) Development of a unified electronic reporting mechanism to improve the efficiency of administrative management requirements regarding the provision of Federal grants to State public health agencies.

SEC. 3317. DEFINITIONS.

For purposes of this part:

(1) The term ''funding agreement'', with respect to a grant under section 3312 to a State, means that the Secretary may make the grant only if the State makes the agreement involved.

(2) The term ''core health functions'', with respect to a State, means the functions described in section 3312(b).

SEC. 3318. SINGLE APPLICATION AND UNIFORM REPORTING SYSTEMS FOR CORE FUNCTIONS OF PUBLIC HEALTH AND PUBLIC HEALTH CATEGORICAL GRANT PROGRAMS ADMINISTERED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) SINGLE APPLICATION.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease

Control and Prevention, shall establish a single consolidated application to enable States to apply for the Core Functions of Public Health Grants Program and any or all of the Public Health Service Act categorical programs described in subsection (b).

(2) REQUIREMENTS.—The application developed under paragraph (1) shall—

(A) be designed so that information collected will be consistent with the requirements of this part including subsection (b);

(B) be designed and implemented not later than 1 year after the date of enactment of this Act; and

(C) be developed with resources made available under section 3316 (not resources made available for the programs described in subsection (b)).

(3) STATE PUBLIC HEALTH OFFICERS.—In developing the single consolidated application form to be used under this subsection the Secretary shall consult with Federal, State and local public health agencies.''.

(4) ELIGIBILITY.—States and local governments that have grants, contracts or cooperative agreements in effect with the Centers for Disease

Control and Prevention on the date of enactment of this Act shall be eligible to use a single application under this section to apply for any or all of the Public Health Service Act categorical programs described in subsection (b).

(b) ELIGIBLE PUBLIC HEALTH SERVICE ACT PROGRAMS.—Eligible Public Health Service Act categorical programs described in this subsection are the following:

(1) The Preventive Health and Health Services Block Grant under section 1903 of the Public Health Service Act.

(2) The Childhood Lead Poisoning Prevention Program under section 317A of the Public Health Service Act.

(3) The Sexually Transmitted Diseases Program under section 318 of the Public Health Service Act.

(4) The Prevention of Sexually Transmitted Diseases-Related Infertility Program under section 318A of the Public Health Service Act.

(5) The Breast and Cervical Cancer Early Detection Program under sections 1501 through 1509 of the Public Health Service Act.

(6) The National Program of Cancer Registries under section 399H of the Public Health Service Act.

(7) The Injury Control and Prevention Program under sections 391 through 394 of the Public Health Service Act.

(8) The preventive health for prostate cancer program under section 317D of the Public Health Service Act.

(9) The birth defects data program under section 317C of the Public Health Service Act.

(10) Programs under subtitle D of this title.

(11) Other relevant programs as determined appropriate by the Secretary.

(c) ALLOCATION OF FUNDS.—In awarding grants to States and local governments under a single application under this section, the Secretary shall delineate to each grantee the amounts to be dedicated to each of the programs described in subsection (b) and ensure that funding allotments for each of such programs are consistent with the requirements of Federal law.

(d) UNIFORM CORE FUNCTIONS OF PUBLIC HEALTH REPORTING SYSTEM.—

(1) DEVELOPMENT.—The Secretary, acting through the Director of the Office of Disease Pre-

vention and Health Promotion and the Director of the Centers for Disease Control and Prevention, in consultation with other relevant Federal and State health agencies with data collection responsibilities, shall develop and implement a Uniform Core Public Health Functions Reporting System to collect program and fiscal data concerning the programs described in subsection (b).

(2) REQUIREMENTS.—The system developed under paragraph (1) shall—

(A) use outcomes consistent with the goals of Healthy People 2000;

(B) be designed so that information collected will be consistent with the requirements of this part including subsection (b);

(C) be designed and implemented not later than 2 years after the date of enactment of this Act; and

(D) be developed with resources made available under section 3316 of this Act (not resources made available for the programs described in subsection (b)).

(3) STATE PUBLIC HEALTH OFFICERS.—In developing the data set to be used under Uniform Core Public Health Functions Reporting System the Sec-

retary shall consult with Federal, State and local public health agencies.

(e) STUDY.—

(1) IN GENERAL.—Within a reasonable period of time after the date of enactment of this Act, the Secretary shall request that the Institute of Medicine conduct a study concerning—

(A) the effects of consolidating any or all of the grant programs administered by the Centers for Disease Control and Prevention and described in subsection (b) into a Core Functions of Public Health Block Grant Program;

(B) the development of alternative methods for implementing a block grant program or categorical grant program; and

(C) alternative formulas for allocating State grants that incorporate measures of health status, population and degree of poverty.

In particular, the impact of program consolidation on the targeted recipients, including women and vulnerable populations, shall be addressed in the study. If the Institute of Medicine declines to do the study, the Secretary shall make grants to or enter into contracts with a public or nonprofit private entity with relevant expertise for the conduct of such a study.

(2) REPORT.—Not later than 1 year after the date of the receipt of the contract under paragraph (1), the contract recipient shall prepare and submit to the Secretary, the Energy and Commerce Committee of the House of Representatives, and the Committee on Labor and Human Resources of the Senate a report that contains the results of the study conducted under paragraph (1).

(3) ISSUANCE OF PLAN.—Not later than 1 year after the date on which the report under paragraph (2) is received by the Secretary and the committees referred to in such paragraph, the Secretary shall issue a plan in response to the report. Such a plan shall include the identification of relevant changes in authorizing language.

PART 3—NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION

Subpart A—General Grants

SEC. 3331. GRANTS FOR NATIONAL PREVENTION INITIATIVES.

(a) IN GENERAL.—The Secretary may make grants to entities described in subsection (b) for the purpose of carrying out projects to develop and implement innovative community-based strategies to provide for health promotion and disease prevention activities for which there

is a significant need, as identified under section 1701 of the Public Health Service Act.

(b) ELIGIBLE ENTITIES.—The entities referred to in subsection (a) are agencies of State or local government, private nonprofit organizations (including research institutions), and coalitions that link two or more of these groups.

(c) CERTAIN ACTIVITIES.—The Secretary shall ensure that projects carried out under subsection (a)—

(1) reflect approaches that take into account the special needs and concerns of the affected populations;

(2) are targeted to the most needy and vulnerable population groups and geographic areas of the Nation;

(3) examine links between various high priority preventable health problems and the potential community-based remedial actions; and

(4) establish or strengthen the links between the activities of agencies engaged in public health activities with those of health alliances, health care providers, and other entities involved in the personal health care delivery system described in title I.

SEC. 3332. PRIORITIES.

(a) ESTABLISHMENT.—

(1) ANNUAL STATEMENT.—The Secretary shall for each fiscal year develop a statement of proposed priorities for grants under section 3331 for the fiscal year.

(2) ALLOCATIONS AMONG PRIORITIES.—With respect to the amounts available under section 3301(b) for the fiscal year for carrying out this part, each statement under paragraph (1) for a fiscal year shall include a specification of the percentage of the amount to be devoted to projects addressing each of the proposed priorities established in the statement.

(3) PROCESS FOR ESTABLISHING PRIORITIES.—

(A) PREFERENCE.—In establishing priorities for grants under this part, preference shall be given to projects that—

(i) reduce the prevalence of chronic diseases including cardiovascular disease, stroke, diabetes, and cancer;

(ii) prevent violence against women by training providers and other health care professionals to identify victims of domestic violence, to provide appropriate examination and treatment, and to refer the victims for appropriate social and legal services; and

(iii) establish community health advisor programs described in subparagraph (B).

(B) COMMUNITY HEALTH ADVISOR PROGRAMS.—For purposes of subparagraph (A)(iii), the term ''community health advisor program'' means a program that performs the following functions:

(i) Provides outreach services to inform the community of the availability of program services.

(ii) Collaborate efforts with health care providers and related entities to facilitate the provision of health services and health related social services.

(iii) Provide public education on health promotion and disease prevention and efforts to facilitate the use of available health services and health-related social services.

(iv) Provide health-related counseling.

(v) Make referrals for available health services and health-related social services.

(vi) Improve the ability of individuals to use health services and health-related

social services under Federal, State, and local programs, through assisting individuals in establishing eligibility under the programs.

(vii) Establish a community health advisor training program.

(viii) Provide services in the language and cultural context most appropriate for the individuals served by the program.

(ix) Provide compensation for the services of, and opportunities for training and employment of, community health advisors.

(x) Such other services as the Secretary determines to be appropriate, which may include transportation and translation services.

(C) PUBLICATION OF STATEMENT.—Not later than January 1 of each fiscal year, the Secretary shall publish a statement under paragraph (1) in the Federal Register. A period of 60 days shall be allowed for the submission of public comments and suggestions concerning the proposed priorities. After analyzing and considering comments on the proposed prior-

ities, the Secretary shall publish in the Federal Register final priorities (and associated reservations of funds) for approval of projects for the following fiscal year.

(D) DEFINITION OF COMMUNITY HEALTH ADVISOR.—For purposes of subparagraph (B), the term ''community health advisor'' means an individual—

(i) who has demonstrated the capacity to carry out one or more of the authorized program services;

(ii) who, for not less than 1 year, has been a resident of the community in which the community health advisor program involved is to be operated; and

(iii) is a member of a socioeconomic group to be served by the program.

(b) APPLICABILITY TO MAKING OF GRANTS.—

(1) IN GENERAL.—The Secretary may make grants under section 3331 for projects that the Secretary determines—

(A) are consistent with the applicable final statement of priorities and otherwise meets the objectives described in subsection (a); and

(B) will assist in meeting a health need or concern of a population within a defined health care coverage area or other service area.

(2) SPECIAL CONSIDERATION FOR CERTAIN PROJECTS.—In making grants under section 3331, the Secretary shall give special consideration to applicants that will carry out projects that, in addition to being consistent with the applicable published priorities under subsection (a) and otherwise meeting the requirements of this part, have the potential for replication in other communities.

SEC. 3333. SUBMISSION OF INFORMATION.

The Secretary may make a grant under section 3331 only if the applicant involved submits to the Secretary the following information:

(1) A description of the activities to be conducted, and the manner in which the activities are expected to contribute to meeting one or more of the priority health needs specified under section 3332 for the fiscal year for which the grant is initially sought.

(2) A description of the total amount of Federal funding requested, the geographic area and populations to be served, and the evaluation procedures to be followed.

(3) Such other information as the Secretary determines to be appropriate.

SEC. 3334. APPLICATION FOR GRANT.

The Secretary may make a grant under section 3331 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 3333, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

Subpart B—Development of Telemedicine in Rural Underserved Areas

SEC. 3341. GRANTS FOR DEVELOPMENT OF RURAL TELEMEDICINE.

(a) IN GENERAL.—

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

link existing networks together, or link such networks to existing fiber optic telecommunications systems.

(2) ELIGIBLE ENTITY DEFINED.—For purposes of this section, the term ''eligible entity'' means public or nonprofit entities in nonmetropolitan areas (as defined by the Department of Commerce) in a consortium of community-based providers that includes at least three of the following:

(A) community or migrant health centers;

(B) local health departments;

(C) community mental health centers;

(D) nonprofit hospitals

(E) private practice health professionals, including rural health clinics; or

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

(b) APPLICATION.—To be eligible to receive a grant under this section an eligible entity shall prepare and submit to the Secretary for approval an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the entity will apply any amounts received under the grant.

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

(1) are health care providers in a rural health care network or that propose to form such a network, if a majority of the providers in such network are located in a medically underserved area or health professional shortage area;

(2) can demonstrate broad geographic coverage in the rural areas of the State, or States, in which the applicant is located;

(3) propose to use the amounts provided under the grant to develop plans for, or to establish, telemedicine systems that will link rural hospitals and other rural health care providers to other hospitals and health care providers;

(4) will use the amounts provided under the grant for a broad range of health care applications such as teleradiology, telepathology, interactive video consultation and remote educational services, and to promote greater efficiency in the use of health care resources and administrative activities; and

(5) propose to use local matching funds to finance projects.

(d) USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall be utilized for the development of telemedicine networks involving three or more providers. Such amounts may be used to cover the costs associated with the development of telemedicine networks and the acquisition or construction of telecommunications facilities and equipment including—

(1) the development and acquisition through lease or purchase of computer hardware and software, audio and visual equipment, computer network equipment, telecommunications transmission facilities, telecommunications terminal equipment, interactive video equipment, data terminal equipment, and other facilities and equipment that would further the purposes of this section;

(2) the provision of technical assistance and instruction for the development and use of such programming equipment or facilities;

(3) the development and acquisition of instructional programming;

(4) demonstration projects for teaching or training medical students, residents, and other health professions students in rural training sites about the applications of telemedicine;

(5) transmission costs, maintenance of equipment, and compensation of specialists and referring practitioners;

(6) demonstration projects to use telemedicine to facilitate collaboration between physicians and nonphysician primary care practitioners such as physician assistants, nurse practitioners, and certified nurse-midwives; or

(7) such other uses that are consistent with achieving the purposes of this section as approved by the Secretary.

SEC. 3342. REPORT AND EVALUATION OF TELEMEDICINE.

Three years after the first grant is awarded under section 3341 the Secretary shall submit a report to Congress that evaluates all telemedicine projects funded through the Department of Health and Human Services. Such report shall evaluate—

(1) whether telemedicine expands access to health care services;

(2) the cost effectiveness of telemedicine services; and

(3) the quality of telemedicine services delivered.

SEC. 3343. RECOMMENDATIONS ON REIMBURSEMENT OF TELEMEDICINE.

The Secretary, in consultation with the Office of Rural Health and the Health Care Financing Administration, shall issue regulations regarding reimbursement for telemedicine services provided under title XVIII of the Social Security Act no later than July 1, 1996.

Subtitle E—Health Services for Medically Underserved Populations

PART 1—INITIATIVES FOR ACCESS TO HEALTH CARE

Subpart A—Authorization of Appropriations

SEC. 3411. AUTHORIZATIONS OF APPROPRIATIONS.

(a) IMPROVING ACCESS TO HEALTH SERVICES.—

(1) SUBPART B.—

(A) Except as provided in subparagraph (B), for the purpose of carrying out subpart B, there are authorized to be appropriated $52,500,000 for fiscal year 1995, $122,500,000 for fiscal year 1996, $192,500,000 for fiscal year 1997, $157,500,000 for fiscal year 1998, $122,500,000 for fiscal year 1999, and $52,500,000 for fiscal year 2000.

(B) With respect to awards to federally qualified health centers (as defined in section

1861(aa)(4) of the Social Security Act) under subpart B, there are authorized to be appropriated $97,500,000 for fiscal year 1995, $227,500,000 for fiscal year 1996, $357,500,000 for fiscal year 1997, $292,500,000 for fiscal year 1998, $227,500,000 for fiscal year 1999, and $97,500,000 for fiscal year 2000.

(2) SUBPART C.—

(A) For the purpose of providing loans under subpart C, there are authorized to be appropriated such sums as may be necessary to support a loan level of $200,000,000 for each of the fiscal years 1995 through 2000.

(B) For the purpose of making grants under subpart C, there are authorized to be appropriated $35,000,000 for each of the fiscal year 1995 through 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

(c) ELIGIBLE ENTITIES.—For purposes of this part, the term ''eligible entities'' means—

(1) covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), except that subsection (a)(4)(L)(iii) and (a)(7) of such section shall not apply;

(2) school health service sites under title III of this Act;

(3) nonprofit hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act, except that subsection (a)(4)(L)(iii) of such section shall not apply, and children's hospitals meeting comparable criteria as determined appropriate by the Secretary;

(4) public and private, nonprofit community mental health centers and substance abuse treatment providers receiving funds from the Substance Abuse and Mental Health Services Administration;

(5) runaway homeless youth centers or transitional living programs for homeless youth for the provision of health services under the Runaway Homeless Youth Act of 1974 (42 U.S.C. 5701 et seq.);

(6) rural referral centers under section 1886(d)(5)(C) of the Social Security Act, except

that such eligibility is restricted to the receipt of grants under section 3441; and

(7) public or nonprofit entities in nonmetropolitan areas (as defined by the Department of Commerce) in a consortium of community-based providers that includes at least three of the following:

(A) community or migrant health centers;

(B) local health departments;

(C) community mental health centers;

(D) nonprofit hospitals;

(E) private practice health professionals, including rural health clinics; or

(F) other publicly funded health or social services agencies;

except that such eligibility is restricted to the receipt of grants or contracts under section 3421(a).

(d) PRIORITY.—In making awards from amounts appropriated under subsection (a)(1)(B) and section 3462, the Secretary shall give the highest priority to providing adequate assistance to federally qualified health centers in order to ensure the provision of comprehensive primary health care services, other covered services and benefits, and enabling services to medically underserved populations that were served by such centers prior to the date of enact-

ment of this Act, except that such federally qualified health centers must continue to meet the requirements for designation under section 1861(aa)(4) of the Social Security Act.

(e) EQUITABLE DISTRIBUTION.—The Secretary shall, in awarding grants, entering into contracts, and making loans under this part, assure an equitable distribution of funds between rural and urban areas.

Subpart B—Development of Community Health Groups and Health Care Sites and Services

SEC. 3421. GRANTS AND CONTRACTS FOR DEVELOPMENT OF PLANS AND NETWORKS AND THE EXPANSION AND DEVELOPMENT OF HEALTH CARE SITES AND SERVICES.

(a) IN GENERAL.—The Secretary may make grants to and enter into contracts with eligible entities described in section 3411(c) for—

(1) the development of community health groups whose principal purpose is to provide the comprehensive benefit package under title I in one or more health professional shortage areas or to provide such items and services to a significant number of individuals who are members of a medically underserved population; and

(2) the expansion of existing health delivery sites and services and the development of new health delivery sites and services.

(b) SERVICE AREA.—In making an award under subsection (a), the Secretary shall designate the geographic area with respect to which the community health group involved is to provide health services.

(c) PRIORITY.—In making awards under subsection (a)(1), the Secretary shall give priority to proposals in which a greater number of eligible entities and other health care providers, especially providers in community- and provider-based health plans under section 1651(d), are participants in the community health group, except in areas such as rural areas, where providers are severely limited in number.

(d) LIMITATION ON AWARDS.—The Secretary may not make awards under subsection (a)(1) for more than 5 years to the same community health group.

(e) DEFINITIONS.—For purposes of this subpart:

(1) The term ''community health group'' means—

(A) a community health network that—

(i) is a public or nonprofit private consortium of health care providers that principally provides some of the items and

services of the basic benefit package to medically underserved populations, and residents of health professional shortage areas;

(ii) has an agreement with one or more health plans; and

(iii) has a written agreement governing the participation of health care providers in the consortium to which each participating provider is a party; or

(B) a community health plan that—

(i) is a public or nonprofit private entity that principally provides all of the items and services of the basic benefit package to medically underserved populations, and residents of health professional shortage areas;

(ii) is a participant in one or more health alliances; and

(iii) has a written agreement governing the participation of health care providers in the consortium to which each participating provider is a party.

(2) The term ''health professional shortage areas'' means health professional shortage areas des-

ignated under section 332 of the Public Health Service Act.

(3) The term ''medically underserved population'' means a medically underserved population designated under section 330(b)(3) of the Public Health Service Act, populations residing in health professional shortage areas under section 332 of the Public Health Service Act, and populations eligible for premium subsidies and cost sharing reductions based on income under title I.

SEC. 3422. CERTAIN USES OF AWARDS.

(a) IN GENERAL.—Amounts awarded under section 3421 may be expended for—

(1) the development of a community health group, including entering into contracts between the recipient of the award and health care providers who are to participate in the group;

(2) the expansion, development and on-going operation of health delivery sites and services; and

(3) activities under paragraphs (1) and (2) which include—

(A) the recruitment, compensation, and training of health professionals and administrative staff;

(B) the purchase and upgrading of equipment, supplies, and information systems including telemedicine systems; and

(C) the establishment of reserves required for furnishing services on a prepaid or capitated basis, except that eligible entities may use non-cash mechanisms (including bonds, letters of credit and federally guaranteed reinsurance pools) for establishing and maintaining financial reserves.

(b) LOANS AND GRANTS.—The Secretary may expend, in any fiscal year, not to exceed 10 percent of the amounts appropriated to carry out this subpart to make loans and grants to eligible entities to support the types of activities described in section 3441, subject to the requirements of subpart C, except that, with respect to amounts available for non-federally qualified health center activities, such funds may be used to convert facilities from providers of acute care service to providers of primary, emergency or long-term care.

SEC. 3423. APPLICATION.

The Secretary may not make an award to an entity under section 3421 until such entity submits and application to the Secretary, in such form and containing such

assurances and information as the Secretary determines appropriate, including—

(1) an assessment of the need that the medically underserved population or populations proposed to be served by the applicant have for health services and for enabling services (as defined in section 3461);

(2) a description of how the applicant will design the proposed community health plan or practice network (including the service sites involved) for such populations based on the assessment of need;

(3) a description of efforts to secure financial and professional assistance and support for the project; and

(4) evidence of significant community involvement in the initiation, development and ongoing operation of the project.

SEC. 3424. PURPOSES AND CONDITIONS.

Grants shall be made under this subpart for the purposes and subject to all of the conditions under which eligible entities otherwise receive funding to provide health services to medically underserved populations under the Public Health Service Act. The Secretary shall prescribe comparable purposes and conditions for eligible entities not receiving funding under the Public Health Service Act.

Subpart C—Capital Cost of Development of Community Health Groups and Other Purposes

SEC. 3441. DIRECT LOANS AND GRANTS.

(a) IN GENERAL.—The Secretary shall make grants and loans to—

(1) eligible entities (as defined in section 3412(c));

(2) hospitals designated by the Secretary as essential access community hospitals under section 1820(i)(1) of the Social Security Act; or

(3) rural primary care hospitals under section 1820(i)(2) of such Act;

for the capital costs of developing community health groups (as defined in section 3421(e)) and expanding existing health delivery sites or developing new health delivery sites.

(b) USE OF ASSISTANCE.—

(1) IN GENERAL.—The capital costs for which grants and loans made pursuant to subsection (a) may be expended are, subject to paragraphs (2) and (3), the following:

(A) The acquisition, modernization, expansion or construction of facilities, or the conversion of unneeded hospital facilities to facilities that will assure or enhance the provision and

accessibility of health care and enabling services to medically underserved populations.

(B) The purchase of major equipment, including equipment necessary for the support of external and internal information systems.

(C) The establishment of reserves required for furnishing services on a prepaid or capitated basis.

(D) Such other capital costs as the Secretary may determine are necessary to achieve the objectives of this section.

(2) PRIORITIES REGARDING USE OF FUNDS.—In providing grants and loans under subsection (a) for an entity, the Secretary shall give priority to authorizing the use of amounts for projects for the renovation and modernization of medical facilities necessary to prevent or eliminate safety hazards including asbestos removal, avoid noncompliance with licensure or accreditation standards, or projects to replace obsolete facilities.

(3) LIMITATION.—The Secretary may authorize the use of grants and loans under subsection (a) for the construction of new buildings only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding

or converting existing buildings, or that construction new buildings will cost less.

(c) AMOUNT OF ASSISTANCE.—

(1) IN GENERAL.—The principal amount of loans under subsection (a) may cover up to 90 percent of the costs involved.

(2) GRANTS.—Grants under this subsection may not exceed 75 percent of the costs involved.

(d) INTEREST SUBSIDIES.—Amounts provided under this section may be used to provide interest subsidies for loans provided under this section where such subsidies are necessary to make a project financial feasible.

SEC. 3442. CERTAIN REQUIREMENTS.

(a) IN GENERAL.—The Secretary may approve a loan under section 3441 only if—

(1) the Secretary is reasonably satisfied that the applicant for the project for which the loan would be made will be able to make payments of principal and interest thereon when due; and

(2) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(b) TERMS AND CONDITIONS.—Any loan made under section 3441 shall, subject to the Federal Credit Reform Act of 1990, meet such terms and conditions (including provisions for recovery in case of default) as the Secretary, in consultation with the Secretary of the Treasury, determines to be necessary to carry out the purposes of such section while adequately protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

(1) Security.

(2) Maturity date.

(3) Amount and frequency of installments.

(4) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

SEC. 3443. DEFAULTS; RIGHT OF RECOVERY.

(a) DEFAULTS.—

(1) IN GENERAL.—The Secretary may take such action as may be necessary to prevent a default on loans under section 3441, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes.

(2) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to section 3441, including selling real property pledged as security for such a loan and for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan.

(3) WAIVERS.—The Secretary may, for good cause, but with due regard to the financial interests of the United States, waive any right of recovery which the Secretary has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made pursuant to section 3441, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(b) TWENTY-YEAR OBLIGATION; RIGHT OF RECOVERY; SUBORDINATION; WAIVERS.—

(1) IN GENERAL.—With respect to an eligible entity for which a grant or loan was made under section 3441, the Secretary may award the grant or

loan only if the applicant involved agrees that the applicant will be liable to the United States for the amount of the grant or loan, together with an amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the entity—

(A) ceases to be an eligible entity utilized by a community health group, or by another public or nonprofit private entity that provides health services in one or more health professional shortage areas or that provides such services to a significant number of individuals who are members of a medically underserved population; or

(B) is sold or transferred to any entity other than an entity that is—

(i) a community health group or other entity described in subparagraph (A); and

(ii) approved by the Secretary as a purchaser or transferee regarding the facility.

(2) SUBORDINATION; WAIVERS.—With respect to essential community providers, the Secretary may subordinate or waive the right of recovery under paragraph (1), and any other Federal interest that

may be derived by virtue of a grant or loan under section 3441, if the Secretary determines that subordination or waiver will further the objectives of this part.

SEC. 3444. PROVISIONS REGARDING CONSTRUCTION OR EXPANSION OF FACILITIES.

(a) SUBMISSION OF INFORMATION.—In the case of a project for construction, conversion, expansion or modernization of a facility, the Secretary may provide loans under section 3441 only if the applicant submits to the Secretary the following:

(1) A description of the site.

(2) Plans and specifications which meet requirements prescribed by the Secretary.

(3) Information reasonably demonstrating that title to such site is vested in one or more of the entities filing the application (unless the agreement described in subsection (b)(1) is made).

(4) A specification of the type of assistance being requested under section 3441.

(b) AGREEMENTS.—In the case of a project for construction, conversion, expansion or modernization of a facility, the Secretary may provide loans under section 3441 only if the applicant makes the following agreements:

(1) Title to such site will be vested in one or more of the entities filing the application (unless the assurance described in subsection (a)(3) has been submitted under such subsection).

(2) Adequate financial support will be available for completion of the project and for its maintenance and operation when completed.

(3) All laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a et seq; commonly known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Appendix) and section 276c of title 40.

(4) The facility will be made available to all persons seeking service regardless of their ability to pay.

SEC. 3445. APPLICATION FOR ASSISTANCE.

The Secretary may provide loans under section 3441 only if an application for such assistance is submitted to

the Secretary, the application contains each agreement described in this subpart, the application contains the information required in section 3444(a), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

SEC. 3446. ADMINISTRATION OF PROGRAMS.

This subpart, and any other program of the Secretary that provides loans, shall be carried out by a centralized loan unit established within the Department of Health and Human Services.

Subpart D—Enabling and Supplemental Services

SEC. 3461. GRANTS AND CONTRACTS FOR ENABLING AND SUPPLEMENTAL SERVICES.

(a) IN GENERAL.—The Secretary may make grants to and enter into contracts with eligible entities to assist such entities in providing the services described in subsections (b) and (c) for the purpose of increasing the capacity of individuals to utilize the items and services included in the comprehensive benefits package under title I, and to provide access to essential supplemental services that are not fully reimbursable under title I prior to January 2001,.

(b) ENABLING SERVICES.—Enabling services shall include transportation, community and patient outreach, patient and family education, translation services, case management, home visiting, and such other services as the Secretary determines to be appropriate in carrying out the purpose described in such subsection.

(c) SUPPLEMENTAL SERVICES.—Supplemental services shall include items or services described in section 1106 or section 1118 of this Act that would otherwise be excluded from coverage prior to January 1, 2001.

(d) CERTAIN REQUIREMENTS REGARDING PROJECT AREA.—The Secretary may make an award of a grant or contract under subsection (a) only if the applicant involved—

(1) submits to the Secretary—

(A) information demonstrating that the medically underserved populations in the community to be served under the award have a need for enabling services; and

(B) a proposed budget for providing such services;

(2) the applicant for the award agrees that the medically underserved residents of the community will be consulted with respect to the design and im-

plementation of the project carried out with the award;

(3) agrees that the services will not be denied because the individual is unable to pay for such services; and

(4) agrees that the applicant will utilize existing resources to the maximum extent practicable.

(e) APPLICATION FOR AWARDS OF ASSISTANCE.—The Secretary may make an award of a grant or contract under subsection (a) only if an application for the award is submitted to the Secretary, the application contains each agreement described in this subpart, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

SEC. 3462. AUTHORIZATIONS OF APPROPRIATIONS.

(a) ENABLING SERVICES.—For the purpose of carrying out section 3461(b), there are authorized to be appropriated $35,000,000 for fiscal year 1996, $140,000,000 for each of the fiscal years 1997 through 1999, and $175,000,000 for fiscal year 2000.

(b) SUPPLEMENTAL SERVICES.—For the purpose of carrying out section 3461(c), there are authorized to be appropriated $100,000,000 for fiscal year 1995,

$150,000,000 for fiscal year 1996, and $250,000,000 for each of the fiscal years 1997 through 2000.

(c) FEDERALLY QUALIFIED HEALTH CENTERS.—With respect to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act), for the purpose of carrying out section 3461(b), there are authorized to be appropriated $65,000,000 for fiscal year 1996, $260,000,000 for each of the fiscal years 1997 through 1999, and $325,000,000 for fiscal year 2000.

(d) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

PART 2—NATIONAL HEALTH SERVICE CORPS

SEC. 3471. AUTHORIZATIONS OF APPROPRIATIONS.

(a) ADDITIONAL FUNDING; GENERAL CORPS PROGRAM; ALLOCATIONS REGARDING NURSES.—For the purpose of carrying out subpart II of part D of title III of the Public Health Service Act, and for the purpose of carrying out section 3472, there are authorized to be appropriated $150,000,000 for fiscal year 1996, $150,000,000 for fiscal year 1997, and $250,000,000 for each of the fiscal years 1998 through 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 3472. ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Of the amounts appropriated under section 3471, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program under section 338A of the Public Health Service Act, or in the Loan Repayment Program under section 338B of such Act, the total number who are being educated as nurse practitioners, nurse midwives, or nurse anesthetists or are serving as nurse practitioners, nurse midwives, or nurse anesthetists, respectively, is increased to 20 percent.

SEC. 3473. ALLOCATION FOR PARTICIPATION OF PSYCHIATRISTS, PSYCHOLOGISTS, AND CLINICAL SOCIAL WORKERS IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Of the amounts appropriate under section 3471, the Secretary shall reserve such amounts as may be necessary to ensure that of the aggregate number of individuals who

are participants in the scholarship program under section 338A of the Public Health Service Act, the number who are being educated as psychiatrists, psychologists, and clinical social workers or are serving as psychiatrists, psychologists, and clinical social workers, respectively, is increased to 15 percent.

PART 3—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

SEC. 3481. PAYMENTS TO HOSPITALS.

(a) ENTITLEMENT STATUS.—The Secretary shall make payments in accordance with this part to eligible hospitals described in section 3482. The preceding sentence—

(1) is an entitlement in the Secretary on behalf of such eligible hospitals (but is not an entitlement in the State in which any such hospital is located or in any individual receiving services from any such hospital); and

(2) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the fiscal years, specified in subsection (b).

(b) APPROPRIATIONS.—

(1) IN GENERAL.—For purposes of subsection (a)(2), the amounts and fiscal years specified in this subsection are (in the aggregate for all eligible hospitals) $1,300,000,000 for the fiscal year in which the general effective date occurs and for each subsequent fiscal year.

(2) SPECIAL RULE FOR YEARS BEFORE GENERAL EFFECTIVE DATE.—

(A) IN GENERAL.—For each of the fiscal years 1996 and 1997, the amount specified in this subsection for purposes of subsection (a)(2) shall be equal to the aggregate DSH percentage of the amount otherwise determined under paragraph (1).

(B) AGGREGATE DSH PERCENTAGE DEFINED.—In subparagraph (A), the ''aggregate DSH percentage'' for a year is the amount (expressed as a percentage) equal to—

(i) the total amount of payment made by the Secretary under section 1903(a) of the Social Security Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in the States in which eligible

hospitals for the year are located; divided by

(ii) the total amount of payment made by the Secretary under section 1903(a) of such Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in all States.

(c) PAYMENTS MADE ON QUARTERLY BASIS.—Payments to an eligible hospital under this section for a year shall be made on a quarterly basis during the year.

SEC. 3482. IDENTIFICATION OF ELIGIBLE HOSPITALS.

(a) STATE IDENTIFICATION.—In accordance with the criteria described in subsection (b) and such procedures as the Secretary may require, each State shall identify the hospitals in the State that meet such criteria and provide the Secretary with a list of such hospitals.

(b) CRITERIA FOR ELIGIBILITY.—A hospital meets the criteria described in this subsection if the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act) is not less than 25 percent.

SEC. 3483. AMOUNT OF PAYMENTS.

(a) DISTRIBUTION OF ALLOCATION FOR LOW-INCOME ASSISTANCE.—

(1) ALLOCATION FROM TOTAL AMOUNT.—Of the total amount available for payments under this section in a year, 66.66 percent shall be allocated to hospitals for low-income assistance in accordance with this subsection.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital from the allocation made under paragraph (1) during a year shall be the equal to the hospital's low-income percentage of the allocation for the year.

(b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE FOR UNCOVERED SERVICES.—

(1) ALLOCATION FROM TOTAL AMOUNT; DETERMINATION OF STATE-SPECIFIC PORTION OF ALLOCATION.—Of the total amount available for payments under this section in a year, 33.33 percent shall be allocated to hospitals for assistance in furnishing hospital services that are not covered services under title I (in accordance with regulations of the Secretary) or in furnishing hospital services to individuals, including those residing in Southwestern border States, who are not eligible individuals under title I, in accordance with this subsection. The

amount available for payments to eligible hospitals in a State shall be equal to an amount determined in accordance with a methodology specified by the Secretary that shall take into consideration the volume of such services provided by hospital in the State as compared to the volume of such services provided by all eligible hospitals.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital in a State from the amount available for payments to eligible hospitals in the State under paragraph (1) during a year shall be the equal to the hospital's low-income percentage of such amount for the year.

(c) LOW-INCOME PERCENTAGE DEFINED.—

(1) IN GENERAL.—In this subsection, an eligible hospital's ''low-income percentage'' for a year is equal to the amount (expressed as a percentage) of the total low-income days for all eligible hospitals for the year that are attributable to the hospital.

(2) LOW-INCOME DAYS DESCRIBED.—For purposes of paragraph (1), an eligible hospital's low-income days for a year shall be equal to the product of—

(A) the total number of inpatient days for the hospital for the year (as reported to the Secretary by the State in which the hospital is located, in accordance with a reporting schedule and procedures established by the Secretary); and

(B) the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act).

SEC. 3484. BASE YEAR.

In this part, the ''base year'' is, with respect to a State and hospitals in a State, the year immediately prior to the year in which the general effective date occurs.

PART 4—SENSE OF THE COMMITTEE

SEC. 3491. SENSE OF THE COMMITTEE.

It is the sense of the Committee on Labor and Human Resources of the Senate that when the Health Security Act is enacted, it and subsequent appropriations Acts should appropriately recognize the success of community and migrant health centers as a proven, cost-effective model for the delivery of health care services to those populations which are medically underserved because of economic, geographic, and cultural barriers.

Subtitle F—Mental Health; Substance Abuse

PART 1—AUTHORITIES REGARDING PARTICIPATING STATES

SEC. 3510. INTEGRATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS.

(a) IN GENERAL.—As a condition of being a participating State under title I, each State shall, not later than January 1, 2001, achieve the integration of the mental illness and substance abuse services of the State and its political subdivisions with the mental illness and substance abuse services offered by health plans pursuant to title I of this Act. A State may petition the Secretary for a waiver of the requirement of this subsection under the circumstances described in section 3511(b)(7).

(b) CERTIFICATION OF READINESS.—

(1) PETITION.—A State may petition the Secretary to integrate the mental illness and substance abuse services of the State and its political subdivisions with the mental illness and substance abuse services offered by health plans pursuant to title I of this Act prior to January 1, 2001.

(2) STATE READINESS TO INTEGRATE.—Upon receiving such a petition, the Secretary shall, based on the reports submitted pursuant to subsections (b)

and (c) of section 3511 and the criteria promulgated pursuant to paragraph (3), ascertain the State's readiness to integrate its mental illness and substance abuse services with the mental illness and substance abuse services offered by health plans pursuant to title I of this Act and certify whether the State is prepared to conduct such an integration.

(3) CRITERIA.—The certification by the Secretary of a State's readiness to integrate under paragraph (2) shall be based on objective criteria promulgated by the Secretary after consultation with the States.

(c) APPLICATION OF PROVISIONS.—Upon the issuance of a certification of readiness by the Secretary for a State, the limits set forth in subsections (d)(2)(B) and (e)(2)(A) of section 1106 shall not apply to the provision of mental illness and substance abuse services in the State.

SEC. 3511. REPORT ON INTEGRATION OF MENTAL HEALTH SYSTEMS.

(a) IN GENERAL.—As a condition of being a participating State under title I, each State shall, not later than October 1, 1998, submit to the Secretary a report containing the information described in subsection (b) on (including a plan for) the measures to be implemented by the State to achieve the integration of the mental illness and

substance abuse services of the State and its political subdivisions with the mental illness and substance abuse services that are included in the comprehensive benefit package under title I. The plan required in the preceding sentence shall meet the conditions described in section 3083(b). In addition, each State shall submit to the Secretary a report containing the information described in subsection (c) for each year in which the State participates under title I up to and including the year 2001 or the date on which an unlimited benefit for mental illness and substance abuse services is provided, whichever occurs later.

(b) REQUIRED CONTENTS OF INTEGRATION REPORT.—With respect to the provision of items and services relating to mental illness and substance abuse, the report of a State under subsection (a) shall, at a minimum, contain the following information:

(1) Information on the number of individuals served by or through mental illness and substance abuse programs administered by State and local agencies and the proportion who are eligible persons under title I.

(2) Information on the extent to which each health provider furnishing mental illness and substance abuse services under a State program partici-

pates or will participate in one or more regional or corporate alliance health plans, and, in the case of providers that do not so participate, the reasons for the lack of participation.

(3) With respect to the two years preceding the year in which the State becomes a participating State under title I—

(A) the amount of funds expended by the State and its political subdivisions for each of such years for items and services that are included in the comprehensive benefit package under such title;

(B) the amount of funds expended for medically necessary and appropriate items and services not included in such benefit package, including medical care, other health care, and supportive services related to the provision of health care.

(4) An estimate of the amount that the State will expend to furnish items and services not included in such package once the expansion of coverage for mental illness and substance abuse services is implemented in the year 2001.

(5) A description of how the State will assure that all individuals served by mental illness and sub-

stance abuse programs funded by the State will be enrolled in a health plan and how mental illness and substance abuse services not covered under the benefit package will continue to be furnished to such enrollees.

(6) A description of the conditions under which the integration of mental illness and substance abuse providers into regional and corporate alliances can be achieved, and an identification of changes in participation and certification requirements that are needed to achieve the integration of such programs and providers into health plans.

(7) If the integration of mental illness and substance abuse programs operated by the State into one or more health plans is not medically appropriate or feasible for one or more groups of individuals treated under State programs, a description of the reasons that integration is not feasible or appropriate and a plan for assuring the coordination for such individuals of the care and services covered under the comprehensive benefit package with the additional items and services furnished by such programs.

(8) A description of the manner in which the resources that the State and its political subdivisions

currently spend on mental health and substance abuse services will be used to facilitate integration.

(c) REQUIRED CONTENTS OF TRANSITION REPORT.—With respect to the a report required under this subsection, the report shall, at a minimum, contain the following information:

(1) The amount of funds expended for substance abuse and mental health services by the source of revenue, including, Federal block grant funds, under title XIX of the Public Health Service Act, Federal categorical grant funds, State and local revenues and health plan payments.

(2) The amount of funds expended for supportive services to individuals enrolled in substance abuse and mental health treatment programs, including transportation, child care, educational and vocational training and coordination with other public systems such as the social service, child welfare and juvenile and criminal justice systems, by source of revenue.

(3) The amount of funds expended on medically necessary and appropriate items and services not covered or reimbursed in the comprehensive benefit package by source of revenue.

(4) The amount of funds expended by the State on substance abuse and mental illness services for individuals who are not eligible to receive the comprehensive benefit package pursuant to this Act, and the source of revenue for such services.

(d) GENERAL PROVISIONS.—Reports under subsections (b) and (c) shall be provided at the time and in the manner prescribed by the Secretary. The Secretary shall also determine what, if any, reports shall be submitted in years following the implementation of an unlimited benefit for mental illness and substance abuse services.

(e) REPORTING REQUIREMENT.—Each State shall report annually to the Secretary on the incidence and prevalence of mental illness and substance abuse disorders in the prison population, changes in such incidence and prevalence in the prison population, and potential causative factors with respect to such changes, including an estimate of the extent to which the denial of treatment, or the provision of inadequate treatment, to individuals with mental illness and substance abuse disorders is contributing to the criminal activity of such individuals.

PART 2—ASSISTANCE FOR STATE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

SEC. 3531. AVAILABILITY OF ASSISTANCE.

(a) IN GENERAL.—The Secretary shall make grants to States for the development and operation of comprehensive managed mental health and substance abuse programs that are integrated with the health delivery system established under this Act. Such programs shall—

(1) promote the development of integrated delivery systems for the management of the mental health and substance abuse services provided under the comprehensive benefits package;

(2) give priority to providing services to low-income adults with serious mental illness or substance abuse disorders and children with serious emotional disturbance or substance abuse disorders and provide for the phase-in of such services for all eligible persons within 5 years;

(3) ensure that individuals participating in the program have access to all medically necessary mental health and substance abuse services;

(4) promote the linkage of mental health and substance abuse services with primary and preventive health care services; and

(5) meet such other requirements as the Secretary may impose.

(b) EXCEPTION.—Nothing in this part shall be construed as preventing States that have separate administrative entities for mental health and for substance abuse services from establishing separate comprehensive managed care programs for such services and receiving assistance under this part for either or both programs.

SEC. 3532. PLAN REQUIREMENTS.

In order to receive a grant under this part, a State must have a plan for a comprehensive managed mental health and substance abuse program which is approved by the Secretary. Such plan shall—

(1) describe the management, access, and referral structure that the State will use to promote and achieve integration of mental health and substance abuse services with the health delivery system established under this Act for eligible individuals in the State;

(2) describe how the State will ensure that providers of specialized services will meet appropriate standards and provide assurances that the State has complied with section 1504 as it affects mental health and substance abuse services;

(3) describe payment, utilization review, and other mechanisms that the State will use to encourage appropriate service delivery and management of costs;

(4) describe uniform patient placement criteria that the State will use to ensure placement in appropriate substance abuse treatment programs;

(5) describe the processes the State will use to ensure that individuals will continue to have access to treatment through referrals from nonhealth public entities, such as the juvenile or criminal justice systems, or social service systems;

(6) specify the methods the State will use to ensure that individuals receiving services under the program have access to all medically necessary and appropriate mental health and substance abuse services;

(7) define terms that will be used by the State in determining the eligibility of individuals for services under the program;

(8) describe how health plans will use services under the comprehensive managed mental health and substance abuse programs established under this part;

(9) describe the role of local government in financing and managing the integrated mental illness and substance abuse treatment system;

(10) describe the sources of funding, including Medicaid and the block grants authorized by title XIX of the Public Health Service Act, that will be used by the State, other than the grant received under this part, to operate the program, and provide the status of any request for a Medicaid waiver made by the State to the Secretary;

(11) describe how the State provided for broad-based public input in the development of the plan, and the mechanism that will be used for ongoing public comment on and review of amendments to the plan; and

(12) describe grievance procedures that will be available for individuals dissatisfied with their health plan's participation in the comprehensive managed mental health and substance abuse program, and mechanisms that will be available to review the performance of health plans and fee-for-service arrangements to ensure against under treatment.

SEC. 3533. ADDITIONAL FEDERAL RESPONSIBILITIES.

The Secretary shall, upon the submission of a State's plan under section 3532, ensure the timely consideration

of any Medicaid waiver requests submitted by the State, affirm that section 1504 has been implemented, and ensure the timely implementation of section 1641(b)(5).

SEC. 3534. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this part, $100,000,000 for each of the fiscal years 1995 through 2000.

Subtitle G—Comprehensive School Health Education; School-Related Health Services

PART 1—HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS FOR SCHOOL HEALTH EDUCATION

SEC. 3601. PURPOSES.

It is the purpose of this part—

(1) to support the development and implementation of comprehensive age appropriate health education programs in public schools for children and youth kindergarten through grade 12; and

(2) to increase access to preventive and primary health care services for children and youth through school-based or school-linked health service sites in accordance with locally determined needs.

SEC. 3602. HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Education, shall award grants to State educational agencies in eligible States to integrate comprehensive school health education in schools within the State, with priority given within States to those communities in greatest need as defined by section 3683(a).

(b) ELIGIBLE USES OF FUNDS.—Funds made available under this section shall be used—

(1) to implement comprehensive school health education programs, as defined in subsection (f)(1) through grants to local educational agencies;

(2) to provide staff development and technical assistance to local educational agencies, schools, local health agencies, and other community organizations involved in providing comprehensive school health education programs;

(3) to evaluate and report to the Secretary on the progress made towards attaining the goals and objectives described under subsection (c)(1)(A); and

(4) to conduct such other activities to achieve the objectives of this subpart as the Secretary may require.

(c) APPLICATION.—An application for a grant under subsection (a), shall be jointly developed by the State edu-

cational agency and the State health agencies of the State involved, and shall contain—

(1) a State plan for comprehensive school health education programs, that outlines—

(A) the goals and objectives of the State for school health education programs, and the manner in which the State will allocate funds to local educational agencies in order to achieve these goals and objectives;

(B) the manner in which the State will coordinate programs under this part with other Federal, State and local health education programs and resources, and school health services;

(C) the manner in which comprehensive school health education programs will be coordinated with other Federal, State and local education programs (such as programs under titles I, II, and IV of the Elementary and Secondary Education Act of 1965), with the school improvement plan of the State, if any, under title III of the Goals 2000: Educate America Act, and with any similar programs;

(D) the manner in which the State shall work with State and local educational agencies

and with State and local health agencies to reduce barriers to implementing school health education programs;

(E) the manner in which the State will monitor the implementation of such programs by local educational agencies and establish outcome criteria by which to evaluate their effectiveness in achieving progress towards the goals and objectives described in subparagraph (A);

(F) the manner in which the State will provide staff development and technical assistance to local educational agencies, and build capacity for professional development of health educators; and

(G) the manner in which such school health education programs will be, to the extent practicable, culturally competent and linguistically appropriate and responsive to the diverse needs of the students served;

(2) a description of the respective roles of the State educational agency, local educational agencies, the State health agency and local health agencies in developing and implementing the State's school health education plan and resulting programs;

(3) a description of the input of the local community (including students and parents) in the development and operation of comprehensive school health education programs;

(4) an assurance that communities identified in section 3683(a) receive priority as locations for comprehensive school health education programs for all grades to the extent that a State does not implement a statewide program; and

(5) an assurance that grants to local educational agencies under subsection (b)(1) are contingent upon submission by such agencies of a plan consistent with the requirements for the State plan as required under this subsection.

(d) WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS.—

(1) WAIVERS.— Except as provided in paragraph (4), upon the request of an entity and under a relevant program described in paragraph (2), the Secretary of Health and Human Services and the Secretary of Education may grant to the entity a waiver of any requirement of such program regarding the use of funds, or of the regulations issued for the program by the Secretary involved, if the following conditions are met with respect to such program:

(A) The Secretary involved determines that the requirements of such program impede the ability of the State educational agency to achieve more effectively the purposes described in section 3601.

(B) The Secretary involved determines that, with respect to the use of funds under such program, the requested use of the funds by the entity would be consistent with the purposes described in section 3601.

(C) The State educational agency provides all interested local educational agencies in the State with notice and an opportunity to comment on the proposal and makes these comments available to the Secretary.

(2) RELEVANT PROGRAMS.—For purposes of paragraph (1), the programs described in this subparagraph are the following:

(A) In the case of programs administered by the Secretary of Health and Human Services, the following:

(i) The program known as the Prevention, Treatment, and Rehabilitation Model Projects for High Risk Youth, carried out

under section 517 of the Public Health Service Act.

(ii) The program known as the State and Local Comprehensive School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes, carried out under such Act.

(B) In the case of programs administered by the Secretary of Education, any program carried out under part B of the Drug-Free Schools and Communities Act of 1986, except that a component of such comprehensive school health education must be consistent with the statutory intent and purposes of such Act.

(3) WAIVER PERIOD.—A waiver under this paragraph shall be for a period not to exceed 3 years, unless the Secretary involved determines that—

(A) the waiver has been effective in enabling the State to carry out the activities for which it was requested and has contributed to improved performance of comprehensive health education programs; and

(B) such extension is in the public interest;

(4) WAIVERS NOT AUTHORIZED.—The Secretary involved under paragraph (1), may not waive, under this section, any statutory or regulatory requirements relating to—

(A) comparability of services;

(B) maintenance of effort;

(C) parental participation and involvement;

(D) the distribution of funds to States or to local educational agencies or other recipients of funds under the programs described in paragraph (2);

(E) maintenance of records;

(F) applicable civil rights requirements; or

(G) the requirements of sections 438 and 439 of the General Education Provisions Act.

(5) TERMINATION OF WAIVER.—The Secretary involved under paragraph (1) shall terminate a waiver under this subsection if the Secretary determines that the performance of the State affected by the waiver has been inadequate to justify a continuation of the waiver or if it is no longer necessary to achieve its original purpose.

(e) DEFINITIONS.—As used in this section:

(1) COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The term ''comprehensive school health

education'' means a planned, sequential program of health education that addresses the physical, emotional and social dimensions of student health in kindergarten through grade 12. Such program shall—

(A) be designed to assist students in developing the knowledge and behavioral skills needed to make positive health choices and maintain and improve their health, prevent disease and injuries, and reduce risk behaviors which adversely impact health;

(B) be comprehensive and include a variety of components addressing personal health, community and environmental health, injury prevention and safety, nutritional health, the effects of substance use and abuse, consumer health regarding the benefits and appropriate use of medical services including immunizations and other clinical preventive services, and other components deemed appropriate by the local educational agencies;

(C) be designed to be linguistically and culturally competent and responsive to the needs of the students served; and

(D) address locally relevant priorities as determined by parents, students, teachers, and school administrators and health officials.

(2) ELIGIBLE STATE.—The term ''eligible State'' means a State with a memorandum of understanding or a written cooperative agreement entered into by the agencies responsible for health and education concerning the planning and implementation of comprehensive school health education programs. Among these States a priority shall be given to qualified States as defined in section 3682(c).

(3) STATE EDUCATIONAL AGENCY.—The term ''State educational agency'' means the officer or agency primarily responsible for the State supervision of public elementary and secondary schools.

(4) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' means a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or such combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or

secondary schools. Such term includes any other public institution or agency having administrative control and direction of a public elementary or secondary school.

(f) AUTHORIZED FUNDING.—For the purpose of carrying out this section, out of the funds available under section 3695(b)(2), there are made available, not to exceed $15,000,000 for fiscal year 1995, $20,000,000 for fiscal year 1996, $25,000,000 for fiscal year 1997, $30,000,000 for fiscal year 1998, $40,000,000 for fiscal year 1999, and $50,000,000 for fiscal year 2000.

SEC. 3603. HEALTHY STUDENTS-HEALTHY SCHOOLS INTERAGENCY TASK FORCE.

(a) ESTABLISHMENT.—Not later than 120 days after the date of enactment of this Act, the Secretary shall establish a Healthy Students-Healthy Schools Interagency Task Force to be composed of representatives of the Office of Disease Prevention and Health Promotion, the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Office of School Health Education within the Department of Education, and other Federal agencies and departments which have responsibility for components of school health and education.

(b) CO-CHAIRPERSONS.—The Assistant Secretary for Health and the Assistant Secretary for Elementary and Secondary Education shall serve as co-chairpersons of the task force established under subsection (a).

(c) FUNCTIONS AND ACTIVITIES.—The task force established under subsection (a) shall—

(1) review and coordinate all Federal efforts in school health education and health services;

(2) provide scientific and technical advice concerning the development and implementation of model comprehensive school health education programs and curricula;

(3) develop model student learning objectives and assessment instruments that shall be made available to all States;

(4) develop a uniform grant application form (a form that serves as the principal document containing the core information concerning a particular entity) and procedures that may be used with respect to all school health education-related programs (including supplementary information procedures to be implemented when an entity that has already submitted an application form is applying for additional assistance) that require the submission of an application; and

(5) recommend to the Secretary, for inclusion in the biennial report required by section 3604(2), methods for effectively linking school health education and health services research findings at the Federal level with implementation at the State and local levels.

(d) CONSOLIDATION OF INITIATIVES.—Not later than 12 months after the date of enactment of this Act, the task force established under subsection (a) shall prepare and submit to the Congress a report containing the recommendations of the task force for the consolidation of Federal school health education initiatives.

SEC. 3604. DUTIES OF THE SECRETARY.

The Secretary shall—

(1) establish and maintain a national clearinghouse, using advanced technologies to the maximum extent practicable, and mechanisms for the diverse dissemination of school health education material, including written, audio-visual, and electronically conveyed information to educators, schools, health care providers, and other individuals, organizations, and governmental entities;

(2) submit a biennial report to the Committee on Labor and Human Resources of the Senate and the appropriate committees of the House of Rep-

resentatives on the implementation and contribution of comprehensive school health education programs funded under this part toward achieving relevant National Healthy People 2000 objectives established by the Secretary; and

(3) encourage coordination among Federal agencies, State and local governments, educators, school health providers, community-based organizations, and private sector entities to support development of comprehensive school health education programs and school health services.

PART 5—SCHOOL-RELATED HEALTH SERVICES

Subpart A—Development and Operation

SEC. 3681. AUTHORIZATION OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subpart, there are authorized to be appropriated $100,000,000 for fiscal year 1995, $200,000,000 for fiscal year 1996, $325,000,000 for fiscal year 1997, $450,000,000 for fiscal year 1998, $575,000,000 for fiscal year 1999, and $700,000,000 for fiscal year 2000.

(b) FUNDING FOR PLANNING AND DEVELOPMENT GRANTS.—Of amounts made available under this section, not to exceed $10,000,000 for each of fiscal years 1995 and 1996 may be utilized to carry out section 3684.

SEC. 3682. ELIGIBILITY FOR GRANTS.

(a) IN GENERAL.—

(1) PLANNING AND DEVELOPMENT GRANTS.—Entities eligible to apply for and receive grants under section 3684 are—

(A) State health agencies that apply on behalf of local community partnerships; or

(B) local community partnerships in States in which health agencies have not successfully applied.

(2) OPERATIONAL GRANTS.—Entities eligible to apply for and receive grants under section 3685 are—

(A) a qualified State as designated under subsection (c) that apply on behalf of local community partnerships; or

(B) local community partnerships in States that are not designated under subparagraph (A).

(b) LOCAL COMMUNITY PARTNERSHIPS.—

(1) IN GENERAL.—A local community partnership under subsection (a)(1)(B) and (a)(2)(B) is an entity that, at a minimum includes—

(A) a local health care provider, which may be a local public health department, with expe-

rience in delivering services to children and youth or medically underserved populations;

(B) local educational agency on behalf of one or more public schools; and

(C) one community-based organization located in the community to be served that has a history of providing services to at-risk children and youth.

(2) RURAL COMMUNITIES.—In rural communities, local partnerships should seek to include, to the fullest extent practicable, providers and community-based organizations with experience in serving the target population.

(3) PARENT AND COMMUNITY PARTICIPATION.—An applicant described in subsection (a) shall, to the maximum extent feasible, involve broad-based community participation (including parents of the youth to be served).

(c) QUALIFIED STATE.—A qualified State under subsection (a)(2)(A) is a State that, at a minimum—

(1) demonstrates an organizational commitment (including a strategic plan) to providing a broad range of health, health education and support services to at-risk youth; and

(2) has a memorandum of understanding or cooperative agreement jointly entered into by the State agencies responsible for health and education regarding the planned delivery of health and support services in school-based or school-linked centers.

SEC. 3683. PREFERENCES.

In making grants under sections 3684 and 3685, the Secretary shall give priority to applicants whose-communities to be served show the most substantial level of need for health services among children and youth.

SEC. 3684. PLANNING AND DEVELOPMENT GRANTS.

(a) IN GENERAL.—The Secretary may make grants during fiscal years 1995 and 1996 to entities eligible under section 3862 to develop school-based or school-linked health service sites.

(b) USE OF FUNDS.—Amounts provided under a grant under this section may be used for the following:

(1) Planning for the provision of school health services, including—

(A) an assessment of the need for health services among youth in the communities to be served;

(B) the health services to be provided and how new services will be integrated with existing services;

(C) assessing and planning for the modernization and expansion of existing facilities and equipment to accommodate such services; and

(D) an affiliation with relevant health plans.

(2) recruitment and training of staff for the administration and delivery of school health services;

(3) the establishment of local community partnerships as described in section 3682 (b);

(4) in the case of States, the development of memorandums of understanding or cooperative agreements for the coordinated delivery of health and support services through school health service sites; and

(5) other activities necessary to assume operational status.

(c) APPLICATION FOR GRANTS.—To be eligible to receive a grant under this section an entity described in section 3682 (a) shall submit an application in a form and manner prescribed by the Secretary.

(d) NUMBER OF GRANTS.—Not more than one planning grant may be made to a single applicant. A planning grant may not exceed 2 years in duration.

(e) AMOUNT AVAILABLE FOR DEVELOPMENT GRANT.—The Secretary may award not to exceed—

(1) $150,000 to entities under section 3682(a)(1)(A) and to localities planning for a city-wide or countywide school health services delivery system; and

(2) $50,000 to entities under section 3682(a)(1)(B).

SEC. 3685. GRANTS FOR OPERATION OF SCHOOL HEALTH SERVICES.

(a) IN GENERAL.—The Secretary may make grants to eligible entities described in section 3682(a)(2) that submit applications consistent with the requirements of this section, to pay the cost of operating school-based or school-linked health service sites.

(b) USE OF GRANT.—Amounts provided under a grant under this section may be used for the following—

(1) health services, including diagnosis and treatment of simple illnesses and minor injuries;

(2) preventive health services, including health screenings follow-up health care, mental health, and preventive health education;

(3) enabling services, as defined in section 3461(b), and other necessary support services;

(4) training, recruitment, and compensation of health professionals and other staff necessary for the administration and delivery of school health services; and

(5) referral services, including the linkage of individuals to health plans, and community-based health and social service providers.

(c) APPLICATION FOR GRANT.—To be eligible to receive a grant under this section an entity described in section 3682(a)(2) shall submit an application in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant must include in the application the following information—

(1) a description of the services to be furnished by the applicant;

(2) the amounts and sources of funding that the applicant will expend, including estimates of the amount of payments the applicant will receive from health plans and other sources;

(3) a description of local community partnerships, including parent and community participation;

(4) a description of the linkages with other health and social service providers; and

(5) such other information as the Secretary determines to be appropriate.

(d) ASSURANCES.—In order to receive a grant under this section, an applicant must meet the following conditions—

(1) school health service sites will, directly or indirectly, provide a broad range of health services, in accordance with the determinations of the local community partnership, that may include—

(A) diagnosis and treatment of simple illnesses and minor injuries;

(B) preventive health services, including health screenings and follow-up health care, mental health and preventive health education;

(C) enabling services, as defined in section 3461(b);

(D) referrals (including referrals regarding mental health and substance abuse) with follow-up to ensure that needed services are received;

(2) the applicant provides services recommended by the health provider, in consultation with the local community partnership, and with the approval of the local education agency;

(3) the applicant provides the services under this subsection to adolescents, and other school age children and their families as deemed appropriate by the local partnership;

(4) the applicant maintains agreements with community-based health care providers with a history of providing services to such populations for the provision of health care services not otherwise provided directly or during the hours when school health services are unavailable;

(5) the applicant establishes an affiliation with relevant health plans and will establish reimbursement procedures and will make every reasonable effort to collect appropriate reimbursement for services provided; and

(6) the applicant agrees to supplement and not supplant the level of State or local funds under the direct control of the applying State or participating local education or health authority expended for school health services as defined by this Act;

(7) services funded under this Act will be coordinated with existing school health services provided at a participating school; and

(8) for applicants in rural areas, the assurances required under paragraph (4) shall be fulfilled to the maximum extent possible.

(e) STATE LAWS.—Notwithstanding any other provision in this part, no school based health clinic may provide services, to any minor, when to do so is a violation of State

laws or regulations pertaining to informed consent for medical services to minors.

(f) LIMITATION ON ADMINISTRATIVE FUNDS.—In the case of a State applying on behalf of local educational partnerships, the applicant may retain not more than 5 percent of grants awarded under this subpart for administrative costs.

(g) DURATION OF GRANT.—A grant under this section shall be for a period determined appropriate by the Secretary.

(h) AMOUNT OF GRANT.—The annual amount of a grant awarded under this section shall not be more than $200,000 per school-based or school-linked health service site.

(i) FEDERAL SHARE.—

(1) IN GENERAL.—Subject to paragraph (3), a grant for services awarded under this section may not exceed—

(A) 90 percent of the non-reimbursed cost of the activities to be funded under the program for the first 2 fiscal years for which the program receives assistance under this section; and

(B) 75 percent of the non-reimbursed cost of such activities for subsequent years for which

the program receives assistance under this section.

The remainder of such costs shall be made available as provided in paragraph (2).

(2) FORM OF NON-FEDERAL SHARE.—The non-Federal share required by paragraph (1) may be in cash or in-kind, fairly evaluated, including facilities, equipment, personnel, or services, but may not include amounts provided by the Federal Government. In-kind contributions may include space within a school facilities, school personnel, program use of school transportation systems, outposted health personnel, and extension of health provider medical liability insurance.

(3) WAIVER.—The Secretary may waive the requirements of paragraph (1) for any year in accordance with criteria established by regulation. Such criteria shall include a documented need for the services provided under this section and an inability of the grantee to meet the requirements of paragraph (1) despite a good faith effort.

(j) TRAINING AND TECHNICAL ASSISTANCE.—Entities that receive assistance under this section may use not to exceed 10 percent of the amount of such assistance to provide staff training and to secure necessary technical as-

sistance. To the maximum extent feasible, technical assistance should be sought through local community-based entities. The limitation contained in this subsection shall apply to individuals employed to assist in obtaining funds under this part. Staff training should include the training of teachers and other school personnel necessary to ensure appropriate referral and utilization of services, and appropriate linkages between class-room activities and services offered.

(k) REPORT AND MONITORING.—The Secretary will submit to the Committee on Labor and Human Resources in the Senate and the Committee on Energy and Commerce in the House of Representatives a biennial report on the activities funded under this Act, consistent with the ongoing monitoring activities of the Department. Such reports are intended to advise the relevant Committees of the availability and utilization of services, and other relevant information about program activities.

Subpart B—Capital Costs of Developing Projects

SEC. 3691. FUNDING.

Amounts available to the Secretary under section 3412 for the purpose of carrying out subparts B and C of part 2 of subtitle E are, in addition to such purpose, available to the Secretary for the purpose of carrying out this subpart.

Subtitle H—Public Health Service Initiative

SEC. 3695. PUBLIC HEALTH SERVICE INITIATIVE.

(a) IN GENERAL.—Subject to subsection (c), the Secretary of Health and Human Services shall pay, from funds in the Treasury not otherwise appropriated, individuals and entities that are eligible to receive assistance pursuant to the provisions referred to in paragraphs (1) through (13) of subsection (b), to the extent of the amounts specified under subsection (b).

(b) AMOUNTS SPECIFIED.—The amounts specified in subsection (a) with respect to a fiscal year shall be—

(1) with respect to the health services research activities authorized under the amendments made by section 3202, $150,000,000 for fiscal year 1995, $400,000,000 for fiscal year 1996, $500,000,000 for fiscal year 1997, and $600,000,000 for each of the fiscal years 1998 through 2000;

(2) with respect to the core functions of public health programs authorized under part 2 of subtitle D of title III, $150,000,000 for fiscal year 1995, $225,000,000 for fiscal year 1996, $325,000,000 for fiscal year 1997, $425,000,000 for fiscal year 1998, $500,000,000 for fiscal year 1999, and $625,000,000 for fiscal year 2000;

(3) with respect to the national initiatives regarding health promotion and disease prevention under part 3 of subtitle D of title III, $125,000,000 for each of the fiscal years 1996 through 1998, and $150,000,000 for each of the fiscal years 1999 and 2000;

(4) with respect to occupational injury and illness prevention under section 3903, $150,000,000 for each of the fiscal years 1995 through 2000;

(5) with respect to activities for the development of plans and networks under subpart B of part 2 of subtitle E of title III—

(A) $52,500,000 for fiscal year 1995, $122,500,000 for fiscal year 1996, $192,500,000 for fiscal year 1997, $157,500,000 for fiscal year 1998, $122,500,000 for fiscal year 1999, and $52,500,000 for fiscal year 2000; and

(B) with respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) under such subpart, $97,500,000 for fiscal year 1995, $227,500,000 for fiscal year 1996, $357,500,000 for fiscal year 1997, $292,500,000 for fiscal year 1998,

$227,500,000 for fiscal year 1999, and $97,500,000 for fiscal year 2000;

(6) with respect to capital costs under subpart C of part 2 of subtitle E of title III, $50,000,000 for each of the fiscal years 1995 through 2000;

(7) with respect to enabling services under subpart D of part 2 of subtitle E of title III—

(A) $35,000,000 for fiscal year 1996, $140,000,000 for each of the fiscal years 1997 through 1999, and $175,000,000 for fiscal year 2000; and

(B) with respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) under such subpart, $65,000,000 for fiscal year 1996, $260,000,000 for each of the fiscal years 1997 through 1999, and $325,000,000 for fiscal year 2000;

(8) with respect to supplemental services under subpart D of part 1 of subtitle E of title III, $100,000,000 for fiscal year 1995, $150,000,000 for fiscal year 1996, and $250,000,000 for each of the fiscal years 1997 through 2000;

(9) with respect to the National Health Service Corps program referred to under section 3471,

$150,000,000 for each of the fiscal years 1996 and 1997, and $250,000,000 for each of the fiscal years 1998 through 2000;

(10) with respect to school-related health service programs under subpart A of part 5 of subtitle G of title III, $100,000,000 for fiscal year 1995, $200,000,000 for fiscal year 1996, $325,000,000 for fiscal year 1997, and $450,000,000 for fiscal year 1998, $575,000,000 for fiscal year 1999, and $700,000,000 for fiscal year 2000;

(11) with respect to the development and operation of comprehensive managed mental health and substance abuse programs under section 3534, $100,000,000 for each of the fiscal years 1995 through 2000;

(12) with respect to programs of the Secretary of Health and Human Services under section 3081, $100,000,000 for each of the fiscal years 1995 and 1996, and $150,000,000 for each of the fiscal years 1997 through 2000; and

(13) with respect to programs of the Secretary of Labor under section 3082, $200,000,000 for each of the fiscal years 1995 through 2000.

(c) AUTHORITY TO TRANSFER FUNDS.—The Committee on Appropriations of the House of Representatives

and the Committee on Appropriations of the Senate, acting through appropriations Acts, may transfer the amounts specified under subsection (b) in each fiscal year among the programs referred to in such subsection.

Subtitle I—Additional Provisions Regarding Public Health

SEC. 3901. CURRICULUM DEVELOPMENT AND IMPLEMENTATION REGARDING DOMESTIC VIOLENCE AND WOMEN'S HEALTH.

(a) IN GENERAL.—The Secretary shall make grants to eligible entities for the purpose of implementing and developing for trainees a curriculum that includes training in identification, treatment and referral of victims of domestic violence and women's health needs.

(b) ELIGIBLE ENTITIES.—For purposes of subsection (a), eligible entities are any school of medicine, school of osteopathic medicine, school of public health, graduate program in mental health practice, school of nursing as defined in section 853 of the Public Health Service Act, a program to train physician assistants, a program for training allied health professionals, and a program for training of family medicine physicians, general internists, general pediatricians, geriatricians, and obstetrician/gynecologists.

(c) CURRICULUM.—A curriculum developed under this section shall include—

(1) identification of victims of domestic violence and maintaining complete medical records that include documentation of the examination, treatment provided, and referral made and recording the location and nature of the victim's injuries;

(2) examining and treating such victims within the scope of the health professional's discipline, training, and practice, including at a minimum providing medical advice regarding the dynamics and nature of domestic violence;

(3) referring the victims to public and nonprofit entities that provide support services for such victims;

(4) training in the identification and diagnosis of diseases afflicting women and other medical disorders as they affect women;

(5) training in the treatment of such diseases and disorders with emphasis on the unique needs of women; and

(6) research into the causes of such diseases and disorders, including determination of appropriate means of prevention.

(d) ALLOCATION OF APPROPRIATIONS.—Of the amounts made available under section 3301(b) for a fiscal year, the Secretary shall reserve not to exceed $20,000,000 for a fiscal year for carrying out this section.

Subtitle J—Occupational Safety and Health

SEC. 3903. OCCUPATIONAL INJURY AND ILLNESS PREVENTION.

(a) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall work together to develop and implement a comprehensive program to expand and coordinate initiatives to prevent occupational injuries and illnesses.

(b) SECRETARY OF LABOR.—The Secretary of Labor after consultation with the Secretary of Health and Human Services shall directly or by grants or contracts—

(1) provide for training and education programs for employees and employers in the recognition and control of workplace hazards and methods and measures to prevent occupational injuries and illnesses;

(2) develop model educational materials for training and educating employees and employers on the recognition and control of workplace hazards, including a core curriculum for general safety and

health training and materials related to specific safety and health hazards; and

(3) provide programs and services for technical assistance to employers and employees on the recognition and control of workplace safety and health hazards including programs for onsite consultation.

Technical assistance and consultative services under paragraph (3) shall be provided in a manner that is separate from the enforcement programs conducted by the Secretary of Labor.

(c) SECRETARY OF HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services after consultation with the Secretary of Labor shall directly or by grants or contracts—

(1) provide education programs for training occupational safety and health professionals including professionals in the fields of occupational medicine, occupational health nursing, industrial hygiene, safety engineering, toxicology and epidemiology;

(2) provide education programs for other health professionals and health care providers and the public to improve the recognition, treatment and prevention of occupationally related injuries and illnesses;

(3) conduct surveillance programs to identify patterns and to determine the prevalence of occupa-

tional illnesses, injuries and deaths related to exposure to particular safety and health hazards;

(4) conduct investigations and evaluations to determine if workplace exposures to toxic chemicals, harmful physical agents or potentially hazardous conditions pose a risk to exposed employees; and

(5) conduct research, demonstrations and experiments relating to occupational safety and health to identify the causes of and major factors contributing to occupational illnesses and injuries.

(d) NATIONAL ADVISORY BOARD.—

(1) ESTABLISHMENT.—There is established a National Advisory Board for Occupational Injury and Illness Prevention to provide oversight, advice and direction on the occupational injury and illness prevention programs and initiatives conducted by the Secretary of Labor and Secretary of Health and Human Services.

(2) COMPOSITION.—The Board shall be composed of 10 members appointed by the Secretary of Labor, 5 of whom are to be designated by the Secretary of Health and Human Services. Such members shall be composed of representatives of employers, employees, and occupational safety and health professionals.

(e) DIRECTOR OF NIOSH.—The responsibilities of the Secretary of Health and Human Services established under this section shall be carried out by the Director of the National Institute for Occupational Safety and Health.

(f) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section there are authorized to be appropriated $150,000,000 for each of the fiscal years 1995 through 2000

Subtitle K—Full Funding for WIC

SEC. 3905. FULL FUNDING FOR WIC.

Section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) is amended—

(1) in the second sentence of subsection (a)—

(A) by striking ''authorized'' and inserting ''established''; and

(B) by striking '', up to the authorization levels set forth in subsection (g) of this section,'' and inserting '', up to the levels made available under this section,'';

(2) in subsection (c)—

(A) in the first sentence of paragraph (1), by striking ''may'' and inserting ''shall'';

(B) in paragraph (2), by striking ''appropriated'' and inserting ''made available'';

(3) in subsection (g)—

(A) by striking paragraph (1) and inserting the following new paragraph:

''(1)(A) There are authorized to be—

''(i) appropriated to carry out this section such amounts as are necessary for each of fiscal years 1995 through 2000; and

''(ii) made available such amounts as are necessary for the Secretary of the Treasury to fulfill the requirements of subparagraph (B).

''(B)(i) Out of any money in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide to the Secretary of Agriculture, on January 1 of each fiscal year, to carry out this subsection—

''(I) $254,000,000 for fiscal year 1996;

''(II) $407,000,000 for fiscal year 1997;

''(III) $384,000,000 for fiscal year 1998;

''(IV) $398,000,000 for fiscal year 1999; and

''(V) $411,000,000 for fiscal year 2000.

''(ii) The Secretary of Agriculture shall be entitled to receive the funds and shall accept the funds.

''(C) In lieu of obligating the funds made available under subparagraph (B) to carry out this subsection, if the amount appropriated (in addition to the amount appropriated under subparagraph (B)(i)) to carry out this subsection for—

''(i) fiscal year 1996 is less than $3,660,000,000, the amount referred to in subparagraph (B)(i)(I) shall be obligated by the Secretary, during the period beginning December 31, 1995, and ending June 30, 1996, to increase the special assistance factor prescribed under section 11(a) of the National School Lunch Act (42 U.S.C. 1759a(a)) for free lunches served under the school lunch program (as established under section 4 of such Act (42 U.S.C. 1753));

''(ii) fiscal year 1997 is less than $3,759,000,000, the amount referred to in subparagraph (B)(i)(II) shall be obligated by the Secretary, during the period beginning December 31, 1996, and ending June 30, 1997, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act);

''(iii) fiscal year 1998 is less than $3,861,000,000, the amount referred to in subparagraph (B)(i)(III) shall be obligated by the Secretary, during the period beginning December 31, 1997, and ending June 30, 1998, to increase the special assistance factor prescribed under section 11(a) of

such Act for free lunches served under the school lunch program (as established under section 4 of such Act);

''(iv) fiscal year 1999 is less than $3,996,000,000, the amount referred to in subparagraph (B)(i)(IV) shall be obligated by the Secretary, during the period beginning December 31, 1998, and ending June 30, 1999, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act); and

''(v) fiscal year 2000 is less than $4,136,000,000, the amount referred to in subparagraph (B)(i)(V) shall be obligated by the Secretary, during the period beginning December 31, 1999, and ending June 30, 2000, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act).

''(D) Any increase in the special assistance factor prescribed under section 11(a) of such Act as a result of subparagraph (C) shall not affect any annual adjustment in the factor under section 11(a)(3) of such Act.'';

(B) in the first sentence of paragraph (4), by striking ''appropriated'' and inserting ''made available''; and

(C) in paragraph (5), by striking ''appropriated'' and inserting ''made available'';

(4) in subsection (h)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking ''appropriated'' both places it appears and inserting ''made available''; and

(ii) in subparagraph (C), by striking ''appropriated'' both places it appears and inserting ''made available''; and

(B) in the first sentence of paragraph (2)(A), by striking ''1990, 1991, 1992, 1993 and 1994'' and inserting ''1990 through 2000''; and

(5) in subsection (l), by striking ''funds appropriated'' and inserting ''funds made available''.

Subtitle L—Border Health Improvement

SEC. 3908. BORDER HEALTH COMMISSION.

(a) ESTABLISHMENT.—The President is authorized and encouraged to conclude an agreement with Mexico to

establish a binational commission to be known as the United States-Mexico Border Health Commission.

(b) DUTIES.—It should be the duty of the Commission—

(1) to conduct a comprehensive needs assessment in the United States-Mexico Border Area for the purposes of identifying, evaluating, preventing, and resolving health problems and potential health problems that affect the general population of the area;

(2) to develop and implement a comprehensive plan for carrying out the actions recommended by the needs assessment through—

(A) assisting in the coordination of public and private efforts to prevent potential health problems and resolve existing health problems;

(B) assisting in the coordination of public and private efforts to educate the population, in a culturally competent manner, concerning such potential and existing health problems; and

(C) developing and implementing culturally competent programs to prevent and resolve such health problems and to educate the population, in a culturally competent manner, concerning such health problems where a new pro-

gram is necessary to meet a need that is not being met through other public or private efforts; and

(3) to formulate recommendations to the Governments of the United States and Mexico concerning a fair and reasonable method by which the government of one country could reimburse a public or private person in the other country for the cost of a health care service that such person furnishes to a citizen or resident alien of the first country who is unable, through insurance or otherwise, to pay for the service.

(c) OTHER AUTHORIZED FUNCTIONS.—In addition to the duties described in subsection (b), the Commission should be authorized to perform the following functions as the Commission determines to be appropriate—

(1) to conduct or support investigations, research, or studies designed to identify, study, and monitor, on an on-going basis, health problems that affect the general population in the United States-Mexico Border Area;

(2) to conduct or support a binational, public-private effort to establish a comprehensive and coordinated system, which uses advanced technologies to the maximum extent possible, for gathering

health-related data and monitoring health problems in the United States-Mexico Border Area; and

(3) to provide financial, technical, or administrative assistance to public or private persons who act to prevent or resolve such problems or who educate the population concerning such health problems.

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT OF UNITED STATES SECTION.—The United States section of the Commission should be composed of 13 members. The section should consist of the following members:

(A) The Secretary of Health and Human Services or the Secretary's delegate.

(B) The commissioners of health or chief health officer from the States of Texas, New Mexico, Arizona, and California or such commissioners' delegates.

(C) Two individuals residing in United States-Mexico Border Area in each of the States of Texas, New Mexico, Arizona, and California who are nominated by the chief executive officer of the respective States and appointed by the President from among individuals—

(i) who have a demonstrated interest or expertise in health issues of the United States-Mexico Border Area; and

(ii) whose name appears on a list of 6 nominees submitted to the President by the chief executive officer of the State where the nominee resides.

(2) COMMISSIONER.—The Commissioner of the United States section of the Commission should be the Secretary of Health and Human Services or such individual's delegate to the Commission. The Commissioner should be the leader of the section.

(3) COMPENSATION.—Members of the United States section of the Commission who are not employees of the United States—

(A) shall each receive compensation at a rate of not to exceed the daily equivalent of the annual rate of basic pay payable for positions at GS–15 of the General Schedule under section 5332 of title 5, United States Code, for each day such member is engaged in the actual performance of the duties of the Commission; and

(B) shall be allowed travel expenses, including per diem in lieu of subsistence at rates

authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services of the Commission.

(e) REGIONAL OFFICES.—The Commission should designate or establish one border health office in each of the States of Texas, New Mexico, Arizona, and California. Such office should be located within the United States-Mexico Border Area, and should be coordinated with—

(1) State border health offices; and

(2) local nonprofit organizations designated by the State's governor and directly involved in border health issues.

If feasible to avoid duplicative efforts, the Commission offices should be located in existing State or local nonprofit offices. The Commission should provide adequate compensation for cooperative efforts and resources.

(f) REPORTS.—Not later than February 1 of each year that occurs more than 1 year after the date of the establishment of the Commission, the Commission should submit an annual report to both the United States Government and the Government of Mexico regarding all activities of the Commission during the preceding calendar year.

(g) DEFINITIONS.—As used in this section:

(1) COMMISSION.—The term ''Commission'' means the United States-Mexico Border Health Commission.

(2) HEALTH PROBLEM.—The term ''health problem'' means a disease or medical ailment or an environmental condition that poses the risk of disease or medical ailment. Such term includes diseases, ailments, or risks of disease or ailment caused by or related to environmental factors, control of animals and rabies, control of insect and rodent vectors, disposal of solid and hazardous waste, and control and monitoring of air quality.

(3) RESIDENT ALIEN.—The term ''resident alien'', when used in reference to a country, means an alien lawfully admitted for permanent residence to the United States or otherwise permanently residing in the United States under color of law (including residence as an asylee, refugee, or parolee).

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

(5) UNITED STATES-MEXICO BORDER AREA.—The term ''United States-Mexico Border Area'' means the area located in the United States and

1 Mexico within 100 kilometers of the border between
2 the United States and Mexico.

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Subtitle A—Quality Management and Improvement

SEC. 5001. NATIONAL QUALITY COUNCIL.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the National Health Board shall establish a council to be known as the National Quality Council to oversee a performance based program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services and access to such services.

(b) APPOINTMENT.—The National Quality Council shall consist of 15 members appointed by the President, with the advice and consent of the Senate, who are broadly representative of the population of the United States and shall include—

(1) individuals and health care providers distinguished in the fields of medicine, public health, health care quality, and related fields of health services research. Such members shall constitute at least one-third of the Council's membership;

(2) individuals representing consumers of health care services. Such members shall constitute at least one-third of the Council's membership; and

(3) other individuals representing purchasers of health care; health plans; States; and nationally recognized health care accreditation organizations.

(c) DUTIES.—The National Quality Council shall:

(1) develop national goals and performance measures of quality;

(2) develop uniform quality goals and performance measures for plans;

(3) design and oversee national surveys of plans and consumers;

(4) design and oversee the production of Consumer Report Cards;

(5) establish and oversee State-based Quality Improvement Foundations; and

(6) evaluate the impact of the implementation of this Act on the quality of health care services in

the United States and the access of consumers to such services.

(d) CONSULTATION.—In carrying out these duties, the National Quality Council shall establish a process of consultation with appropriate interested parties.

(e) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council shall serve for a term of 4 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (b), the President shall appoint members to serve for a term of between 1 and 4 years so that no more than one third of the Council seats are vacated each year.

(3) SERVICE BEYOND TERM.—A member of the Council may continue to serve after the expiration of the term of the member until a successor is appointed.

(f) VACANCIES.—If a member of the Council does not serve the full term applicable under subsection (e), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(g) CHAIR.—The President shall designate an individual to serve as the chair of the Council.

(h) MEETINGS.—The Council shall meet not less than once during each 4-month period and shall otherwise meet at the call of the President or the chair.

(i) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Council shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(j) CONFLICTS OF INTEREST.—Members of the Council shall disclose upon appointment to the Council or at any subsequent time that it may occur, conflicts of interest.

(k) STAFF.—The National Health Board shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(l) HEALTH CARE PROVIDER.—For purposes of this subtitle, the term ''health care provider'' means an individual who, or entity that, provides an item or service to an individual that is covered under the health plan (as defined in section 1500) in which the individual is enrolled.

SEC. 5002. NATIONAL GOALS AND PERFORMANCE MEASURES OF QUALITY.

(a) IN GENERAL.—The National Quality Council shall develop a set of national goals and performance measures of quality for both the general population and for population subgroups defined by demographic characteristics and health status. The goals and measures shall incorporate standards identified by the Secretary of Health and Human Services for meeting public health objectives utilizing, but not limited to, goals delineated in Healthy People 2000.

(b) SUBJECT OF MEASURES.—National measures of quality performance shall be selected in a manner that provides statistical and other information on at least the following subjects:

(1) Outcomes of health care services and procedures.

(2) Health promotion.

(3) Prevention of diseases, disorders, and other health conditions.

(4) Access to care and appropriateness of care.

SEC. 5003. STANDARDS AND PERFORMANCE MEASURES FOR HEALTH PLANS.

(a) IN GENERAL.—The National Quality Council shall establish national standards and performance measures for health plans, which may be used to assess the

provision of health care services and access to such services, both for the general population and population subgroups defined by demographic characteristics and health status. In subject matter areas with which the National Quality Council determines that sufficient information and consensus exist, the Council shall establish goals for performance by health plans consistent with the national goals and performance measures established under section 5002. These quality measures shall relate to, at a minimum:

(1) Access to health care services by consumers, including provider to patient ratios, waiting times for appointments, travel distances, and community involvement and outreach.

(2) Appropriateness of health care services, including failure to provide appropriate services and continuity of care.

(3) Consumer satisfaction with care and compliance with members rights, including dissenrollment, referral, patterns of claims denials and out-of-network utilization patterns.

(4) Quality improvement and accountability, including showing that the plan can continuously monitor and improve the quality of health care provided.

(5) Provider credentialing and competency.

(6) Management of clinical, and administrative and financial information.

(7) Utilization management including criteria for monitoring underutilization, techniques and provider feedback to minimize interference with the provider-patient relationship, and supervision of utilization determinations by qualified medical professionals.

(b) CERTIFICATION OF PLANS.—The National Quality Council shall provide information and technical assistance to the Board and the States on the use of national standards and performance measures in this section for State certification of health plans.

SEC. 5004. PLAN DATA ANALYSIS AND CONSUMER SURVEYS.

(a) IN GENERAL.—The National Quality Council shall conduct (either directly or through contract) periodic surveys of health care consumers and plans to gather information concerning the quality measures established in sections 5002 and 5003. The surveys shall monitor consumer reaction to the implementation of this Act and, in coordination with relevant data from health plans and other sources, be designed to assess the impact of this Act both for the general population of the United States and for populations vulnerable to discrimination or to receiving

inadequate care due to health status, demographic characteristics, or geographic location.

(b) SURVEY ADMINISTRATION AND DATA ANALYSIS.—The National Quality Council shall approve a standard design for the consumer surveys and sampling of relevant plan data which shall be administered by the Administrator for Health Care Policy and Research or such other appropriate entity the Council shall designate on a plan-by-plan and State-by-State basis. Sufficient consumer survey and plan data shall be collected and verified to provide for reliable and valid analysis. A State may add survey questions on quality measures of local interest to surveys conducted in the State. The plan-level survey shall include a subset of consumer survey responses related to consumer satisfaction, perceived health status, access, and such other survey items designated by the Council.

(c) SAMPLING STRATEGIES.—The National Quality Council shall approve sampling strategies that ensure that appropriate survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care or may be difficult to reach through consumer-sampling methods, including individuals who—

(1) fail to enroll in a health plan;

(2) resign from a plan; or

(3) are vulnerable to discrimination or to receiving inadequate care due to health status, demographic characteristics, or geographic location.

(d) SURVEY INTEGRATION.—To the extent feasible, the consumer and plan surveys shall be integrated with existing Federal surveys.

SEC. 5005. EVALUATION AND REPORTING OF QUALITY PERFORMANCE.

(a) PERFORMANCE REPORTS.—

(1) HEALTH PLAN REPORTS.—Each State annually shall publish and make available to the public a performance report in a standard format, designated by the National Quality Council, outlining the performance of each health plan offered in the State, on the set of national measures of quality performance in section 5002 and 5003. The report shall include the results of a smaller number of such measures for health care providers if the available information is statistically meaningful. The report shall also include the results of consumer surveys described in section 5004 that were conducted in the State during the year that is the subject of the report and be based on the data collected and analyzed in section 5004.

(2) CONSUMER REPORT CARDS.—The health plan reports shall be summarized in a consumer report card as specified by the National Quality Council and made available by the State to all individuals in the State.

(3) QUALITY REPORTS.—The National Quality Council annually shall provide recommendations to the Congress, the National Health Board, and the Secretary a summary report that—

(A) outlines in a standard format the performance of each State;

(B) discusses State-level and national trends relating to health care quality; and

(C) presents data for each State from health plan reports and consumer surveys that were conducted during the year that is the subject of the report.

(4) STATE REPORTS.—The National Quality Council annually shall provide to each State a summary report that—

(A) outlines in a standard format the performance of each health plan;

(B) discusses State-level and national trends relating to health care quality; and

(C) presents data for each health plan from health plan reports and consumer surveys that were conducted during the year that is the subject of the report.

(b) PUBLIC AVAILABILITY OF INFORMATION IN NATIONAL PRACTITIONER DATA BANK ON DEFENDANTS, AWARDS, AND SETTLEMENTS.—

(1) IN GENERAL.—Section 427(a) of the Health Care Quality Improvement Act (42 U.S.C. 11137 (a)) is amended by adding at the end the following new sentence: ''Not later than January 1, 1996, the Secretary shall promulgate regulations under which individuals seeking to enroll in health plans under the Health Security Act shall be able to obtain information reported under this part with respect to physicians and other licensed health practitioners participating in such plans for whom information has been reported under this part on repeated occasions.''.

(2) ACCESS TO DATA BANK FOR POINT-OF-SERVICE CONTRACTORS UNDER MEDICARE.—Section 427(a) of such Act (42 U.S.C. 11137(a)) is amended—

(A) by inserting ''to sponsors of point-of-service networks under section 1990 of the Social Security Act,'', and

(B) in the heading, by inserting ''RELATED'' after ''CARE''.

SEC. 5006. DEVELOPMENT AND DISSEMINATION OF PRACTICE GUIDELINES.

(a) DEVELOPMENT OF GUIDELINES.—The National Quality Council may advise the Secretary and the Administrator for Health Care Policy and Research on priorities for the development and periodic review and updating of clinically relevant guidelines established under section 912 of the Public Health Service Act.

(b) HEALTH SERVICE UTILIZATION PROTOCOLS.—The National Quality Council shall establish standards and procedures for evaluating the clinical appropriateness of protocols used to manage health service utilization.

SEC. 5007. RESEARCH ON HEALTH CARE QUALITY.

The National Quality Council may make recommendations to the Secretary and the Administrator for Agency for Health Care Policy and Research concerning priorities for research with respect to the quality, appropriateness, and effectiveness of health care.

SEC. 5008. QUALITY IMPROVEMENT FOUNDATIONS.

(a) ESTABLISHMENT.—The National Quality Council shall oversee the operation of quality improvement foundations to perform the duties specified in subsection (c).

(b) STRUCTURE AND MEMBERSHIP.—

(1) GRANT PROCESS.—The Secretary, in consultation with the States and the Council, shall select a number of regional foundations through a competitive grantmaking process. The Secretary shall allow for foundations to serve only one State if the State so requests.

(2) ELIGIBLE APPLICANTS.—Eligible applicants shall meet the following conditions:

(A) The entity shall be a not-for-profit entity.

(B) The entity shall have a board which includes—

(i) representatives of health care providers from throughout the State, including both practicing providers and experts in the field of quality measurement and improvement, which together shall comprise at least one-fourth of the advisory board's membership;

(ii) at least one representative of Academic Health Centers or schools defined in

section 799 of the Public Health Service Act, which shall comprise up to one-fourth of the membership;

(iii) representatives of consumers, who shall comprise one-fourth of the membership; and

(iv) representatives of purchasers of health care, health plans, the State, and other interested parties.

(C) STAFFING.—Each entity shall have sufficient, competent staff of experts possessing the skills and knowledge necessary to enable the foundation perform its duties.

(c) DUTIES.—

(1) IN GENERAL.—Each quality improvement foundation shall carry out the duties described in paragraph (2) for the region in which the foundation is located. The foundation shall establish a program of activities incorporating such duties and shall be able to demonstrate the involvement of a broad cross-section of the providers and health care institutions throughout the region. A foundation may apply for and conduct research described in section 5007.

(2) DUTIES DESCRIBED.—The duties described in this paragraph include the following:

(A) Collaboration with and technical assistance to providers and health plans in ongoing efforts to improve the quality of health care provided to individuals in the State.

(B) Population-based monitoring of practice patterns and patient outcomes, and auditing samples of such data to assure its validity.

(C) Developing programs in lifetime learning for health professionals to improve the quality of health care by ensuring that health professionals remain abreast of new knowledge, acquire new skills, and adopt new roles as technology and societal demands change.

(D) Disseminating information about successful quality improvement programs, practice guidelines, and research findings, including information on innovative staffing of health professionals.

(E) Assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their health care.

(F) Issuing a report to the public regarding the foundation's activities for the previous

year including areas of success during the previous year and areas for opportunities in improving health outcomes for the community, and the adoption of guidelines.

(G) Providing notice to the State or appropriate entity if the foundation finds, after reasonable opportunities for improvement, that a provider or plan appears unwilling or unable to successfully engage in quality improvement activities related to the services described.

SEC. 5009. AUTHORIZATION OF APPROPRIATIONS.

For the purposes of carrying out this subtitle, there are authorized to be appropriated such sums as may be necessary for fiscal years 1995 through 2000.

SEC. 5010. ROLE OF STATES IN QUALITY ASSURANCE.

Each State shall—

(1) disseminate to consumers information related to quality and access to aid in their selection of plans in accordance with section 1206;

(2) disseminate information on the quality of health plans and health care providers contained in reports of the National Quality Council under section 5005;

(3) ensure through collaboration with the Quality Improvement Foundation that performance and quality standards are continually improved; and

(4) ensure that educational programs are developed in cooperation with quality improvement foundations to assist consumers in using quality and other information in choosing health plans.

SEC. 5011. ROLE OF HEALTH PLANS IN QUALITY MANAGEMENT.

Each health plan shall—

(1) measure and disclose performance on quality measures as designated by this Act;

(2) furnish information required under subtitle B of this title and provide such other reports and information on the quality of care delivered by health care providers who are members of a provider network of the plan (as defined in section 1502 (h)(3)) as may be required under this Act; and

(3) maintain quality management systems that—

(A) use the national measures of quality performance developed by the National Quality Council under section 5003; and

(B) measure the quality of health care furnished to enrollees under the plan by all health care providers of the plan.

SEC. 5012. INFORMATION ON HEALTH CARE PROVIDERS.

Each State shall make available to consumers, upon request, information concerning providers of health care services or supplies. Such information shall include—

(1) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply;

(2) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

(3) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and

(4) the identity of any provider whose license to provide health care services or supplies has been re-

voked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity, or any provider who surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

SEC. 5013. CONFORMING AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act is amended—

(1) in section 903(a)(4) (42 U.S.C. 299a-1(a)(4)), by inserting ''and Quality Improvement Foundations'' after ''health agencies'';

(2) in section 904(c)(1) (42 U.S.C. 299a-2(c)(1)), by inserting ''the National Quality Council and'' after ''in consultation with'';

(3) in section 912(b)(4) (42 U.S.C. 299b-1(b)(4))—

(A) by inserting ''outcomes,'' before ''risks''; and

(B) by inserting before the semicolon ''to the extent feasible given the availability of unbiased, reliable, and valid data'';

(4) in section 914 (42 U.S.C. 299b-3)—

(A) in subsection (a)(2)(B)—

(i) by inserting ''the National Quality Council,'' after ''shall consult with''; and

(ii) by inserting before the period ''and relevant sections of the Health Security Act'';

(B) in subsection (c), by inserting ''Quality Improvement Foundations and other'' after ''carried out through''; and

(C) in subsection (f)—

(i) by striking ''TO ADMINISTRATOR'' in the subsection heading;

(ii) by striking ''Administrator'' and inserting ''National Quality Council and the''; and

(5) in section 927 (42 U.S.C. 299c-6), by adding at the end thereof the following new paragraphs:

''(5) The term 'National Quality Council' means the Council established under section 5001 of the Health Security Act.

''(6) The term ''Quality Improvement Foundations'' means the Foundations established under section 5008 of the Health Security Act.''.

Subtitle B—Information Systems, Privacy, and Administrative Simplification

PART 1—NATIONAL HEALTH CARE DATA NETWORK

Subpart A—Purpose and Definitions

SEC. 5101. PURPOSE.

It is the purpose of this part to improve the efficiency and effectiveness of the health care system by requiring health plans and health care providers in the health care system to—

(1) standardize certain health care transactions and data in a manner established by the Board;

(2) transmit standard index markers with respect to such standardized data to entities that are certified by the Board; and

(3) make standardized data electronically available for disclosure as authorized under this subtitle.

SEC. 5102. DEFINITIONS.

For purposes of this part:

(1) CERTIFIED CLEARINGHOUSE.—

(A) IN GENERAL.—The term ''certified clearinghouse'' means a clearinghouse that is certified under section 5109.

(B) CLEARINGHOUSE.—The term ''clearinghouse'' means a public or private entity that has the ability to—

(i) process nonstandard health care data into standard health care data; or

(ii) store standard health care data and make such data available to another entity.

(2) CERTIFIED INDEXING SYSTEM.—

(A) IN GENERAL.—The term ''certified indexing system'' means an indexing system that is certified under section 5109.

(B) INDEXING SYSTEM.—The term ''indexing system'' means a public or private entity that stores standard index markers and has the ability to comply with section 5108(b).

(3) HEALTH CARE DATA NETWORK.—The term ''health care data network'' means the health care information system that is formed through the application of the requirements under this part.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a provider of services

(as defined in section 1861(u) of the Social Security Act), a physician, a laboratory (as defined in section 353(a) of the Public Health Service Act), a supplier, and any other person furnishing health care.

(5) HEALTH INFORMATION PROTECTION ORGANIZATION.—The term ''health information protection organization'' means a private entity or an entity operated by a State that has the capability to access standard health care data through entities in the national health care data network and process such data into data that is non-identifiable health information.

(6) HEALTH PLAN.—The term ''health plan'' has the meaning given such term in section 1500 and includes—

(A) workers compensation or similar insurance insofar as it relates to workers compensation medical benefits (as defined by the Board);

(B) automobile medical insurance insofar as it relates to automobile insurance medical benefits (as defined by the Board); and

(C) a Federal, State, or local program that pays for, or provides directly for, the provision of health care.

(7) INDEX MARKER.—The term ''index marker'' means data that indicate the location of specific standard health care data, the unique identifier of the holder of such data, and information necessary to access such data.

(8) NON-IDENTIFIABLE HEALTH INFORMATION.—The term ''non-identifiable health information'' means health care data that is not protected health information as defined in section 5163.

(9) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' has the meaning given such term in section 5163.

(10) STANDARD.—The term ''standard'' when referring to a transaction or to data means the transaction or data meets any standard established by the Board under subpart D that applies to such transaction or data.

Subpart B—Requirements on Health Care Providers and Health Plans

SEC. 5103. REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND DATA.

(a) ENROLLMENT AND DISENROLLMENT DATA.—With respect to each enrollment and disenrollment transaction, a health plan shall be responsible for ensuring the transmission of a standard index marker for the standard

enrollment and disenrollment data described in section 5114(a)(1) to a certified indexing system.

(b) FINANCIAL AND ADMINISTRATIVE TRANSACTIONS AND DATA.—

(1) FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—Any financial and administrative transaction described in section 5113 that is conducted by a health care provider or a health plan shall be conducted in accordance with standards established by the Board under such section and the financial and administrative data transmitted in connection with such a financial and administrative transaction shall be standard data.

(2) FINANCIAL AND ADMINISTRATIVE DATA.—

(A) IN GENERAL.—A health plan shall be responsible for ensuring the transmission to a certified indexing system of a standard index marker for any standard financial and administrative data held by a health plan as a result of a financial and administrative transaction.

(B) SPECIAL RULE FOR CERTAIN HEALTH PLANS.—In the case of a health plan that does not file claims, such plan shall be responsible for ensuring the transmission to a certified indexing system of a standard index marker for

the financial and administrative data determined appropriate by the Board.

(c) QUALITY-RELATED PATIENT MEDICAL RECORD DATA.—

(1) IN GENERAL.—A health care provider (including a health care provider that consists of a health maintenance organization) shall be responsible for ensuring the transmission to a certified indexing system of a standard index marker for the standard quality-related patient medical record data described in section 5114(a)(3).

(2) TRANSMISSION TO HEALTH PLANS.—A health care provider may satisfy the requirement under paragraph (1) by transmitting standard quality-related patient medical record data to a health plan. If a health care provider transmits data in accordance with the preceding sentence, the health plan to which such data is transmitted shall be responsible for ensuring the transmission of a standard index marker for such data to a certified indexing system.

(3) REQUIREMENTS NOT APPLICABLE TO COMPLETE MEDICAL RECORDS.—Nothing in this section shall be construed as preventing a health service provider or health benefit plan from storing and

maintaining patient medical records in a form and manner selected by such providers or plans (so long as such providers and plans are able to comply with the reporting requirements of this subtitle).

(d) GOVERNMENT REQUIRED DATA.—A health plan or health care provider shall be responsible for ensuring the transmission to a certified indexing system of a standard index marker for the standard Government required data described in section 5114(a)(5).

(e) SATISFACTION OF REQUIREMENTS.—

(1) FINANCIAL AND ADMINISTRATIVE DATA.—A health care provider or health plan may satisfy the requirement imposed on such provider or plan under subsection (b)(1) by—

(A) directly transmitting standard financial and administrative data; or

(B) submitting nonstandard financial and administrative data to a certified clearinghouse for processing into standard data and transmission.

(2) INDEX MARKERS.—A health care provider or health plan may satisfy a requirement imposed on such provider or plan under subsection (a), (b)(2), (c), or (d) by—

(A) transmitting a standard index marker for standard data directly to a certified indexing system; or

(B) entering into a contract with a certified clearinghouse under which the clearinghouse transmits a standard index marker for such data directly to a certified indexing system.

(3) TIMELINESS.—A health care provider or health plan shall be determined to have satisfied a requirement imposed under subsection (a), (b), (c), or (d) only if the action required under such subsection is completed in a timely manner, as determined by the Board.

(f) FORMS NOT TO INCLUDE PATIENT MEDICAL RECORDS.—Nothing in this section shall be construed as giving the National Health Board the authority to require the disclosure and transmission of complete patient medical records without Congressional approval.

(g) ENFORCEMENT.—The National Health Board shall ensure that the requirements of this part are satisfied.

SEC. 5104. AVAILABILITY OF STANDARD HEALTH CARE DATA.

(a) IN GENERAL.—A health care provider or health plan shall be capable of disclosing all standard health care data with respect to which a standard index marker has been transmitted to a certified indexing system under section 5103 when such disclosure is authorized under part 2.

(b) SATISFACTION.—A health care provider or health plan may satisfy the requirement imposed under subsection (a) by—

(1) being capable of disclosing standard health care data directly; or

(2) entering into a contract with a certified clearinghouse under which the clearinghouse is capable of disclosing such data.

(c) CONSTRUCTION.—Nothing in this section shall be construed to require a health plan or health care provider to disclose health care data under this section.

SEC. 5105. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

(a) INITIAL COMPLIANCE.—

(1) IN GENERAL.—Not later than 12 months after the date on which standards are established under subpart D with respect to a type of financial and administrative transaction, a type of data, or

index markers for such data a health plan or health care provider shall comply with the requirements of this subpart with respect to such transaction, data, or index marker.

(2) ADDITIONAL DATA.—Not later than 12 months after the date on which the Board makes an addition to a set of health care data under subpart D, a health plan or health care provider shall comply with the requirements of this subpart with respect to such data.

(b) COMPLIANCE WITH MODIFIED STANDARDS.—

(1) IN GENERAL.—If the Board modifies a standard established under subpart D, a health plan or health care provider shall be required to transmit or receive data in accordance with the modified standard at such time as the Board determines appropriate taking into account the time needed to comply due to the nature and extent of the modification.

(2) SPECIAL RULE.—In the case of modifications to standards that do not occur within the 12-month period beginning on the date such standards are established, the time determined appropriate by the Board under paragraph (1) shall be no sooner than the last day of the 90-day period beginning on

the date such modified standard is established and no later than the last day of the 12-month period beginning on the date such modified standard is established.

SEC. 5106. PREEMPTION OF STATE "QUILL PEN" LAWS.

A requirement under this part or a standard established by the Board under this part shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained in written rather than electronic form, except where the Board determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

Subpart C—Standards and Certification for Indexing Systems and Clearinghouses

SEC. 5108. ESTABLISHMENT OF STANDARDS.

(a) IN GENERAL.—The Board shall establish standards with respect to the operation of indexing systems and clearinghouses, including standards ensuring that—

(1) such entities develop, operate, and cooperate with one another to form a national health care data network;

(2) such entities meet all of the requirements under part 2 that are applicable to such entities;

(3) such entities make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Board;

(4) such entities have the highest security procedures that are practicable with respect to the processing of health care data; and

(5) indexing systems meet the additional requirements for such systems described in subsection (b).

(b) ADDITIONAL REQUIREMENTS FOR INDEXING SYSTEMS.—The additional requirements for indexing systems that are referred to in subsection (a)(6) are as follows:

(1) INDEXING STANDARD HEALTH CARE DATA.—An indexing system shall have the capability to index the standard health care data that is made available to the system.

(2) INTEROPERABILITY.—

(A) AVAILABILITY OF DATA.—An indexing system shall make any index marker received by such system pursuant to the requirements of subpart B available to all other certified index-

ing systems operating in the national health care data network.

(B) ABILITY TO ACCESS DATA.—An indexing system shall have the ability to receive index markers from all other certified indexing systems operating in the national health care data network.

(3) RATES CHARGED.—The rate that an indexing system applies to a service performed for another indexing system shall not exceed the amount of the weighted average of the rates such system applies to the same service performed for health plans or health care providers.

(c) TIMETABLE FOR ESTABLISHMENT.—The Board shall establish standards under this section not later than 9 months after the date of the enactment of this part.

SEC. 5109. CERTIFICATION PROCEDURE.

(a) IN GENERAL.—Not later than 12 months after the date of the enactment of this part, the Board shall establish a certification procedure for indexing systems and clearinghouses which ensures that certified entities are qualified to meet the requirements of this subtitle.

(b) APPLICATION.—The procedure established by the Board under subsection (a) shall provide that each entity described in such subsection desiring to be certified as an

indexing system or clearinghouse shall apply to the Board for certification in such form and in such manner as the Board determines appropriate.

(c) AUDITS AND REPORTS.—The procedure established under subsection (a) shall provide for audits by the Board and reports by certified entities at such intervals as the Board determines appropriate in order to monitor compliance with the standards established under section 5108.

(d) RECERTIFICATION.—An indexing system or clearinghouse must be recertified under this section at least every 3 years.

(e) LOSS OF CERTIFICATION.—

(1) MANDATORY TERMINATION.—If an indexing system or clearinghouse violates a requirement imposed on such system or clearinghouse under part 2, the entity's certification under this section shall be terminated unless the Board determines that appropriate corrective action has been taken.

(2) DISCRETIONARY TERMINATION.—If an indexing system or clearinghouse violates a requirement of this part and a penalty has been imposed under section 5124 with respect to such violation, the Board shall review the certification of such sys-

tem or clearinghouse and may terminate such certification.

SEC. 5110. STATE OPERATION OF INDEXING SYSTEMS AND CLEARINGHOUSES.

(a) IN GENERAL.—A State may operate an indexing system or a clearinghouse that is certified under section 5109.

(b) EXCLUSIVE STATE SYSTEMS PERMITTED.—A State operating a certified indexing system or a certified clearinghouse may require each health plan or health care provider in the State to use such system or clearinghouse to satisfy the requirements imposed on such plan or provider under subpart B.

SEC. 5111. ENSURING AVAILABILITY OF DATA.

The Board shall establish a procedure under which health plans and health care providers which do not have access to certified indexing systems and clearinghouses are able to make health care data available to the health care data network in accordance with the purposes of this part.

Subpart D—Standards for Transactions, Data Elements, and Index Markers.

SEC. 5112. GENERAL REQUIREMENTS ON BOARD.

In establishing standards under this subpart, the Board shall, to the maximum extent practicable (consistent with the requirements of this Act)—

(1) require the use of data that are verifiable, timely, accurate, reliable, useful, complete, and relevant;

(2) establish standards that are consistent with the objective of reducing the costs of providing and paying for health care;

(3) incorporate standards in use and generally accepted that are recommended by recognized public or private standard setting or development groups, including the American National Standard Institute's ASC X12, the Healthcare Informatics Standards Planning Panel, and the Department of Health and Human Services; and

(4) promote the development of standards necessary to fulfill the requirements of this Act.

The Board shall insure that new standards are developed in collaboration with Federal health agencies, participating States, health plans, representatives of providers, employers and consumers, experts in public health, and nationally recognized standard setting groups.

SEC. 5113. FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) IN GENERAL.—The Board shall establish the standards necessary for health care providers and health

plans to conduct the following transactions relating to the financing or administering of health care:

(1) Eligibility.

(2) Payment and remittance advice.

(3) Claims.

(4) Encounters.

(5) Claims status.

(6) Coordination of benefits.

(7) First report of injury.

(8) Claim attachments.

(9) Referrals, certification, and authorization.

(10) Any other transactions determined appropriate by the Board.

(b) SPECIAL RULE.—Any standards established by the Board under subsection (a) that relate to coordination of benefits shall be consistent with the rules and procedures developed by the Board under section 5127.

SEC. 5114. ELEMENTS OF HEALTH CARE DATA.

(a) IN GENERAL.—The Board shall establish standards necessary to make the following health care data uniform and compatible for electronic transmission through a national health care data network:

(1) enrollment and disenrollment data;

(2) financial and administrative data that the Board determines is appropriate for transmission in

connection with a financial and administrative transaction described in section 5113;

(3) a set of quality-related patient medical record data that the Board determines is necessary in order to conduct meaningful quality measurement;

(4) patient medical record data that is not included in a set of quality-related patient medical record data established by the Board under paragraph (3);

(5) a set of health care data that is not described in paragraphs (1) through (3) and that is required by the Board, a State, or the National Center for Consumer Advocacy for such entity to perform its functions under this Act.

(b) ADDITIONS.—The Board may make additions to the sets of health care data established under paragraphs (1), (2), (3), and (5) of subsection (a) as the Board determines appropriate.

(c) CERTAIN DATA ELEMENTS.—

(1) UNIQUE IDENTIFIERS.—The Board shall establish a system to provide for a unique identifier for each individual, employer, health plan, and health care provider.

(2) CODE SETS.—The Board shall select code sets for any appropriate data elements from among the code sets that are maintained by private and public entities such as the American National Standards Institute, the National Uniform Billing Committee, or the Department of Health and Human Services.

(d) FORMAT OF DATA ELEMENTS.—The Board shall establish standards with respect to the format in which data elements shall be transmitted.

(e) DEFINITIONS.—For purposes of this section:

(1) DEFINITION.—The term ''code set'' means any set of codes used for encoding data elements, including tables of terms, medical diagnostic codes, or medical procedure codes.

(2) PATIENT MEDICAL RECORD DATA DEFINED.—The term ''patient medical record data'' means health care data derived from a clinical encounter that relates to the physical or mental condition of an individual and that is not financial and administrative data.

(3) QUALITY MEASUREMENT DEFINED.—The term ''quality measurement'' means monitoring and measuring the quality of health care consistent with

the measures established by the National Quality Council under section 5002.

SEC. 5115. INDEX MARKERS.

The Board shall establish the standards necessary for a health care provider or health plan to ensure the transmission of an index marker with respect to standard health care data to a certified indexing system.

SEC. 5116. TIMETABLES FOR ESTABLISHMENT.

(a) INITIAL STANDARDS.—The Board shall establish standards relating to—

(1) financial and administrative transactions not later than 9 months after the date of the enactment of this part (except in the case of standards for claims attachments which shall be established not later than 24 months after the date of the enactment of this part);

(2) the first set of enrollment data not later than 9 months after the date of the enactment of this part;

(3) financial and administrative data not later than 9 months after the date of the enactment of this part (except in the case of standards with respect to data transmitted in connection with claims attachments which shall be established not later

than 24 months after the date of the enactment of this part);

(4) the first set of quality-related patient medical record data not later than 24 months after the date of the enactment of this part;

(5) patient medical record data that is not included in a set of quality-related patient medical record data not later than 7 years after the date of the enactment of this part;

(6) the first set of Government required data not later than 9 months after the date of the enactment of this part;

(7) index markers for standard data not later than 9 months after the date of the enactment of this part; and

(8) any addition to a set of health care data under this part, in conjunction with making such an addition.

(b) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Board shall review the standards established under this subpart no more frequently than every 6 months but at least every 12 months, and shall modify such standards as determined appropriate.

(2) SPECIAL RULES.—

(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—The Board shall not modify any standards established under this subpart during the 12-month period beginning on the date such standards are established unless the Board determines that a modification is necessary in order to permit health plans and health care providers to comply with the requirements of subpart B.

(B) CODE SETS.—

(i) RECOMMENDED MODIFICATIONS.—The Board shall establish a procedure under which an entity described in section 5114(b)(2)(A) may submit any modification to a code set selected by the Board that is determined appropriate by the entity.

(ii) ADDITIONAL RULES.—A code set selected by the Board may not be modified more frequently than once annually unless the Board determines that a modification is necessary in order to permit health plans and health care providers to comply with the requirements of subpart B. If

such a code set is modified under the preceding sentence, the modified set shall include instructions on how data elements that were encoded prior to such modification are to be converted or translated so as to preserve the value of the elements. Any modification under this subparagraph shall be implemented in a manner that minimizes the disruption and cost to health plans and health care providers of complying with such modification.

(C) EVALUATION OF STANDARDS.—The Board may establish a process to measure or verify the consistency of standards established or modified under this subpart with the requirements of this Act. Such process may include demonstration projects and analyses of the costs of implementation of such standards and modifications.

Subpart E—Accessing Health Care Data

SEC. 5117. ACCESSING FINANCIAL AND ADMINISTRATIVE DATA IN CONNECTION WITH A FINANCIAL AND ADMINISTRATIVE TRANSACTION.

The Board shall establish technical standards under which a health care provider or health plan may access

financial and administrative data through entities in the national health care data network in connection with a financial and administrative transaction when such access is authorized under part 2.

SEC. 5118. ACCESSING DATA FOR AUTHORIZED PURPOSES.

The Board shall establish technical standards that shall apply to any request to access standard health care data that is not described in section 5117, including standards relating to access by enrollees, through entities in the national health care data network. Such technical standards shall provide any such request shall be satisfied—

(1) if the request is for data that is protected health information and is authorized for disclosure under part 2; or

(2) if the request is for data that is non-identifiable health information, by obtaining such data through a health information protection organization certified under section 5119.

SEC. 5119. HEALTH INFORMATION PROTECTION ORGANIZATIONS.

(a) RIGHT TO ACCESS DATA.—The Board shall establish standards under which a health information protection organization that is certified under subsection (d)

may access health care data through entities in the national health care data network.

(b) LIMITATION ON DISCLOSURE.—A health information protection organization that is certified under subsection (d) may disclose health care data—

(1) if the data is non-identifiable health information; or

(2) if the data is protected health care information only when such disclosure is authorized under part 2.

(c) STANDARDS FOR OPERATION.—The Board shall establish standards with respect to the operation of health information protection organizations, including standards ensuring that such organizations have the highest security procedures that are practicable with respect to processing health care data.

(d) CERTIFICATION BY THE BOARD.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this part, the Board shall establish a certification procedure for health information protection organizations which ensures that certified organizations are qualified to meet the requirements of this section.

(2) APPLICATION.—Each entity desiring to be certified as a health information protection organiza-

tion shall apply to the Board for certification in a form and manner determined appropriate by the Board.

(3) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits by the Board and reports by an entity certified under paragraph (2) at such intervals as the Board determines appropriate in order to monitor such entity's compliance with the requirements of this section and the standards established by the Board under this section.

(4) RECERTIFICATION.—A health information protection organization must be recertified under this subsection at least every 3 years.

(e) LOSS OF CERTIFICATION.—

(1) MANDATORY TERMINATION.—If a health information protection organization violates a requirement imposed on such organization under part 2, the organization's certification under this section shall be terminated unless the Board determines that appropriate corrective action has been taken.

(2) DISCRETIONARY TERMINATION.—If a health information protection organization violates a requirement of this part, the Board shall review the

certification of such organization and may terminate such certification.

SEC. 5120. ACCESS BY THE BOARD AND OTHER FEDERAL AGENCIES.

(a) IN GENERAL.—The Board or any other Federal agency may access health care data through entities in the national health care data network only when authorized under part 2.

(b) ACCESS THROUGH HEALTH INFORMATION PROTECTION ORGANIZATIONS.—

(1) IN GENERAL.—Health information protection organizations certified under section 5119 shall make available to the Board or another Federal agency pursuant to a cost reimbursement contract (as defined under the Federal Acquisition Regulation), any health care information that is requested by such agency.

(2) CERTAIN INFORMATION AVAILABLE TO HEALTH INFORMATION PROTECTION ORGANIZATIONS AT NO CHARGE.—If a health information protection organization needs data from a health plan or health care provider in order to comply with a request of the Board or another a Federal agency under paragraph (1) that relates to a requirement on such agency under this Act, such plan or provider shall

make such data available to such organization at no charge.

(c) DISCLOSURE.—

(1) IN GENERAL.—Health care data accessed by the Board or another Federal agency under this section shall be disclosed only as authorized under the provisions of this Act.

(2) DISCLOSURE FOR PUBLIC USE FUNCTIONS.—The Board and any other Federal agency shall make the non-identifiable health care information accessed by such agency under this section available to private, not-for-profit organizations for public use functions (as determined by the Board through regulations) in an affordable and timely manner.

SEC. 5121. ACCESS TO HEALTH CARE DATA BY THE STATES.

(a) IN GENERAL.—The Board shall establish standards under which a State may access health care data through entities in the national health care data network.

(b) ACCESS THROUGH HEALTH INFORMATION PROTECTION ORGANIZATIONS.—Health information protection organizations certified under section 5119 shall make health care data available to the States in accordance with section 5119 pursuant to a cost reimbursement contract (as defined under the Federal Acquisition Regulation).

SEC. 5122. LENGTH OF TIME DATA SHOULD BE ACCESSIBLE.

The Board shall establish standards with respect to the length of time any specific standard health care data should be accessible through the health care data network.

SEC. 5123. TIMETABLES FOR ESTABLISHMENT AND COMPLIANCE.

(a) INITIAL STANDARDS.—The Board shall establish standards under this subpart not later than 9 months after the date of the enactment of this part and such standards shall be effective upon establishment.

(b) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Board shall review the standards established under this subpart no more frequently than every 6 months but at least every 12 months, and shall modify such standards as determined appropriate by the Board. Any modifications to standards established under this subpart shall be effective upon establishment.

(2) SPECIAL RULE.—The Board shall not modify any standards established under this subpart during the 12-month period beginning on the date such standards are established unless the Board determines that a modification is necessary in order to

permit compliance with the requirements of this subpart.

Subpart F—Penalties

SEC. 5124. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

(a) IN GENERAL.—Except as provided in section 5125, the Board shall impose on a health plan, health care provider, indexing system, or clearinghouse that violates a requirement or standard imposed under this part a penalty of not more than $1,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under section 1128A of such Act.

(b) LIMITATIONS.—

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

(2) FAILURES DUE TO REASONABLE CAUSE.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), a penalty may not be imposed under subsection (a) if—

(i) the failure to comply was due to reasonable cause and not to willful neglect; and

(ii) the failure to comply is corrected during the 30-day period beginning on the 1st date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(B) PLANS AND PROVIDERS.—

(i) NO PENALTY.—If a health plan or health care provider demonstrates to the Board that a failure to comply occurred because the plan or provider was unable to comply, no penalty may be imposed under subsection (a) until such time as the plan or provider is able to comply.

(ii) ASSISTANCE.—The Board shall provide technical assistance to a health plan or health care provider described in clause (i) to obtain compliance. Such as-

sistance shall be provided in any manner determined appropriate by the Board.

(C) INDEXING SYSTEMS AND CLEARINGHOUSES.—In the case of an indexing system or clearinghouse, the period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Board based on the nature and extent of the failure to comply.

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

SEC. 5125. PENALTIES RELATING TO ACCESSING DATA.

A person who violates a standard established under sections 5117, 5118, and 5119 shall—

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

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

(3) if the offense is committed with intent to sell, transfer, or use health care data for commercial

advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

Subpart G—Miscellaneous

SEC. 5126. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) IN GENERAL.—A health plan or health care provider may not impose a standard on another plan or provider that is in addition to the standards established by the Board under this part unless—

(1) such plan or provider voluntarily agrees to such standard; or

(2) a waiver is granted under subsection (b) to establish such standard.

(b) CONDITIONS FOR WAIVERS.—

(1) IN GENERAL.—A health plan or health care provider may request a waiver from the Board in order to require another plan or provider to comply with a standard that is in addition to the standards imposed by the Board under this part.

(2) CONSIDERATION OF WAIVER REQUESTS.—In determining whether to grant a waiver under this subsection the Board shall consider the value of the data to be exchanged for research or other purposes determined appropriate by the Board, the administrative cost of the additional standard, the burden of

the additional standard, and the burden of the timing of the imposition of the additional standard.

(3) ANONYMOUS REPORTING.—If a health plan or health care provider attempts to impose a standard in addition to the standards imposed under this part, the plan or provider on which such additional standard is being imposed may contact the Board. The Board shall develop a procedure under which the contacting plan or provider shall remain anonymous. The Board shall notify the plan or provider imposing the additional standard that the additional standard may not be imposed unless the other plan or provider voluntarily agrees to such standard or a waiver is obtained under this subsection.

SEC. 5127. RULES REGARDING COORDINATION OF BENEFITS.

Not later than 9 months after the date of the enactment of this part, the Board shall develop rules and procedures for determining and coordinating the financial obligations of health plans when health care benefits are payable under 2 or more health plans.

SEC. 5128. EFFECT ON STATE LAW.

(a) IN GENERAL.—Except as provided in subsection (b), the provisions of this part shall supersede any provi-

sions of the law of any State to the extent that the provisions of this part conflict with such provisions of law.

(b) EXCEPTION.—Nothing in this part shall supersede any provision of State law that requires health plans or health care providers to use an indexing system or a clearinghouse that is certified under section 5109 and that is operated by the State to satisfy the requirements imposed on such plan or provider under subpart B.

SEC. 5129. HEALTH CARE DATA CONTINUITY.

(a) DATA HELD BY HEALTH PLANS AND PROVIDERS.—Any health care data held by a health plan or health care provider that ceases to function shall be obtained by the State in connection with the execution of the State's responsibilities under section 1204. The State shall ensure that such health care data is transferred to a health plan or health care provider under procedures developed by the Board.

(b) DATA HELD BY INDEXING SYSTEMS AND CLEARINGHOUSES.—If an indexing system or clearinghouse is decertified or ceases to function in a manner that would threaten the continued existence of health care data or index markers held by such system or clearinghouse, such data or index markers shall be transferred to a certified indexing system or clearinghouse designated by the Board.

SEC. 5130. PROTECTION OF COMMERCIAL INFORMATION.

In establishing standards under this part, the Board shall ensure that the trade secrets and confidential commercial information of entities operating in the health care data network is protected from—

(1) use other than as described in this title; and

(2) release to or access by third parties.

SEC. 5131. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1995 through 2000, to carry out the purposes of this subtitle.

Subpart H—Assistance to the Board

SEC. 5132. GENERAL REQUIREMENT ON BOARD.

In complying with any requirements imposed under this part, the Board shall rely on recommendations of the Health Care Data Advisory Panel established under section 5133 and shall consult with appropriate Federal agencies.

SEC. 5133. HEALTH CARE DATA ADVISORY PANEL.

(a) ESTABLISHMENT.—There is established a panel to be known as the Health Care Data Advisory Panel.

(b) DUTY.—The panel shall provide assistance to the Board in complying with the requirements imposed on the Board under this part and part 2. In performing such duty, the Panel shall receive technical assistance from appropriate Federal agencies.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Panel shall consist of 15 members to be appointed by the President not later than 60 days after the date of the enactment of this part. The Panel shall designate 1 member as the Chair.

(2) EXPERTISE.—The membership of the Panel shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the Panel.

(3) TERMS.—Each member of the Panel shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of no more than 3 members expire at one time.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the Panel shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be ap-

pointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(5) CONFLICTS OF INTEREST.—Members of the Panel shall disclose upon appointment to the Panel or at any subsequent time that it may occur, conflicts of interest.

(d) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Panel shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the Panel have been appointed, the Panel shall hold its first meeting.

(3) QUORUM.—A majority of the members of the Panel shall constitute a quorum, but a lesser number of members may hold hearings.

(e) POWER TO HOLD HEARINGS.—The Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers advisable to carry out the purposes of this section.

(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) of the Social Security Act shall apply to the Panel in the same manner as they apply to the Prospective Payment Assessment Commission.

(g) REPORTS.—

(1) IN GENERAL.—The Panel shall annually prepare and submit to Congress and the Board a report on—

(A) the status of the national health care data network established pursuant to this part, including—

(i) whether the network is fulfilling the purpose described in section 5101; and

(ii) information relating to the cost and quality of health care rendered by health care providers;

(B) the savings and costs of the network; and

(C) any legislative recommendations related to the network.

(2) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under paragraph (1) shall be made available to the public unless such information may not be disclosed by law.

(h) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Panel shall continue in existence until otherwise provided by law.

(i) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until expended.

Subpart I—Demonstration Projects for Community-Based Clinical Information Systems

SEC. 5135. GRANTS FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Board may make grants for demonstration projects to promote the development and use of electronically integrated community-based clinical information systems and computerized patient medical records.

(b) APPLICATIONS.—

(1) SUBMISSION.—To apply for a grant under this subpart for any fiscal year, an applicant shall submit an application to the Board in accordance with the procedures established by the Board.

(2) CRITERIA FOR APPROVAL.—The Board may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Board regarding the following:

(A) USE OF EXISTING TECHNOLOGY.—Funds received under this subpart will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

(B) USE OF EXISTING INFORMATION SYSTEMS.—Funds received under this subpart will be used—

(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

(iii) to connect additional users to telecommunications or information net-

works or systems that are operating on the date the application is submitted.

(C) MATCHING FUNDS.—The applicant will make available funds for the demonstration project in an amount that equals at least 50 percent of the cost of the project.

(c) GEOGRAPHIC DIVERSITY.—In making any grants under this subpart, the Board shall, to the extent practicable, make grants to persons representing different geographic areas of the United States, including urban and rural areas.

(d) REVIEW AND SANCTIONS.—The Board shall review at least annually the compliance of a person receiving a grant under this subpart with the provisions of this subpart. The Board shall establish a procedure for determining whether such a person has failed to comply substantially within the provisions of this subpart and the sanctions to be imposed for any such noncompliance.

(e) ANNUAL REPORT.—The Board shall include in the annual report under section 1705 of the Public Health Service Act (42 U.S.C. 300u–4) a description of the activities carried out under this subpart.

Subpart J—Health Security Cards

SEC. 5136. HEALTH SECURITY CARDS.

(a) PERMISSIBLE USES OF CARD.—A health security card that is issued to an eligible individual under section 1001(b) may be used by an individual or entity, in accordance with regulations promulgated by the Board, only for the purpose of providing or assisting the eligible individual in obtaining an item or service that is covered under—

(1) the applicable health plan in which the individual is enrolled (as defined in section 1902);

(2) a policy consisting of a supplemental health policy (described in part 2 of subtitle E of title I), a cost sharing policy (described in such part), or both;

(3) a FEHBP supplemental plan (described in subtitle C of title VIII);

(4) a FEHBP medicare supplemental plan (described in such subtitle); or

(5) such other programs as the Board may specify.

(b) FORM OF CARD AND ENCODED INFORMATION.—The Board shall establish standards respecting the form of health security cards and the information to be encoded in electronic form on the cards. Such information shall include—

(1) the identity of the individual to whom the card is issued;

(2) the applicable health plan in which the individual is enrolled;

(3) any policy described in paragraph (2), (3), or (4) of subsection (a) in which the individual is enrolled; and

(4) any other information that the Board determines to be necessary in order for the card to serve the purpose described in subsection (a).

(c) UNIQUE IDENTIFIER NUMBERS.—The unique identifier number system developed by the Board under section 5114(b) shall be used in encoding the information described in subsection (b).

(d) TRADEMARK REGISTRATION.—The Board shall take appropriate steps to ensure the registration of health security cards and other indicia relating to such cards as trademarks or service marks (as appropriate) under the Trademark Act of 1946. For purposes of this subsection, the ''Trademark Act of 1946'' refers to the Act entitled ''An Act to provide for the registration and protection of trademarks used in commerce, to carry out the provisions of international conventions, and for other purposes'', approved July 5, 1946 (15 U.S.C. et seq.).

PART 2—PRIVACY OF INFORMATION

Subpart A—Short Title; Findings and Purposes

SEC. 5160. SHORT TITLE.

This part may be cited as the ''Health Care Privacy Protection Act''.

SEC. 5161. FINDINGS AND PURPOSES.

(a) FINDINGS.—The Congress finds as follows:

(1) The improper disclosure of personally identifiable health care information may cause significant harm to a person's interests in privacy, health care, and reputation and may unfairly affect the ability of a person to obtain employment, education, insurance, and credit.

(2) The movement of people and health care-related information across State lines, availability of access to and exchange of health care-related information from automated data banks and networks, and emergence of multistate health care providers and payors create a need for uniform Federal law governing the disclosure of health care information.

(b) PURPOSE.—The purpose of this Act is to establish effective mechanisms to protect the privacy of persons with respect to personally identifiable health care information that is created or maintained as part of health treatment, enrollment, payment, testing, or research processes.

Subpart B—Judicial Proceedings

SEC. 5162. PRIVACY OF PERSONALLY IDENTIFIABLE HEALTH CARE INFORMATION.

(a) OFFENSE.—Part I of title 18, United States Code, is amended by inserting after chapter 84, the following new chapter:

"CHAPTER 84A—PRIVACY OF PERSONALLY IDENTIFIABLE HEALTH CARE INFORMATION

''Sec.
''1755. Wrongful disclosure of personally identifiable health care information.
''1756. Misuse of health security card or unique identifier.

"§ 1755. Wrongful disclosure of protected health information

''(a) DEFINITION.—The term 'protected health information' shall have the meaning given such term under section 5163 of the Health Security Act.

''(b) OFFENSE.—A person who knowingly—

''(1) obtains protected health information relating to an individual in violation of subpart C of the Health Care Privacy Protection Act; or

''(2) discloses protected health information to another person in violation of subpart C of the Health Care Privacy Protection Act,

shall be punished as provided in subsection (c).

''(c) PENALTIES.—A person who violates subsection (b) shall—

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

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

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

''§ 1756. Misuse of health security card or unique identifier

''A person who—

''(1) requires the display of, requires the use of, or uses a health security card that is issued under the Health Security Act for any purpose other than obtaining or paying for health care; or

''(2) requires the disclosure of, requires the use of, or uses a unique identifier number for any purpose that is not authorized by the National Health Board,

shall be fined not more than $25,000, imprisoned not more than 2 years, or both.''.

(b) TECHNICAL AMENDMENT.—The part analysis for part I of title 18, United States Code, is amended by inserting after the item related to chapter 84, the following new item:

''84A. Privacy of personally identifiable health care information ..... 1755.''.

Subpart C—Limitations on Disclosure of Protected Health Information

SEC. 5163. DEFINITIONS.

In this subpart:

(1) ENROLLEE.—The term ''enrollee'' means an individual who is covered under a health plan. The term includes a deceased individual who was covered under a health plan.

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

(3) HEALTH CARE.—The term ''health care''—

(A) means—

(i) a preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

(I) with respect to the physical or mental condition of an individual; or

(II) affecting the structure or function of the human body or any part of the human body; or

(ii) any sale or dispensing of a drug, device, equipment, or other item to an individual, or for the use of an individual, pursuant to a prescription; but

(B) does not include any item or service that is not furnished for the purpose of examining, maintaining, or improving the health of an individual.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession.

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

(A) a health care provider, health plan, health oversight agency, certified indexing system, certified clearinghouse, certified health information protection organization, or employer,

insofar as it creates, receives, maintains, uses, or transmits protected health information; and

(B) any person who obtains protected health information under section 5169, 5170, 5171, 5172, 5173, 5174, or 5177.

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

(A) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers; or

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

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a Federal or State statute governing

the assessment, evaluation, determination, or investigation.

(7) HEALTH PLAN.—The term ''health plan'' shall have the meaning given such term under section 5102(6).

(8) HEALTH RESEARCHER.—The term ''health researcher'' means a person who conducts a biomedical, public health, health services or health statistics research project or a research project on social and behavioral factors relating to health, that has been approved by—

(A) an institutional review board for the organization sponsoring the project;

(B) an institutional review board for each health information trustee that maintains protected health information intended to be used in the project; or

(C) an institutional review board established or designated by the Board.

(9) INSTITUTIONAL REVIEW BOARD.—The term ''institutional review board'' means—

(A) a board established in accordance with regulations of the Board under section 491(a) of the Public Health Service Act (42 U.S.C. 289);

(B) a similar board established by the Board for the protection of human subjects in research conducted by the Board; or

(C) a similar board established under regulations of a Federal Government authority other than the Board.

(10) LAW ENFORCEMENT INQUIRY.—The term ''law enforcement inquiry'' means an investigation or official proceeding inquiring into whether there is a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

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

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

(A)(i) is created or received by a health care provider, health plan, health oversight agency, public health authority, certified indexing system, certified clearinghouse, or certified health information protection organization; or

(ii) is created or received by an employer through the process of testing, screening, or assisting applicants or employees; and

(B) relates to the past, present, or future physical or mental health or condition of an enrollee, the provision of health care to an enrollee, past, present, or future payment for the provision of health care to an enrollee, or demographic data collected from the enrollee and—

(i) identifies an individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.

(12) PUBLIC HEALTH AUTHORITY.—The term ''public health authority'' means an authority or instrumentality of the United States, a State, or a political subdivision of a State that is (A) responsible for public health matters; and (B) engaged in such activities as injury reporting, public health surveillance, and public health investigation or intervention.

(13) REFERENCES TO CERTAIN CERTIFIED ENTITIES.—

(A) CERTIFIED INDEXING SYSTEM.—The term ''certified indexing system'' shall have the meaning given such term under section 5102.

(B) CERTIFIED CLEARINGHOUSE.—The term ''certified clearinghouse'' shall have the meaning given such term under section 5102.

(C) CERTIFIED HEALTH INFORMATION PROTECTION ORGANIZATION.—The term ''certified health information protection organization'' means a health information protection organization (as defined in section 5102(5)) that is certified under section 5119.

SEC. 5164. GENERAL LIMITATIONS ON DISCLOSURE.

(a) IN GENERAL.—

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

(A) was collected; or

(B) was received by that trustee.

(2) DISCLOSURE OUTSIDE A TRUSTEE.—A health information trustee may disclose protected health information to a person other than an officer,

employee, or agent of the trustee only for a purpose that is authorized under this Act.

(3) SCOPE OF DISCLOSURE.—

(A) IN GENERAL.—Every disclosure of protected health information by a health information trustee shall be limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed.

(B) GUIDELINES.—Not later than July 1, 1996, the Board, after notice and opportunity for public comment, shall issue guidelines to implement subparagraph (A), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting disclosure.

(4) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—Except with respect to protected health information that is disclosed under section 5179, and except as provided in paragraph (5), a health information trustee may not disclose protected health information unless such information is clearly identified as protected health information that is subject to this section.

(5) ROUTINE DISCLOSURES SUBJECT TO WRITTEN AGREEMENT.—A health information trustee who routinely discloses protected health information to a person may satisfy the identification requirement in paragraph (4) through a written agreement between the trustee and the person with respect to the protected health information.

(6) AGREEMENT TO LIMIT DISCLOSURE.—A health information trustee who receives protected health information from any person pursuant to a written agreement to restrict disclosure of the information to a greater extent than would otherwise be required under this section shall comply with the terms of the agreement, except in circumstances in which disclosure of the information is required by law notwithstanding the agreement.

(7) NO GENERAL REQUIREMENT TO DISCLOSE.—Except as provided in the section 5179 relating to inspection, nothing in this section shall be construed to require a health information trustee to disclose protected health information not otherwise required to be disclosed by law.

(b) DISCLOSURE BY OFFICER, EMPLOYEE, OR AGENT.—No officer, employee, or agent of a health information trustee may disclose protected health information,

except insofar as the health information trustee is permitted to disclose such information for a purpose that is authorized under this Act.

SEC. 5165. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) WRITTEN AUTHORIZATIONS.—A health care provider and health plan may disclose protected health information pursuant to an authorization executed by the enrollee who is the subject of the information, if each of the following requirements is met:

(1) WRITING.—The authorization is in writing, signed by the enrollee who is the subject of the information, and dated on the date of such signature.

(2) SEPARATE FORM.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

(3) TRUSTEE DESCRIBED.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

(4) RECIPIENT DESCRIBED.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

(5) STATEMENT OF INTENDED DISCLOSURES.—The authorization contains an acknowledgment that the enrollee who is the subject of the information has received a statement of the disclosures that the person to receive the protected health information intends to make, which statement shall be in writing, on a form that is distinct from the authorization for disclosure, and which statement must be received by the enrollee authorizing the disclosure on or before such authorization is executed.

(6) INFORMATION DESCRIBED.—The information to be disclosed is described in the authorization.

(7) AUTHORIZATION TIMELY RECEIVED.—The authorization is received by the trustee during a period described in subsection (c)(1).

(8) DISCLOSURE TIMELY MADE.—The disclosure occurs during a period described in subsection (c)(2).

(b) AUTHORIZATIONS REQUESTED IN CONNECTION WITH PROVISION OF HEALTH CARE.—

(1) IN GENERAL.—A health information trustee may not request that an individual person provide to any other person an authorization described in subsection (a) on a day on which—

(A) the trustee provides health care to the individual requested to provide the authorization; or

(B) in the case of a trustee that is a health facility, the individual is admitted into the facility as a resident or inpatient in order to receive health care.

(2) EXCEPTION.—Paragraph (1) does not apply if a health information trustee requests that an individual provide an authorization described in subsection (a) for the purpose of assisting the individual in obtaining counseling or social services from a person other than the trustee.

(c) TIME LIMITATIONS ON AUTHORIZATIONS.—

(1) RECEIPT BY TRUSTEE.—For purposes of subsection (a)(7), an authorization is timely received if it is received by the trustee during—

(A) the 1-year period beginning on the date on which the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person who provides health counseling or social services to individuals; or

(B) the 30-day period beginning on the date on which the authorization is signed under

subsection (a)(1), if the authorization permits the disclosure of protected health information to a person other than a person described in subparagraph (A).

(2) DISCLOSURE BY TRUSTEE.—For purposes of subsection (a)(8), a disclosure is timely made if it occurs before—

(A) the date or event (if any) specified in the authorization upon which the authorization expires; and

(B) the expiration of the 6-month period beginning on the date on which the trustee receives the authorization.

(d) REVOCATION OR AMENDMENT OF AUTHORIZATION.—

(1) IN GENERAL.—An individual may in writing revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except when—

(A) disclosure of protected health information has been authorized to permit validation of expenditures for health care; or

(B) action has been taken in reliance on the authorization.

(2) NOTICE OF REVOCATION.—A health information trustee who discloses protected health information pursuant to an authorization that has been revoked shall not be subject to any liability or penalty under this subpart if—

(A) the reliance was in good faith;

(B) the trustee had no notice of the revocation; and

(C) the disclosure was otherwise in accordance with the requirements of this subpart.

(e) DECEASED INDIVIDUAL.—The Board shall develop and establish through regulation a procedure for obtaining protected health information relating to a deceased individual when there is no administrator or executor of such individual's estate.

(f) MODEL AUTHORIZATIONS.—The Board, after notice and opportunity for public comment, shall develop and disseminate model written authorizations of the type described in subsection (a) and model statements of intended disclosures of the type described in paragraph (a)(5).

(g) EFFECT OF AUTHORIZATION ON PRIVILEGES.—The execution by an individual of an authorization that meets the requirements of this section for the purpose of receiving health care or providing for the payment for health care shall not be construed to affect any privilege

that the individual may have under common or statutory law in a court of a State or the United States.

(h) ADDITIONAL REQUIREMENTS OF TRUSTEE.—A health information trustee may impose requirements for an authorization that are in addition to the requirements in this subsection.

(i) COPY.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization as part of the information.

(j) RULE OF CONSTRUCTION.—This section shall not be construed—

(1) to require a health information trustee to disclose protected health information; or

(2) to limit the right of a health information trustee to charge a fee for the disclosure or reproduction of protected health information.

(k) SUBPOENAS.—If a health information trustee discloses protected health information pursuant to an authorization in order to comply with a subpoena, the authorization—

(1) shall specifically authorize the disclosure for the purpose of permitting the trustee to comply with the subpoena; and

(2) shall otherwise meet the requirements in this subsection.

SEC. 5166. TREATMENT; FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) DISCLOSURE OF INFORMATION.—

(1) IN GENERAL.—A health care provider, health plan, or employer may disclose protected health information to a health care provider for the purpose of providing health care to an enrollee if the enrollee who is the subject of the information has not previously objected to the disclosure in writing.

(2) PROVIDING FOR PAYMENT.—A health care provider, health plan, employer, or certified indexing system may disclose protected health information to a health plan for the purpose of providing for the payment for health care furnished to an enrollee.

(3) COOPERATIVE.—A health care provider or health plan may disclose protected health information to a consumer purchasing cooperative established under subtitle D of title I in connection with a financial and administrative transaction described in section 5113.

(4) INDEXING SYSTEMS.—A health care provider or health plan may disclose protected health information to a certified indexing system or cer-

tified clearinghouse for the purpose of carrying out the functions of such system or clearinghouse under part 1.

(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be limited to the minimum amount necessary to accomplish the purpose for which the disclosure is authorized.

SEC. 5167. OVERSIGHT.

(a) IN GENERAL.—A health information trustee may disclose protected health information to a health oversight agency for a purpose authorized by law.

(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be limited to the minimum amount necessary to accomplish the purpose for which the disclosure is authorized.

(c) USE IN ACTION AGAINST ENROLLEES.—Protected health information about an enrollee that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the enrollee who is the subject of the information, except in an action or investigation arising out of and directly related to receipt of health care or payment for health care or an action involving a fraudulent claim related to health.

SEC. 5168. NEXT OF KIN AND DIRECTORY INFORMATION.

(a) NEXT OF KIN.—A health care provider or person that receives protected health information under section 5170 may disclose protected health information to the next of kin or enrollee representative of the enrollee who is the subject of the information or to an individual with whom that enrollee has a personal relationship if—

(1) the enrollee who is the subject of the information has not previously objected to the disclosure after being notified of the right to object; and

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

(b) DIRECTORY INFORMATION.—A health care provider and a person receiving protected health information under section 5170 may disclose information to any person if—

(1) the information does not reveal specific information about the physical or mental condition of the enrollee who is the subject of the information or health care provided to that person;

(2) the enrollee who is the subject of the information has not objected in writing to the disclosure after being notified of the right to object; and

(3) the information consists only of 1 or more of the following items:

(A) The name of the enrollee who is the subject of the information.

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

(i) the location of the enrollee on the premises; and

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

(c) IDENTIFICATION OF DEAD PERSON.—A health care provider, health plan, employer, certified indexing system, or certified clearinghouse may disclose protected health information if necessary to assist in the identification of a dead person.

(d) MINIMUM DISCLOSURE.—The disclosure of protected health information under this section shall be limited to the minimum amount necessary to accomplish the purpose for which the disclosure is authorized.

SEC. 5169. PUBLIC HEALTH.

(a) IN GENERAL.—A health care provider, health plan, public health authority, employer, or person that receives protected health information under section 5170

may disclose protected health information to a public health authority or other person authorized by law for use in legally authorized—

(1) disease or injury reporting;

(2) public health surveillance; or

(3) public health investigation or intervention.

(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be limited to the minimum amount necessary to accomplish the purpose for which the disclosure is authorized.

SEC. 5170. EMERGENCY CIRCUMSTANCES.

(a) IN GENERAL.—A health care provider, health plan, employer, certified indexing system, certified clearinghouse, or person that receives protected health information under this section may disclose protected health information in emergency circumstances when necessary to protect the health or safety of an individual from imminent harm.

(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be limited to the minimum amount necessary to accomplish the purpose for which the disclosure is permitted and shall be limited to persons who need the information to take action to protect the health or safety of the enrollee.

(c) USE IN ACTION AGAINST ENROLLEE.—Protected health information about an enrollee that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the enrollee.

SEC. 5171. JUDICIAL AND ADMINISTRATIVE PURPOSES.

(a) IN GENERAL.—A health care provider, health plan, health oversight agency, or employer may disclose protected health information—

(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which the enrollee who is the subject of the information is a party and in which the enrollee has placed the enrollee's physical or mental condition in issue;

(2) if ordered by a court in connection with an examination of an enrollee; or

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

(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be lim-

ited to the minimum amount necessary to accomplish the purpose for which the disclosure is permitted.

(c) LIMIT ON ADDITIONAL DISCLOSURE.—A person that receives protected health information under this section may use the information and disclose such information only for the purpose for which it was received.

SEC. 5172. HEALTH RESEARCH.

(a) IN GENERAL.—Subject to subsection (d), a health information trustee may disclose protected health information to a health researcher if an institutional review board has determined that the research project engaged in by the health researcher—

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

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

(b) OBLIGATIONS OF RECIPIENT.—A person who receives protected health information pursuant to subsection (a)—

(1) shall remove or destroy, at the earliest opportunity consistent with the purposes of the project, information that would enable an enrollee to be identified, unless—

(A) an institutional review board has determined that there is a health or research justification for retention of such identifiers; and

(B) there is an adequate plan to protect the identifiers from disclosure that is inconsistent with this section; and

(2) shall use protected health information solely for purposes of the health research project for which disclosure was authorized under this section.

(c) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be limited to the minimum amount necessary to accomplish the research purpose for which the disclosure is authorized.

(d) RESEARCH REQUIRING DIRECT CONTACT.—Protected information may not be disclosed to a health researcher for a research project that includes direct contact with an enrollee who is the subject of protected health information unless the enrollee has been given notice by the health information trustee that such contact is possible, has been given the opportunity to object to the disclosure, and has not objected.

SEC. 5173. LAW ENFORCEMENT.

(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or other person that receives protected health information under section

5170 may disclose protected health information to a law enforcement agency (other than a health oversight agency governed by section 5167) if the information is requested for use—

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

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

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

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

(1) specifies the information requested;

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

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

(c) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be lim-

ited to the minimum amount necessary to accomplish the purposes for which the disclosure is permitted.

(d) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—Protected health information about an enrollee that is disclosed to a law enforcement agency under this section—

(1) may not be disclosed for, or used in, any administrative, civil, or criminal action or investigation against the enrollee, except in an action or investigation arising out of and directly related to the action or investigation for which the information was obtained; and

(2) may not be otherwise used or disclosed by the law enforcement agency, unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not otherwise prohibited by law.

SEC. 5174. SUBPOENAS AND WARRANTS.

(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person that receives protected health information under section 5170 may disclose protected health information under this section if the disclosure is pursuant to—

(1) a subpoena issued under the authority of a grand jury, and the trustee is provided a written certification by the grand jury seeking the information

that the grand jury has complied with the applicable access provisions of section 5175;

(2) an administrative subpoena or a judicial subpoena or warrant, and the trustee is provided a written certification by the person seeking the information that the person has complied with the applicable access provisions of section 5175 or 5176; or

(3) an administrative subpoena or a judicial subpoena or warrant, and the disclosure otherwise meets the conditions of section 5167, 5169, 5170, 5171, or 5173.

(b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—Protected health information about an enrollee that is received under—

(1) subsection (a) may not be disclosed for, or used in, any administrative, civil, or criminal action or investigation against the enrollee, except in an action or investigation arising out of and directly related to the inquiry for which the information was obtained;

(2) subsection (a)(2) may not be otherwise disclosed by the recipient unless the disclosure is necessary to fulfill the purpose for which the information was obtained; and

(3) subsection (a)(3) may not be disclosed by the recipient unless the recipient complies with the conditions and restrictions on disclosure with which the recipient would have been required to comply if the disclosure had been made under section 5168, 5169, 5170, 5171, or 5173.

SEC. 5175. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS AND WARRANTS.

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about an enrollee under section 5174(a) (1) or (2) for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

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

(c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected

health information about an enrollee under circumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served on the enrollee on or before the date of return of the subpoena, together with a notice of the enrollee's right to challenge the subpoena in accordance with section 5176, and—

(1) 30 days have passed from the date of service on the enrollee and within that time period the enrollee has not initiated a challenge in accordance with section 5176; or

(2) disclosure is ordered by a court after challenge under section 5176.

(d) APPLICATION FOR DELAY.—

(1) IN GENERAL.—A government authority may apply ex parte and under seal to an appropriate court to delay (for an initial period of not longer than 90 days) serving a copy of a subpoena or notice required under subsection (b) or (c) with respect to a law enforcement inquiry. The government authority may apply to the court for extensions of the delay.

(2) REASONS FOR DELAY.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

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

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

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

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

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

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

(ii) flight from prosecution;

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

(iv) intimidation of potential witnesses.

SEC. 5176. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS.

(a) MOTION TO QUASH SUBPOENA.—Within 30 days after the date of service of a subpoena of a government authority seeking protected health information about an enrollee under section 5174 (a) (1) or (2), or notice that protected health information has been obtained by a government authority, the enrollee may file a motion to quash the subpoena—

(1) in the case of a State judicial subpoena, in the court which issued the subpoena;

(2) in the case of a subpoena issued under the authority of a State that is not a State judicial subpoena, in a court of competent jurisdiction;

(3) in the case of a subpoena issued under the authority of a Federal court, in the United States district court for the district in which the enrollee resides or in which the subpoena was issued; or

(4) in the case of any other subpoena issued under the authority of the United States, in the

United States district court for the district in which the enrollee resides or in which the subpoena was issued.

(b) COPY.—A copy of the motion shall be served by the enrollee upon the government authority by registered or certified mail.

(c) PROCEEDINGS.—The government authority may file with the court such papers, including affidavits and other sworn documents, as sustain the validity of the subpoena. The enrollee may file with the court reply papers in response to the government authority's filing. The court, upon the request of the enrollee or the government authority or both, may proceed in camera. The court may conduct such proceedings as it deems appropriate to rule on the motion, but shall endeavor to expedite its determination.

(d) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds there is probable cause to believe the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds the enrollee's privacy interest outweighs the government authority's need for the information. The enrollee shall have the burden of demonstrating that the en-

rollee's privacy interest outweighs the need established by the government authority for the information.

(e) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In reaching its determination, the court shall consider—

(1) the particular purpose for which the information was collected;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the enrollee;

(3) the effect of the disclosure on the enrollee's future health care;

(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

(5) any other factor deemed relevant by the court.

(f) ATTORNEY'S FEES.—In the case of a motion brought under subsection (a) in which the enrollee has substantially prevailed, the court may assess against the government authority a reasonable attorney's fee and other litigation costs (including expert's fees) reasonably incurred.

(g) NO INTERLOCUTORY APPEAL.—A ruling denying a motion to quash under this section shall not be deemed

to be a final order, and no interlocutory appeal may be taken therefrom by the enrollee. An appeal of such a ruling may be taken by the enrollee within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the enrollee arising out of or based upon the protected health information disclosed.

SEC. 5177. ACCESS AND CHALLENGE PROCEDURES FOR SUBPOENAS OTHER THAN LAW ENFORCEMENT SUBPOENAS.

(a) IN GENERAL.—A private party may not obtain protected health information from a health care provider, health plan, employer, or person that receives protected health information under section 5170 pursuant to a subpoena unless—

(1) a copy of the subpoena together with a notice of the enrollee's right to challenge the subpoena by filing a motion to quash under subsection (b), has been served upon the enrollee who is the subject of the protected health information on or before the date on which the subpoena was served; and

(2)(A) 30 days have passed since the date of service, and within that time period the enrollee has not filed a motion under subsection (b); or

(B) disclosure is ordered by a court under that subsection.

(b) MOTION TO QUASH.—Within 30 days after service of a subpoena seeking protected health information under subsection (a), the enrollee who is the subject of the protected health information may file in any court of competent jurisdiction a motion to quash the subpoena, with a copy served on the person seeking the information. The enrollee may oppose or seek to limit the subpoena on any ground that would be available if the enrollee were in sole possession of the information, including privacy and relevance.

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

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

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

(d) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (c) whether the need of the respondent for the information outweighs the privacy interest of the enrollee, the court shall consider—

(1) the particular purpose for which the information was collected;

(2) the degree to which disclosure of the information would embarrass, injure, or invade the privacy of the enrollee;

(3) the effect of the disclosure on the enrollee's future health care;

(4) the importance of the information to the lawsuit or proceeding; and

(5) any other relevant factor.

(e) ATTORNEY'S FEES.—In the case of a motion brought under subsection (b) in which the enrollee has substantially prevailed, the court may assess against the respondent a reasonable attorney's fee and other litigation costs and expenses (including expert's fees) reasonably incurred.

SEC. 5178. SECURITY.

(a) IN GENERAL.—A health information trustee shall establish and maintain appropriate administrative, technical, and physical safeguards—

(1) to ensure the integrity and confidentiality of protected health information created or received by the trustee; and

(2) to protect against any anticipated threats or hazards to the security or integrity of such information.

(b) SPECIFIC SECURITY MEASURES.—The security measures adopted by a health information trustee shall include the following:

(1) officers, employees, and agents of the trustee who have access to protected health information created or received by the trustee shall be regularly trained in the requirements governing such information;

(2) complete, accurate, and readily available documentation of security features shall be maintained, if the maintenance of such documentation is practicable, taking into account the technical capabilities of the system used to maintain protected health information and the costs of such maintenance; and

(3) appropriate signs and warnings shall be posted to advise of the need to secure protected health information.

(c) REGULATIONS.—The Board shall promulgate regulations regarding security measures for protected health information.

SEC. 5179. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) INSPECTION OF PROTECTED HEALTH INFORMATION.—

(1) IN GENERAL.—Except as provided in paragraph (3), a health care provider or health plan—

(A) shall permit an enrollee who is the subject of protected health information to inspect any such information that the provider or plan maintains;

(B) shall permit the enrollee to have a copy of the information;

(C) shall permit a person who has been designated in writing by the enrollee who is the subject of the information to inspect, or to have a copy of, the information on behalf of the enrollee or to accompany the enrollee during the inspection; and

(D) may offer to explain or interpret information that is inspected or copied under this subsection.

(2) USE OF INDEXING SYSTEMS.—Except as provided in paragraph (3), a health plan or health care provider shall, upon written request of an enrollee—

(A) determine the identity of previous providers to the enrollee; and

(B) obtain protected health information regarding the enrollee.

The plan or provider may obtain such information through use of a certified indexing system.

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

(A) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes, and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the notes would cause sufficient harm to the enrollee who is the subject of the notes so as to outweigh the desirability of permitting access, and the provider or plan has not disclosed the notes to any person not directly engaged in treating the enrollee, except with the authorization of the enrollee or under compulsion of law.

(B) INFORMATION ABOUT OTHERS.—The information relates to an individual other than

the enrollee seeking to inspect or have a copy of the information and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the information would cause sufficient harm to 1 or both of the individuals so as to outweigh the desirability of permitting access.

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

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

(E) ADMINISTRATIVE PURPOSES.—The information—

(i) is used by the provider or plan solely for administrative purposes and not in the provision of health care to the en-

rollee who is the subject of the information; and

(ii) has not been disclosed by the provider or plan to any other person.

(3) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health care provider or health plan shall permit inspection and copying under paragraph (1) of any reasonably segregable portion of a record after deletion of any portion that is exempt under paragraph (2).

(4) CONDITIONS.—A health care provider or health plan may—

(A) require a written request for the inspection and copying of protected health information under this subsection; and

(B) charge a reasonable fee (not greater than the actual cost) for—

(i) permitting inspection of information under this subsection; and

(ii) providing a copy of protected health information under this subsection.

(5) STATEMENT OF REASONS FOR DENIAL.—If a health care provider or health plan denies a request for inspection or copying under this subsection, the provider or plan shall provide the en-

rollee who made the request (or the enrollee's designated representative) with a written statement of the reasons for the denial.

(6) DEADLINE.—A health care provider or health plan shall comply with or deny a request for inspection or copying of protected health information under this subsection within the 30-day period beginning on the date on which the provider or plan receives the request.

SEC. 5180. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A health care provider or health plan that is required to comply with section 5179 shall, within the 45-day period beginning on the date on which the provider or plan receives from an enrollee a written request that the provider or plan correct or amend the information—

(1) make the correction or amendment requested;

(2) inform the enrollee of the correction or amendment that has been made;

(3) inform any certified indexing system or certified clearinghouse to which the uncorrected or unamended portion of the information was pre-

viously disclosed, of the correction or amendment; and

(4) inform any person who is identified by the enrollee, who is not an officer, employee or agent of the provider or plan, and to whom the uncorrected or unamended portion of the information was previously disclosed, of the correction or amendment that has been made.

(b) REFUSAL TO CORRECT.—If the provider or plan refuses to make the corrections, the provider or plan shall inform the enrollee of—

(1) the reasons for the refusal of the provider or plan to make the correction or amendment;

(2) any procedures for further review of the refusal; and

(3) the enrollee's right to file with the provider or plan a concise statement setting forth the requested correction or amendment and the enrollee's reasons for disagreeing with the refusal of the provider or plan.

(c) BASES FOR REQUEST TO CORRECT OR AMEND.—An enrollee may request correction or amendment of protected health information about the enrollee under paragraph (a) if the information is not timely, accurate, relevant to the system of records, or complete.

(d) STATEMENT OF DISAGREEMENT.—After an enrollee has filed a statement of disagreement under paragraph (b)(3), the provider or plan, in any subsequent disclosure of the disputed portion of the information—

(1) shall include a copy of the enrollee's statement; and

(2) may include a concise statement of the reasons of the provider or plan for not making the requested correction or amendment.

(e) RULE OF CONSTRUCTION.—This section shall not be construed to require a health care provider or health plan to conduct a formal, informal, or other hearing or proceeding concerning a request for a correction or amendment to protected health information the provider or plan maintains.

(f) CORRECTION.—For purposes of paragraph (a), a correction is deemed to have been made to protected health information when information that is not timely, accurate, relevant to the system of records, or complete is clearly marked as incorrect or when supplementary correct information is made part of the information.

(g) NOTICE OF INFORMATION PRACTICES.—

(1) PREPARATION OF WRITTEN NOTICE.—A health care provider or health plan shall prepare a

written notice of information practices describing the following:

(A) PERSONAL RIGHTS OF AN ENROLLEE.—The rights under this section of an enrollee who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclosures of protected health information and for revoking such authorizations.

(B) PROCEDURES OF PROVIDER OR PLAN.—The procedures established by the provider or plan for the exercise of the rights of enrollees about whom protected health information is maintained.

(C) AUTHORIZED DISCLOSURES.—The disclosures of protected health information that are authorized.

(2) DISSEMINATION OF NOTICE.—A health care provider or health plan—

(A) shall, upon request, provide any enrollee with a copy of the notice of information practices described in paragraph (1); and

(B) shall make reasonable efforts to inform enrollees in a clear and conspicuous manner of the existence and availability of the notice.

(3) MODEL NOTICE.—The Board, after notice and opportunity for public comment, shall develop and disseminate a model notice of information practices for use by health care providers and health plans under this section.

SEC. 5181. ACCOUNTING FOR DISCLOSURES.

(a) IN GENERAL.—A health care provider or health plan that is required to comply with sections 5179 and 5180 shall create and maintain, with respect to any protected health information disclosed, a record of—

(1) the date and purpose of the disclosure;

(2) the name of the person to whom or to which the disclosure was made;

(3) the address of the person to whom or to which the disclosure was made or the location to which the disclosure was made; and

(4) the information disclosed, if the recording of the information disclosed is practicable, taking into account the technical capabilities of the system used to maintain the record and the costs of such maintenance.

(b) DISCLOSURE RECORD PART OF INFORMATION.—A record created and maintained under paragraph (a) shall be maintained as part of the protected health information to which the record pertains, except for requests from and disclosures to health oversight agencies.

(c) CERTIFIED INDEXING SYSTEMS AND CERTIFIED CLEARINGHOUSES.—

(1) IN GENERAL.—Certified indexing systems and certified clearinghouses shall account for disclosures of protected health information in the manner prescribed under subsection (a).

(2) SPECIAL RULE.—Paragraph (1) shall not apply to disclosures made in connection with financial and administrative transactions and to health information protection organizations (as such terms are defined under part 1) for the creation of health information that is non-identifiable health information.

SEC. 5182. STANDARDS FOR ELECTRONIC DOCUMENTS AND COMMUNICATIONS.

The Board, after notice and opportunity for public comment, shall promulgate standards with respect to the creation, transmission, receipt, and maintenance, in electronic form, of each written document required or authorized under this subpart. When a signature is required with

respect to a written document under any other provision of this subpart, such standards shall provide for an electronic substitute that serves the functional equivalent of a signature.

SEC. 5183. RIGHTS OF INCOMPETENTS.

(a) EFFECT OF DECLARATION OF INCOMPETENCE.—Except as provided in section 5184, if an enrollee has been declared to be incompetent by a court of competent jurisdiction, the rights of the enrollee under this subpart shall be exercised and discharged in the best interests of the enrollee through the enrollee's representative.

(b) NO COURT DECLARATION.—Except as provided in section 5184, if a health care provider determines that an enrollee, who has not been declared to be incompetent by a court of competent jurisdiction, suffers from a medical condition that prevents the enrollee from acting knowingly or effectively on the enrollee's own behalf, the right of the enrollee to authorize disclosure may be exercised and discharged in the best interest of the enrollee by the enrollee's next of kin.

SEC. 5184. RIGHTS OF MINORS.

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

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

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

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

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

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

SEC. 5185. NO LIABILITY FOR PERMISSIBLE DISCLOSURES.

A health information trustee who makes a disclosure of protected health information about an enrollee that is permitted by this subpart shall not be liable to the enrollee for the disclosure under common law.

SEC. 5186. NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.

If the members of an institutional review board make a determination in good faith that—

(1) a health research project is of sufficient importance to outweigh the intrusion into the privacy of an enrollee; and

(2) the effectiveness of the project requires use of protected health information,

the members, the board, and the parent institution of the board shall not be liable to the enrollee as a result of the determination.

SEC. 5187. GOOD FAITH RELIANCE ON CERTIFICATION.

A health information trustee who relies in good faith on a certification by a government authority or other person and discloses protected health information about an enrollee in accordance with this subpart shall not be liable to the enrollee for such disclosure.

SEC. 5188. CIVIL PENALTY.

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

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C.

1320a–7a), other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of that Act.

SEC. 5189. CIVIL ACTION.

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

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

(2) punitive damages;

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

(4) costs of litigation; and

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

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

SEC. 5190. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as provided in subsections (b), (c), and (d), this subpart preempts any State law to the extent that such law is inconsistent with this subpart.

(b) LAWS RELATING TO PUBLIC HEALTH.—Nothing in this subpart is intended to preempt or operate to the exclusion of any State public health law that prevents or regulates disclosure of protected health information otherwise allowed under this Act.

(c) PRIVILEGES.—Nothing in this subpart is intended to preempt or modify State common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the State. This subpart does not supersede or modify Federal common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the United States.

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

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

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

(3) subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications

of emergency response employees of possible exposure to infectious diseases); or

(4) any federal law that prevents or regulates disclosure of protected health information.

SEC. 5191. PRIOR WRITTEN CONSENT.

Except as otherwise provided in this title, no individually identifiable health care information may be disclosed, shared or otherwise transmitted without the prior, valid, written consent of the individuals about whom the information is maintained. Such consent may not be provided on a form that is used to authorize or facilitate the provision of, or payment for, health care. A separate consent shall be obtained for each proposed disclosure under this section. With respect to minors or individuals deemed incapable of giving valid written consent, State law shall apply as appropriate.

SEC. 5192. PROVIDER IDENTIFIABLE DATA.

The Board shall establish standards for the disclosure and transmission of provider identifiable data.

PART 3—INTERIM REQUIREMENTS FOR ADMINISTRATIVE SIMPLIFICATION

SEC. 5195. STANDARD BENEFIT FORMS.

(a) DEVELOPMENT.—Not later than 1 year after the date of the enactment of this Act, the National Health Board shall develop, promulgate, and publish in the Fed-

eral Register the following standard health care benefit forms:

(1) An enrollment and disenrollment form to be used to record enrollment and disenrollment in a health benefit plan.

(2) A clinical encounter record to be used by health benefit plans and health service providers.

(3) A claim form to be used in the submission of claims for benefits or payment under a health benefit plan.

(b) INSTRUCTIONS, DEFINITIONS, AND CODES.—Each standard form developed under subsection (a) shall include instructions for completing the form that—

(1) specifically define, to the extent practicable, the data elements contained in the form; and

(2) standardize any codes or data sets to be used in completing the form.

(c) REQUIREMENTS FOR ADOPTION OF FORMS.—

(1) HEALTH SERVICE PROVIDERS.—On or after the date that is 270 days after the publication of the standard forms developed under subsection (a), a health service provider that furnishes items or services in the United States for which payment may be made under a health benefit plan may not—

(A) maintain records of clinical encounters involving such items or services that are required to be maintained by the National Health Board in a paper form that is not the clinical encounter record promulgated by the Board; or

(B) submit any claim for benefits or payment for such services to such plan in a paper form that is not the claim form promulgated by the National Health Board.

(2) HEALTH BENEFIT PLANS.—On or after the date that is 270 days after the publication of the standard forms developed under subsection (a), a health benefit plan may not—

(A) record enrollment and disenrollment in a paper form that is not the enrollment and disenrollment form promulgated by the National Health Board;

(B) maintain records of clinical encounters that are required to be maintained by the National Health Board in a paper form that is not the clinical encounter record promulgated by the Board; or

(C) reject a claim for benefits or payment under the plan on the basis of the form or medium in which the claim is submitted if—

(i) the claim is submitted on the claim form promulgated by the National Health Board; and

(ii) the plan accepts claims submitted in paper form.

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

(1) HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''health benefit plan'' means, except as provided in subparagraphs (B) through (D), any public or private entity or program that provides for payments for health care services, including—

(i) a group health plan (as defined in section 5000(b)(1) of the Internal Revenue Code of 1986); and

(ii) any other health insurance arrangement, including any arrangement consisting of a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.

(B) PLANS EXCLUDED.—Such term does not include—

(i) accident-only, credit, or disability income insurance;

(ii) coverage issued as a supplement to liability insurance;

(iii) an individual making payment on the individual's own behalf (or on behalf of a relative or other individual) for deductibles, coinsurance, or services not covered under a health benefit plan; and

(iv) such other plans as the National Health Board may determine, because of the limitation of benefits to a single type or kind of health care, such as dental services or hospital indemnity plans, or other reasons should not be subject to the requirements of this section.

(C) PLANS INCLUDED.—Such term includes—

(i) workers compensation or similar insurance insofar as it relates to workers compensation medical benefits (as defined in section 10000(3)) provided by or through health plans; and

(ii) automobile medical insurance insofar as it relates to automobile insurance

medical benefits (as defined in section 10100(2)) provided by or through health plans.

(D) TREATMENT OF DIRECT PROVISION OF SERVICES.—Such term does not include a Federal or State program that provides directly for the provision of health services to beneficiaries.

(2) HEALTH SERVICE PROVIDER.—The term ''health service provider'' includes a provider of services (as defined in section 1861(u) of the Social Security Act), physician, supplier, and other person furnishing health care services. Such term includes a Federal or State program that provides directly for the provision of health services to beneficiaries.

(e) INTERIM NATURE OF REQUIREMENTS.—Any requirement with respect to a standard form imposed under this part shall cease to be effective upon a determination by the Board that the health care data network (as defined in section 5102(3)) is operational.

Subtitle C—Remedies and Enforcement

PART 1—REVIEW OF BENEFIT DETERMINATIONS FOR ENROLLED INDIVIDUALS

Subpart A—General Rules

SEC. 5201. HEALTH PLAN CLAIMS PROCEDURE.

(a) DEFINITIONS.—For purposes of this section—

(1) CLAIM.—The term ''claim'' means a claim for payment or provision of benefits under a health plan, a request for preauthorization of items or services which is submitted to a health plan prior to receipt of the items or services, or the denial, reduction or termination of any service or request for a referral or reimbursement.

(2) INDIVIDUAL CLAIMANT.—The term ''individual claimant'' with respect to a claim means any individual who submits the claim to a health plan in connection with the individual's enrollment under the plan, or on whose behalf the claim is submitted to the plan by a provider.

(3) PROVIDER CLAIMANT.—The term ''provider claimant'' with respect to a claim means any provider who submits the claim to a health plan with respect to items or services provided to an individual enrolled under the plan.

(b) GENERAL RULES GOVERNING TREATMENT OF CLAIMS.—

(1) ADEQUATE NOTICE OF DISPOSITION OF CLAIM.—In any case in which a claim is submitted in complete form to a health plan, the plan shall provide to the individual claimant and any provider claimant with respect to the claim a written notice of the plan's approval or denial of the claim within 15 days after the date of the submission of the claim. The notice to the individual claimant shall be written in language calculated to be understood by the typical individual enrolled under the plan and in a form which takes into account accessibility to the information by individuals whose primary language is not English. In the case of a denial of the claim, the notice shall be provided within 5 days after the date of the determination to deny the claim, and shall set forth the specific reasons for the denial. Such notice shall include an explanation of the specific reasons and facts underlying the decision to reduce or fail to provide services or pay the claim. The notice of a denial shall clearly explain the right to appeal the denial under paragraph (2) and a description of the process for appealing such decision sufficient to allow the claimant to initiate an appeal

and submit evidence to the decision maker in support of the position of the claimant. Failure by any plan to comply with the requirements of this paragraph with respect to any claim submitted to the plan shall be treated as approval by the plan of the claim.

(2) PLAN'S DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.—The plan shall review its denial of the claim if an individual claimant or provider claimant with respect to the claim submits to the plan a written request for reconsideration of the claim after receipt of written notice from the plan of the denial. The plan shall allow any such claimant not less than 60 days, after receipt of written notice from the plan of the denial, to submit the claimant's request for reconsideration of the claim.

(3) TIME LIMIT FOR REVIEW.—The plan shall complete any review required under paragraph (2), and shall provide the individual claimant and any provider claimant with respect to the claim written notice of the plan's decision on the claim after reconsideration pursuant to the review, within 30 days after the date of the receipt of the request for reconsideration.

(4) DE NOVO REVIEWS.—Any review required under paragraph (2)—

(A) shall be de novo,

(B) shall be conducted by an individual who did not make the initial decision denying the claim and who is authorized to approve the claim, and

(C) shall include review by a qualified physician in the same speciality as the treating physician if the resolution of any issues involved requires medical expertise.

(c) TREATMENT OF URGENT REQUESTS TO PLANS FOR PREAUTHORIZATION.—

(1) IN GENERAL.—This subsection applies in the case of any claim submitted by an individual claimant or a provider claimant consisting of a request for preauthorization of items or services (other than emergency services which under section 1406(b) may not be subject to preauthorization) which is accompanied by an attestation that—

(A) failure to immediately provide the items or services could reasonably be expected to result in—

(i) placing the health of the individual claimant (or, with respect to an individual

claimant who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part,

or

(B) immediate provision of the items or services is necessary because the individual claimant has made or is at serious risk of making an attempt to harm such individual claimant or another individual.

(2) SHORTENED TIME LIMIT FOR CONSIDERATION OF REQUESTS FOR PREAUTHORIZATION.—Notwithstanding subsection (b)(1), a health plan shall approve or deny any claim described in paragraph (1) within 12 hours after submission of the claim to the plan. Failure by the plan to comply with the requirements of this paragraph with respect to the claim shall be treated as approval by the plan of the claim.

(3) EXPEDITED EXHAUSTION OF PLAN REMEDIES.—Any claim described in paragraph (1) which is denied by the plan shall be treated as a claim with

respect to which all remedies under the plan provided pursuant to this section are exhausted, irrespective of any review provided under subsection (b)(2).

(4) DENIAL OF PREVIOUSLY AUTHORIZED CLAIMS NOT PERMITTED.—In any case in which a health plan approves a claim described in paragraph (1)—

(A) the plan may not subsequently deny payment or provision of benefits pursuant to the claim, unless the plan makes a showing of an intentional misrepresentation of a material fact by the individual claimant, and

(B) in the case of a violation of subparagraph (A) in connection with the claim, all remedies under the plan provided pursuant to this section with respect to the claim shall be treated as exhausted.

(d) TIME LIMIT FOR DETERMINATION OF INCOMPLETENESS OF CLAIM.—For purposes of this section—

(1) any claim submitted by an individual claimant and accepted by a provider serving under contract with a health plan and any claim described in subsection (b)(1) shall be treated with respect to the

individual claimant as submitted in complete form, and

(2) any other claim for benefits under the plan shall be treated as filed in complete form as of 10 days after the date of the submission of the claim, unless the plan provides to the individual claimant and any provider claimant, within such period, a written notice of any required matter remaining to be filed in order to complete the claim.

Any filing by the individual claimant or the provider claimant of additional matter requested by the plan pursuant to paragraph (2) shall be treated for purposes of this section as an initial filing of the claim.

(e) ADDITIONAL NOTICE AND DISCLOSURE REQUIREMENTS FOR HEALTH PLANS.—In the case of a denial of a claim for benefits under a health plan, the plan shall include, together with the specific reasons provided to the individual claimant and any provider claimant under subsection (b)(1)—

(1) if the denial is based in whole or in part on a determination that the claim is for an item or service which is not covered by the comprehensive benefit package or exceeds payment rates under the applicable fee schedule, the factual basis for the determination,

(2) if the denial is based in whole or in part on exclusion of coverage with respect to services because the services are determined to comprise an experimental treatment or investigatory procedure, the medical basis for the determination and a description of the process used in making the determination, and

(3) if the denial is based in whole or in part on a determination that the treatment is not medically necessary or appropriate or is inconsistent with the plan's practice guidelines, the medical basis for the determination, the guidelines used in making the determination, and a description of the process used in making the determination.

(f) WAIVER OF RIGHTS PROHIBITED.—A health plan may not require any party to waive any right under the plan or this Act as a condition for approval of any claim under the plan, except to the extent otherwise specified in a formal settlement agreement.

SEC. 5202. REVIEW IN AREA COMPLAINT REVIEW OFFICES OF GRIEVANCES BASED ON ACTS OR PRACTICES BY HEALTH PLANS.

(a) COMPLAINT REVIEW OFFICES.—

(1) IN GENERAL.—In accordance with rules which shall be prescribed by the Secretary of Labor,

in consultation with the National Health Board, each State shall establish and maintain a complaint review office for each health care coverage area established by such State. According to designations which shall be made by each State under regulations of the Secretary of Labor, in consultation with such Board, the complaint review office for a health care coverage area established by such State shall also serve as the complaint review office for large group sponsors operating in the State with respect to individuals who are enrolled under health plans maintained by such sponsors and who reside within the area of the health care coverage area.

(2) HEALTH SYSTEMS NOT ESTABLISHED BY STATES.—In the case of any health care system established in any State by the Secretary of Health and Human Services, the Secretary of Health and Human Services shall assume all duties and obligations of such State under this part in accordance with the applicable regulations of the Secretary of Labor, in consultation with the National Health Board, under this part.

(b) FILINGS OF COMPLAINTS BY AGGRIEVED PERSONS.—In the case of any person who is aggrieved by—

(1) any act or practice engaged in by any health plan which consists of or results in denial of payment or provision of benefits under the plan or delay in the payment or provision of benefits, or

(2) any act or practice engaged in by any other plan maintained in a health care coverage area or by a large group sponsor which consists of or results in denial of payment or provision of benefits under a supplemental benefit policy described in section 1421(b)(1) or a cost sharing policy described in section 1421(b)(2) or delay in the payment or provision of the benefits,

if the denial or delay consists of a failure to comply with the terms of the plan (including the provision of benefits in full when due in accordance with the terms of the plan), or with the applicable requirements of this Act, such person may file a complaint with the appropriate complaint review office.

(c) EXHAUSTION OF PLAN REMEDIES.—Any complaint including a claim to which section 5201 applies may not be filed until the complainant has exhausted all remedies provided under the plan with respect to the claim in accordance with such section.

(d) FORM OF COMPLAINT.—The complaint shall be in writing under oath or affirmation, shall set forth the

complaint in a manner calculated to give notice of the nature of the complaint, and shall contain such information as may be prescribed in regulations of the Secretary of Labor.

(e) NOTICE OF FILING.—The complaint review office shall serve by certified mail a notice of the complaint (including the date, place, and circumstances of the alleged violation) on the person or persons alleged in the complaint to have committed the violation within 10 days after the filing of the complaint.

(f) TIME LIMITATION.—Complaints may not be brought under this section with respect to any violation later than one year after the date on which the complaining party knows or should have reasonably known that a violation has occurred. This subsection shall not prevent the subsequent amending of a complaint.

SEC. 5203. INITIAL PROCEEDINGS IN COMPLAINT REVIEW OFFICES.

(a) ELECTIONS.—Whenever a complaint is brought to the complaint review office under section 5202(b), the complaint review office shall provide the complainant with an opportunity, in such form and manner as shall be prescribed in regulations of the Secretary of Labor, to elect one of the following:

(1) to forego further proceedings in the complaint review office and rely on remedies available in a court of competent jurisdiction, with respect to any matter in the complaint,

(2) to submit the complaint as a dispute under the Early Resolution Program established under subpart B and thereby suspend further review proceedings under this section pending termination of proceedings under the Program, or

(3) in any case in which an election under paragraph (2) is not made, or such an election was made but resolution of all matters in the complaint was not obtained upon termination of proceedings pursuant to the election by settlement agreement or otherwise, to proceed with the complaint to a hearing in the complaint review office under section 5204 regarding the unresolved matters.

(b) DUTY OF COMPLAINT REVIEW OFFICE.—The complaint review office shall provide (in a linguistically appropriate manner) an explanation to complainants bringing complaints to the office concerning the legal and other ramifications of each option available under this section.

(c) EFFECT OF PARTICIPATION IN EARLY RESOLUTION PROGRAM.—Any matter in a complaint brought to the complaint review office which is included in a dispute

which is timely submitted to the Early Resolution Program established under subpart B shall not be assigned to a hearing under section 5204 unless the proceedings under the Program with respect to the dispute are terminated without settlement or resolution of the dispute with respect to such matter. Upon termination of any proceedings regarding a dispute submitted to the Program, the applicability of this section to any matter in a complaint which was included in the dispute shall not be affected by participation in the proceedings, except to the extent otherwise required under the terms of any settlement agreement or other formal resolution obtained in the proceedings.

SEC. 5204. HEARINGS BEFORE HEARING OFFICERS IN COMPLAINT REVIEW OFFICES.

(a) HEARING PROCESS.—

(1) ASSIGNMENT OF COMPLAINTS TO HEARING OFFICERS AND NOTICE TO PARTIES.—

(A) IN GENERAL.—In the case of an election under section 5203(a)(3)—

(i) the complaint review office shall assign the complaint, and each motion in connection with the complaint, to a hearing officer employed by the State in the office; and

(ii) the hearing officer shall have the power to issue and cause to be served upon the plan named in the complaint a copy of the complaint and a notice of hearing before the hearing officer at a place fixed in the notice, not less than 5 days after the serving of the complaint.

(B) QUALIFICATIONS FOR HEARING OFFICERS.—No individual may serve in a complaint review office as a hearing officer unless the individual meets standards which shall be prescribed by the Secretary of Labor. Such standards shall include experience, training, ability to communicate with the enrollee, affiliations, diligence, absence of actual or potential conflicts of interest, and other qualifications deemed relevant by the Secretary of Labor. At no time shall a hearing officer have any official, financial, or personal conflict of interest with respect to issues in controversy before the hearing officer.

(2) AMENDMENT OF COMPLAINTS.—Any such complaint may be amended by the hearing officer conducting the hearing, upon the motion of the com-

plainant, in the hearing officer's discretion at any time prior to the issuance of an order based thereon.

(3) ANSWERS.—The party against whom the complaint is filed shall have the right to file an answer to the original or amended complaint and to appear in person or otherwise and give testimony at the place and time fixed in the complaint.

(b) ADDITIONAL PARTIES.—In the discretion of the hearing officer conducting the hearing, any other person may be allowed to intervene in the proceeding and to present testimony.

(c) HEARINGS.—

(1) DE NOVO HEARING.—Each hearing officer shall hear complaints and motions de novo.

(2) TESTIMONY.—The testimony taken by the hearing officer shall be reduced to writing. Thereafter, the hearing officer, in his or her discretion, upon notice may provide for the taking of further testimony or hear argument.

(3) AUTHORITY OF HEARING OFFICERS.—The hearing officer may compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing. In case of contumacy or refusal to obey a subpoena lawfully issued under this paragraph and upon application of the

hearing officer, an appropriate district court of the United States may issue an order requiring compliance with the subpoena and any failure to obey the order may be punished by the court as a contempt thereof. The hearing officer may also seek enforcement of the subpoena in a State court of competent jurisdiction.

(4) EXPEDITED HEARINGS.—Notwithstanding section 5203 and the preceding provisions of this section, upon receipt of a complaint containing a claim described in section 5201(c)(1), the complaint review office shall promptly provide the complainant with the opportunity to make an election under section 5203(a)(3) and assignment to a hearing on the complaint before a hearing officer. The complaint review office shall ensure that such a hearing commences not later than 24 hours after receipt of the complaint by the complaint hearing office and not later than 3 days after the receipt of a complaint, the Complaint Review Office shall provide a decision.

(d) DECISION OF HEARING OFFICER.—

(1) IN GENERAL.—Not later than 120 days after the date on which a complaint is assigned under this section, the hearing officer shall decide if the preponderance of the evidence justifies the denial

of services and whether to decide in favor of the complainant with respect to each alleged act or practice. Each such decision—

(A) shall include the hearing officer's findings of fact, and

(B) shall constitute the hearing officer's final disposition of the proceedings.

(2) DECISIONS FINDING IN FAVOR OF COMPLAINANT.—If the hearing officer's decision includes a determination that any party named in the complaint has engaged in or is engaged in an act or practice described in section 5202(b), the hearing officer shall issue and cause to be served on such party an order which requires such party—

(A) to cease and desist from such act or practice,

(B) to provide the benefits due under the terms of the plan and to otherwise comply with the terms of the plan and the applicable requirements of this Act,

(C) to pay to the complainant prejudgment interest on the actual costs incurred in obtaining the items and services at issue in the complaint,

(D) to pay to the prevailing complainant a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the hearing on the charges on which the complainant prevails, and

(E) to provide other appropriate relief.

(3) DECISIONS NOT IN FAVOR OF COMPLAINANT.—If the hearing officer's decision includes a determination that the party named in the complaint has not engaged in or is not engaged in an act or practice referred to in section 5202(b), the hearing officer—

(A) shall include in the decision a dismissal of the charge in the complaint relating to the act or practice, and

(B) upon a finding that such charge is frivolous, shall issue and cause to be served on the complainant an order which requires the complainant to pay to such party a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the proceedings on such charge.

(4) SUBMISSION AND SERVICE OF DECISIONS.—The hearing officer shall submit each decision to the complaint review office at the conclusion of the pro-

ceedings and the office shall cause a copy of the decision to be served on the parties to the proceedings.

(e) REVIEW.—

(1) IN GENERAL.—The decision of the hearing officer shall be final and binding upon all parties. Except as provided in paragraph (2), any party to the complaint may, within 30 days after service of the decision by the complaint review office, file an appeal of the decision with the Federal Health Plan Review Board under section 5205 in such form and manner as may be prescribed by such Board.

(2) EXCEPTION.—The decision in the case of an expedited hearing under subsection (c)(4) shall not be subject to review.

(f) COURT ENFORCEMENT OF ORDERS.—

(1) IN GENERAL.—If a decision of the hearing officer in favor of the complainant is not appealed under section 5205, the complainant may petition any court of competent jurisdiction for enforcement of the order. In any such proceeding, the order of the hearing officer shall not be subject to review.

(2) AWARDING OF COSTS.—In any action for court enforcement under this subsection, a prevailing complainant shall be entitled to a reasonable attor-

ney's fee, reasonable expert witness fees, and other reasonable costs relating to such action.

SEC. 5205. REVIEW BY FEDERAL HEALTH PLAN REVIEW BOARD.

(a) ESTABLISHMENT AND MEMBERSHIP.—The Secretary of Labor, in consultation with the National Health Board, shall establish by regulation a Federal Health Plan Review Board (hereinafter in this subtitle referred to as the ''Review Board''). The Review Board shall be composed of 5 members appointed by the Secretary of Labor, in consultation with the National Health Board, from among persons who by reason of training, education, or experience are qualified to carry out the functions of the Review Board under this subtitle, and be balanced to fairly represent all interested parties. The Secretary of Labor, in consultation with the National Health Board, shall prescribe such rules as are necessary for the orderly transaction of proceedings by the Review Board. Every official act of the Review Board shall be entered of record, and its hearings and records shall be open to the public.

(b) REVIEW PROCESS.—The Review Board shall ensure, in accordance with rules prescribed by the Secretary of Labor, in consultation with the National Health Board, that reasonable notice is provided for each appeal before the Review Board of a hearing officer's decision under sec-

tion 5304, and shall provide for the orderly consideration of arguments by any party to the hearing upon which the hearing officer's decision is based. In the discretion of the Review Board, any other person may be allowed to intervene in the proceeding and to present written argument. The National Health Board may intervene in the proceeding as a matter of right.

(c) SCOPE OF REVIEW.—The Review Board shall review the decision of the hearing officer from which the appeal is made, except that the review shall be only for the purposes of determining—

(1) whether the determination is supported by substantial evidence on the record considered as a whole,

(2) in the case of any interpretation by the hearing officer of contractual terms (irrespective of the extent to which extrinsic evidence was considered), whether the determination is supported by a preponderance of the evidence,

(3) whether the determination is in excess of statutory jurisdiction, authority, or limitations, or in violation of a statutory right, or

(4) whether the determination is without observance of procedure required by law.

(d) DECISION OF REVIEW BOARD.—The decision of the hearing officer as affirmed or modified by the Review Board (or any reversal by the Review Board of the hearing officer's final disposition of the proceedings) shall become the final order of the Review Board and binding on all parties, subject to review under subsection (e). The Review Board shall cause a copy of its decision to be served on the parties to the proceedings not later than 5 days after the date of the decision.

(e) REVIEW OF FINAL ORDERS.—

(1) IN GENERAL.—Not later than 60 days after the entry of the final order, any person aggrieved by any such final order under which the amount or value in controversy exceeds $10,000 may seek a review of the order in the United States court of appeals for the circuit in which the violation is alleged to have occurred or in which the complainant resides.

(2) FURTHER REVIEW.—Upon the filing of the record with the court, the jurisdiction of the court shall be exclusive and its judgment shall be final, except that the judgment shall be subject to review by the Supreme Court of the United States upon writ of certiorari or certification as provided in section 1254 of title 28 of the United States Code.

(3) ENFORCEMENT DECREE IN ORIGINAL REVIEW.—If, upon appeal of an order under paragraph (1), the United States court of appeals does not reverse the order, the court shall have the jurisdiction to make and enter a decree enforcing the order of the Review Board.

(f) AWARDING OF ATTORNEYS' FEES AND OTHER COSTS AND EXPENSES.—In any proceeding before the Review Board under this section or any judicial proceeding under subsection (e), the Review Board or the court (as the case may be) shall award to a prevailing complainant reasonable costs and expenses (including a reasonable attorney's fee) on the causes on which the complainant prevails.

SEC. 5206. CIVIL MONEY PENALTIES.

(a) DENIAL OR DELAY IN PAYMENT OR PROVISION OF BENEFITS.—

(1) IN GENERAL.—The Secretary of Labor, in consultation with the National Health Board, may assess a civil penalty against any health plan, or against any other plan in connection with benefits provided thereunder under a supplemental benefit policy described in section 1421(b)(1) or a cost sharing policy described in section 1421(b)(2), for unrea-

sonable denial or delay in the payment or provision of benefits thereunder, in an amount not to exceed—

(A) $25,000 per violation, or $75,000 per violation in the case of a finding of bad faith on the part of the plan, and

(B) in the case of a finding of a pattern or practice of such violations engaged in by the plan, $1,000,000 in addition to the total amount of penalties assessed under subparagraph (A) with respect to such violations.

For purposes of subparagraph (A), each violation with respect to any single individual shall be treated as a separate violation.

(2) CIVIL ACTION TO ENFORCE CIVIL PENALTY.—The Secretary of Labor, in consultation with the National Health Board, may commence a civil action in any court of competent jurisdiction to enforce a civil penalty assessed under paragraph (1).

(3) SUPPLEMENTAL PLANS.—Nothing in this section shall be construed to limit the rights and remedies available under State law with respect to supplemental benefit plans.

(b) CIVIL PENALTIES FOR CERTAIN OTHER ACTIONS.—The Secretary of Labor, in consultation with the National Health Board, may assess a civil penalty de-

scribed in section 5412(b)(1) against any experience-rated health plan, or against any other plan sponsored by a large group sponsor in connection with benefits provided thereunder under a cost sharing policy described in section 1421(b)(2), for any action described in section 5412(a). The Secretary of Labor, in consultation with the National Health Board, may initiate proceedings to impose such penalty in the same manner as the Secretary of Health and Human Services may initiate proceedings under section 5412 with respect to actions described in section 5412(a).

Subpart B—Early Resolution Programs

SEC. 5211. ESTABLISHMENT OF EARLY RESOLUTION PROGRAMS IN COMPLAINT REVIEW OFFICES.

(a) ESTABLISHMENT OF PROGRAMS.—Each State shall establish and maintain an Early Resolution Program in each complaint review office in such State. The Program shall include—

(1) the establishment and maintenance of forums for mediation of disputes in accordance with this subpart, and

(2) the establishment and maintenance of such forums for other forms of alternative dispute resolution (including binding arbitration) as may be pre-

scribed in regulations of the Secretary of Labor, in consultation with the National Health Board.

Each State shall ensure that the standards applied in Early Resolution Programs administered in such State which apply to any form of alternative dispute resolution described in paragraph (2) and which relate to time requirements, qualifications of facilitators, arbitrators, or other mediators, and confidentiality are at least equivalent to the standards which apply to mediation proceedings under this subpart.

(b) DUTIES OF COMPLAINT REVIEW OFFICES.—Each complaint review office in a State—

(1) shall administer its Early Resolution Program in accordance with regulations of the Secretary of Labor, in consultation with the National Health Board,

(2) shall, pursuant to subsection (a)(1)—

(A) recruit and train individuals to serve as facilitators for mediation proceedings under the Early Resolution Program from attorneys who have the requisite expertise for such service, which shall be specified in regulations of the Secretary of Labor, in consultation with the National Health Board,

(B) provide meeting sites, maintain records, and provide facilitators with administrative support staff, and

(C) establish and maintain attorney referral panels,

(3) shall ensure that, upon the filing of a complaint with the office, the complainant is adequately apprised of the complainant's options for review under this part, and

(4) shall monitor and evaluate the Program on an ongoing basis.

SEC. 5212. INITIATION OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) ELIGIBILITY OF CASES FOR SUBMISSION TO EARLY RESOLUTION PROGRAM.—A dispute may be submitted to the Early Resolution Program only if the following requirements are met with respect to the dispute:

(1) NATURE OF DISPUTE.—The dispute consists of an assertion by an individual enrolled under a health plan of one or more claims against the health plan for payment or provision of benefits, or against any other plan community-rated health plan or large group sponsor sponsoring the health plan with respect to benefits provided under a supplemental benefit policy described in section 1421(b)(1)

or a cost sharing policy described in section 1421(b)(2), based on alleged coverage under the plan, and a denial of the claims, or a denial of appropriate reimbursement based on the claims, by the plan.

(2) NATURE OF DISPUTED CLAIM.—Each claim consists of—

(A) a claim for payment or provision of benefits under the plan; or

(B) a request for information or documents the disclosure of which is required under this Act (including claims of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

(b) FILING OF ELECTION.—A complainant with a dispute which is eligible for submission to the Early Resolution Program may make the election under section 5203(a)(2) to submit the dispute to mediation proceedings under the Program not later than 15 days after the date the complaint is filed with the complaint review office under section 5202(b).

(c) AGREEMENT TO PARTICIPATE.—

(1) ELECTION BY CLAIMANT.—A complainant may elect participation in the mediation proceedings only by entering into a written participation agree-

ment (including an agreement to comply with the rules of the Program and consent for the complaint review office to contact the health plan regarding the agreement), and by releasing plan records to the Program for the exclusive use of the facilitator assigned to the dispute.

(2) PARTICIPATION BY PLANS OR HEALTH BENEFITS CONTRACTORS.—Each party whose participation in the mediation proceedings has been elected by a claimant pursuant to paragraph (1) shall participate in, and cooperate fully with, the proceedings. The claims review office shall provide such party with a copy of the participation agreement described in paragraph (1), together with a written description of the Program. Such party shall submit the copy of the agreement, together with its authorized signature signifying receipt of notice of the agreement, to the claims review office, and shall include in the submission to the claims review office a copy of the written record of the plan claims procedure completed pursuant to section 5201 with respect to the dispute and all relevant plan documents. The relevant documents shall include all documents under which the plan is or was administered or operated, including copies of any insurance contracts under

which benefits are or were provided and any fee or reimbursement schedules for health care providers.

SEC. 5213. MEDIATION PROCEEDINGS.

(a) ROLE OF FACILITATOR.—In the course of mediation proceedings under the Early Resolution Program, the facilitator assigned to the dispute shall prepare the parties for a conference regarding the dispute and serve as a neutral mediator at such conference, with the goal of achieving settlement of the dispute.

(b) PREPARATIONS FOR CONFERENCE.—In advance of convening the conference, after identifying the necessary parties and confirming that the case is eligible for the Program, the facilitator shall analyze the record of the claims procedure conducted pursuant to section 5201 and any position papers submitted by the parties to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents.

(c) CONFERENCE.—Upon convening the conference, the facilitator shall assist the parties in identifying undisputed issues and exploring settlement. If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement. If no settlement is reached, the facilitator shall present the facilitator's evaluation, including an assessment of the parties' positions,

the likely outcome of further administrative action or litigation, and suggestions for narrowing the issues in dispute.

(d) TIME LIMIT.—The facilitator shall ensure that mediation proceedings with respect to any dispute under the Early Resolution Program shall be completed within 120 days after the election to participate. The parties may agree to one extension of the proceedings by not more than 30 days if the proceedings are suspended to obtain an agency ruling or to reconvene the conference in a subsequent session.

(e) INAPPLICABILITY OF FORMAL RULES.—Formal rules of evidence shall not apply to mediation proceedings under the Early Resolution Program. All statements made and evidence presented in the proceedings shall be admissible in the proceedings. The facilitator shall be the sole judge of the proper weight to be afforded to each submission. The parties to mediation proceedings under the Program shall not be required to make statements or present evidence under oath.

(f) REPRESENTATION.—Parties may participate pro se or be represented by attorneys throughout the proceedings of the Early Resolution Program.

(g) CONFIDENTIALITY.—

(1) IN GENERAL.—Under regulations of the Secretary of Labor, rules similar to the rules under section 574 of title 5, United States Code (relating to confidentiality in dispute resolution proceedings) shall apply to the mediation proceedings under the Early Resolution Program.

(2) CIVIL REMEDIES.—The Secretary of Labor may assess a civil penalty against any person who discloses information in violation of the regulations prescribed pursuant to paragraph (1) in the amount of three times the amount of the claim involved. The Secretary of Labor may bring a civil action to enforce such civil penalty in any court of competent jurisdiction.

SEC. 5214. LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) PROCESS NONBINDING.—Findings and conclusions made in the mediation proceedings of the Early Resolution Program shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the Program.

(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a case is settled through participation in mediation proceedings under the Program, the facilitator shall

assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties, which shall be enforceable under section 5215.

(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under subpart A, or any other right under this Act or the plan, with respect to any person who is not a party to the settlement agreement.

SEC. 5215. ENFORCEMENT OF SETTLEMENT AGREEMENTS.

(a) ENFORCEMENT.—Any party to a settlement agreement entered pursuant to mediation proceedings under this subpart may petition any court of competent jurisdiction for the enforcement of the agreement, by filing in the court a written petition praying that the agreement be enforced. In such a proceeding, the order of the hearing officer shall not be subject to review.

(b) COURT REVIEW.—It shall be the duty of the court to advance on the docket and to expedite to the greatest possible extent the disposition of any petition filed under this section, with due deference to the role of settlement agreements under this part in achieving prompt resolution of disputes involving health plans.

(c) AWARDING OF ATTORNEY'S FEES AND OTHER COSTS AND EXPENSES.—In any action by an individual enrolled under a health plan for court enforcement under this section, a prevailing plaintiff shall be entitled to reasonable costs and expenses (including a reasonable attorney's fee and reasonable expert witness fees) on the charges on which the plaintiff prevails.

SEC. 5216. DUE PROCESS FOR HEALTH CARE PROVIDERS.

(a) PUBLICLY AVAILABLE STANDARDS AND PROCESS.—Each health plan shall establish and utilize—

(1) publicly available standards for contracting with health care providers; and

(2) a publicly available process for dismissing such providers or failing to renew contracts with such providers.

(b) NOTICE REQUIREMENT.—

(1) IN GENERAL.—The process established by a health plan under subsection (a) shall include reasonable notification to a health care provider of a decision to dismiss such provider or not to renew a contract with such provider before such decision takes effect.

(2) EXCEPTION.—The notice required under paragraph (1) shall not apply if failure to dismiss a

provider or renewing a provider's contract would adversely affect the health or safety of a patient.

(3) CONTENTS OF NOTICE.—Each notice to a health care provider under paragraph (1) shall contain the reasons for the dismissal or failure to renew. Such reasons shall be consistent with the standards established under subsection (a).

(c) REVIEW.—The process established by a health plan under subsection (a) shall include an opportunity for review of the health plan's action by a health care provider who is dismissed by a health plan or with respect to whom a health plan fails to renew a contract. Such review shall be conducted by—

(1) the provider's peers who have contracts with, or are employed by, the health plan; and

(2) if there is mutual consent of the provider and the health plan, one or more enrollees in the health plan.

A health care provider may have an attorney present in connection with any review under this subsection if the provider notifies the health plan that an attorney will be present in advance of the review proceeding.

(d) EFFECT ON OTHER LAWS.—The provisions of this section shall not supersede any other provision of Federal or State law.

PART 2—ADDITIONAL REMEDIES AND ENFORCEMENT PROVISIONS

SEC. 5231. JUDICIAL REVIEW OF FEDERAL ACTION ON STATE SYSTEMS.

(a) IN GENERAL.—Any State that is aggrieved by a determination by the National Health Board under subpart B of part 1 of subtitle F of title I shall be entitled to judicial review of such determination in accordance with this section.

(b) JUDICIAL REVIEW.—

(1) JURISDICTION.—The courts of appeals of the United States (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction to review a determination described in subsection (a), to affirm the determination, or to set it aside, in whole or in part. A judgment of a court of appeals in such an action shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(2) PETITION FOR REVIEW.—A State that desires judicial review of a determination described in subsection (a) shall, within 30 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which the State is located a petition for review of such deter-

mination. A copy of the petition shall be transmitted by the clerk of the court to the National Health Board, and the Board shall file in the court the record of the proceedings on which the determination or action was based, as provided in section 2112 of title 28, United States Code.

(3) SCOPE OF REVIEW.—The findings of fact of the National Health Board, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Board to take further evidence, and the Board may make new or modified findings of fact and may modify its previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

SEC. 5232. ADMINISTRATIVE AND JUDICIAL REVIEW RELATING TO COST CONTAINMENT.

There shall be no administrative or judicial review of any determination by the National Health Board respecting any matter under subtitle A of title VI.

SEC. 5233. CIVIL ENFORCEMENT.

Unless otherwise provided in this Act, the district courts of the United States shall have jurisdiction of civil actions brought by—

(1) the Secretary of Labor, in consultation with the National Health Board, to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this Act; and

(2) the Secretary of Health and Human Services to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this Act.

SEC. 5234. PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.

Section 507(a)(8) of title 11, United States Code, is amended to read as follows:

''(8) Eighth, allowed unsecured claims—

''(A) based upon any commitment by the debtor to the Federal Deposit Insurance Corporation, the Resolution Trust Corporation, the Director of the Office of Thrift Supervision, the Comptroller of the Currency, or the Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution;

''(B) for payments under subtitle B of title IV of the Health Security Act owed to a State (as defined in section 1301 of such Act);

''(C) for payments owed to an experienced-rated health plan under trusteeship of the Secretary of Labor under section 1395 of the Health Security Act; or

''(D) for assessments and related amounts owed to the Secretary of Labor under section 1397 of the Health Security Act.''.

SEC. 5235. PRIVATE RIGHT TO ENFORCE STATE RESPONSIBILITIES.

The failure of a participating State to carry out a responsibility applicable to participating States under this Act constitutes a deprivation of rights secured by this Act for the purposes of section 1977 of the Revised Statutes of the United States (42 U.S.C. 1983). In an action brought under such section, the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 5236. PRIVATE RIGHT TO ENFORCE FEDERAL RESPONSIBILITIES IN OPERATING A SYSTEM IN A STATE.

(a) IN GENERAL.—The failure of the Secretary of Health and Human Services to carry out a responsibility under section 1522 (relating to State participation) confers an enforceable right of action on any person who is

aggrieved by such failure. Such a person may commence a civil action against the Secretary in an appropriate State court or district court of the United States.

(b) EXHAUSTION OF REMEDIES.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

(c) RELIEF.—In an action under subsection (a), if the court finds that a failure described in such subsection has occurred, the aggrieved person may recover compensatory damages and the court may award any other appropriate relief.

(d) ATTORNEY'S FEES.—In an action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

SEC. 5237. PRIVATE RIGHT TO ENFORCE RESPONSIBILITIES OF COOPERATIVES.

(a) IN GENERAL.—The failure of a consumer purchasing cooperative, large group sponsor, or health plan to carry out a responsibility applicable to the entity under this Act confers an enforceable right of action on any per-

son who is aggrieved by such failure. Such a person may commence a civil action against the cooperative, large group sponsor or health plan in an appropriate State court or district court of the United States.

(b) EXHAUSTION OF REMEDIES.—

(1) IN GENERAL.—Except as provided in paragraph (2), in an action under subsection (a) the court may not exercise jurisdiction until the aggrieved person has exhausted any administrative remedies that may be provided by law.

(2) NO EXHAUSTION REQUIRED.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law if the action relates to—

(A) whether the person is an eligible individual within the meaning of section 1001(c);

(B) whether the person is eligible for a premium discount under subpart A of part 1 of subtitle B of title VI;

(C) whether the person is eligible for a reduction in cost sharing under subpart D of part 3 of subtitle D of title I; or

(D) enrollment or disenrollment in a health plan.

(c) RELIEF.—In an action under subsection (a), if the court finds that a failure described in such subsection has occurred, the court may award any appropriate relief.

(d) ATTORNEY'S FEES.—In any action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

SEC. 5237A. ENFORCEMENT OF CONSUMER PROTECTIONS.

(a) COVERED VIOLATIONS.—The provisions of this section shall apply with respect to a health plan that fails to fulfill a duty imposed on the plan under section 1204 and subtitle A of this title.

(b) ADMINISTRATIVE ENFORCEMENT AND CIVIL PENALTIES.—The penalties described in section 1867(d)(1) of the Social Security Act and the procedures described in section 1128A of such Act (other than the first two sentences of subsection (a) and subsection (b)) shall apply to health plans described in subsection (a). In addition to such penalties, an amount not to exceed $1,000,000 may be assessed in the case of a finding of a pattern or practice of such violations. The Secretary

shall establish procedures whereby, when a consumer has disenrolled from a health plan violating the duties described in subsection (a), successor health plans may recover from the original health plan for health care costs attributable to such violations.

(c) CORRECTION OF SUBSTANTIAL VIOLATIONS.—Upon an administrative or judicial finding of a substantial violation of the duties described in subsection (a), the State or court may—

(1) inform all current enrollees of the plan of the violation and that they may disenroll immediately from that plan and enroll with another community-rated health plan; and

(2) notify the health plan that it shall immediately cease enrollment activities until it has obtained certifications from the appropriate certifying entity or court that the violation has been corrected.

Such actions shall not be taken without providing the health plan with a reasonable opportunity to correct such violations, except where providing such an opportunity would risk health or safety.

SEC. 5238. DISCRIMINATION CLAIMS.

(a) CIVIL ACTION BY AGGRIEVED PERSON.—

(1) IN GENERAL.—Any person who is aggrieved by a violation of section 1914 may commence a civil

action against the party or parties committing such violation in an appropriate State court or district court of the United States.

(2) STANDARDS.—The standards used to determine whether a violation has occurred in a complaint alleging discrimination on the basis of age or disability under section 1914 shall be the standards applied under the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et. seq.).

(3) RELIEF.—In any action under paragraph (1), if the court finds a violation of section 1914, the court may award such equitable and injunctive relief as it deems appropriate, and may award to the aggrieved person any sums lost as a result of the violation. If the court finds that the party or parties committing a violation engaged in intentional discrimination in violation of section 1914, the aggrieved person may recover compensatory damages. If the court finds that the party or parties committing such violation did so with malice or reckless indifference to the federally protected rights of the aggrieved person, the aggrieved person may recover punitive damages under this section against a de-

fendant other than a government, government agency or political subdivision.

(4) ATTORNEYS' FEES.—In any action under paragraph (1), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees and other litigation expenses) as part of the costs, and the United States shall be liable for costs the same as a private person.

(b) ACTION BY SECRETARY.—Whenever the Secretary of Health and Human Services finds that a party has failed to comply with section 1914 or with an applicable regulation issued under such section, the Secretary shall notify the party. If within a reasonable period of time the party fails or refuses to comply, the Secretary may—

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

(2) terminate or limit the participation of such party in the programs authorized by this Act;

(3) withhold Federal financial assistance to the party; or

(4) take such other action as may be provided by law.

(c) ACTION BY ATTORNEY GENERAL.—When a matter is referred to the Attorney General under subsection (b)(1), the Attorney General may bring a civil action in a district court of the United States for such relief as may be appropriate, including injunctive relief. In a civil action under this section, the court—

(1) may grant any equitable relief that the court considers to be appropriate;

(2) may award such other relief as the court considers to be appropriate, including in cases of intentional discrimination compensatory and punitive damages; and

(3) may, to vindicate the public interest when requested by the Attorney General, assess a civil money penalty against the party in an amount—

(A) not exceeding $50,000 for a first violation; and

(B) not exceeding $100,000 for any subsequent violation.

SEC. 5239. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

Federal payments under subtitle C of title VI shall be treated as Federal financial assistance for purposes of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 303 of the Age Discrimination Act of 1975

(42 U.S.C. 6102), and section 601 of the Civil Rights Act of 1964 (42 U.S.C. 2000d).

SEC. 5240. CIVIL AND ADMINISTRATION ACTION BY ESSENTIAL COMMUNITY PROVIDER.

(a) IN GENERAL.—An electing essential community provider (as defined in section 1431(d)) who is aggrieved by the failure of a health plan to fulfill a duty imposed on the plan by section 1431 may commence a civil action against the plan in an appropriate State court or district court of the United States.

(b) RELIEF.—In an action under subsection (a), if the court finds that the health plan has failed to fulfill a duty imposed on the plan by section 1431, the electing essential community provider may recover compensatory damages and the court may order any other appropriate relief.

(c) ATTORNEY'S FEES.—In any action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(d) STATE COMPLAINT SYSTEM REQUIRED.—Prior to commencing an action under subsection (a), the aggrieved essential community provider may first elect to

utilize the administrative process provided under this subsection as follows:

(1) The Secretary shall prescribe regulations governing administrative grievance actions by essential community providers that shall be consistent with the requirements of section 5204 and that shall provide for the consolidation of complaints (at the election of the essential community providers) in cases involving multiple complaints against a single health plan.

(2) A State shall make available to each electing essential community provider that is aggrieved by an action of a health plan under section 1431, the opportunity to file a complaint in the complaint review office established under section 5202. In the case of essential community providers located in a cooperative established in any State by the Secretary, the Secretary shall assume all of the duties and obligations of such State under this section.

SEC. 5241. FACIAL CONSTITUTIONAL CHALLENGES.

(a) JURISDICTION.—The United States District Court for the District of Columbia shall have original and exclusive jurisdiction of any civil action brought to invalidate this Act or a provision of this Act on the ground of its being repugnant to the Constitution of the United

States on its face and for every purpose. In any action described in this subsection, the district court may not grant any temporary order or preliminary injunction restraining the enforcement, operation, or execution of this Act or any provision of this Act.

(b) CONVENING OF THREE-JUDGE COURT.—An action described in subsection (a) shall be heard and determined by a district court of three judges in accordance with section 2284 of title 28, United States Code.

(c) CONSOLIDATION.—When actions described in subsection (a) involving a common question of law or fact are pending before a district court, the court shall order all the actions consolidated.

(d) DIRECT APPEAL TO SUPREME COURT.—In any action described in subsection (a), an appeal may be taken directly to the Supreme Court of the United States from any final judgment, decree, or order in which the district court—

(1) holds this Act or any provision of this Act invalid; and

(2) makes a determination that its holding will materially undermine the application of the Act as whole.

(e) CONSTRUCTION.—This section does not limit—

(1) the right of any person—

(A) to a litigation concerning the Act or any portion of the Act; or

(B) to petition the Supreme Court for review of any holding of a district court by writ of certiorari at any time before the rendition of judgment in a court of appeals; or

(2) the authority of the Supreme Court to grant a writ of certiorari for the review described in paragraph (1)(B).

SEC. 5242. TREATMENT OF PLANS AS PARTIES IN CIVIL ACTIONS.

(a) IN GENERAL.—A health plan may sue or be sued under this Act as an entity. Service of summons, subpoena, or other legal process of a court or hearing officer upon a trustee or an administrator of any such plan in his capacity as such shall constitute service upon the plan. In a case where a plan has not designated in applicable plan documents an individual as agent for the service of legal process, service upon the Secretary of Health and Human Services (in the case of a community-rated health plan) or the Secretary of Labor (in the case of an experienced-rated health plan) shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(b) OTHER PARTIES.—Any money judgment under this Act against a plan referred to in subsection (a) shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this Act.

SEC. 5243. WHISTLEBLOWER PROTECTIONS.

(a) IN GENERAL.—A health care entity (as defined in section 11101(7)) or a health plan may not discharge, discriminate or otherwise take adverse action against any employee with respect to compensation, terms, conditions or privileges of employment because the employee (or any person acting pursuant to the request of the employee) provided information to any Federal, State or private supervisory agency or entity regarding a possible violation of any provision of this Act or any regulation issued under this Act.

(b) CIVIL ACTION.—An employee or former employee who believes that such employee has been discharged, discriminated or otherwise subject to adverse action in violation of subsection (a) may file a civil action in the appropriate United States district court within 2 years of the date of such discharge, discrimination or adverse action.

(c) DETERMINATION OF COURT.—If a court in an action under subsection (b) determines that a violation of

subsection (a) has occurred, the court may order the health care entity or plan that committed the violation—

(1) to reinstate the employee to his or her former position;

(2) to pay compensatory damages to the employee;

(3) to pay reasonable costs and attorneys fees incurred by the employee in bringing such action; and

(4) to take such other appropriate actions to remedy any past discrimination.

SEC. 5244. GENERAL NONPREEMPTION OF RIGHTS AND REMEDIES.

Nothing in this title shall be construed to deny, impair, or otherwise adversely affect a right or remedy available under law to any person, except to the extent the right or remedy is inconsistent with this title.

Subtitle D—Medical Malpractice

PART 1—LIABILITY REFORM

SEC. 5301. FEDERAL TORT REFORM.

(a) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in section 5302, this part shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this part shall

not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

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

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

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

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

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

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

(3) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—

Nothing in this part shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

(b) DEFINITIONS.—In this subtitle, the following definitions apply:

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

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

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

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

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

(6) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a cause of action brought in a State or Federal court against a health care provider or health care professional by which the plaintiff alleges a medical malpractice claim.

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

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

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

(C) any claim brought pursuant to subtitle C of this title.

SEC. 5302. STATE-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) APPLICATION TO MALPRACTICE CLAIMS UNDER PLANS.—Prior to or immediately following the commencement of any medical malpractice action, the parties shall participate in the alternative dispute resolution system administered by the State under subsection (b). Such participation shall be in lieu of any other provision of Federal or State law or any contractual agreement made by or on behalf of the parties prior to the commencement of the medical malpractice action.

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

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

from the provision of (or failure to provide) health care services to individuals enrolled in a health plan; and

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

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

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

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

(B) CLAIMANT-REQUESTED BINDING ARBITRATION.—For claims involving a sum of money that falls below a threshold amount set by the Board, the use of arbitration not subject

to subsection (d). Such binding arbitration shall be at the sole discretion of the claimant.

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

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

(E) CERTIFICATE OF MERIT.—The requirement that a medical malpractice plaintiff submit to the court before trial a written report by a qualified specialist that includes the specialist's determination that, after a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant.

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

methods under paragraph (1), the Board shall assure that the methods promote the resolution of medical malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) provides for timely resolution of claims;

(C) provides for the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution for individuals enrolled in plans.

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

(d) FURTHER REDRESS.—Except with respect to the claimant-requested binding arbitration method set forth in subsection (c)(1)(B), and notwithstanding any other provision of a law or contractual agreement, a plan enrollee dissatisfied with the determination reached as a result of an alternative dispute resolution method applied under this section may, after the final resolution of the enrollee's

claim under the method, bring a cause of action to seek damages or other redress with respect to the claim to the extent otherwise permitted under State law. The results of any alternative dispute resolution procedure are inadmissible at any subsequent trial, as are all statements, offers, and other communications made during such procedures, unless otherwise admissible under State law.

SEC. 5303. LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

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

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

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

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

attributable to the normal operating expenses of the attorney.

(b) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) may, in the discretion of the court, be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

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

SEC. 5304. REDUCTION OF AWARDS FOR RECOVERY FROM COLLATERAL SOURCES.

(a) REDUCTION OF AWARD.—The total amount of damages recovered by a plaintiff in a medical malpractice liability action shall be reduced by an amount that equals—

(1) the amount of any payment which the plaintiff has received or to which the plaintiff is presently

entitled on account of the same injury for which the damages are awarded, including payment under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) private disability insurance programs;

(D) employer wage continuation programs; and

(E) any other program, if the payment is intended to compensate the plaintiff for the same injury for which damages are awarded; less

(2) the amount of any premiums or any other payments that the plaintiff has paid to be eligible to receive the payment described in paragraph (1) and any portion of the award subject to a subrogation lien or claim.

(b) SUBROGATION.—The court may reduce a subrogation lien or claim described in subsection (a)(2) by an amount representing reasonable costs incurred in securing the award subject to the lien or claim.

(c) INAPPLICABILITY OF SECTION.—This section shall not apply to any case in which the court determines that the reduction of damages pursuant to subsection (a)

would compound the effect of any State law limitation on damages so as to render the plaintiff less than fully compensated for his or her injuries.

SEC. 5305. PERIODIC PAYMENT OF AWARDS.

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

(b) FAILURE OR INABILITY TO PAY.—With respect to an award of damages described in subsection (a), if a defendant fails to make payments in a timely fashion, or if the defendant becomes or is at risk of becoming insolvent, upon such a showing the claimant may petition the court for an order requiring that remaining balance be discounted to present value and paid to the claimant in a lump-sum.

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

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

SEC. 5306. CONSTRUCTION.

Nothing in this subtitle shall be construed to preempt any State law that sets a maximum limit on total damages.

PART 2—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 5311. STATE MALPRACTICE REFORM DEMONSTRATION PROJECTS.

(a) ESTABLISHMENT.—The Secretary shall award grants to States for the establishment of malpractice reform demonstration projects in accordance with this section. Each such project shall be designed to assess the fairness and effectiveness of one or more of the following models:

(1) No-fault liability.

(2) Enterprise liability.

(3) Practice guidelines.

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

(1) MEDICAL ADVERSE EVENT.—The term ''medical adverse event'' means an injury that is the result of medical management as opposed to a dis-

ease process that creates disability lasting at least one month after discharge, or that prolongs a hospitalization for more than one month, and for which compensation is available under a no-fault medical liability system established under this section.

(2) NO-FAULT MEDICAL LIABILITY SYSTEM.—The terms ''no-fault medical liability system'' and ''system'' mean a system established by a State receiving a grant under this section which replaces the common law tort liability system for medical injuries with respect to certain qualified health care organizations and qualified insurers and which meets the requirements of this section.

(3) PROVIDER.—The term ''provider'' means physician, physician assistant, or other individual furnishing health care services in affiliation with a qualified health care organization.

(4) QUALIFIED HEALTH CARE ORGANIZATION.—The term ''qualified health care organization'' means a hospital, a hospital system, a managed care network, or other entity determined appropriate by the Secretary which elects in a State receiving a grant under this section to participate in a no-fault medical liability system and which meets the requirements of this section.

(5) QUALIFIED INSURER.—The term ''qualified insurer'' means a health care malpractice insurer, including a self-insured qualified health care organization, which elects in a State receiving a grant under this section to participate in a no-fault medical liability system and which meets the requirements of this section.

(6) ENTERPRISE LIABILITY.—The term ''enterprise liability'' means a system in which State law imposes malpractice liability on the health plan in which a physician participates in place of personal liability on the physician in order to achieve improved quality of care, reductions in defensive medical practices, and better risk management.

(7) PRACTICE GUIDELINES.—The term ''practice guidelines'' means guidelines established by the Agency for Health Care Policy and Research pursuant to the Public Health Service Act or this Act.

(c) APPLICATIONS BY STATES.—

(1) IN GENERAL.—Each State desiring to establish a malpractice reform demonstration project shall submit an application to the Secretary at such time and in such manner as the Secretary shall require.

(2) CONTENTS OF APPLICATION.—An application under paragraph (1) shall include—

(A) an identification of the State agency or agencies that will administer the demonstration project and be the grant recipient of funds for the State;

(B) a description of the manner in which funds granted to a State will be expended and a description of fiscal control, accounting, and audit procedures to ensure the proper dispersal of and accounting for funds received under this section; and

(C) such other information as the Secretary determines appropriate.

(3) CONSIDERATION OF APPLICATIONS.—In reviewing all applications received from States desiring to establish malpractice demonstration projects under paragraph (1), the Secretary shall consider—

(A) data regarding medical malpractice and malpractice litigation patterns in each State;

(B) the contributions that any demonstration project will make toward reducing malpractice and costs associated with health care injuries;

(C) diversity among the populations serviced by the systems;

(D) geographic distribution; and

(E) such other criteria as the Secretary determines appropriate.

(d) EVALUATION AND REPORTS.—

(1) BY THE STATES.—Each State receiving a grant under this section shall conduct on-going evaluations of the effectiveness of any demonstration project established in such State and shall submit an annual report to the Secretary concerning the results of such evaluations at such times and in such manner as the Secretary shall require.

(2) BY THE SECRETARY.—The Secretary shall submit an annual report to Congress concerning the fairness and effectiveness of the demonstration projects conducted under this section. Such report shall analyze the reports received by the Secretary under paragraph (1).

(e) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) LIMITATIONS ON EXPENDITURES.—

(A) ADMINISTRATIVE EXPENSES.—Not more than 10 percent of the amount of each grant awarded to a State under this section may be used for administrative expenses.

(B) WAIVER OF COST LIMITATIONS.—The limitation under subparagraph (A) may be waived as determined appropriate by the Secretary.

(f) ELIGIBILITY FOR NO-FAULT DEMONSTRATION.—A State is eligible to receive a no-fault liability demonstration grant if the application of the State under subsection (c) includes—

(1) an identification of each qualified health care organization selected by the State to participate in the system, including—

(A) the location of each organization;

(B) the number of patients generally served by each organization;

(C) the types of patients generally served by each organization;

(D) an analysis of any characteristics of each organization which makes such organization appropriate for participation in the system;

(E) whether the organization is self-insured for malpractice liability; and

(F) such other information as the Secretary determines appropriate;

(2) an identification of each qualified insurer selected by the State to participate in the system, including—

(A) a schedule of the malpractice insurance premiums generally charged by each insurer under the common law tort liability system; and

(B) such other information as the Secretary determines appropriate;

(3) a description of the procedure under which qualified health care organizations and insurers elect to participate in the system;

(4) a description of the system established by the State to assure compliance with the requirements of this section by each qualified health care organization and insurer; and

(5) a description of procedures for the preparation and submission to the State of an annual report by each qualified health care organization and qualified insurer participating in a system that shall include—

(A) a description of activities conducted under the system during the year; and

(B) the extent to which the system exceeded or failed to meet relevant performance standards including compensation for and deterrence of medical adverse events.

(g) ELIGIBILITY FOR ENTERPRISE LIABILITY DEMONSTRATION.—A State is eligible to receive an enterprise liability demonstration grant if the State—

(1) has entered into an agreement with a health plan (other than a fee-for-service plan) operating in the State under which the plan assumes legal liability with respect to any medical malpractice claim arising from the provision of (or failure to provide) services under the plan by any physician participating in the plan; and

(2) has provided that, under the law of the State, a physician participating in a plan that has entered into an agreement with the State under paragraph (1) may not be liable in damages or otherwise for such a claim and the plan may not require such physician to indemnify the plan for any such liability.

(h) ELIGIBILITY FOR PRACTICE GUIDELINES DEMONSTRATION.—A State is eligible to receive a practice guidelines demonstration grant if the law of the State provides that in the resolution of any medical malpractice ac-

tion, compliance or non-compliance with an appropriate practice guideline shall be admissible at trial as a rebuttable presumption regarding medical negligence.

Subtitle E—Expanded Efforts To Combat Health Care Fraud and Abuse

PART 1—IMPROVED ENFORCEMENT

SEC. 5401. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1995, the Secretary and the Attorney General of the United States shall establish a joint program—

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

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

(3) to facilitate the enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under sub-

section (a), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH CONSUMER PURCHASING COOPERATIVES AND HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of consumer purchasing cooperatives and health plans.

(d) AUTHORITIES OF ATTORNEY GENERAL AND SECRETARY.—In carrying out duties under subsection (a), the Attorney General and the Secretary are authorized—

(1) to conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the program established under such subsection;

(2) to have access (including on-line access as requested and available) to all records available to consumer purchasing cooperatives and health plans relating to the activities described in paragraph (1) (subject to restrictions based on the confidentiality

of certain information under part 2 of subtitle B); and

(3) to require the issuance of advisory opinions, fraud alerts, and other appropriate educational material to assist in compliance with the provisions of this subtitle.

(e) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or the Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act.

(f) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out duties and responsibilities under the program established under subsection (a), the Inspector General is authorized to exercise all powers granted under the Inspector General Act of 1978 to the same manner and extent as provided in that Act.

(g) DEFINITIONS.—In this subtitle:

(1) HEALTH CARE.—The term ''health care'' includes long-term care benefits under title II of this Act.

(2) INSPECTOR GENERAL.—The term ''Inspector General'' means the Inspector General of the Department of Health and Human Services.

SEC. 5402. ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is hereby established an account to be known as the ''All-Payer Health Care Fraud and Abuse Control Account'' (in this section referred to as the ''Anti-Fraud Account''). The Anti-Fraud Account shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in such Anti-Fraud Account as provided in section 5411(d)(2). It shall also include the following:

(A) All criminal fines imposed in cases involving a Federal health care offense (as defined in subsection (d)).

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

(C) Administrative penalties and assessments imposed under section 5411 (except as otherwise provided by law).

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

Any such funds received on or after the date of the enactment of this Act shall be deposited in the Anti-Fraud Account.

(2) AUTHORIZATION TO ACCEPT GIFTS.—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for the benefit of the Anti-Fraud Account or any activity financed through the Anti-Fraud Account.

(b) USE OF FUNDS.—

(1) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and the Attorney General of the United States in carrying out the All-Payer Health Care Fraud and Abuse Control Program established under section 5401 (including the administration of the Program), and may be used to cover costs in-

curred in operating the Program, including costs of—

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

(B) investigations (including equipment, salaries, administratively uncontrollable work, travel, and training of law enforcement personnel);

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

(D) inspections and other evaluations;

(E) rewards paid under section 5404; and

(F) provider and consumer education (including the provision of advisory opinions) regarding compliance with the provisions of this subtitle.

Twenty percent of the amounts available in the Anti-Fraud Account for any fiscal year shall be used for costs described in subparagraph (F).

(2) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(c) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(d) FEDERAL HEALTH CARE OFFENSE DEFINED.—For purposes of subsection (a)(1)(A) and section 5404(a), the term ''Federal health care offense'' means a violation of, or a criminal conspiracy to violate—

(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;

(2) section 1128B of the Social Security Act;

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

(4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; or

(5) sections 301, 303(a)(2), or 303 (b) or (e) of the Federal Food Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.

SEC. 5403. USE OF FUNDS BY INSPECTOR GENERAL.

(a) REIMBURSEMENTS FOR INVESTIGATIONS.—

(1) IN GENERAL.—The Inspector General is authorized to receive and retain for current use reim-

bursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payer, or otherwise.

(2) CREDITING.—Funds received by the Inspector General as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of their deposit.

(3) EXCEPTION FOR FORFEITURES.—This subsection does not apply to investigative costs paid to the Inspector General from the Department of Justice Asset Forfeiture Fund, which monies shall be deposited and expended in accordance with subsection (b).

(b) HHS OFFICE OF INSPECTOR GENERAL ASSET FORFEITURE PROCEEDS FUND.—

(1) IN GENERAL.—There is hereby established the ''HHS Office of Inspector General Asset Forfeiture Proceeds Fund,'' to be administered by the Inspector General, which shall be available to the Inspector General without fiscal year limitation for expenses relating to the investigation of matters within the jurisdiction of the Inspector General.

(2) DEPOSITS.—There shall be deposited in the Fund all proceeds from forfeitures that have been transferred to the Inspector General from the Department of Justice Asset Forfeiture Fund under section 524 of title 28, United States Code.

SEC. 5404. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

(a) IN GENERAL.—In special circumstances, the Secretary and the Attorney General of the United States may jointly make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution of a Federal health care offense (as defined in section 5402(d)).

(b) INELIGIBLE PERSONS.—A person is not eligible for a payment under subsection (a) if—

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

(2) the person knowingly participated in the offense;

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

(A) in a criminal, civil, or administrative proceeding;

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

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

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

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

(d) NO JUDICIAL REVIEW.—Neither the failure of the Secretary and the Attorney General to authorize a payment under subsection (a) nor the amount authorized shall be subject to judicial review.

PART 2—CIVIL PENALTIES AND RIGHTS OF ACTION

SEC. 5411. CIVIL MONETARY PENALTIES.

(a) ACTIONS SUBJECT TO PENALTY.—Any person who is determined by the Secretary to have committed any action with respect to an applicable health plan that would subject the person to a penalty under paragraphs (1) through (3) of section 1128A(a) of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act, shall be subject to a penalty in accordance with subsection (b).

(b) PENALTIES DESCRIBED.—

(1) GENERAL RULE.—In the case of a person who the Secretary determines has committed an action described in subsection (a), the person shall be subject to the civil monetary penalty (together with any additional assessment) to which the person would be subject under section 1128A of the Social Security Act if the action on which the determination is based had been committed with respect to title V, XVIII, XIX, or XX of such Act, by substituting ''$10,000'' for ''$2,000'', and ''3 times the amount claimed'' for ''twice the amount claimed''.

(2) INTEREST ON PENALTIES.—Interest shall accrue on the civil monetary penalties and assessments imposed by a final determination of the Sec-

retary under this subsection, in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where such penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of such penalties and assessments owed to cover the costs of collection.

(3) DETERMINATIONS TO EXCLUDE PERMITTED.—In addition to any civil monetary penalty or assessment imposed under this subsection, the Secretary may make a determination in the same proceeding to exclude a provider from participation in all applicable health plans for the delivery of or payment for health care items or services (in accordance with section 5414(c)).

(c) PROCEDURES FOR IMPOSITION OF PENALTIES.—

(1) APPLICABILITY OF PROCEDURES UNDER SOCIAL SECURITY ACT.—Except as otherwise provided in paragraph (2), the provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil monetary penalty, assessment, or exclusion under this section in the same manner as such provisions apply with respect to the imposition of a penalty, assessment, or exclusion under section 1128A of such Act.

(2) AUTHORITY OF SECRETARY OF LABOR AND STATES TO IMPOSE PENALTIES, ASSESSMENTS, AND EXCLUSIONS.—

(A) IN GENERAL.—The Secretary of Labor or a State may initiate an action to impose a civil monetary penalty, assessment, or exclusion under this section with respect to actions relating to a large group sponsor if authorized by the Attorney General of the United States and the Secretary pursuant to regulations promulgated by the Secretary in consultation with the Attorney General.

(B) REQUIREMENTS DESCRIBED.—Under the regulations promulgated under subparagraph (A), the Attorney General and the Sec-

retary shall review an action proposed by the Secretary of Labor or a State, and not later than 60 days after receiving notice of the proposed action from the Secretary of Labor or the State, shall—

(i) approve the proposed action to be taken by the Secretary of Labor or the State;

(ii) disapprove the proposed action; or

(iii) assume responsibility for initiating a criminal, civil, or administrative action based on the information provided in the notice.

(C) ACTION DEEMED APPROVED IF DEADLINE MISSED.—If the Attorney General and the Secretary fail to respond to a proposed action by the Secretary of Labor or a State within the period described in subparagraph (B), the Attorney General and the Secretary shall be deemed to have approved the proposed action to be taken by the Secretary of Labor or the State.

(d) TREATMENT OF AMOUNTS RECOVERED.—Any amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) Such portions of the amounts recovered as is determined to have been improperly paid from an applicable health plan for the delivery of or payment for health care items or services shall be repaid to such plan (and enrollees of such plan as appropriate).

(2) The remainder of the amounts recovered shall be deposited in the All-Payer Health Care Fraud and Abuse Control Account established under section 5402.

(e) NOTIFICATION OF LICENSING AUTHORITIES.—Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) of the Social Security Act) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

SEC. 5412. PERMITTING PARTIES TO BRING ACTIONS ON OWN BEHALF.

(a) IN GENERAL.—Subject to subsections (b) and (c), a health plan or large group sponsor that suffers harm or monetary loss exceeding the sum or value of $10,000 (excluding interest) as a result of any activity of an individual or entity which makes the individual or entity sub-

ject to a civil monetary penalty under section 5411 may, in a civil action against the individual or entity in the United States District Court, obtain treble damages and costs including attorneys' fees against the individual or entity and such equitable relief as is appropriate.

(b) REQUIREMENTS FOR BRINGING ACTION.—A person may bring a civil action under this section only if—

(1) the person provides the Secretary with written notice of—

(A) the person's intent to bring an action under this section,

(B) the identities of the individuals or entities the person intends to name as defendants to the action, and

(C) all information the person possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under section 5411 against the defendants, and

(2) one of the following conditions is met:

(A) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (1), the Secretary does not notify the person that the Secretary

intends to initiate an investigation to determine whether to impose a civil monetary penalty under section 5411 against the defendants.

(B) The Secretary notifies the person during the 60-day period described in subparagraph (A) that the Secretary intends to initiate an investigation to determine whether to impose a civil monetary penalty under such section against the defendants, and the Secretary subsequently notifies the person that the Secretary no longer intends to initiate an investigation or proceeding to impose a civil monetary penalty against the defendants.

(C) After the expiration of the 1-year period that begins on the date written notice is provided to the Secretary, the Secretary has not initiated a proceeding to impose a civil monetary penalty against the defendants.

(c) TREATMENT OF EXCESS AWARDS.—If a person is awarded any amounts in an action brought under this section that are in excess of the damages suffered by the person as a result of the defendant's activities, 20 percent of such amounts shall be withheld from the person for payment into the All-Payer Health Care Fraud and Abuse Control Account established under section 5402(a).

(d) STATUTE OF LIMITATIONS.—No action may be brought under this section more than 6 years after the date of the activity with respect to which the action is brought.

(e) NO LIMITATION ON OTHER ACTIONS.—Nothing in this section shall limit the right of any person to pursue any other right of action or remedy available under the law.

(f) PENDENT JURISDICTION.—Nothing in this section shall be construed, by reason of a claim arising under this section, to confer on the Courts of the United States jurisdiction over any State law claim.

SEC. 5413. EXCLUSION FROM PROGRAM PARTICIPATION.

(a) MANDATORY EXCLUSION.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall exclude an individual or entity from participation in any applicable health plan if the individual or entity—

(A) is excluded from participation in a public program under, or is otherwise described in, section 1128(a) of the Social Security Act (relating to individuals and entities convicted of health care-related crimes or patient abuse);

(B) has been convicted after the date of the enactment of this section, under Federal or

State law, in connection with the delivery of a health care item or service of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

(C) has been convicted after such date, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(2) WAIVER PERMITTED.—

(A) IN GENERAL.—When, in the opinion of the Secretary, mandatory exclusion of an individual or entity would significantly harm the public health or pose a significant risk to the public health, the Secretary may waive such exclusion and shall apply such other appropriate penalties as authorized under this subtitle.

(B) APPLICATION FOR WAIVER OF EXCLUSION.—

(i) IN GENERAL.—An individual or entity subject to mandatory exclusion under this subsection may apply to the Secretary, in a manner specified by the

Secretary in regulations, for waiver of the exclusion.

(ii) SECRETARIAL RESPONSE.—The Secretary may waive the exclusion for the reasons described in subparagraph (A).

(C) NOTIFICATION OF TERMINATION.—The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of each termination of exclusion made under this paragraph.

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude an individual or entity from participation in any applicable health plan if the individual or entity—

(1) is excluded from participation in a public program under, or is otherwise described in, section 1128(b) of the Social Security Act (other than paragraphs (3), (6)(A), (6)(C), (6)(D), (10), or (13) of such section);

(2) has been convicted after the date of the enactment of this section, under Federal or State law, in connection with the delivery of a health care item or service of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement,

breach of fiduciary responsibility, or other financial misconduct; or

(3) has been convicted after the date of the enactment of this section, under Federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—

(1) NOTICE OF EXCLUSION.—An exclusion under this section or section 5411(b)(3) shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2) EFFECTIVE DATE OF EXCLUSION.—Such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(3) PERIOD OF EXCLUSION.—

(A) IN GENERAL.—The Secretary shall specify, in the notice of exclusion under paragraph (1) and the notice under section 5411(e), the minimum period (or, in the case of an exclusion of an individual excluded from participa-

tion in a public program under, or is otherwise described in, section 1128(b)(12) of the Social Security Act, the period) of the exclusion.

(B) MINIMUM PERIOD FOR MANDATORY EXCLUSIONS.—In the case of a mandatory exclusion under subsection (a), the minimum period of exclusion shall be not less than 2 years.

(C) MINIMUM PERIOD FOR CERTAIN PERMISSIVE EXCLUSIONS.—

(i) FRAUD, OBSTRUCTION OF INVESTIGATION, AND CONTROLLED SUBSTANCE CONVICTION.—In the case of an exclusion of an individual excluded from participation in a public program under, or is otherwise described in, paragraph (1) or (2) of section 1128(b) of the Social Security Act or paragraph (2) or (3) of subsection (b) of this section, the period of exclusion shall be a minimum of 1 year, unless the Secretary determines that a longer period is necessary because of aggravating circumstances.

(ii) SUSPENSIONS.—In the case of an exclusion of an individual or entity excluded from participation in a public pro-

gram under, or is otherwise described in, paragraph (4), (5)(A), or (5)(B) of section 1128(b) of the Social Security Act, the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(iii) UNNECESSARY SERVICES.—In the case of an exclusion of an individual or entity described in paragraph (6)(B) of section 1128(b) of the Social Security Act, the period of the exclusion shall be not less than 1 year.

(iv) DENIAL OF IMMEDIATE ACCESS.—In the case of an exclusion of an individual described in paragraph (12) of section 1128(b) of the Social Security Act, the period of the exclusion shall be equal to the sum of—

(I) the length of the period in which the individual failed to grant

the immediate access described in that paragraph, and

(II) an additional period, not to exceed 90 days, set by the Secretary.

(d) NOTICE TO ENTITIES ADMINISTERING PUBLIC PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR HEALTH CARE ITEMS OR SERVICES.—

(1) IN GENERAL.—The Secretary shall exercise the authority under this section in a manner that results in an individual's or entity's exclusion from all applicable health plans for the delivery of or payment for health care items or services.

(2) NOTIFICATION REQUIREMENTS.—The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of the fact and circumstances of each exclusion (together with the period thereof) effected against an individual or entity under this section or under section 5411(b)(3).

(e) NOTICE TO STATE LICENSING AGENCIES.—The provisions of section 1128(e) of the Social Security Act shall apply to this section in the same manner as such provisions apply to sections 1128 and 1128A of such Act.

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—

(1) IN GENERAL.—Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b) of the Social Security Act, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g) of such Act, except that such action shall be brought in the Court of Appeals of the United States for the judicial circuit in which the individual or entity resides, or has a principal place of business, or, if the individual or entity does not reside or have a principal place of business within any such judicial circuit, in the United States Court of Appeals for the District of Columbia Circuit.

(2) ADMINISTRATIVE HEARING.—Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination based on paragraphs (6)(B), (7), (8), (9), (11), (12), (14), or (15) of section 1128(b) of the Social Security Act, shall be entitled to a hearing by an administrative

law judge (as provided under section 205(b) of the Social Security Act) on the determination before any exclusion based upon the determination takes effect. If a hearing is requested, the exclusion shall be effective upon the issuance of an order by the administrative law judge upholding the determination of the Secretary to exclude.

(3) SPECIAL RULES.—The provisions of section 205(h) of the Social Security Act shall apply with respect to this section or section 5411(b)(3) to the same extent as such provisions apply with respect to title II of such Act.

(g) APPLICATION FOR TERMINATION OF EXCLUSION.—

(1) IN GENERAL.—An individual or entity excluded (or directed to be excluded) from participation under this section or section 5411(b)(3) may apply to the Secretary, in a manner specified by the Secretary in regulations and at the end of the minimum period of exclusion (or, in the case of an individual or entity described in section 1128(b)(12), the period of exclusion) provided under this section or section 5411(b)(3) and at such other times as the Secretary may provide, for termination of the exclusion.

(2) SECRETARIAL RESPONSE.—The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under this section or section 5411(b)(3) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) NOTIFICATION OF TERMINATION.—The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of each termination of exclusion made under this subsection.

(h) CONVICTED DEFINED.—In this section, the term ''convicted'' has the meaning given such term in section 1128(i) of the Social Security Act.

(i) REQUEST FOR EXCLUSION.—The sponsor of any applicable health plan (including a State in the case of a consumer purchasing cooperative and the Secretary of

Labor in the case of a large group sponsor) may request that the Secretary of Health and Human Services exclude an individual or entity with respect to actions under such a plan in accordance with this section.

(j) EFFECT OF EXCLUSION.—Notwithstanding any other provision of this Act, no payment may be made under a health plan for the delivery of or payment for any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(1) by an individual or entity during the period when such individual or entity is excluded pursuant to this section or section 5411(b)(3) from participation in a health plan; or

(2) at the medical direction or on the prescription of a physician during the period when the physician is excluded pursuant to this section or section 5411(b)(3) from participation in a health plan and the person furnishing the item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 5421. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

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

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

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

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

''(b) As used in this section—

''(1) the terms 'consumer purchasing cooperative' and 'health plan' have the meanings given those terms in title I of the Health Security Act; and

''(2) the term 'health care' includes long-term care under title II of the Health Security Act.''.

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

''1347. Health care fraud.''.

SEC. 5422. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''§ 668. Theft or embezzlement in connection with health care

''(a) Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a consumer purchasing cooperative, health plan, or of any fund connected with such a cooperative or plan, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) As used in this section, the terms 'consumer purchasing cooperative' and 'health plan' have the meanings given those terms in title I of the Health Security Act.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''668. Theft or embezzlement in connection with health care.''.

SEC. 5423. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"§ 1033. False statements relating to health care matters

''(a) Whoever, in any matter involving a consumer purchasing cooperative or health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section, the terms 'consumer purchasing cooperative' and 'health plan' have the meanings given those terms under title I of the Health Security Act.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''1033. False statements relating to health care matters.''.

SEC. 5424. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 226. Bribery and graft in connection with health care

''(a) Whoever—

''(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to any other person, with intent—

''(A) to influence any of the health care official's actions, decisions, or duties relating to a consumer purchasing cooperative or health plan;

''(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a consumer purchasing cooperative or health plan; or

''(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

''(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection;

shall be fined under this title or imprisoned not more than 15 years, or both.

''(b) Whoever, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a consumer purchasing cooperative or health plan, shall be fined under this title or imprisoned not more than two years, or both.

''(c) As used in this section—

''(1) the term 'health care official' means—

''(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any consumer purchasing cooperative or health plan;

''(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any consumer purchasing cooperative or health plan;

''(C) an official or employee of a State agency having regulatory authority over any consumer purchasing cooperative or health plan;

''(D) an officer, counsel, agent, or employee of a health care sponsor;

''(2) the term 'health care sponsor' means any individual or entity serving as the sponsor of a consumer purchasing cooperative or health plan for purposes of the Health Security Act, and includes the joint board of trustees or other similar body used by two or more employers to administer a consumer purchasing cooperative or health plan for purposes of such Act; and

''(3) the terms 'consumer purchasing cooperative' and 'health plan' have the meanings given those terms under title I of the Health Security Act.''.

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''226. Bribery and graft in connection with health care.''.

SEC. 5425. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 5402(d) of the Health Security Act);''.

SEC. 5426. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

''(c) A person who is privy to grand jury information concerning a health law violation—

''(1) received in the course of duty as an attorney for the Government; or

''(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 5402(d) of the Health Security Act).''.

SEC. 5427. FORFEITURES FOR VIOLATIONS OF FRAUD STATUTES.

Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

''(6) The court, in imposing sentence on a person convicted of a Federal health care offense (as defined in section 5402(d) of the Health Security Act), shall order such person to forfeit to the United States any property, real or personal, constituting or traceable to the gross proceeds obtained, directly or indirectly, as a result of the commission of the offense.''.

PART 4—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

SEC. 5431. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

Section 3729 of title 31, United States Code, is amended—

(1) in subsection (a)(7), by inserting ''or to a health plan'' after ''property to the Government'';

(2) in the matter following subsection (a)(7), by inserting ''or health plan'' before ''sustains because of the act of that person,'';

(3) at the end of the first sentence of subsection (a), by inserting ''or health plan'' before ''sustains because of the act of the person.'';

(4) in subsection (c)—

(A) by inserting ''the term'' after ''section,''; and

(B) by adding at the end the following: ''The term also includes any request or demand, whether under contract of otherwise, for money or property which is made or presented to a health plan.''; and

(5) by adding at the end the following:

''(f) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' has the meaning given such term under section 1400 of the Health Security Act.''.

PART 5—EFFECTIVE DATE

SEC. 5441. EFFECTIVE DATE.

Except as otherwise provided in this subtitle, the provisions of, and amendments made by, this subtitle shall be effective on and after January 1, 1995.

Subtitle F—Repeal of Exemption

SEC. 5501. REPEAL OF EXEMPTION FOR HEALTH INSURANCE.

(a) IN GENERAL.—Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson Act, is amended by adding at the end the following:

''(c) Notwithstanding that the business of insurance is regulated by State law, nothing in this Act shall limit the applicability of the following Acts to the business of

insurance to the extent that such business relates to the provision of health benefits:

''(1) The Sherman Act (15 U.S.C. 1 et seq.).

''(2) The Clayton Act (15 U.S.C. 12 et seq.).

''(3) Federal Trade Commission Act (15 U.S.C. 41 et seq.).

''(4) The Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 21a et seq.), known as the Robinson-Patman Antidiscrimination Act.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the first day of the sixth month beginning after the date of the enactment of this Act.

TITLE VI—PREMIUM CAPS; PREMIUM-BASED FINANCING; AND PLAN PAYMENTS

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SEC. 6000. GENERAL DEFINITIONS.

(a) DEFINITIONS RELATING TO PER CAPITA PREMIUM RATES.—In this title:

(1) FILED PER CAPITA COMMUNITY BID.—The term ''filed per capita community bid'' means the per capita premium bid that is filed with a State for a community-rated plan offered in a health care coverage area under subpart A of part 1 and is available to all community rate eligible individuals enrolling directly with a health plan.

(2) ACCEPTED PER CAPITA COOPERATIVE BID.—The term ''accepted per capita cooperative bid'' means the per capita premium rate agreed upon by a cooperative and a plan taking into account any discount to such bid negotiated under section 1302(c)(2).

(3) FINAL COMMUNITY RATE.—The term ''final community rate'' means the filed per capita community bid, taking into account any voluntary reduction in such bid made under section 6004(e).

(4) FINAL COOPERATIVE RATE.—The term ''final cooperative bid'' means the accepted per capita cooperative bid, taking into account any voluntary reductions in such bid made under section 6004(e).

(b) DEFINITIONS RELATED TO WEIGHTED AVERAGE PER CAPITA PREMIUM RATES.—In this title:

(1) WEIGHTED AVERAGE ACCEPTED BID.—The term ''weighted average accepted bid'' means, for a health care coverage area for a year, the average across all plans of—

(A) the filed per capita community bid for each community-rated health plan offered in a health care coverage area weighted to reflect the relative enrollment (net of any enrollment

through a cooperative) of community rate eligible individuals among such plans; and

(B) the accepted per capita cooperative bid for each community-rated health plan offered in a health care coverage area weighted to reflect the relative enrollment of community rate eligible individuals through a cooperative among such plans.

(2) WEIGHTED AVERAGE DISCOUNT RATE.—The term ''weighted average discount rate'' means, for a health care coverage area for a year, the lesser of—

(A) the per capita premium target for the health care coverage area (as defined in section 6003) for the year; or

(B) the average across all plans of the lesser of—

(i) the final community rate; or

(ii) the final cooperative rate, (applicable only for plans offered through the cooperative);

for each community-rated health plan, weighted to reflect the total enrollment of community rate eligible individuals among such plans.

(3) WEIGHTED AVERAGE PREMIUM.—The term ''weighted average premium'' means, for a class of enrollment and with respect to a health care coverage area for the year, the product of—

(A) the weighted average discount rate (as defined in paragraph (2));

(B) the uniform per capita conversion factor (established under section 6211 for the area; and

(C) the premium class factor established by the Board for that class under section 1631.

(d) INCORPORATION OF OTHER DEFINITIONS.—Except as otherwise provided in this title, the definitions of terms in subtitle J of title I of this Act shall apply to this title.

Subtitle A—Premium Caps

PART 1—HEALTH EXPENDITURES OF HEALTH CARE COVERAGE AREAS

Subpart A—Computation of Targets and Accepted Bids

SEC. 6001. COMPUTATION OF HEALTH CARE COVERAGE AREA INFLATION FACTORS.

(a) COMPUTATION.—

(1) IN GENERAL.—This section provides for the computation of factors that limit the growth of pre-

miums for the comprehensive benefit package in community-rated health plans. The Board shall compute and publish, not later than March 1 of each year (beginning with 1995) the health care coverage area inflation factor (as defined in paragraph (2)) for each health care coverage area for the following year.

(2) HEALTH CARE COVERAGE AREAS INFLATION FACTOR.—In this part, the term ''health care coverage area inflation factor'' means, for a year for a health care coverage area—

(A) the general health care inflation factor for the year (as defined in paragraph (3));

(B) adjusted under subsection (c) (to take into account material changes in the demographic and socio-economic characteristics of the population of community rate eligible individuals);

(C) decreased by the percentage adjustment (if any) provided with respect to the health care coverage area under subsection (d) (relating to adjustment for previous excess expenditures); and

(D) in the case of the year 2001, increased by a factor that the Board determines to reflect

the ratio of (i) the actuarial value of the increase in benefits provided in that year under the comprehensive benefit package to (ii) the actuarial value of the benefits that would have been in such package in the year without regard to the increase.

For purposes of subparagraph (D)(i), the actuarial value of the increase with respect to mental illness and substance abuse services (included within the comprehensive benefit package) shall not exceed an actuarial value based on the amount of the total expenditures that would have been made in 2001 by States and subdivisions of States for mental illness and substance abuse services (included in such package as of 2001) if this Act had not been enacted.

(3) GENERAL HEALTH CARE INFLATION FACTOR.—

(A) 1996 THROUGH 2000.—In this part, the term ''general health care inflation factor'', for a year, means the percentage increase in the CPI (as specified under subsection (b)) for the year plus the following:

(i) For 1996, 1.5 percentage points.

(ii) For 1997, 1.0 percentage points.

(iii) For 1998, 0.5 percentage points.

(iv) For 1999 and for 2000, 0 percentage points.

(B) YEARS AFTER 2000.—

(i) RECOMMENDATION TO CONGRESS.—In 1999, the Board shall submit to Congress recommendations, after consultation with the Federal Reserve Board, on what the general health care inflation factor should be for years beginning with 2001.

(ii) FAILURE OF CONGRESS TO ACT.—If the Congress fails to enact a law specifying the general health care inflation factor for a year after 2000, the Board, in January of the year before the year involved, shall compute such factor for the year involved. Such factor shall be the product of the factors described in subparagraph (C) for that fiscal year, minus 1.

(iii) STUDY BY FEDERAL RESERVE BOARD.—Not later than January 1, 1999, the Federal Reserve Board shall conduct a study, and report to the National Health Board, concerning what the general health care inflation factor should be for years be-

ginning with 2001. Such study shall consider whether continued indexing with respect to such factor is advisable and whether the consumer price index should be used (in whole or in part, modified or unmodified) with respect to premium caps for future years. The recommendations of the Federal Reserve Board under such study shall be considered in the recommendations submitted under clause (i).

(C) FACTORS.—The factors described in this subparagraph for a year are the following:

(i) CPI.—1 plus the percentage change in the CPI for the year, determined based upon the percentage change in the average of the CPI for the 12-month period ending with August 31 of the previous fiscal year over such average for the preceding 12-month period.

(ii) REAL GDP PER CAPITA.—1 plus the average annual percentage change in the real, per capita gross domestic product of the United States during the 3-year period ending in the preceding calendar year,

determined by the Board based on data supplied by the Department of Commerce.

(b) PROJECTION OF INCREASE IN CPI.—

(1) IN GENERAL.—For purposes of this section, the Board shall specify, as of the time of publication, the annual percentage increase in the CPI (as defined in section 1902(9)) for the following year.

(2) DATA TO BE USED.—Such increase shall be the projection of the CPI contained in the budget of the United States transmitted by the President to the Congress in the year.

(c) SPECIAL ADJUSTMENT FOR MATERIAL CHANGES IN DEMOGRAPHIC CHARACTERISTICS OF POPULATION.—

(1) ADJUSTMENT FOR LARGE GROUP PURCHASER OPT-IN.—

(A) IN GENERAL.—The Board shall develop a method for adjusting the health care coverage area inflation factor for each health care coverage area in order to reflect material changes in the demographic characteristics of community rate eligible individuals residing in the coverage area (in comparison with such characteristics for the previous year) as a result of the termination of an election of one or more large group purchasers under section 1406.

(B) BASIS FOR ADJUSTMENTS.—Adjustments under this paragraph (whether an increase or decrease) shall be based on the characteristics and factors used for making adjustments in payments under section 6124.

(2) ADJUSTMENT FOR AREA TREND COMPARED TO NATIONAL TREND.—

(A) IN GENERAL.—The Board shall develop a method for adjusting the health care coverage area inflator factor for each health care coverage area in order to reflect material changes in the demographic characteristics (including at least age, gender, and socio-economic status) and health status of community rate eligible individuals residing in the coverage area in comparison with the average change in such characteristics for such individuals residing in the United States. The adjustment under this paragraph shall be for changes not taken into account in the adjustment under paragraph (1).

(B) NEUTRAL ADJUSTMENT.—Such method (and any annual adjustment under this paragraph) shall be designed to result in the adjustment effected under this paragraph for a

year not changing the weighted average of the health care coverage area inflation factors.

(3) APPLICATION.—The Board shall provide, on an annual basis, for an adjustment of health care coverage area inflation factors under this subsection using such methods.

(d) CONSULTATION PROCESS.—The Board shall have a process for consulting with representatives of States before establishing the health care coverage area inflation factors for each year under this section.

SEC. 6002. BOARD DETERMINATION OF NATIONAL PER CAPITA BASELINE PREMIUM TARGET.

(a) IN GENERAL.—Not later than January 1, 1995, the Board shall determine a national per capita baseline premium target. Such target is equal to—

(1) the national average per capita current coverage health expenditures (determined under subsection (b)),

(2) updated under subsection (c).

(b) DETERMINATION OF NATIONAL AVERAGE PER CAPITA CURRENT COVERAGE HEALTH EXPENDITURES.—

(1) IN GENERAL.—The Board shall determine the national average per capita current coverage health expenditures equal to—

(A) total covered current health care expenditures (described in paragraph (2)), divided by

(B) the estimated population in the United States of community rate eligible individuals (as determined by the Board as of 1993 under paragraph (4)) for whom such expenditures were determined.

The population under subparagraph (B) shall not include SSI recipients or AFDC recipients.

(2) CURRENT HEALTH CARE EXPENDITURES.—For purposes of paragraph (1)(A), the Board shall determine current health care expenditures as follows:

(A) DETERMINATION OF TOTAL EXPENDITURES.—The Board shall first determine the amount of total payments made for items and services included in the comprehensive benefit package (determined without regard to cost sharing) in the United States in 1993.

(B) REMOVAL OF CERTAIN EXPENDITURES NOT TO BE COVERED IN THE COMPREHENSIVE BENEFIT PACKAGE.—The amount so determined shall be decreased by the proportion of

such amount that is attributable to any of the following:

(i) Medicare beneficiaries (other than such beneficiaries who are community rate eligible individuals).

(ii) AFDC recipients or SSI recipients.

(iii) Expenditures which are paid for through workers' compensation or automobile or other liability insurance.

(iv) Expenditures by parties (including the Federal Government) that the Board determines will not be payable by community-rated plans for coverage of the comprehensive benefit package under this Act (as defined in section 1101).

(C) ADDITION OF PROJECTED EXPENDITURES FOR UNINSURED AND UNDERINSURED INDIVIDUALS.—The amount so determined and adjusted shall be increased to take into account increased utilization of, and expenditures for, items and services covered under the comprehensive benefit package likely to occur, as a result of coverage under a community-rated health plan of individuals who, as of 1993 were

uninsured or underinsured with respect to the comprehensive benefit package. In making such determination, such expenditures shall be based on the estimated average cost for such services in 1993 (and not on private payment rates established for such services). In making such determination, the estimated amount of uncompensated care in 1993 shall be removed and will not include adjustments to offset payments below costs by public programs.

(D) ADDITION OF COSTS OF ADMINISTRATION.—The amount so determined and adjusted shall be increased by an estimated percentage (determined by the Board, but no more than 15 percent) that reflects the proportion of premiums that are required for health plan administration for State administration (including costs for administration of income-related premium discounts and cost sharing reductions) and for State premium taxes (which taxes shall be limited to such amounts in 1993 as are attributable to the health benefits to be included in the comprehensive benefit package). Such adjustments shall not include any marketing fees

(described in section 1511) or cooperative fees (described in section 1305).

(E) DECREASE FOR COST SHARING.—The amount so determined and adjusted shall be decreased by a percentage that reflects (i) the estimated average percentage of total amounts payable for items and services covered under the comprehensive benefit package that will be payments in the form of cost sharing under a higher cost sharing plan, and (ii) the percentage reduction in utilization estimated to result from the application of high cost sharing.

(3) SPECIAL RULES.—

(A) BENEFITS USED.—The determinations under this section shall be based on the comprehensive benefit package as in effect in 1996.

(B) ASSUMING NO CHANGE IN EXPENDITURE PATTERN.—The determination under paragraph (2) shall be made without regard to any change in the pattern of expenditures that may result from the enrollment of AFDC recipients and SSI recipients in community-rated health plans.

(4) ELIGIBLE INDIVIDUALS.—In this subsection, the determination of who are community

rate eligible individuals under this subsection shall be made as though this Act was fully in effect in each State as of 1993.

(c) UPDATING.—

(1) IN GENERAL.—Subject to paragraph (3), the Board shall update the amount determined under subsection (b)(1) for each of 1994 and 1995 by the appropriate update factor described in paragraph (2) for the year.

(2) APPROPRIATE UPDATE FACTOR.—In paragraph (1), the appropriate update factor for a year is 1 plus the annual percentage increase for the year (as determined by the Secretary, based on actual or projected information) in private sector health care spending for items and services included in the comprehensive benefit package (as of 1996).

(3) LIMIT.—The total, cumulative update under this subsection shall not exceed 15 percent.

SEC. 6003. DETERMINATION OF AREA PER CAPITA PREMIUM TARGETS.

(a) INITIAL DETERMINATION.—Not later than January 1, 1995, the Board shall determine, for each health care coverage area for 1996, a health care coverage area per capita premium target. Such target shall equal—

(1) the national per capita baseline premium target (determined by the Board under section 6002),

(2) updated by the health care coverage area inflation factor (as determined under section 6001(a)(2)) for 1996, and

(3) adjusted by the adjustment factor for the health care coverage area (determined under subsection (c)).

(b) SUBSEQUENT DETERMINATIONS.—

(1) DETERMINATION.—Not later than March 1 of each year (beginning with 1996) the Board shall determine, for each health care coverage area for the succeeding year a health care coverage area per capita premium target.

(2) GENERAL RULE.—Subject to subsection (e), such target shall equal—

(A) the health care coverage area per capita target determined under this section (without regard to subsection (e)) for the health care coverage area for the previous year,

(B) updated by the health care coverage area inflation factor (as determined in section 6001(a)) for the year.

(3) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF INCREASE IN EXPENDITURES.—Such target for a year is subject to a decrease under section 6001(d).

(c) ADJUSTMENT FACTORS FOR HEALTH CARE COVERAGE AREAS FOR INITIAL DETERMINATION.—

(1) IN GENERAL.—The Board shall establish an adjustment factor for each health care coverage area in a manner consistent with this subsection.

(2) CONSIDERATIONS.—In establishing the factor for each health care coverage area, the Board shall consider, using information of the type described in paragraph (3), the difference between the national average of the factors taken into account in determining the national per capita baseline premium target and such factors for the health care coverage area, including variations in health care expenditures and in rates of uninsurance and underinsurance in the different areas and including variations in the proportion of expenditures for services provided by academic health centers in the different areas.

(3) TYPE OF INFORMATION.—The type of information described in this paragraph is—

(A) information on variations in premiums across States and across health care coverage

areas within a State (based on surveys and other data);

(B) information on variations in per capita health spending by State, as measured by the Secretary;

(C) information on variations across States in per capita spending under the medicare program and in such spending among health care coverage areas within a State under such program;

(D) area rating factors commonly used by actuaries;

(E) information on variations in the extent to which States and health care coverage areas need additional investment because they have successfully controlled health care costs; and

(F) information on variations among States and health care coverage areas due to underutilization of health care services resulting from geographic barriers and lack of access to health care services, particularly in underserved rural and urban areas.

(4) APPLICATION OF FACTORS IN NEUTRAL MANNER.—The application of the adjustment factors under this subsection for 1996 shall be done in a

manner so that the weighted average of the health care coverage area per capita premium targets for 1996 is equal to the national per capita baseline premium target determined under section 6002. Such weighted average shall be based on the Board's estimate of the expected distribution of community rate eligible individuals (taken into account under section 6002) among the health care coverage areas.

(5) CONSULTATION PROCESS.—The Board shall have a process for consulting with representatives of States and purchasing cooperative before establishing the adjustment for health care coverage areas under this subsection.

(d) TREATMENT OF CERTAIN STATES.—

(1) NON-PARTICIPATING.—In the case of a State that is not a participating State or otherwise has not established health care coverage areas, the entire State shall be treated under the provisions of this part as composing a single health care coverage area.

(2) CHANGES IN AREA BOUNDARIES.—In the case of a State that changes the boundaries of its health care coverage areas (including the establishment of such areas after 1996), the Board shall provide a method for computing a health care coverage

area per capita premium target for each health care coverage area affected by such change in a manner that—

(A) reflects the factors taken into account in establishing the adjustment factors for health care coverage areas under subsection (c), and

(B) results in the weighted average of the newly computed regional targets for the health care coverage areas affected by the change equal to the weighted average of the regional targets for the health care coverage areas as previously established.

(e) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF INCREASE IN EXPENDITURES.—

(1) IN GENERAL.—If the actual weighted average accepted bid for a health care coverage area for a year (as determined by the Board based on actual enrollment in the first month of the year) exceeds the health care coverage area per capita premium target (determined under this section) for the year, then the health care coverage area per capita premium target shall be reduced, by ½ of the excess percentage (described in paragraph (2)) for the year, for each of the 2 succeeding years.

(2) EXCESS PERCENTAGE.—The excess percentage described in this paragraph for a year is the percentage by which—

(A) the actual weighted average accepted bid (referred to in paragraph (1)) for a health care coverage area for the year, exceeds

(B) the health care coverage area per capita premium target (determined under this section) for the year.

SEC. 6004. INITIAL RATE FILING AND BID NEGOTIATION PROCESS.

(a) FILING AND BIDDING PROCESS.—

(1) FILING COMMUNITY BIDS.—

(A) IN GENERAL.—Not later than July 1 before the first year, and not later than August 1 of each succeeding year, each plan seeking to participate as a community-rated health plan, with respect to the health care coverage area, in the following year shall file a per capita community bid in the manner specified under subsection (c).

(B) SUBMISSION OF BIDS TO COOPERATIVES.—Each plan filing a per capita community bid with respect to a health care coverage area under subparagraph (A) shall also submit

to the cooperative of such health care coverage area a per capita premium bid (not to exceed the rate filed under subparagraph (A) for such plan) for coverage of the comprehensive benefit package as specified in section 1101 in the manner described under subsection (c).

(C) ESTABLISHMENT OF RULES AND PROCEDURES FOR FILING PREMIUM BIDS.—In accordance with section 1660, each participating State shall establish rules and procedures for the filing of premium rates and submission of premium bids by plans.

(D) DISCLOSURE.—In conjunction with the filing of per capita community bids, the State may determine to disclose (or not to disclose) the health care coverage area per capita premium target for the health care coverage area (determined under section 6003) for the year involved.

(E) CONDITION.—Each community bid filed and cooperative bid submitted under this subsection with respect to a community-rated health plan shall be conditioned upon the plan's agreement to accept any payment reduction that may be imposed under section 6011.

(2) NEGOTIATION PROCESS.—Following the bidding process under paragraph (1), a cooperative may conduct negotiations with health plans relating to the premiums to be charged for such community-rated health plans within a cooperative. Such negotiations may result in the resubmission of bids to the cooperative, but in no case shall a health plan resubmit a bid that exceeds its prior bid.

(3) LEGALLY BINDING BIDS.—All rates filed and bids submitted under this subsection must be legally binding with respect to the plans involved.

(4) ACCEPTANCE.—

(A) PER CAPITA COMMUNITY BID.—The final community rate for a community-rated health plan under this subsection shall be considered to be the accepted bid for such plan, except as provided in subsection (e).

(B) PER CAPITA COOPERATIVE BID.—The final cooperative bid submitted to a cooperative for a community-rated health plan under this subsection shall be considered to be the accepted bid for such plan, except as provided in subsection (e).

(5) ASSISTANCE.—The Board shall provide States and cooperatives with such information and

technical assistance as may assist such States and cooperatives in carrying out the provisions of this subsection.

(b) SUBMISSION OF INFORMATION TO BOARD.—By not later than September 1 of each year for which community per capita bids are filed under subsection (a), each State shall submit to the Board a report that discloses for each community-rating area—

(1) information regarding the per capita community bid filed and accepted cooperative bids negotiated under subsection (a) by the different plans;

(2)(A) for the first year, any information the Board may request concerning an estimation of the—

(i) enrollment likely in each such plan of community rate eligible individuals through cooperatives; and

(ii) the enrollment likely in each such plan of community rate eligible individuals by enrollment mechanisms other than cooperatives in accordance with section 1660, or

(B) for a succeeding year—

(i) the actual distribution of enrollment of community rate eligible individuals in commu-

nity-rated health plans through cooperatives; and

(ii) the actual distribution of enrollment of community rate eligible individuals in community-rated health plans through enrollment mechanisms other than cooperatives, in accordance with section 1660;

in the year in which the report is transmitted; and

(3) limitations on capacity of community-rated health plans.

(c) COMPUTATION OF WEIGHTED AVERAGE ACCEPTED BID.—

(1) IN GENERAL.—For each health care coverage area the Board shall determine a weighted average accepted bid for each year for which rates are filed with the State under subsection (a). Such determination shall be based on information on accepted bids for the year, submitted under subsection (b)(1), and shall take into account, subject to paragraph (2), the information on enrollment distribution submitted under subsection (b)(2).

(2) ENROLLMENT DISTRIBUTION RULES.—In making the determination under paragraph (1) for a health care coverage area, the Board shall establish

rules respecting the treatment of enrollment in plans that are discontinued or are newly offered.

(3) EXCLUSION OF WORKSITE HEALTH PROMOTION DISCOUNTS.—For purposes of calculating the weighted average accepted bid and enforcing the per capita premium targets in a health care coverage area in a State, the Board shall consider the accepted bids for the year, without consideration or inclusion of any worksite health promotion discount.

(d) NOTICE TO CERTAIN STATES.—

(1) IN GENERAL.—By not later than October 1 of each year for which rates are filed with a State, the Board shall notify a State—

(A) if the weighted average accepted bid (determined under subsection (c)) for the health care coverage area is greater than the health care coverage area per capita premium target for such area (determined under section 6003) for the year, and

(B) of the weighted average discount rate for the health care coverage area.

(2) NOTICE OF PREMIUM REDUCTIONS.—If notice is provided to a State under paragraph (1), the Board shall notify the State and each noncomplying plan of any plan payment reduction computed under

section 6011 for such a plan and the opportunity to voluntarily reduce the accepted bid under subsection (e) in order to avoid such a reduction.

(e) VOLUNTARY REDUCTION OF ACCEPTED BIDS.—After the Board has determined under subsection (c) the weighted average accepted bid for a health care coverage area and the Board has determined plan payment reductions, before such date as the Board may specify (in order to provide for an open enrollment period), a noncomplying plan has the opportunity to voluntarily reduce its filed community bid (and if applicable, its accepted cooperative bid) by the amount of the plan payment reduction that would otherwise apply to the plan. Such reduction shall not affect the amount of the plan payment reduction for any other plan for that year.

SEC. 6005. STATE FINANCIAL INCENTIVES.

(a) ELECTION.—Any participating State may elect to assume responsibility for containment of health care expenditures in the State consistent with this part. Such responsibility shall include submitting annual reports to the Board on any activities undertaken by the State to contain such expenditures. A participating State may regulate the rates charged by providers furnishing health care items and services to all private payers. Such regulation of rates may not cause an experienced-rated health plan to be

charged, directly or indirectly, rates different from those charged other community-rated health plans for the same items and services or otherwise discriminate against experience-rated health plans.

(b) FINANCIAL INCENTIVE.—In the case of a State that has made an election under subsection (a), if the Board determines for a particular year (beginning with the first year) that the statewide weighted average of the weighted average discount rates (based on actual average enrollment for the year), for health care coverage areas in the State, is less than the statewide weighted average of the health care coverage area per capita premium targets (based upon such enrollment) for such areas for the year, then the amount of the State maintenance-of-effort payment under section 9001(b), for the following year, shall be reduced by ½ of the product of—

(1) the amount by which the amount of such statewide average target exceeds the amount of such statewide average accepted bid, divided by the amount of such target; and

(2) the total of the amount of the Federal payments made in that particular year to the State under subtitle B of title IX.

(c) ALTERNATIVE STATE PROVIDER PAYMENT SYSTEMS.—Notwithstanding any other provision of law, in the

case of an alternative State provider payment system that has been approved by the Secretary and in continuous operation since July 1, 1977, the payment rates and methodologies required under the State system for services provided in that State shall apply to all purchasers and payors, including those under employee welfare benefit plans authorized under the Employee Retirement Income Security Act of 1974, workers' compensation programs under State law, the Federal Employees' Compensation Act under chapter 81 of title 5, United States Code, and Federal employee health benefit plans under chapter 89 of title 5, United States Code.

SEC. 6006. RECOMMENDATIONS TO ELIMINATE REGIONAL VARIATIONS IN AREA TARGETS DUE TO VARIATION IN PRACTICE PATTERNS; CONGRESSIONAL CONSIDERATION.

(a) ESTABLISHMENT OF ADVISORY COMMISSION ON REGIONAL VARIATIONS IN HEALTH EXPENDITURES.—The chair of the Board shall establish, by not later than 60 days after the date of appointment of the first chair, an advisory commission on regional variations in health expenditures.

(b) COMPOSITION.—The advisory commission shall be composed of consumers, employers, providers, representatives of health plans, States, individuals with exper-

tise in the financing of health care, individuals with expertise in the economics of health care, and representatives of diverse geographic areas.

(c) ELIMINATION OF REGIONAL VARIATION IN PREMIUMS DUE TO PRACTICE PATTERN.—

(1) COMMISSION STUDY.—The advisory commission shall examine methods of reducing or eliminating variation in health care coverage area per capita premium targets that are clearly due to variation in practice patterns not justified by differences in need for health care services, presence of academic health centers or other facilities meeting research, training, or care needs broader than those of the population in the area, or other factors (such as health care input prices and demographic factors), by 2002.

(2) COMMISSION REPORT.—The advisory commission shall submit to the Board a report that specifies one or more methods for reducing or eliminating the variation described in paragraph (1).

(3) BOARD RECOMMENDATIONS.—The Board, after reviewing the report and such other studies as it deems appropriate and after consulting with the Prospective Payment Assessment Commission, the Physician Payment Review Commission and such

other experts as it deems appropriate, shall submit to Congress, by not later October 1, 1996, detailed recommendations respecting the specific method to be used to reduce or eliminate the variation described in paragraph (1) by 2006. Such recommendations shall not propose the reduction or elimination of differences in per capita premium targets that are not the result of inappropriate differences in practice patterns and shall be designed to avoid unnecessary disruption in the health care systems and economies of affected regions.

(d) CONGRESSIONAL CONSIDERATION.—

(1) IN GENERAL.—Detailed recommendations submitted under subsection (c)(3) shall apply under this subtitle unless a joint resolution (described in paragraph (2)) disapproving such recommendations is enacted, in accordance with the provisions of paragraph (3), before the end of the 60-day period beginning on the date on which such recommendations were submitted. For purposes of applying the preceding sentence and paragraphs (2) and (3), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(2) JOINT RESOLUTION OF DISAPPROVAL.—A joint resolution described in this paragraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the Board submits recommendations under subsection (e)(3) and—

(A) which does not have a preamble;

(B) the matter after the resolving clause of which is as follows: ''That Congress disapproves the recommendations of the National Health Board concerning elimination of regional variation in health care coverage area premiums, as submitted by the Board on _____.'', the blank space being filled in with the appropriate date; and

(C) the title of which is as follows: ''Joint resolution disapproving recommendations of the National Health Board concerning elimination of regional variation in health care coverage area premiums, as submitted by the Board on _____.'', the blank space being filled in with the appropriate date.

(3) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF DISAPPROVAL.—Subject to paragraph (4), the provisions of section 2908 (other than sub-

section (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in paragraph (2) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(4) SPECIAL RULES.—For purposes of applying paragraph (3) with respect to such provisions—

(A) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under subsection (c)(3)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the Senate (specified by the Majority Leader of the Senate at the time of submission of recommendations under subsection (c)(3)); and

(B) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the Board submits a recommendation under subsection (c)(3).

(e) ELIMINATION OF REGIONAL VARIATION STATE PAYMENT AMOUNTS.—

(1) COMMISSION STUDY.—The advisory commission shall examine methods of reducing inappropriate variation among States in the level of payments required under subtitle A of title IX by 2002.

(2) COMMISSION REPORT.—The advisory commission shall submit to the Board a report that specifies one or more methods for reducing the variation described in paragraph (1).

(3) BOARD RECOMMENDATIONS.—The Board shall submit to Congress, by not later than July 1, 1995, detailed recommendations respecting the specific method to be used to reduce the variation described in paragraph (1) by 2002 in a budget neutral manner with respect to total government payments and payments by the Federal Government. In submitting recommendations under this paragraph, the Board shall consider the fiscal capacity of the States.

(4) CONGRESSIONAL CONSIDERATION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the provisions of subsection (d) shall apply to recommendations under paragraph (3) in the same manner

as they apply to recommendations under subsection (c)(3).

(B) SPECIAL RULES.—In applying subparagraph (A)—

(i) the following shall be substituted for the matter after the resolving clause described in subsection (d)(2)(B): ''That Congress disapproves the recommendations of the National Health Board concerning reduction of regional variation in State payments, as submitted by the Board on _____.''; and

(ii) the following shall be substituted for the title described in subsection (d)(2)(C): ''Joint resolution disapproving recommendations of the National Health Board concerning reducing regional variation in State payments, as submitted by the Board on _____.''.

(f) INFORMATION.—The advisory commission shall provide the Board, States, and community-rated health plans with information about regional differences in health care costs and practice patterns.

SEC. 6007. REFERENCE TO LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN DETERMINATIONS.

For limitation on administrative and judicial review of certain determinations under this part, see section 5232.

SEC. 6008. APPLICATION OF MARKETING AND COOPERATIVE FEES.

Cooperative fees (as described in section 1305) and health plan marketing fees (as described in section 1511(b)) shall not be incorporated into the calculation of plan and health care coverage areas' compliance with the premium targets established in this part or in the determination of eligibility for discounts under subtitle B of this title.

Subpart B—Plan and Provider Payment Reductions to Maintain Expenditures within Targets

SEC. 6011. PLAN PAYMENT REDUCTION.

(a) PLAN PAYMENT REDUCTION.—In order to assure that premium-related payments to community-rated health plans offered in a health care coverage area are consistent with the applicable area per capita target for the health care coverage area (computed under this subtitle), payment to a noncomplying plan (as defined in subsection (b)(2)) for a year is subject to a reduction in plan

payment by the amount equal to plan payment reduction specified in subsection (c) for the year.

(b) NONCOMPLYING HEALTH CARE COVERAGE AREA AND NONCOMPLYING PLAN DEFINED.—In this part:

(1) NONCOMPLYING HEALTH CARE COVERAGE AREA.—The term ''noncomplying health care coverage area'' means, for a year, a health care coverage area for which the weighted average accepted bid (computed under section 6004(c)) exceeds the health care coverage area per capita premium target for the year.

(2) NONCOMPLYING PLAN.—The term ''noncomplying plan'' means, for a year, a community rated health plan offered in a noncomplying health care coverage area if the applicable premium rate for the year exceeds the maximum complying bid (as defined in subsection (d)) for the year. No plan shall be a noncomplying plan for a year before the first year in which the plan is offered as a community rated health plan under this Act.

(c) AMOUNT OF PLAN PAYMENT REDUCTION.—

(1) IN GENERAL.—The amount of the plan payment reduction, for a noncomplying plan offered in a health care coverage area, is the area-wide reduction percentage (as defined in paragraph (2)) of the

excess bid amount (as defined in paragraph (3)) for the plan.

(2) AREA-WIDE REDUCTION PERCENTAGE.—

(A) IN GENERAL.—In paragraph (1), the term ''area-wide reduction percentage'' means, for a noncomplying plan offered in a health care coverage area for a year—

(i) the amount by which—

(I) the weighted average accepted bid (computed under section 6004(c)(1)) for the health care coverage area for the year, exceeds (II) the health care coverage area per capita target for the area for the year; divided by

(ii) the sum, for noncomplying plans offered in the health care coverage area, of the plan proportions of area excess bid amounts (described in subparagraph (B)(i)) for the year.

(B) PLAN PROPORTION OF HEALTH CARE COVERAGE AREA EXCESS BID AMOUNT DESCRIBED.—

(i) IN GENERAL.—The ''plan proportion of area excess bid amount'' described

in this clause, for a noncomplying plan, is the product of—

(I) the excess bid amount (as defined in paragraph (3)) for the plan, and

(II) the plan enrollment proportion (as defined in clause (ii)) for the plan.

(ii) PLAN ENROLLMENT PROPORTION.—In clause (i)(II), the term ''plan enrollment proportion'' means, with respect to a health plan offered in a health care coverage area, the total enrollment of community-rate eligible individuals enrolled in such plan expressed as a percentage of the total enrollment of community-rate eligible individuals in all community-rated plans offered in the health care coverage area. Such proportion shall be computed based on the information used in computing the weighted average accepted bid for the area under section 6004(c)(1).

(3) EXCESS BID AMOUNT.—In this subsection, the ''excess bid amount'', with respect to a noncomplying plan for a year, is the amount by which—

(A) the accepted bid for the year (not taking into account any voluntary reduction under section 6004(e)), exceeds

(B) the maximum complying bid (as defined in subsection (d)) for the plan for the year.

(d) COMMUNITY-RATED HEALTH PLANS WITH AN ACCEPTED COOPERATIVE BID NOT EQUAL TO THE FINAL COMMUNITY RATE FOR SUCH PLAN.—

(1) IN GENERAL.—For the purposes of this section (relating to determining plan compliance and plan payment reduction), if a community-rated health plan has more than one applicable premium rate, such health plan shall be treated as a separate health plan with respect to each applicable premium rate and the enrollment in each such health plan shall be considered to be the number of community-rated individuals enrolled in the community-rated plan at the applicable premium rate.

(2) The applicable final premium rate with respect to a community rated health plan shall be—

(A) for a community-rated plan offered through the state-designated enrollment process (or through any other manner of enrollment

other than through a cooperative), the final community rate; or

(B) for a community rated health plan offered through a cooperative, the final cooperative rate for such cooperative.

(e) MAXIMUM COMPLYING BID.—

(1) IN GENERAL.—In this part for the first year and for subsequent years, the ''maximum complying bid'' for each community-rated health plan, is the health care coverage area per capita premium target for the area (determined under section 6003) for the year.

(2) SPECIAL RULES FOR NEW PLANS.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a community rated health plan that is first offered in a health care coverage area in a year after the first year the maximum complying bid shall be the health care coverage area per capita premium target for the year.

(B) AUTHORITY.—The Board or a State may establish rules to modify the application of subparagraph (A) for community-rated health plans in the State in order—

(i) to prevent abusive premium practices by entities previously offering plans, or

(ii) to encourage the availability of all types of plans in the State and to permit establishment of new plans.

SEC. 6012. PROVIDER PAYMENT REDUCTION.

(a) PARTICIPATING PROVIDERS.—

(1) IN GENERAL.—Each community-rated health plan in the health care coverage area, as part of its contract or agreement with any participating provider or group of participating providers shall—

(A) include a provision that provides that if the plan is a noncomplying plan for a year, payments to the provider (or group) shall be reduced by the applicable network reduction percentage (described in paragraph (2)) for the year; and

(B) not include any provision which the State determines otherwise varies the payments to such providers (or group) because of, or in relation to, a plan payment reduction under section 6011 or otherwise is intended to nullify the effect of subparagraph (A).

For purposes of this section, a plan described in section 6011(d) shall be treated as a single plan with the total enrollment of such plan equal to the sum of the amounts described in section 6011(d)(1). The Board may issue regulations relating to the requirements of this paragraph.

(2) APPLICABLE NETWORK REDUCTION PERCENTAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), the ''applicable network reduction percentage'', with respect to participating providers of a noncomplying plan for a year equals—

(i) the plan payment reduction amount for the plan for the year (as determined under section 6011(c)), divided by

(ii) the final accepted bid for the plan for the year, adjusted under subparagraph (B).

(B) INDUCED VOLUME OFFSET.—The Board shall provide for an appropriate increase of the percentage reduction computed under subparagraph (A) to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a con-

sequence of applying a reduction in payment under this subsection. The Board may compute and apply such increase differently for different classes of providers or services or different types of health plans (as the Board may define).

(b) OTHER PROVIDERS.—

(1) IN GENERAL.—Each community rated health plan that is a noncomplying plan in a year shall provide for a reduction in the amount of payments to providers (or groups of providers) that are not participating providers under the applicable fee schedule under section 1523 by the applicable nonnetwork reduction percentage (described in paragraph (2)) for the year.

(2) APPLICABLE NONNETWORK REDUCTION PERCENTAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), the ''applicable nonnetwork reduction percentage'', with respect to nonparticipating providers of a noncomplying plan for a year is—

(i) the plan payment reduction amount for the plan for the year (as determined under section 6011(c)), divided by

(ii) the final accepted bid for the plan for the year, adjusted under subparagraph (B).

(B) INDUCED VOLUME OFFSET.—The Board shall provide for an appropriate increase of the percentage reduction computed under subparagraph (A) to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a consequence of applying a reduction in payment under this subsection. The Board may compute and apply such increase differently for different classes of providers or services or different types of health plans (as the Board may define).

(c) APPLICATION TO COST SHARING AND TO BALANCE BILLING RESTRICTIONS.—For purposes of applying section 1523 (relating to balance billing limitations) and part 2 of subtitle B of title I (relating to computation of cost sharing), the payment basis otherwise used for computing any limitation on billing or cost sharing shall be such payment basis as adjusted by any reductions effected under this section.

PART 2—HEALTH EXPENDITURES OF LARGE GROUP PURCHASERS

SEC. 6021. CALCULATION OF PREMIUM EQUIVALENTS.

(a) IN GENERAL.—By January 1, 1998, the Board shall develop a methodology for calculating an annual per capita expenditure equivalent for amounts paid for coverage for the comprehensive benefit package within a large group purchaser.

(b) ADJUSTMENT PERMITTED.—Such methodology shall permit a large group purchaser to petition the Secretary of Labor for an adjustment of the inflation adjustment that would otherwise apply to compensate for material changes in the demographic characteristics of the experience rate eligible individuals receiving coverage through plans offered in a health care coverage area.

(c) REPORTING.—In 2001 and each subsequent year, each large group purchaser shall report to the Secretary of Labor, in a form and manner specified by the Secretary, the average of the annual per capita expenditure equivalent for the previous 3-year period.

SEC. 6022. SANCTIONS FOR LARGE GROUP PURCHASER FOR EXCESS INCREASE IN EXPENDITURES.

(a) SANCTION.—

(1) ACTIONS AGAINST LARGE EMPLOYERS.—If a large group purchaser that is a large employer has two excess years (as defined in subsection (b)) in a

3-year-period, then, effective beginning with the second year following the second excess year in such period, the Secretary of Labor shall take action under section 1402.

(2) TERMINATION OF SPONSORSHIP FOR OTHER LARGE GROUP PURCHASERS.—If a large group purchaser that is not a large employer has two excess years (as defined in subsection (b)) in a 3-year-period, then, effective beginning with the second year following the second excess year in such period—

(A) the Secretary of Labor shall terminate the election of the large group purchaser under section 1402; and

(B) an employer that was an experience-rated employer with respect to such purchaser shall become a community-rated employer (unless the employer has become an experience-rated employer of another such large group purchaser).

(3) INITIAL 3-YEAR PERIOD.—Paragraph (1) shall apply to the 3-year period beginning on January 1, 1998.

(b) EXCESS YEAR.—

(1) IN GENERAL.—In subsection (a), the term ''excess year'' means, for a large group purchaser, a

year (after 2000) for which the rate of increase for the large group purchaser (specified in paragraph (2)) for the year, exceeds the national corporate inflation factor (specified in paragraph (3)) for the year.

(2) RATE OF INCREASE FOR LARGE GROUP PURCHASER.—The rate of increase for a large group purchaser for a year, specified in this paragraph, is the percentage by which the average of the annual per capita expenditure equivalent for the large group purchaser (reported under section 6021 (c)) for the 3-year period ending with such year, exceeds the average of the annual per capita expenditure equivalent for the large group purchaser (reported under such subsection) for the 3-year period ending with the previous year.

(3) NATIONAL CORPORATE INFLATION FACTOR.—The national corporate inflation factor for a year, specified in this paragraph, is the average of the general health care inflation factors (as defined in section 6001(a)(3)) for each of the 3 years ending with such year.

PART 3—TREATMENT OF SINGLE-PAYER STATES

SEC. 6031. SPECIAL RULES FOR SINGLE-PAYER STATES.

In the case of a Statewide single-payer State, for purposes of section 1222(6), the Board shall compute a Statewide per capita premium target for each year in the same manner as the health care coverage area per capita premium target is determined under section 6003.

PART 4—TRANSITION PROVISIONS

SEC. 6041. MONITORING PRICES AND EXPENDITURES.

(a) IN GENERAL.—The Secretary shall establish a program to monitor prices and expenditures in the health care system in the United States.

(b) REPORTS.—The Secretary shall periodically report to the President on—

(1) the rate of increase in expenditures in each sector of the health care system, and

(2) how such rates compare with rate of overall increase in health care spending and rate of increase in the consumer price index.

(c) ACCESS TO INFORMATION.—

(1) IN GENERAL.—The Secretary may obtain, through surveys or otherwise, information on prices and expenditures for health care services. The Secretary may compel health care providers and third party payers to disclose such information as is necessary to carry out the program under this section.

(2) CONFIDENTIALITY.—Non-public information obtained under this subsection with respect to individual patients is confidential.

(d) PERIODIC REPORTS.—The Secretary shall periodically issue public reports on the matters described in subsection (b).

SEC. 6042. HEALTH CARE UTILIZATION RESEARCH PROGRAM.

To assist health plans in determining the appropriate cost of services to populations not previously covered by private health insurance, the Secretary of Health and Human Services shall conduct a program of research on the characteristics and health care utilization patterns of such populations, including Medicaid eligible individuals, unemployed individuals, and out-of-labor force individuals. Not later than 6 months after the date of enactment of this Act, such program shall be completed and a report concerning such program shall be submitted by the Secretary to health plans in such form as the Secretary determines is the most useful to such plans

Subtitle B—Premium-Related Financings

PART 1—FAMILY PREMIUM PAYMENTS

Subpart A—Family Share

SEC. 6101. FAMILY SHARE OF PREMIUM.

(a) REQUIREMENT.—Each family enrolled in a community-rated health plan or in a, experienced-rated health plan in a class of family enrollment is responsible for payment of the family share of premium payable respecting such enrollment. Such premium may be paid by an employer or other person on behalf of such a family.

(b) FAMILY SHARE OF PREMIUM DEFINED.—

(1) IN GENERAL.—In this subtitle, the term ''family share of premium'' means, with respect to enrollment of a family—

(A) in a community-rated health plan, the amount specified in paragraph (2) for the class, or

(B) in an experienced-rated health plan, the amount specified in paragraph (3) for the class.

(2) COMMUNITY-RATED PLANS.—

(A) IN GENERAL.—The amount specified in this paragraph for a health plan based on a class of family enrollment is the sum of the

base amounts described in subparagraph (B) reduced (but not below zero) by the sum of the amounts described in subparagraph (C).

(B) BASE.—The base amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) PLAN PREMIUM.—The applicable premium specified in section 6102(a) with respect to such class of enrollment.

(ii) FAMILY COLLECTION SHORTFALL.—20 percent of the family collection shortfall add-on (computed under section 6107 for such class).

(iii) MARKETING FEE.—Any applicable marketing fee as described in section 1511(b).

(C) CREDITS AND DISCOUNTS.—The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) FAMILY CREDIT.—The amount of the family credit under section 6103(a).

(ii) INCOME RELATED DISCOUNT.—The amount of any income-related discount provided under section 6104(a)(1).

(iii) EXCESS PREMIUM CREDIT.—The amount of any excess premium credit provided under section 6105.

(iv) LARGE GROUP SPONSOR OPT-IN CREDIT.—The amount of any large group sponsor opt-in credit provided under section 6106.

(v) ADDITIONAL CREDIT FOR SSI AND AFDC RECIPIENTS.—In the case of an SSI or AFDC family or for whom the amount described in clause (ii) is equal to the amount described in section 6104(b)(1)(A), the amount described in subparagraph (B)(ii).

(D) LIMIT ON MISCELLANEOUS CREDITS.—In no case shall the family share, due to credits under subparagraph (C), be less than zero.

(E) LIMITATION.—In no case shall the family share for a particular plan be greater than the premium otherwise payable under section 6101 due to the application of the worksite health promotion discount under section 6102(a)(1) and the worksite health promotion adjustment to the credit under section 6103.

(3) EXPERIENCE-RATED PLANS.—

(A) IN GENERAL.—The amount specified in this paragraph for an experience-rated health plan based on a class of family enrollment is the premium described in subparagraph (B) reduced (but not below zero) by the sum of the amounts described in subparagraph (C).

(B) PREMIUM.—The premium described in this subparagraph (for a plan for a class of enrollment) is the premium specified under section 1404 with respect to the plan and class of enrollment involved.

(C) CREDITS AND DISCOUNTS.—The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) FAMILY CREDIT.—The amount of the family credit under section 6103(b).

(ii) INCOME RELATED DISCOUNT.—The amount of any income-related discount provided under section 6104(a)(2).

SEC. 6102. AMOUNT OF PREMIUM.

(a) COMMUNITY-RATED PLANS.—The amount of the applicable premium charged by a community-rated health plan for all families in a class of family enrollment under

a community-rated health plan offered in the health care coverage area—

(1) with respect to a family enrolled through a mechanism other than a cooperative, equal to the product of—

(A) the final community rate for the plan (as defined in section 6000(a)(3)),

(B) the uniform per capita conversion factor (as specified in section 6211) for the health care coverage area, and

(C) the premium class factor established by the Board for that class under section 1631; increased for any applicable marketing fees (described in section 1511); or

(2) with respect to a family enrolled through a cooperative, equal to the product of—

(A) the final cooperative rate for the plan (as defined in section 6000(a)(4));

(B) the uniform per capita conversion factor (described under section 6211) for the health care coverage area;

(C) the premium class factor established by Board for that class under section 1631.

(b) REFERENCE TO OTHER PREMIUMS.—The amount of the premium charged by a large group pur-

chaser for all families in a class of family enrollment under an experience-rated health plan offered by the purchaser is specified under section 1404.

(c) SPECIAL RULES FOR DIVIDED FAMILIES.—In the case of an individual who is a qualifying employee of an employer, if the individual has a spouse or child who is not treated as part of the individual's family because of section 1012—

(1) the combined premium for both families under this section shall be computed as though such section had not applied if such combined premium is less than the total of the premiums otherwise applicable (without regard to this subsection),

(2) the large group purchaser and the entity described in section 1252 shall divide such combined premium between the families proportionally (consistent with rules established by the Board), and

(3) in such case, credits and other amounts shall be pro-rated in a manner consistent with rules established by the Board.

SEC. 6103. FAMILY CREDIT.

(a) COMMUNITY-RATED PLANS.—The credit provided under this section for a family enrolled in a community-rated plan for a class of family enrollment is equal to 80 percent of the weighted average premium (as defined

in section 6000(b)) for community-rated plans offered in the health care coverage area for the class.

(b) EXPERIENCE-RATED PLANS.—The credit provided under this section for a family enrolled in an experience-rated health plan for a class of family enrollment is equal to the minimum employer premium payment required under section 6131 with respect to the family.

SEC. 6104. PREMIUM DISCOUNT BASED ON INCOME.

(a) IN GENERAL.—

(1) ENROLLEES IN COMMUNITY-RATED PLANS.—Subject to paragraph (2), each family enrolled with a community-rated or experience-rated plan is entitled to a premium discount under this section, in the amount specified in subsection (b)(1) if the family—

(A) is an AFDC or SSI family;

(B) is determined, under subtitle C of title I, to have family adjusted income below 150 percent of the applicable poverty level; or

(C) is a family described in subsection (c)(3) for which the family obligation amount under subsection (c) for the year would otherwise exceed a specified percent of family adjusted income described in such subsection.

(2) NO LIABILITY FOR INDIANS AND CERTAIN VETERANS AND MILITARY PERSONNEL.—

(A) IN GENERAL.—In the case of an individual described in subparagraph (B), because the applicable health plan does not impose any premium for such an individual, the individual is not eligible for any premium discount under this section.

(B) INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is—

(i) an electing veteran (as defined in section 1012(d)(1)) who is enrolled under a health plan of the Department of Veterans Affairs and who, under the laws and rules as in effect as of December 31, 1994, has a service-connected disability or who is unable to defray the expenses of necessary care as determined under section 1722(a) of title 38, United States Code;

(ii) active duty military personnel (as defined in section 1012(d)(2)); and

(iii) an electing Indian (as defined in section 1012(d)(3)).

(3) MONTHLY APPLICATION TO AFDC AND SSI FAMILIES.—Paragraph (1)(A) (and the family obli-

gation amount under subsection (c) insofar as it relates to an AFDC or SSI family) shall be applied to the premium or family obligation amount only for months in which the family is such an AFDC or SSI family.

(b) AMOUNT OF PREMIUM DISCOUNT.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the amount of the premium discount under this subsection for a family under a class of family enrollment is equal to—

(A) 20 percent of—

(i) for a family enrolled in a community-rated plan offered in a community-rating area, the weighted average premium for community-rated plans offered in the community-rating area, increased by any amount provided under paragraph (2); or

(ii) for a family enrolled in an experience-rated plan offered in a premium area, the weighted average premium for experience-rated plans offered in the premium area (as determined under section 6131(b)(1)(A)) or, if less, the amount determined under clause (i) for the commu-

nity-rating area in which the family resides;

reduced (but not below zero) by—

(B) the sum of—

(i) the family obligation amount described in subsection (c); and

(ii) the amount of any employer payment (not required under part 2) towards the family share of premiums for covered members of the family.

(2) INCREASE FOR COMMUNITY-RATED FAMILIES TO ASSURE ENROLLMENT IN AT-OR-BELOW-AVERAGE-COST PLAN.—In the case of a family enrolled in a community-rated plan, if a State determines that a family eligible for a discount under this section is unable to enroll in an at-or-below-average-cost plan (as defined in paragraph (3)) that serves the area in which the family resides, the amount of the premium discount under this subsection is increased to the extent that such amount will permit the family to enroll in a community-rated plan without the need to pay a family share of premium under this part in excess of the sum described in paragraph (1)(B).

(3) AT-OR-BELOW-AVERAGE-COST PLAN DEFINED.—In this section, the term ''at-or-below-average-cost plan'' means a community-rated plan the premium for which does not exceed, for the class of family enrollment involved, the weighted average premium for the community-rating area.

(c) FAMILY OBLIGATION AMOUNT.—

(1) DETERMINATION.—Subject to paragraphs (2) and (3), the family obligation amount under this subsection is determined as follows:

(A) NO OBLIGATION IF INCOME BELOW INCOME THRESHOLD AMOUNT OR IF AFDC OR SSI FAMILY.—If the family adjusted income (as defined in section 1282(d)) of the family is less than the income threshold amount (specified in paragraph (4)) or if the family is an AFDC or SSI family, the family obligation amount is zero.

(B) INCOME ABOVE INCOME THRESHOLD AMOUNT.—If such income is at least such income threshold amount and the family is not an AFDC or SSI family, the family obligation amount is the sum of the following:

(i) FOR INCOME (ABOVE INCOME THRESHOLD AMOUNT) UP TO THE POV-

ERTY LEVEL.—The product of the initial marginal rate (specified in paragraph (2)) and the amount by which—

(I) the family adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds;

(II) such income threshold amount.

(ii) GRADUATED PHASE OUT OF DISCOUNT UP TO 150 PERCENT OF POVERTY LEVEL.—The product of the final marginal rate (specified in paragraph (2)) and the amount by which the family adjusted income exceeds 100 percent (but is less than 150 percent) of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1), for a year:

(A) INITIAL MARGINAL RATE.—The initial marginal rate is the ratio of—

(i) 3 percent of the applicable poverty level for the class of enrollment involved for the year; to

(ii) the amount by which such poverty level exceeds such income threshold amount.

(B) FINAL MARGINAL RATE.—The final marginal rate is 5.7 percent.

(3) LIMITATION TO 3.9 PERCENT FOR ALL FAMILIES.—

(A) IN GENERAL.—In no case shall the family obligation amount under this subsection for the year exceed 3.9 percent.

(B) INDEXING OF PERCENTAGE.—

(i) IN GENERAL.—The percentage specified in subparagraph (A) shall be adjusted for any year after 1994 so that the percentage for the year bears the same ratio to the percentage so specified as the ratio of—

(I) 1 plus the general health care inflation factor (as defined in section 6001(a)(3)) for the year, bears to

(II) 1 plus the percentage specified in section 1135 (relating to indexing of dollar amounts related to cost sharing) for the year.

(ii) ROUNDING.—Any adjustment under clause (i) for a year shall be rounded to the nearest multiple of 1/10 of 1 percentage point.

(4) INCOME THRESHOLD AMOUNT.—

(A) IN GENERAL.—For purposes of this subtitle, the income threshold amount specified in this paragraph is $1,000 (adjusted under subparagraph (B)).

(B) INDEXING.—For the 1-year period beginning on January 1, 1995, the income threshold amount specified in subparagraph (A) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1902(12)) for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31. 1993.

(C) ROUNDING.—Any increase or decrease under subparagraph (B) for a year shall be rounded to the nearest multiple of $10.

SEC. 6105. EXCESS PREMIUM CREDIT.

(a) IN GENERAL.—If plan payment reductions are made for one or more community-rated health plans of-

fered in a health care coverage area for plan payments in a year under section 6021, all families enrolling in community-rated health plans shall receive a credit under this section, in the amount described in subsection (b), in the case of each family enrolled in a community-rated health plan offered in the health care coverage area for premiums in the year.

(b) AMOUNT OF CREDIT.—

(1) IN GENERAL.—Subject to paragraph (2), the amount of the credit under this subsection, for a family enrolled in a class of family enrollment in a health care coverage area for a year, is the amount that would be the weighted average premium for such area, class, and year, if the per capita excess premium amount (determined under subsection (c)) for the area for the year were substituted for the weighted average discount rate for the health care coverage area for the year.

(2) ADJUSTMENT TO ACCOUNT FOR USE OF ESTIMATES.—Subject to section 9201, if the total payments made to all community-rated health plans in a year under section 6203 exceeds (or is less than) the total of such payments estimated by the State (based on the weighted average discount rate under subsection (c)(1)), because of a difference between—

(A) the State's estimate of the distribution of enrolled families between excess premium plans and other plans, and

(B) the actual distribution of such enrolled families among such plans,

the amount of the credit under this section in the second succeeding year shall be reduced (or increased, respectively) by the amount of such excess (or deficit) in the total of such payments made to all such plans.

(c) PER CAPITA EXCESS PREMIUM AMOUNT.—The per capita excess premium amount, for a health care coverage area for a year, is the amount by which—

(1) the weighted average discount rate (as defined in section 6000(a)(2)) for the area for the year, exceeds

(2) the health care coverage area per capita premium target for the area for the year.

SEC. 6106. LARGE GROUP PURCHASER OPT-IN CREDIT.

(a) IN GENERAL.—If community-rated individuals are owed a payment adjustment under section 6124 for a year, then the State shall provide for a credit under this section equal to 20 percent of the amount described in subsection (b), in the case of each family enrolled in a

community-rated plan offered in the health care coverage area.

(b) AMOUNT OF CREDIT.—The amount described in this subsection, for a family enrolled in a class of family enrollment for a health care coverage area for a year, is the amount that would be the weighted average premium for such area, class, and year, if the per capita large group purchaser opt-in amount (determined under subsection (c)) for the area for the year were substituted for the weighted average discount rate for the area for the year.

(c) PER CAPITA LARGE GROUP PURCHASER OPT-IN AMOUNT.—The per capita large group purchaser opt-in amount, for a health care coverage area for a year, is—

(1) the total amount of the payment adjustments owed for the year under section 6124, divided by

(2) the estimated average number of community rate eligible individuals in the health care coverage area during the year (reduced by the average number of such individuals whose family share of premiums, determined without regard to this section and section 6107, is zero).

SEC. 6107. FAMILY COLLECTION SHORTFALL ADD-ON.

(a) IN GENERAL.—The family collection shortfall add-on, for a health care coverage area for a class of en-

rollment for a year, is the amount that would be the weighted average premium for such area, class, and year, if the per capita collection shortfall amount (determined under subsection (b)) for the area for the year were substituted for the weighted average discount rate for the health care coverage area for the year.

(b) COMPUTATION OF PER CAPITA ADJUSTMENT FOR COLLECTION SHORTFALLS.—

(1) PER CAPITA COLLECTION SHORTFALL AMOUNT.—The per capita collection shortfall amount, for a health care coverage area for a year, under this subsection is equal to—

(A) the amount estimated under paragraph (2)(A) for the year, divided by

(B) the estimated average number of community rate eligible individuals in the health care coverage area during the year (reduced by the average number of such individuals whose family share of premiums, determined without regard to this section and section 6106, is zero).

(2) AGGREGATE COLLECTION SHORTFALL.—

(A) IN GENERAL.—Each State shall estimate, for each year (beginning with the first year) the total amount of payments which the

State can reasonably identify as owed to community-rated health plans under this Act (taking into account any premium reduction or discount under this subtitle and including amounts owed under subpart B and not taking into account any penalties) for the year and not likely to be collected (after making collection efforts described in section 6209) during a period specified by the Secretary beginning on the first day of the year.

(B) EXCLUSION OF GOVERNMENT DEBTS.—The amount under subparagraph (A) shall not include any payments owed to a community-rated health plan by the Federal, State, or local governments.

(C) ADJUSTMENT FOR PREVIOUS SHORTFALL ESTIMATION DISCREPANCY.—Subject to section 9201, the amount estimated under this paragraph for a year shall be adjusted to reflect over (or under) estimations in the amounts so computed under this paragraph for previous years (based on actual collections), taking into account interest payable based upon borrowings (or savings) attributable to such over or under estimations.

(c) APPORTIONMENT OF ADJUSTMENT.—The Board shall implement a method for the distribution of the aggregate collection shortfall amount for each health care coverage area (as described in (b)(2)) across premiums in the area. Such method shall reflect a blend of each plan's share of the area's aggregate shortfall and the unadjusted per-capita collection shortfall amount.

SEC. 6108. NO LOSS OF COVERAGE.

In no case shall the failure to pay amounts owed under this Act result in an individual's or family's loss of coverage.

SEC. 6109. APPLICATION OF ADJUSTMENTS.

Per-capita adjustments described in sections 6105, 6106, 6107 and 6125 shall be converted into adjustments applicable to each class of premium under a methodology to be established by the Board.

Subpart B—Repayment of Family Credit by Certain Families

SEC. 6110. REPAYMENT OF FAMILY CREDIT BY CERTAIN FAMILIES.

(a) IN GENERAL.—Subject to the succeeding provisions of this subpart, each family which is provided a family credit under section 6103(a) for a class of enrollment is liable for repayment of an amount equal to the base

employment monthly premium (applicable to such class) for the month under section 6122.

(b) REDUCTION FOR SELF-EMPLOYMENT PAYMENTS.—The liability of a family under this section for a year shall be reduced (but not below zero) by the amount of any employer payments made in the year under section 6126 based on the net earnings from self-employment of a family member.

SEC. 6111. NO LIABILITY FOR FAMILIES EMPLOYED FULL-TIME; REDUCTION IN LIABILITY FOR PART-TIME EMPLOYMENT.

(a) IN GENERAL.—The amount of any liability under section 6110 shall be reduced, in accordance with rules established by the National Health Board consistent with this section, based on employer premiums payable under section 6121 with respect to the employment of a family member who is a qualifying employee or with respect to a family member. In no case shall the reduction under this section result in any payment owing to a family.

(b) CREDIT FOR FULL-TIME AND PART-TIME EMPLOYMENT.—

(1) IN GENERAL.—Under rules of the Board, in the case of a family enrolled under a class of family enrollment, if a family member is a qualifying employee for a month and (except in the case described

in section 6114(a)) the employer is liable for payment under section 6121 based on such employment—

(A) FULL-TIME EMPLOYMENT CREDIT.—If the employment is on a full-time basis (as defined in section 1901(b)(2)(A)) the liability under section 6110 shall be reduced by the credit amount described in subparagraph (C).

(B) PART-TIME EMPLOYMENT CREDIT.—If the employment is on a part-time basis (as defined in section 1901(b)(2)(A)) the liability under section 6110 shall be reduced by the employment ratio (as defined in section 1901(b)(2)(B)) of the credit amount described in subparagraph (C).

(C) FULL-TIME MONTHLY CREDIT.—The amount of the credit under this subparagraph, with respect to employment by an employer in a month, is 1/12 (or, if applicable, the fraction described in paragraph (2)) of the amount owed under section 6110, based on the class of enrollment, for the year.

(2) COVERAGE DURING ONLY PART OF A YEAR.—In the case of a family that is not enrolled in a community-rated health plan for all the months

in a year, the fraction described in this paragraph is 1 divided by the number of months in the year in which the family was enrolled in such a plan.

(3) AGGREGATION OF CREDITS.—For purposes of paragraph (1)—

(A) INDIVIDUALS.—In the case of an individual who is a qualifying employee of more than one employer in a month, the credit for the month shall equal the sum of the credits earned with respect to employment by each employer. Such sum may exceed the credit amount described in paragraph (1)(C).

(B) COUPLES.—In the case of a couple each spouse of which is a qualifying employee in a month, the credit for the month shall equal the sum of the credits earned with respect to employment by each spouse. Such sum may exceed the credit amount described in paragraph (1)(C).

(c) TREATMENT OF CHANGE OF ENROLLMENT STATUS.—In the case of a family for which the class of family enrollment changes during a year, the Board shall establish rules for appropriate conversion and allocation of the credit amounts under the previous provisions of this section in a manner that reflects the relative values of the

base employment monthly premiums (as determined under section 6122) among the different classes of family enrollment.

SEC. 6112. LIMITATION OF LIABILITY BASED ON INCOME.

(a) IN GENERAL.—In the case of an eligible family described in subsection (b), the repayment amount required under this subpart (after taking into account any work credit earned under section 6111) with respect to a year shall not exceed the amount of liability described in subsection (c) for the year.

(b) ELIGIBLE FAMILY DESCRIBED.—An eligible family described in this subsection is a family which is determined, under section 1282 by the State for the health care coverage area in which the family resides, to have wage-adjusted income (as defined in subsection (d)) below 300 percent of the applicable poverty level.

(c) AMOUNT OF LIABILITY.—

(1) DETERMINATION.—Subject to subsection (f), in the case of a family enrolled in a class of enrollment with wage-adjusted income (as defined in subsection (d)), the amount of liability under this subsection is determined as follows:

(A) NO OBLIGATION IF INCOME BELOW INCOME THRESHOLD AMOUNT OR IF AFDC OR SSI FAMILY.—If such income is than the income

threshold amount (specified in section 6104(c)(4)) or if the family is an AFDC or SSI family, the amount of liability is zero.

(B) INCOME ABOVE INCOME THRESHOLD AMOUNT.—If such income is at least such income threshold amount and the family is not an AFDC or SSI family, the amount of liability is the sum of the following:

(i) FOUR PERCENT OF INCOME (ABOVE INCOME THRESHOLD AMOUNT) UP TO THE POVERTY LEVEL.—The initial marginal rate (specified in paragraph (2)(A)) of the amount by which—

(I) the wage-adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds

(II) such income threshold amount.

(ii) SECOND MARGINAL RATE.—The second marginal rate (specified in paragraph (2)(B) of the amount by which—

(I) the wage adjusted income (not including any portion that exceeds twice the applicable poverty

level for the class of family involved), exceeds

(II) the applicable poverty level for the class of family enrollment.

(iii) FINAL MARGINAL RATE.—Where wage-adjusted income exceeds 200 percent of the applicable poverty level, the final marginal rate (specified in paragraph (2)(C)) of the amount by which the wage-adjusted income exceeds 100 percent of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1)—

(A) INITIAL MARGINAL RATE.—The initial marginal rate, for a year for a class of enrollment, is the ratio of—

(i) 4 percent of the applicable poverty level for the class of enrollment for the year, to

(ii) the amount by which such poverty level exceeds such income threshold amount.

(B) SECOND MARGINAL RATE.—The second marginal rate, for a year for the class of enrollment, is 7.6 percent.

(C) FINAL MARGINAL RATE.—The final marginal rate, for a year for a class of enrollment, is the ratio of—

(i) the amount by which (I) the amount of the repayment amount described in section 6111(a) exceeds (II) 5.8 percent of twice the applicable poverty level (for the class and year); to

(ii) 200 percent of such poverty level.

(3) SECOND MARGINAL RATE.—

(A) IN GENERAL.—If, for a class of enrollment for a health care coverage area in a State, the second marginal rate exceeds the final marginal rate, the State may adjust such marginal rates as provided in subparagraph (B).

(B) SAME RATE APPLICABLE.—Under an adjustment made by a State under subparagraph (A), the second marginal rate and the final marginal rate shall be the same and shall be the ratio of—

(i) the amount by which (I) the amount of the repayment amount described in section 6111(a) exceeds (II) 4 percent of the applicable poverty level (for the class and year); to

(ii) 200 percent of such poverty level.

(4) MONTHLY APPLICATION TO AFDC AND SSI FAMILIES.—Paragraph (1) insofar as it relates to an AFDC or SSI family shall be applied so as to reduce to zero the liability amount only for months in which the family is such an AFDC or SSI family.

(d) WAGE-ADJUSTED INCOME DEFINED.—In this subtitle, the term ''wage-adjusted income'' means, for a family, family adjusted income of the family (as defined in section 1282), reduced by the sum of the following:

(1)(A) Subject to subparagraph (B), the amount of any wages included in such family's income that is received for employment which is taken into account in the computation of the amount of employer premiums under section 6121 (without consideration of section 6126).

(B) The reduction under subparagraph (A) shall not exceed for a year $5,000 (adjusted under section 6104(c)(3)(B)) multiplied by the number of months (including portions of months) of employment with respect to which employer premiums were payable under section 6121 (determined in a manner consistent with section 1901(b)(3)).

(2) The amount of net earnings from self employment of the family taken into account under section 6126.

(3) The amount of unemployment compensation included in income under section 85 of the Internal Revenue Code of 1986.

(e) DETERMINATIONS.—A family's wage-adjusted income and the amount of liability under subsection (c) shall be determined by the applicable health care coverage area upon application by a family under subpart B of part 3 of subtitle D of title I.

(f) NO LIABILITY FOR INDIANS AND CERTAIN VETERANS AND MILITARY PERSONNEL.—The provisions of paragraph (3) of section 6104(a) shall apply to the reduction in liability under this section in the same manner as such paragraph applies to the premium discount under section 6104.

SEC. 6113. PAYMENTS BY NONQUALIFYING EMPLOYEES.

(a) IN GENERAL.—In the case of an eligible family described in paragraph (b), the net liability of the family under this section shall be the amount described in subsection (c), limited by the amount described in subsection (d) plus the amount described in subsection (e).

(b) ELIGIBLE FAMILY DESCRIBED.—The family described in this paragraph is a family that has one or more

nonqualifying employees and has no full-time qualifying employees. The Board shall develop rules for applying this section to families whose employment status with respect to exempt employers changes during the year.

(c) AMOUNT.—The amount described in this subsection is the sum of—

(1) the family share as defined in section 6101 (including any discounts under 6104); and

(2) the family credit repayment amount described in subpart B of title VI (including any reductions under section 6113); reduced by—

(3) the amount (if any) by which that the premium specified in 6102(a) with respect to such family exceeds the weighted average premium (applicable to the family).

(d) LIMIT.—The limit described in this subsection is the following:

(1) for a family with family adjusted income of less than 150 percent of the applicable poverty level, 4 percent of family adjusted income;

(2) for a family with family adjusted income of at least 150 percent but less than 175 percent of the applicable poverty level, 4.5 percent of family adjusted income;

(3) for a family with family adjusted income of at least 175 percent but less than 225 percent of the applicable poverty level, 5 percent of family adjusted income; and

(4) for a family with family adjusted income of at least 225 percent but less than 400 percent of the applicable poverty level, 6 percent of family adjusted income.

(e) The amount described in this subsection is the amount in subsection (c)(3).

(f) INDEXING OF PERCENTAGES.—

(1) IN GENERAL.—The percentage of family adjusted income specified in paragraphs (1) through (4) of subsection (d) shall be adjusted for any year after 1994 so that the percentage for the year bears the same ratio to the percentage so specified as the ratio of—

(A) 1 plus the general health care inflation factor (as defined in section 6001(a)(3)) for the year, bears to

(B) 1 plus the percentage specified in section 1135 (relating to indexing of dollar amounts related to cost sharing) for the year.

(2) ROUNDING.—Any adjustment under paragraph (1) for a year shall be rounded to the nearest multiple of 1/10 of 1 percentage point.

SEC. 6114. SPECIAL TREATMENT OF CERTAIN RETIREES AND QUALIFIED SPOUSES AND CHILDREN.

(a) TREATMENT AS FULL-TIME EMPLOYEE.—Subject to subsection (d), an individual who is an eligible retiree (as defined in subsection (b)) or a qualified spouse or child (as defined in subsection (c)) for a month in a year (beginning with 1998) is considered, for purposes of section 6112, to be a full-time employee described in such section in such month.

(b) ELIGIBLE RETIREE DEFINED.—In this section, the term ''eligible retiree'' means, for a month, an individual who establishes to the satisfaction of the State (for the health care coverage area in which the individual resides), pursuant to rules of the Secretary, that the individual, as of the first day of the month—

(1) is at least 55, but less than 65, years of age,

(2) is not employed on a full-time basis (as defined in section 1901(b)(2)(A)),

(3) would be eligible (under section 226(a) of the Social Security Act) for hospital insurance benefits under part A of title XVIII of such Act if the

individual were 65 years of age based only on the employment of the individual, or has completed 40 quarters of employment through a State or local government, or has completed 40 quarters of employment through a State or local government, and

(4) is not a medicare-eligible individual.

(c) QUALIFIED SPOUSE OR CHILD DEFINED.—In subsection (a), the term ''qualified spouse or child'' means, in relation to an eligible retiree for a month, an individual who establishes to the satisfaction of the community-rated health plan (for the health care coverage area in which the individual resides) under rules of the Secretary that the requirements in one of the following paragraphs is met with respect to the individual:

(1) The individual (A) is under 65 years of age and is (and has been for a period of at least one year) married to an eligible retiree or (B) is a child of the eligible retiree.

(2) In the case of a person who was an eligible retiree at the time of the person's death—

(A) the individual was (and had for a period of at least one year been) married to the retiree at the time of the person's death,

(B) the individual is under 65 years of age,

(C) the individual is not employed on a full-time basis (as defined in section 1901(b)(2)(A)),

(D) the individual is not remarried, and

(E) the deceased spouse would still be an eligible retiree in the month if such spouse had not died.

(3) The individual is a child of an individual described in paragraph (2).

(d) APPLICATION.—An individual may not be determined to be an eligible retiree or qualified spouse or child unless an application has been filed with the State. Such application shall contain such information as the Secretary may require to establish such status and verify information in the application. Any material misrepresentation in the application is subject to a penalty in the same manner as a misrepresentation described in section 1282.

SEC. 6115. SPECIAL TREATMENT OF CERTAIN MEDICARE BENEFICIARIES.

In the case of an individual who would be a medicare-eligible individual in a month but for the application of section 1012(a) on the basis of employment (in the month or a previous month) of the individual or the individual's spouse or parent, the individual (or spouse or parent, as the case may be) so employed is considered, for purposes

of section 6112, to be a full-time employee described in such section in such month.

PART 2—EMPLOYER PREMIUM PAYMENTS

Subpart A—Employers Exempt From Coverage Obligations

SEC. 6116. EXEMPTION FROM COVERAGE OBLIGATIONS.

An exempt employer as defined section 6117 shall be exempt from requirements described in this part, except the requirement described in section 6120, unless the employer elects under section 6118 to be treated as a community-rated employer.

SEC. 6117. EXEMPT EMPLOYER DEFINED.

(a) IN GENERAL.—In this section—

(1) the term ''exempt employer'' means an employer that does not employ, on average, more than 10 full-time equivalent employees;

(2) and is an employer with average annual wages per full-time equivalent employee of less than $24,000; and

(3) the average number of full-time equivalent employees shall be determined by averaging the number of full-time equivalent employees employed by the employer in each countable month during the year.

(b) COUNTABLE MONTH.—In paragraph (1), the term ''countable month'' means, for an employer, a month in which the employer employs any qualifying employee.

(c) DETERMINATIONS.—The number of full-time equivalent employees shall be determined using the rules under section 1901(b)(2).

(d) EXEMPT EMPLOYER.—The term ''exempt employer'' shall not include an individual described in section 6126(c)(2).

SEC. 6118. ELECTION.

A exempt employer may elect to be treated as a community-rated employer under the procedures described in section.

SEC. 6119. TREATMENT OF EXEMPT EMPLOYERS.

(a) IN GENERAL.—

(1) COMMUNITY RATED EMPLOYER.—An exempt employer shall be treated as a community rated employer as of the first date of the first year following an election made under section 6118.

(2) ELIGIBILITY FOR DISCOUNTS.—An exempt employer making an election under section 6118 shall be eligible for discounts under 6123.

SEC. 6120. NONELECTING EXEMPT EMPLOYER.

(a) IN GENERAL.—The term ''nonelecting exempt employer'' means an exempt employer that has not made an election under section 6118.

(b) ASSESSMENT IN LIEU OF PARTICIPATION.—Each State shall establish a mechanism to collect an assessment of payroll from each non-electing employer to be used to defray the cost of subsidies to the employees of such employer.

(c) AMOUNT OF ASSESSMENT.—For purposes of subsection (b)—

(1) with respect to employers with 5 or fewer full-time equivalent employees, the assessment of payroll under such subsection shall be 1 percent; and

(2) with respect to employers with more than 6 but less than 11 full-time equivalent employees, the assessment of payroll under such subsection shall be 2 percent.

Subpart B—Community-Rated Employers

SEC. 6121. EMPLOYER PREMIUM PAYMENT REQUIRED.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each community-rated employer described in paragraph (2) for a month shall pay at least an amount equal to the sum across all qualifying employees of the amount specified in subsection (b) for each such qualifying employee of the

employer. Such payments shall be made in accordance with section 1345(c).

(2) EMPLOYER DESCRIBED.—An employer described in this paragraph for a month is an employer that—

(A) in a month employs one or more qualifying employees (as defined in section 1901(b)(1)); and

(B) is not exempt under section 3127 of the Internal Revenue Code of 1986 from the taxes imposed in section 3111 of such code.

(3) TREATMENT OF CERTAIN EMPLOYMENT BY EXPERIENCE-RATED EMPLOYERS.—An experience-rated employer shall be deemed, for purposes of this subpart, to be a community-rated employer with respect to qualifying employees who are not experience rate eligible individuals.

(b) PREMIUM PAYMENT AMOUNT.—

(1) IN GENERAL.—Except as provided in section 6123 (relating to a discount for certain employers), section 6124 (relating to large employers electing coverage through community-rated health plans), section 6125 (relating to the employer collection shortfall add-on), and section 6127 (relating to qualified worksite health promotion programs, the

amount of the employer premium payment, for a month for each qualifying employee of the employer who is residing in a health care coverage area, is the payment amount computed under paragraph (2) with respect to such employee in such area.

(2) PAYMENT AMOUNT FOR EACH EMPLOYEE IN A CLASS OF FAMILY ENROLLMENT.—Subject to paragraph (4), the payment amount under this paragraph, for an employer for each qualifying employee residing in a health care coverage area, is the product of—

(A) the base employment monthly premium determined under section 6122 for the applicable class of family enrollment (as defined in paragraph (3)) for the previous month for the health care coverage area, and

(B) the full-time employment ratio (as defined in section 1901 for the previous month.

(3) APPLICABLE CLASS OF FAMILY ENROLLMENT.—The applicable class of family enrollment described in this paragraph is the class of family enrollment selected by the qualifying employee.

(4) TREATMENT OF CERTAIN EMPLOYEES.—In applying this subpart in the case of a qualifying em-

ployee (other than a medicare-eligible individual) who is not enrolled in any health plan—

(A) the employee is deemed enrolled in a community-rated health plan (for the health care coverage area in which the individual resides) in the dual parent class of enrollment, and

(B) if the employee's residence is not known, the employee is deemed to reside in the health care coverage area in which the employee principally is employed for the employer.

(5) TRANSITIONAL RULES FOR FIRST MONTH IN FIRST YEAR FOR A STATE.—In the case of an employer for a State in the first month of the State's first year—

(A) the premium amount for each qualifying employee for such month shall be computed by substituting ''month'' for ''previous month'' in paragraph (2);

(B) payment for such month shall be made on the first of the month based on an estimate of the payment for such month;

(C) an adjustment shall be made to the payment in the following month to reflect the difference between the payment in the first

month and the payment in the following month (calculated without regard to the adjustment under this subparagraph); and

(D) the reconciliation of premiums for such first month under section 1602(c) shall be included in the reconciliation of premiums for the following 12 months.

(6) SPECIAL RULES FOR DIVIDED FAMILIES.—In the case of an individual who is a qualifying employee of an employer, if the individual has a spouse or child who is not treated as part of the individual's family because of section 1012—

(A) the employer premium payment under this section shall be computed as though such section had not applied, and

(B) the State shall provide for proportional payments (consistent with rules established by the Secretary) to the health plans (if different) of the qualifying employee and of the employee's spouse and children.

(7) SPECIAL RULES FOR CERTAIN EMPLOYEES RESIDING ABROAD.—The Office of Personnel Management shall determine the appropriate (voluntary) employer premium amount with respect to each em-

ployee described in section 1707 electing to purchase coverage through the FEHBP.

(c) APPLICATION DURING TRANSITION PERIOD.—

(1) IN GENERAL.—For purposes of applying this subpart in the case of an employer described in paragraph (3), there shall only be taken into account qualifying employees (and wages of such employees) who reside in a participating State.

(2) EXCEPTION.—Paragraph (1) shall not apply in determining the average number of full-time equivalent employees or whether an employer is a medium employer.

(3) EMPLOYER DESCRIBED.—An employer described in this paragraph is an employer that employs one or more qualifying employees in a participating State and one or more qualifying employees in a State that is not a participating State.

(d) EXEMPTION FROM PREMIUM PAYMENTS.—An employer shall be exempt from the payment of health care premiums for exempt individuals defined in section 1902(19).

SEC. 6122. COMPUTATION OF BASE EMPLOYMENT MONTHLY PREMIUM.

(a) IN GENERAL.—Each State shall provide for the computation for each year (beginning with the first year)

of a base employment monthly premium for each class of family enrollment as follows:

(1) INDIVIDUAL ENROLLMENT.—The base employment monthly premium for the individual class of enrollment is equal to 1/12 of 80 percent of the credit-adjusted weighted average premium (as defined in paragraph (4)) for the health care coverage area for the individual class of enrollment.

(2) COUPLE-ONLY ENROLLMENT.—

(A) IN GENERAL.—The base employment monthly premium for the couple-only class of enrollment is equal to 1/12 of 80 percent of the product described in subparagraph (B), divided by the sum described in subparagraph (C).

(B) TOTAL PREMIUMS FOR COUPLE-ONLY ENROLLMENTS.—The product described in this subparagraph is—

(i) the credit-adjusted weighted average premium for such health care coverage area for the couple-only class of enrollment, multiplied by

(ii) the sum, for all the months in the year, of the number of covered families receiving coverage through community-rated

health plans within such class of enrollment in each such month.

(C) NUMBER OF WORKERS AND EXTRA WORKERS.—The sum described in this subparagraph is—

(i) the sum specified in subparagraph (B)(ii), plus

(ii) the number of additional workers (determined under subsection (b)(1)), for families receiving coverage within such class from community-rated health plans offered for the health care coverage area.

(3) SINGLE AND DUAL PARENT ENROLLMENTS.—

(A) IN GENERAL.—The base employment monthly premium for the single parent and dual parent classes of enrollment is equal to 1/12 of 80 percent of the sum described in subparagraph (B), divided by the sum described in subparagraph (C).

(B) TOTAL PREMIUMS FOR SINGLE AND DUAL PARENT ENROLLMENTS.—The sum described in this subparagraph is the sum of the products described in the following clauses: