

Calendar No. 542

103<sup>RD</sup> CONGRESS  
2<sup>D</sup> Session

**S. 2357**

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**A BILL**

To achieve universal health insurance coverage, and  
for other purposes.

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August 5, 1984

Read the second time and placed on the calendar



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

# S. 2357

To achieve universal health insurance coverage, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

AUGUST 3 (legislative day, JULY 20), 1994

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

AUGUST 5, 1984

Read the second time and placed on the calendar

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## A BILL

To achieve universal health insurance coverage, and for other purposes.

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

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

4       (a) **SHORT TITLE.**—This Act may be cited as the  
5       “Health Security Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED ACCESS TO STANDARDIZED AND  
AFFORDABLE HEALTH PLANS

Subtitle A—Rules and Definitions of General Applicability

PART 1—RULES OF GENERAL APPLICABILITY

- Sec. 1001. Access to standardized coverage.
- Sec. 1002. Standard health plan principles.
- Sec. 1003. Protection of consumer choice.

PART 2—DEFINITIONS

- Sec. 1011. Definitions relating to health plans.
- Sec. 1012. Definitions relating to employment and income.
- Sec. 1013. Other general definitions.

Subtitle B—Health Plan Standards

PART 1—ESTABLISHMENT AND APPLICATION OF STANDARDS

- Sec. 1101. Establishment of National standards.
- Sec. 1102. General rules.

PART 2—INSURANCE MARKET REFORM

- Sec. 1111. Guaranteed issue, availability, and renewability.
- Sec. 1112. Enrollment.
- Sec. 1113. Coverage of dependents.
- Sec. 1114. Nondiscrimination based on health status.
- Sec. 1115. Benefits.
- Sec. 1116. Community rating requirements.
- Sec. 1117. Risk adjustment and reinsurance.
- Sec. 1118. Financial solvency requirements and consumer protection against provider claims.

PART 3—DELIVERY SYSTEM REFORM

- Sec. 1121. Prohibition of discrimination.
- Sec. 1122. Quality assurance standards.
- Sec. 1123. Consumer grievance process.
- Sec. 1124. Health security cards.
- Sec. 1125. Information and marketing standards.
- Sec. 1126. Information regarding a patient's right to self-determination in health care services.
- Sec. 1127. Contracts with purchasing cooperatives.
- Sec. 1128. Health plan arrangements with providers.
- Sec. 1129. Utilization management protocols and physician incentive plans.

PART 4—SUPPLEMENTAL HEALTH BENEFITS PLANS

- Sec. 1141. Supplemental health benefits plans.

Subtitle C—Benefits and Cost-Sharing

PART 1—STANDARD BENEFITS PACKAGES

- Sec. 1201. General description of standard benefits packages.
- Sec. 1202. Description of categories of items and services.
- Sec. 1203. Definitions.

PART 2—NATIONAL HEALTH BENEFITS BOARD

- Sec. 1211. Creation of National health benefits board; membership.

- Sec. 1212. Qualifications of board members.
- Sec. 1213. General duties and responsibilities.
- Sec. 1214. Powers.
- Sec. 1215. Funding.
- Sec. 1216. Applicability of Federal Advisory Committee Act.
- Sec. 1217. Congressional consideration of Board proposals.

Subtitle D—Access to Health Plans

PART 1—ACCESS THROUGH EMPLOYERS

- Sec. 1301. General employer responsibilities.
- Sec. 1302. Auditing of records.
- Sec. 1303. Prohibition of certain employer discrimination.
- Sec. 1304. Prohibition on self-insuring cost-sharing benefits.
- Sec. 1305. Responsibilities in single-payer States.
- Sec. 1306. Development of large employer purchasing groups.
- Sec. 1307. Rules governing litigation involving retiree health benefits.
- Sec. 1308. Enforcement.

PART 2—ACCESS THROUGH HEALTH INSURANCE PURCHASING  
COOPERATIVES

SUBPART A—GENERAL REQUIREMENTS

- Sec. 1321. Organization and operation.
- Sec. 1322. Membership.
- Sec. 1323. Agreements with standard health plans.
- Sec. 1324. Membership and marketing fees.

SUBPART B—COMMUNITY-RATED EMPLOYERS

- Sec. 1331. Duties of purchasing cooperatives.

SUBPART C—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

- Sec. 1341. Requirements applicable to FEHBP.
- Sec. 1342. Special rules for FEHBP supplemental plans.
- Sec. 1343. Definitions.

PART 3—TREATMENT OF ASSOCIATION PLANS

- Sec. 1351. Rules relating to multiple employer welfare arrangements.
- Sec. 1352. Association plans.

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PART 1—SECRETARY OF HEALTH AND HUMAN SERVICES

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- Sec. 1401. General duties and responsibilities.
- Sec. 1402. Annual report.
- Sec. 1403. Assistance with family collections.
- Sec. 1404. Advisory opinions.
- Sec. 1405. Funding.

SUBPART B—RESPONSIBILITIES RELATING TO REVIEW AND APPROVAL OF  
STATE SYSTEMS

- Sec. 1411. Federal review and action on State systems.
- Sec. 1412. Failure of participating States to meet conditions for compliance.
- Sec. 1413. Reduction in payments for health programs by Secretary of Health and Human Services.
- Sec. 1414. Review of Federal determinations.
- Sec. 1415. Federal support for State implementation.

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- Sec. 1421. Application of subpart.
- Sec. 1422. Federal assumption of responsibilities in non-participating States.
- Sec. 1423. Imposition of surcharge on premiums under federally-operated system.
- Sec. 1424. Return to State operation.

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- Sec. 1431. Premium class and age class factors.

SUBPART E—RISK ADJUSTMENT AND REINSURANCE METHODOLOGY FOR  
PAYMENT OF PLANS

- Sec. 1435. Development of a risk adjustment and reinsurance methodology.

SUBPART F—RESPONSIBILITIES FOR FINANCIAL REQUIREMENTS

- Sec. 1441. Capital standards for community-rated plans.
- Sec. 1442. Standard for guaranty funds.

SUBPART G—OPEN ENROLLMENT

- Sec. 1445. Periods of authorized changes in enrollment.
- Sec. 1446. Distribution of comparative information.
- Sec. 1455. Reports.

PART 2—ESSENTIAL COMMUNITY PROVIDERS

- Sec. 1461. Certification.
- Sec. 1462. Categories of providers automatically certified.
- Sec. 1463. Standards for additional providers.
- Sec. 1464. Certification process; review; termination of certifications.
- Sec. 1465. Notification of participating States.
- Sec. 1466. Health plan requirement.
- Sec. 1467. Recommendation on continuation of requirement.
- Sec. 1468. Definitions.

PART 3—SPECIFIC RESPONSIBILITIES OF SECRETARY OF LABOR

- Sec. 1481. Responsibilities of Secretary of Labor.
- Sec. 1482. Federal role with respect to multi-State self-insured health plans.
- Sec. 1483. Assistance with employer collections.
- Sec. 1484. Penalties for failure of large employer purchasing groups to meet requirements.
- Sec. 1485. Applicability of ERISA enforcement mechanisms for enforcement of certain requirements.
- Sec. 1486. Workplace wellness program.

## PART 4—OFFICE OF RURAL HEALTH POLICY

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- Sec. 1502. Community rating areas and health plan service areas.
- Sec. 1503. Open enrollment periods.
- Sec. 1504. Risk adjustment program.
- Sec. 1505. Guaranty funds.
- Sec. 1506. Enrollment activities.
- Sec. 1507. Rural and medically underserved areas.
- Sec. 1508. Public access sites.
- Sec. 1509. Requirements relating to possessions of the United States.
- Sec. 1510. Right of recovery of certain taxes against providers.

## PART 2—TREATMENT OF STATE LAWS

- Sec. 1511. Preemption of certain State laws relating to health plans.
- Sec. 1512. Override of restrictive State practice laws.

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- Sec. 1521. Continuance of existing Federal law waivers.
- Sec. 1522. Hawaii prepaid Health Care Act.
- Sec. 1523. Alternative State provider payment systems.
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- Sec. 1531. Single-payer system described.
- Sec. 1532. General requirements for single-payer systems.
- Sec. 1533. Special rules for States operating statewide single-payer system.
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## SUBPART C—EARLY IMPLEMENTATION OF COMPREHENSIVE STATE PROGRAMS

- Sec. 1541. Early implementation of comprehensive State programs.

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- Sec. 1602. Antidiscrimination.

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## PART 1—COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS

- Sec. 2001. Coverage of outpatient prescription drugs.
- Sec. 2002. Payment rules and related requirements for covered outpatient drugs.
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- Sec. 2004. Prescription drug payment review commission.
- Sec. 2005. Coverage of home infusion drug therapy services.
- Sec. 2006. Medicare drug benefit plans.
- Sec. 2007. Payment for covered outpatient drug benefit under medicare contracts with HMOs and CMPS.
- Sec. 2008. Maintenance of effort.

#### Subtitle B—Home and Community-Based Services

##### PART 1—HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

- 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. Appropriations; allotments to States.
- Sec. 2110. Federal evaluations.

##### PART 2—GRANTS RELATING TO THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS

- Sec. 2111. Information and technical assistance grants relating to development of hospital linkage programs.

#### Subtitle C—Long-Term Care Insurance Improvement and Accountability

- Sec. 2200. Short title.

##### PART 1—PROMULGATION OF STANDARDS AND MODEL BENEFITS

- Sec. 2201. Standards.

##### PART 2—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

- Sec. 2211. Implementation of policy standards.
- Sec. 2212. Regulation of sales practices.
- Sec. 2213. Additional responsibilities for carriers.
- Sec. 2214. Renewability standards for issuance, and basic for cancellation of policies.
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- Sec. 2301. Short title.  
 Sec. 2302. Life care: public insurance program for nursing home care.

Subtitle E—Study and Report

- Sec. 2401. Study of issues related to end of life care.

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- Sec. 3000. Definitions.

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- Sec. 3001. National Council on Graduate Medical Education.

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- Sec. 3011. Cooperation regarding approved physician training programs.  
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- Sec. 3062. Application for payments.
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- Sec. 3072. National Council on Graduate Nurse Training.

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- Sec. 3905. Full funding for WIC.

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- Sec. 4210. Application of competitive acquisition process for part B items and services.
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- Sec. 10131. Enrollment and premium payments.
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1 **TITLE I—IMPROVED ACCESS TO**  
 2 **STANDARDIZED AND AFFORD-**  
 3 **ABLE HEALTH PLANS**

4 **Subtitle A—Rules and Definitions**  
 5 **of General Applicability**

6 **PART 1—RULES OF GENERAL APPLICABILITY**

7 **SEC. 1001. ACCESS TO STANDARDIZED COVERAGE.**

8 (a) IN GENERAL.—A participating State system shall  
 9 require that each health plan (whether insured or self-in-  
 10 sured) or long-term care policy issued, sold, offered for  
 11 sale, or operated in the State shall be certified by the ap-  
 12 propriate certifying authority as one of the following:

13 (1) A certified standard health plan.

14 (2) A certified supplemental health benefits  
 15 plan.

16 (3) A certified long-term care policy under part  
 17 2 of subtitle B of title II.

18 (b) FEDERAL CERTIFICATION OF MULTISTATE  
 19 SELF-INSURED PLANS.—For Federal certification of  
 20 multistate self-insured health plans, see section 1482.

1 **SEC. 1002. STANDARD HEALTH PLAN PRINCIPLES.**

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

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

8 (2) A standard health plan—

9 (A) shall offer an annual open enrollment  
10 period and accept all eligible individuals for cov-  
11 erage;

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

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

16 (3) A standard health plan shall ensure that all  
17 medically necessary or appropriate services, as de-  
18 fined in the benefits package, are provided.

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

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

24 **SEC. 1003. PROTECTION OF CONSUMER CHOICE.**

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



1 (i) Coverage only for accidental death  
2 or dismemberment.

3 (ii) Coverage providing wages or pay-  
4 ments in lieu of wages for any period dur-  
5 ing which the employee is absent from  
6 work on account of sickness or injury.

7 (iii) A medicare supplemental policy  
8 (as defined in section 1882(g)(1) of the  
9 Social Security Act).

10 (iv) Coverage issued as a supplement  
11 to liability insurance.

12 (v) Worker's compensation or similar  
13 insurance.

14 (vi) Automobile medical-payment in-  
15 surance.

16 (vii) A long-term care policy, including  
17 a nursing home fixed indemnity policy (un-  
18 less the Secretary determines that such a  
19 policy provides sufficiently comprehensive  
20 coverage of a benefit so that it should be  
21 treated as a health plan).

22 (viii) An equivalent health care pro-  
23 gram.

1                   (ix) Such other plan or arrangement  
2                   as the Secretary determines is not a health  
3                   plan.

4                   Such term includes any plan or arrangement  
5                   not described in any preceding subparagraph  
6                   which provides for benefit payments, on a peri-  
7                   odic basis, for a specified disease or illness or  
8                   period of hospitalization without regard to the  
9                   costs incurred or services rendered during the  
10                  period to which the payments relate.

11                  (B) INSURED HEALTH PLAN.—

12                   (i) IN GENERAL.—The term “insured  
13                   health plan” means any health plan which  
14                   is a hospital or medical service policy or  
15                   certificate, hospital or medical service plan  
16                   contract, or health maintenance organiza-  
17                   tion group contract offered by a carrier.

18                   (ii) CARRIER.—The term “carrier”  
19                   means a licensed insurance company, a  
20                   hospital or medical service corporation (in-  
21                   cluding an existing Blue Cross or Blue  
22                   Shield organization, within the meaning of  
23                   section 833(c)(2) of Internal Revenue Code  
24                   of 1986 as in effect before the date of the  
25                   enactment of this Act), a health mainte-

1 nance organization, or other entity licensed  
 2 or certified by the State to provide health  
 3 insurance or health benefits. The Secretary  
 4 may issue regulations that provide for af-  
 5 filiated carriers to be treated as a single  
 6 carrier where appropriate under this Act.

7 (C) SELF-INSURED HEALTH PLAN.—The  
 8 term ‘self-insured health plan’ means an em-  
 9 ployee welfare benefit plan, church plan, or  
 10 other arrangement which—

11 (i) provides health benefits funded in  
 12 a manner other than through the purchase  
 13 of one or more insured health plans, but

14 (ii) does not include any coverage or  
 15 insurance described in clauses (i) through  
 16 (ix) of subparagraph (A).

17 (2) CERTIFIED STANDARD HEALTH PLAN.—

18 (A) IN GENERAL.—The term “certified  
 19 standard health plan” means a standard health  
 20 plan which is certified by the appropriate certi-  
 21 fying authority as meeting the other applicable  
 22 requirements of this title.

23 (B) STANDARD HEALTH PLAN.—The term  
 24 “standard health plan” means a health plan  
 25 which provides for the standard benefits pack-

1 age or the alternative standard benefits package  
2 established under subtitle C.

3 (3) CERTIFIED SUPPLEMENTAL HEALTH BENE-  
4 FITS PLAN.—

5 (A) IN GENERAL.—The term “certified  
6 supplemental health benefits plan” means a  
7 supplemental health benefits plan which is cer-  
8 tified by the appropriate certifying authority as  
9 meeting the applicable requirements of part 4  
10 of subtitle B.

11 (B) SUPPLEMENTAL HEALTH BENEFITS  
12 PLAN.—The term “supplemental health benefits  
13 plan” means an insured or self-insured health  
14 plan which provides health benefits which con-  
15 sist of supplemental services or cost-sharing de-  
16 scribed in part 4 of subtitle B. Such term does  
17 not include a plan which provides for benefit  
18 payments, on a periodic basis, for a specified  
19 disease or illness or period of hospitalization  
20 without regard to the costs incurred or services  
21 rendered during the period to which the pay-  
22 ments relate.

23 (4) CERTIFIED LONG-TERM CARE INSURANCE  
24 POLICY.—

1 (A) IN GENERAL.—The term “certified  
2 long-term care insurance policy” means a long-  
3 term care insurance policy which is certified by  
4 the applicable certifying authority as meeting  
5 the applicable requirements of part 2 of subtitle  
6 B of title II.

7 (B) LONG-TERM CARE INSURANCE POL-  
8 ICY.—The term “long-term care insurance pol-  
9 icy” has the meaning given such term by sec-  
10 tion 2721.

11 (5) TERMS AND RULES RELATING TO COMMU-  
12 NITY AND EXPERIENCE RATING.—

13 (A) COMMUNITY-RATED PLAN.—The term  
14 “community-rated plan” means a health plan  
15 provided to community-rated individuals which  
16 meets the requirements of section 1116.

17 (B) COMMUNITY-RATED EMPLOYER.—The  
18 term “community-rated employer” means, with  
19 respect to an employee, an employer that is not  
20 an experience-rated employer with respect to  
21 such employee.

22 (C) COMMUNITY-RATED INDIVIDUAL.—The  
23 term “community-rated individual” means an  
24 individual who is not an experience-rated indi-  
25 vidual.

1 (D) EXPERIENCE-RATED PLAN.—

2 (i) IN GENERAL.—The term “experi-  
3 ence-rated plan” means a health plan  
4 which—

5 (I) is a self-insured health plan  
6 of an experience-rated employer, or

7 (II) is an insured health plan  
8 which is experience-rated,

9 but any such plan may cover only experi-  
10 ence-rated individuals.

11 (ii) COMMUNITY RATING OF GOVERN-  
12 MENT PLANS.—Such term shall not include  
13 a government plan of a State or local gov-  
14 ernment.

15 (E) EXPERIENCE-RATED EMPLOYER.—

16 (i) IN GENERAL.—The term “experi-  
17 ence-rated employer” means, with respect  
18 to any calendar year—

19 (I) any employer if, on each of  
20 20 days during the preceding calendar  
21 year (each day being in a different  
22 week), such employer (or any prede-  
23 cessor) employed more than 500 em-  
24 ployees for some portion of the day; or

1 (II) a multiemployer plan or  
2 rural electric cooperative or rural tele-  
3 phone cooperative association plan  
4 that covers 500 or more individuals.

5 (ii) SPECIAL RULE FOR LEASING  
6 BUSINESSES.—In the case of an employer  
7 the primary trade or business of which is  
8 employee leasing—

9 (I) all of the employees which  
10 such employer leases to other employ-  
11 ers shall be treated as community-  
12 rated individuals, and

13 (II) this Act shall be applied sep-  
14 arately with respect to its other em-  
15 ployees.

16 (iii) U.S. POSTAL SERVICE.—Such  
17 term includes the United States Postal  
18 Service.

19 (F) EXPERIENCE-RATED INDIVIDUAL.—  
20 The term “experience-rated individual” means  
21 an individual who is an employee of an experi-  
22 ence-rated employer or a member of a plan de-  
23 scribed in subparagraph (E)(i)(II).

24 (6) SPECIAL RULE FOR SPOUSES AND DEPEND-  
25 ENTS.—If any individual is offered coverage under a

1 health plan as the spouse or a dependent of a pri-  
2 mary enrollee of such plan, such individual shall  
3 have the status of such enrollee unless such indi-  
4 vidual is eligible to elect other coverage and so  
5 elects.

6 **SEC. 1012. DEFINITIONS RELATING TO EMPLOYMENT AND**  
7 **INCOME.**

8 Except as otherwise specifically provided, in this Act  
9 the following definitions and rules apply:

10 (1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND  
11 WAGES DEFINED.—Except as provided in this sec-  
12 tion—

13 (A) the terms “wages” and “employment”  
14 have the meanings given such terms under sec-  
15 tion 3121 of the Internal Revenue Code of  
16 1986,

17 (B) the term “employee” has the meaning  
18 given such term under section 3121 of such  
19 Code, subject to the provisions of chapter 25 of  
20 such Code, and

21 (C) the term “employer” has the same  
22 meaning as the term “employer” as used in  
23 such section 3121.

24 (2) EXCEPTIONS.—For purposes of paragraph  
25 (1)—

1 (A) EMPLOYMENT.—

2 (i) EMPLOYMENT INCLUDED.—Para-  
3 graphs (1), (2), (5), (7) (other than  
4 clauses (i) through (iv) of subparagraph  
5 (C) and clauses (i) through (v) of subpara-  
6 graph (F)), (8), (9), (10), (11), (13), (15),  
7 (18), and (19) of section 3121(b) of the  
8 Internal Revenue Code of 1986 shall not  
9 apply.

10 (ii) EXCLUSION OF INMATES AS EM-  
11 PLOYEES.—Employment shall not include  
12 services performed in a penal institution by  
13 an inmate thereof or in a hospital or other  
14 health care institution by a patient thereof.

15 (B) WAGES.—Paragraph (1) of section  
16 3121(a) of the Internal Revenue Code of 1986  
17 shall not apply.

18 (C) EMPLOYEES.—

19 (i) TREATMENT OF SELF-EM-  
20 PLOYED.—The term “employee” includes a  
21 self-employed individual.

22 (ii) EXCLUSION OF CERTAIN FOREIGN  
23 EMPLOYMENT.—The term “employee” does  
24 not include an individual with respect to  
25 service, if the individual is not a citizen or

1           resident of the United States and the serv-  
2           ice is performed outside the United States.

3           (3) AGGREGATION RULES FOR EMPLOYERS.—

4           For purposes of this Act—

5           (A) all employers treated as a single em-  
6           ployer under subsection (a) or (b) of section 52  
7           of the Internal Revenue Code of 1986 shall be  
8           treated as a single employer, and

9           (B) under regulations of the Secretary of  
10          Labor, all employees of organizations which are  
11          under common control with one or more organi-  
12          zations which are exempt from income tax  
13          under subtitle A of the Internal Revenue Code  
14          of 1986 shall be treated as employed by a single  
15          employer.

16          The regulations prescribed under subparagraph (B)  
17          shall be based on principles similar to the principles  
18          which apply to taxable organizations under subpara-  
19          graph (A).

20       **SEC. 1013. OTHER GENERAL DEFINITIONS.**

21          Except as otherwise specifically provided, in this Act  
22       the following definitions apply:

23          (1) APPROPRIATE CERTIFYING AUTHORITY.—

24          The term “appropriate certifying authority”  
25       means—

1 (A) except as provided in subparagraph  
2 (B), in the case of a standard health plan, a  
3 supplemental health benefits plan, or a long-  
4 term care insurance plan, the State commis-  
5 sioner or superintendent of insurance or other  
6 State authority in the participating State; or

7 (B) in the case of a multistate self-insured  
8 health plan or a multistate self-insured supple-  
9 mental health benefits plan, the Secretary of  
10 Labor.

11 (2) COMMUNITY RATING AREA.—The term  
12 “community rating area” means an area specified by  
13 a State under section 1502(a).

14 (3) EQUIVALENT HEALTH CARE PROGRAM.—  
15 The term “equivalent health care program” means—

16 (A) part A or part B of the medicare pro-  
17 gram under title XVIII of the Social Security  
18 Act,

19 (B) the medicaid program under title XIX  
20 of the Social Security Act,

21 (C) the health care program for active  
22 military personnel under title 10, United States  
23 Code,

1 (D) the veterans health care program  
2 under chapter 17 of title 38, United States  
3 Code,

4 (E) the Civilian Health and Medical Pro-  
5 gram of the Uniformed Services (CHAMPUS),  
6 as defined in section 1073(4) of title 10, United  
7 States Code,

8 (F) the Indian health service program  
9 under the Indian Health Care Improvement Act  
10 (25 U.S.C. 1601 et seq.), and

11 (G) a State single-payer system approved  
12 by the Secretary under subpart B of part 3 of  
13 subtitle F.

14 (4) ESSENTIAL COMMUNITY PROVIDER.—The  
15 term “essential community provider” means an enti-  
16 ty certified as such a provider under subpart B of  
17 part 2 of subtitle E.

18 (5) HEALTH PLAN SPONSOR.—The term  
19 “health plan sponsor” means—

20 (A) with respect to a community-rated  
21 plan, the carrier providing the plan,

22 (B) with respect to an insured experience-  
23 rated plan, the carrier providing the plan, and

1 (C) with respect to a self-insured experi-  
2 ence-rated plan, the experience-rated employer  
3 providing the plan.

4 (6) MEDICARE PROGRAM.—The term “medicare  
5 program” means the health insurance program  
6 under title XVIII of the Social Security Act.

7 (7) MEDICARE-ELIGIBLE INDIVIDUAL.—The  
8 term “medicare-eligible individual” means an indi-  
9 vidual who is entitled to benefits under part A of the  
10 medicare program.

11 (8) MULTIEMPLOYER PLAN.—The term “multi-  
12 employer plan” has the meaning given such term in  
13 section 3(37) of the Employee Retirement Income  
14 Security Act of 1974, and includes any plan that is  
15 treated as such a plan under title I of such Act.

16 (9) NAIC.—The term “NAIC” means the Na-  
17 tional Association of Insurance Commissioners.

18 (10) PARTICIPATING PROVIDER.—The term  
19 “participating provider” means, with respect to a  
20 health plan, a provider of health care services who  
21 is a member of a provider network of the plan.

22 (11) PARTICIPATING STATE.—The term “par-  
23 ticipating State” means a State establishing a State  
24 program under this title.

1           (12) PURCHASING COOPERATIVE.—The term  
2 “purchasing cooperative” means a health insurance  
3 cooperative established under part 2 of subtitle D.

4           (13) RESIDENCE.—

5           (A) IN GENERAL.—An individual is consid-  
6 ered to reside in the location in which the indi-  
7 vidual maintains a primary residence (as estab-  
8 lished under rules of the Secretary).

9           (B) MULTIPLE RESIDENCES.—Under such  
10 rules and subject to section 1112, in the case  
11 of an individual who maintains more than one  
12 residence, the primary residence of the indi-  
13 vidual shall be determined taking into account  
14 the proportion of time spent at each residence.

15           (C) COUPLE.—In the case of a couple only  
16 one spouse of which is a qualifying employee,  
17 except as the Secretary may provide, the resi-  
18 dence of the employee shall be the residence of  
19 the couple.

20           (14) RURAL ELECTRIC COOPERATIVE.—The  
21 term “rural electric cooperative” has the meaning  
22 given such term in section 3(40)(A)(iv) of the Em-  
23 ployee Retirement Income Security Act of 1974.

24           (15) RURAL TELEPHONE COOPERATIVE ASSO-  
25 CIATIONS.—The term “rural telephone cooperative

1 association” has the meaning given such term in  
 2 section 3(40)(A)(v) of the Employee Retirement In-  
 3 come Security Act of 1974.

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

6 (17) STATE.—The term “State” includes the  
 7 District of Columbia, Puerto Rico, the Virgin Is-  
 8 lands, Guam, American Samoa, and the Northern  
 9 Mariana Islands.

10 (18) UNITED STATES.—The term “United  
 11 States” means the 50 States, the District of Colum-  
 12 bia, Puerto Rico, the Virgin Islands, Guam, Amer-  
 13 ican Samoa, and Northern Mariana Islands.

## 14 **Subtitle B—Health Plan Standards**

### 15 **PART 1—ESTABLISHMENT AND APPLICATION OF**

#### 16 **STANDARDS**

##### 17 **SEC. 1101. ESTABLISHMENT OF NATIONAL STANDARDS.**

18 In order for a standard health plan to be eligible to  
 19 be certified as a standard health plan by a participating  
 20 State, the standard health plan shall meet the require-  
 21 ments of this Act, including the following uniform national  
 22 standards established in this subtitle and described in reg-  
 23 ulations promulgated by the Secretary:

24 (1) The insurance market reform standards of  
 25 part 2.

1           (2) The delivery system reform standards of  
2           part 3.

3           (3) Standards for participation in a guaranty  
4           fund established by the State under section 1505  
5           (established by the Secretary of Labor in the case of  
6           multistate self-insured standard health plans).

7           (4) Standards for the collection and reporting  
8           of data in accordance with subtitle B of title V.

9           (5) Standards for effective grievance procedures  
10          that enrollees may utilize in pursuing complaints in  
11          accordance with subtitle C of title V.

12 **SEC. 1102. GENERAL RULES.**

13          (a) CONSTRUCTION.—Whenever in this subtitle a re-  
14          quirement or standard is imposed on a standard health  
15          plan, the requirement or standard is deemed to have been  
16          imposed on the insurer or sponsor of the plan or policy  
17          in relation to that plan or policy.

18          (b) USE OF INTERIM, FINAL REGULATIONS.—In  
19          order to permit the timely implementation of the provi-  
20          sions of this subtitle, the Secretary and the Secretary of  
21          Labor are each authorized to issue regulations under this  
22          subtitle on an interim basis that become final on the date  
23          of publication, subject to change based on subsequent pub-  
24          lic comment.

1           **PART 2—INSURANCE MARKET REFORM**

2   **SEC. 1111. GUARANTEED ISSUE, AVAILABILITY, AND RE-**  
3                   **NEWABILITY.**

4           (a) **GUARANTEED ISSUE.**—Except as otherwise pro-  
5 vided in this section, a standard health plan sponsor—

6                   (1) offering a community-rated standard health  
7 plan shall offer such plan to any community-rated  
8 individual applying for coverage (either directly with  
9 the plan or through an employer or a purchasing co-  
10 operative); and

11                   (2) offering an experience-rated standard health  
12 plan shall offer such plan to any experience-rated in-  
13 dividual eligible for coverage under the plan through  
14 such individual's experience-rated employer.

15 No plan may engage in any practice that has the effect  
16 of attracting or limiting enrollees on the basis of personal  
17 characteristics, such as occupation or affiliation with any  
18 person or entity, or those characteristics described in sec-  
19 tion 1602.

20           (b) **AVAILABILITY.**—

21                   (1) **IN GENERAL.**—A community-rated standard  
22 health plan shall be made available to community-  
23 rated individuals throughout the entire community  
24 rating area in which such plan is offered, including  
25 through any employer purchasing cooperative choos-  
26 ing to offer such plan.

## 1 (2) GEOGRAPHIC LIMITATIONS.—

2 (A) NONNETWORK PLANS.—A community-  
3 rated nonnetwork plan (as defined in section  
4 1127(d)(2)(A)) may deny coverage under the  
5 plan to a community-rated individual who re-  
6 sides outside the community rating area in  
7 which such plan is offered.

8 (B) NETWORK PLANS.—A community-  
9 rated network plan (as defined in section  
10 1127(e)(5)(A)) may deny coverage under the  
11 plan to a community-rated individual who re-  
12 sides outside the health plan service area in  
13 which such plan is offered.

14 (C) RULES REGARDING DENIALS.—No de-  
15 nial may be made under subparagraph (A) or  
16 (B) unless such denial is applied uniformly,  
17 without regard to health status, insurability of  
18 individuals, or other characteristics described in  
19 section 1602.

## 20 (3) CAPACITY LIMITATIONS.—

21 (A) IN GENERAL.—With the approval of  
22 the appropriate regulatory authority, a stand-  
23 ard health plan may limit enrollment because of  
24 the plan's capacity to deliver services or to  
25 maintain financial stability. If such a limitation

1 is imposed, the limitation may not be imposed  
2 on a basis of personal characteristics, such as  
3 occupation or affiliation with any person or en-  
4 tity, or those characteristics described in section  
5 1602.

6 (B) RESTRICTIONS.—If such a limitation  
7 is imposed—

8 (i) the plan may only enroll individ-  
9 uals under the plan consistent with rules  
10 established by the State consistent with  
11 subparagraph (C); and

12 (ii) the plan may not discriminate  
13 based on the method through which a fam-  
14 ily seeks enrollment under the plan.

15 (C) STATE OVERSIGHT.—Each State shall,  
16 in accordance with rules promulgated by the  
17 Secretary, establish procedures and methods to  
18 assure equal opportunity of enrollment for all  
19 families, regardless of when during the open en-  
20 rollment period, or the method by which, the  
21 enrollment has been sought.

22 (c) RENEWABILITY; LIMITATION ON TERMI-  
23 NATION.—

24 (1) IN GENERAL.—Except as provided in para-  
25 graphs (2) and (3), a standard health plan that is

1 issued to an individual shall be renewed, at the op-  
2 tion of the individual.

3 (2) GROUND FOR REFUSAL TO RENEW OR  
4 TERMINATE.—A standard health plan sponsor may  
5 refuse to renew, or may terminate, a standard health  
6 plan under this title only for—

7 (A) in the case of plan in a participating  
8 State and any community rating area in such  
9 State with respect to which the requirements of  
10 title X have not become effective, nonpayment  
11 of premiums;

12 (B) fraud on the part of the individual re-  
13 lating to such plan; or

14 (C) misrepresentation of material facts on  
15 the part of the individual relating to an applica-  
16 tion for coverage or claim for benefits.

17 (3) TERMINATION OF PLANS.—A standard  
18 health plan may elect not to renew or make available  
19 the standard health plan through a particular type  
20 of delivery system in a community rating area, but  
21 only if the standard health plan—

22 (A) elects not to renew all of its standard  
23 health plans using such delivery system in such  
24 community rating area; and

1           (B) provides notice to the appropriate cer-  
2           tifying authority and each individual covered  
3           under the plan of such termination at least 180  
4           days before the date of expiration of the plan.  
5 In such case, a standard health plan sponsor may not pro-  
6 vide for the issuance of any standard health plan using  
7 such a delivery system in such community rating area dur-  
8 ing a 5-year period beginning on the date of the termi-  
9 nation of the last plan not so renewed. For purposes of  
10 this paragraph, the term “delivery system” means a deliv-  
11 ery system used by a network plan (as defined in section  
12 1128(e)(5)(A)) or a nonnetwork plan.

13           (d) CERTAIN EXCLUDED PLANS.—The provisions of  
14 this section, other than subsections (c) and (e)(2)(B), shall  
15 not apply to any religious fraternal benefit society in exist-  
16 ence as of September 1993, which bears the risk of pro-  
17 viding insurance to its members, and which is an organiza-  
18 tion described in section 501(c)(8) of the Internal Revenue  
19 Code of 1986 which is exempt from taxation under section  
20 501(a) of such Code.

21           (e) APPLICATION OF INTERIM STANDARDS.—

22           (1) IN GENERAL.—During the interim stand-  
23           ards application period, a health plan sponsor may  
24           only offer a health plan in a State if such plan spon-  
25           sor publicly discloses the health plans such sponsor

1 offers in the State and each offered plan meets the  
2 standards specified in paragraph (2).

3 (2) SPECIFIED STANDARDS.—

4 (A) ISSUE AND AVAILABILITY.—The stand-  
5 ards specified in subsections (a) and (b) if the  
6 individual or group applies for coverage during  
7 the open enrollment period required under sec-  
8 tion 1112(h).

9 (B) RENEWAL.—The standards specified  
10 in subsection (c), except paragraph (3) shall be  
11 applied by substituting “State” for “community  
12 rating area”.

13 (3) INTERIM STANDARDS APPLICATION PERI-  
14 ODS.—The interim standards application period is—

15 (A) in the case of the standard specified in  
16 paragraph (2)(A), on or after January 1, 1995,  
17 and before January 1, 1997; and

18 (B) in the case of the standard specified in  
19 paragraph (2)(B), on or after August 1, 1994,  
20 and before January 1, 1997.

21 (4) PREEMPTION.—The requirements of this  
22 subsection do not preempt any State law unless  
23 State law directly conflicts with such requirements.  
24 The provision of additional protections under State  
25 law shall not be considered to directly conflict with

1 such requirements. The Secretary may issue letter  
2 determinations with respect to whether this sub-  
3 section preempts a provision of State law.

4 (5) CONSTRUCTION.—The provisions of this  
5 subsection shall be construed in a manner that  
6 assures, to the greatest extent practicable, continuity  
7 of health benefits under health plans in effect on the  
8 effective date of this title.

9 (6) SPECIAL RULES FOR ACQUISITIONS AND  
10 TRANSFERS.—The Secretary may issue regulations  
11 regarding the application of this subsection in the  
12 case of health plans (or groups of such plans) which  
13 are transferred from one health plan sponsor to an-  
14 other sponsor through assumption, acquisition, or  
15 otherwise.

16 **SEC. 1112. ENROLLMENT.**

17 (a) IN GENERAL.—Each standard health plan shall  
18 establish an enrollment process consistent with this sec-  
19 tion.

20 (b) ANNUAL OPEN ENROLLMENT PERIOD.—Each  
21 standard health plan shall permit eligible individuals to  
22 enroll (or change enrollment) in the plan during each an-  
23 nual open enrollment period for each community rating  
24 area specified by the appropriate certifying authority  
25 under section 1503.

1           (c) ADDITIONAL PERIODS OF AUTHORIZED CHANGES  
2 IN ENROLLMENT.—

3           (1) IN GENERAL.—Each standard health plan  
4 shall provide for changes in enrollment with respect  
5 to such other periods and occurrences (including  
6 changes in residence, appropriate changes in employ-  
7 ment, and the insolvency of carriers or experience-  
8 rated employers) for which an individual is author-  
9 ized to change enrollment in standard health plans,  
10 as the Secretary shall specify.

11           (2) DISENROLLMENT FOR CAUSE.—

12           (A) IN GENERAL.—The Secretary shall es-  
13 tablish procedures by which individuals enrolled  
14 in a standard health plan may disenroll from  
15 such plan for good cause (as defined by Sec-  
16 retary) at any time during a year and enroll in  
17 another standard health plan. Such procedures  
18 shall be implemented by participating States in  
19 a manner that ensures continuity of coverage  
20 for the standard benefits package or the alter-  
21 native standard benefits package for such indi-  
22 viduals during the year.

23           (B) ADDITIONAL REMEDIES.—In the case  
24 of an individual who changes enrollment from a  
25 plan for good cause due to a pattern of under-

1 service under a plan, the Secretary may provide  
2 rules under which the carrier providing the  
3 standard health plan is liable, to the subsequent  
4 standard health plan in which the individual is  
5 enrolled, for excess costs (as identified in ac-  
6 cordance with such rules) during the period for  
7 which it may be reasonably anticipated that the  
8 individual would (but for such cause) have con-  
9 tinued enrollment with the original standard  
10 health plan.

11 (d) EFFECTIVENESS OF CHANGE OF ENROLL-  
12 MENT.—Except as the Secretary may provide, changes in  
13 enrollment during an annual open enrollment period under  
14 subsection (a) shall take effect as determined by the ap-  
15 propriate certifying authority. The Secretary shall also  
16 provide when a change of enrollment under subsection (c)  
17 becomes effective.

18 (e) DIRECT ENROLLMENT.—

19 (1) IN GENERAL.—Subject to paragraph (2),  
20 each community-rated standard health plan shall  
21 provide for the direct enrollment of community-rated  
22 individuals in the plan under methods and proce-  
23 dures established by the Secretary.

24 (2) ENROLLMENT PROCESSES.—The Secretary  
25 shall provide standards for States to ensure the

1 broad availability and processing of enrollment  
2 forms, including direct enrollment through the mail,  
3 and other such processes as the Secretary may des-  
4 ignate.

5 (f) **MARKETING FEES.**—A community-rated standard  
6 health plan may impose a marketing fee surcharge for  
7 community-rated individuals enrolling in the plan through  
8 an agent, broker, or other authorized sales method, or  
9 through a direct enrollment process. Such surcharge shall  
10 be in addition to the highest marketing fee of such plan  
11 for community-rated individuals enrolled in such a plan  
12 through any purchasing cooperative in the community rat-  
13 ing area.

14 (g) **CHANGE OF ENROLLMENT.**—As used in this sec-  
15 tion, the term “change of enrollment” includes, with re-  
16 spect to an individual—

17 (1) a change in the standard health plan in  
18 which the individual is enrolled,

19 (2) a change in the type of family enrollment,  
20 and

21 (3) the enrollment of the individual at the time  
22 the individual’s status changes to a community-rated  
23 individual, experience-rated individual, or a premium  
24 subsidy-eligible individual under section 6002.

25 (h) **APPLICATION OF INTERIM STANDARD.**—

1           (1) IN GENERAL.—During the interim standard  
2 application period, a health plan sponsor may only  
3 offer a health plan in a State if such plan sponsor  
4 publicly discloses the health plans such sponsor of-  
5 fers in the State and each offered plan provides for  
6 an annual open enrollment period of at least 30  
7 days.

8           (2) INTERIM STANDARD APPLICATION PERI-  
9 ODS.—The interim standard application period is on  
10 or after January 1, 1995, and before January 1,  
11 1997.

12           (3) APPLICATION OF RULES.—Paragraphs (4),  
13 (5), and (6) of section 1111(d) shall apply to this  
14 subsection.

15 **SEC. 1113. COVERAGE OF DEPENDENTS.**

16           (a) IN GENERAL.—Except as otherwise provided in  
17 this Act, a standard health plan shall enroll all members  
18 of the same family (as defined in subsection (b)).

19           (b) FAMILY DEFINED.—In this Act, unless otherwise  
20 provided, the term “family”—

21           (1) means, with respect to an individual who is  
22 not a child (as defined in subsection (c)), the indi-  
23 vidual; and

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

25           (A) The individual’s spouse.

1 (B) The individual's children (and, if appli-  
2 cable, the children of the individual's spouse).

3 (c) CLASSES OF ENROLLMENT; TERMINOLOGY.—

4 (1) IN GENERAL.—In this Act, each of the fol-  
5 lowing is a separate class of enrollment:

6 (A) Coverage only of an individual (re-  
7 ferred to in this Act as the “individual” enroll-  
8 ment or class of enrollment).

9 (B) Coverage only of a child (referred to in  
10 this Act as the ‘single child’ enrollment or class  
11 of enrollment).

12 (C) Coverage only of one or more children  
13 (referred to in this Act as the ‘multiple chil-  
14 dren’ enrollment or class of enrollment).

15 (D) Coverage of a married couple without  
16 children (referred to in this Act as the “couple-  
17 only” enrollment or class of enrollment).

18 (E) Coverage of an individual and one or  
19 more children (referred to in this Act as the  
20 “single parent” enrollment or class of enroll-  
21 ment).

22 (F) Coverage of a married couple and one  
23 or more children (referred to in this Act as the  
24 “dual parent” enrollment or class of enroll-  
25 ment).

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

3           (A) FAMILY.—The terms “family enroll-  
4 ment” and “family class of enrollment”, refer  
5 to enrollment in a class of enrollment described  
6 in any subparagraph of paragraph (1) (other  
7 than subparagraph (A)).

8           (B) COUPLE.—The term “couple class of  
9 enrollment” refers to enrollment in a class of  
10 enrollment described in subparagraph (D) or  
11 (F) of paragraph (1).

12 (d) SPOUSE; MARRIED; COUPLE.—

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

18           (2) COUPLE.—The term “couple” means an in-  
19 dividual and the individual’s spouse.

20 (e) CHILD DEFINED.—

21           (1) IN GENERAL.—In this Act, except as other-  
22 wise provided, the term “child” means an individual  
23 who is a child (as determined under paragraph (3))  
24 who—

- 1                   (A) is under 25 years of age or is disabled,  
2                   and  
3                   (B) is unmarried.

4           The Secretary may adjust the age limitation in sub-  
5           paragraph (A) with respect to part-time or full-time  
6           students.

7           (2) APPLICATION OF STATE LAW.—Subject to  
8           paragraph (3), determinations of whether a person  
9           is the child of another person shall be made in ac-  
10          cordance with applicable State law.

11          (3) NATIONAL RULES.—The Secretary may es-  
12          tablish such national rules respecting individuals  
13          who will be treated as children under this Act as the  
14          Secretary determines to be necessary. Such rules  
15          shall be consistent with the following principles:

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

19                (B) DISABLED CHILD.—A child includes  
20                an unmarried dependent individual regardless  
21                of age who is incapable of self-support because  
22                of mental or physical disability which existed  
23                before age 25.

1           (C) CERTAIN INTERGENERATIONAL FAMI-  
2 LIES.—A child includes the grandchild of an in-  
3 dividual if—

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

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

9           (D) TREATMENT OF EMANCIPATED MI-  
10 NORS.—An emancipated minor shall not be  
11 treated as a child.

12           (E) CHILDREN PLACED FOR ADOPTION.—

13           (i) IN GENERAL.—A child includes a  
14 child who is placed for adoption with an in-  
15 dividual, except when the child is a child in  
16 State-supervised care.

17           (ii) PLACED FOR ADOPTION.—The  
18 term “placed for adoption” in connection  
19 with any placement for adoption of a child  
20 with any individual, means the assumption  
21 and retention by such individual of a legal  
22 obligation for total or partial support of  
23 such child in anticipation of the adoption  
24 of such child.

25           (f) ADDITIONAL RULES.—

1           (1) IN GENERAL.—The Secretary shall provide  
2 for such additional exceptions and special rules, in-  
3 cluding rules relating to—

4           (A) families in which members are not re-  
5 siding in the same area or in which children are  
6 not residing with their parents,

7           (B) changes in family composition occur-  
8 ring during a year,

9           (C) treatment of children in State-superv-  
10 ised care, and

11           (D) treatment of children of parents who  
12 are separated or divorced,

13 as the Secretary finds appropriate.

14           (2) CHILDREN IN STATE-SUPERVISED CARE.—

15           (A) IN GENERAL.—In the case of a child  
16 in State-supervised care (as described in sub-  
17 paragraph (B)), the child shall be considered as  
18 a family of one and enrolled by the State agen-  
19 cy who has been awarded temporary or perma-  
20 nent custody of the child (or which has legal re-  
21 sponsibility for the child) in a high cost-sharing  
22 plan unless the State agency has established a  
23 special health service delivery system designated  
24 to customize and more efficiently provide health  
25 services to children in State-supervised care, in

1           which case the State agency will enroll the child  
2           in the plan appropriate to ensure access to such  
3           a special health service delivery system.

4           (B) CHILDREN IN STATE-SUPERVISED  
5           CARE.—For purposes of subparagraph (A), the  
6           term “child in State-supervised care” means  
7           any child who is residing away from the child’s  
8           parents and is temporarily or permanently, on  
9           a voluntary or involuntary basis, under the re-  
10          sponsibility of a public child welfare or juvenile  
11          services agency or court. Such term includes  
12          any child who is not yet made a ward of the  
13          court or adjudicated as a delinquent residing in  
14          emergency shelter care, any child in the phys-  
15          ical custody of public or private agencies, and  
16          any child who is with foster parents, or other  
17          group or residential care providers. Such term  
18          also includes any child who is legally adopted  
19          and for whom the Federal or State government  
20          is providing adoption assistance payments.

21          (g) APPLICATION OF INTERIM STANDARDS.—

22               (1) IN GENERAL.—During the interim stand-  
23          ards application period, a health plan sponsor may  
24          only offer a health plan in a State if such plan meets  
25          the standards specified in this section.



1           (4) impose waiting periods before coverage be-  
2           gins; or

3           (5) impose a rider that serves to exclude cov-  
4           erage of particular individuals or particular health  
5           conditions.

6           (b) TREATMENT OF PREEXISTING CONDITION EX-  
7           CLUSIONS.—

8           (1) IN GENERAL.—Subject to paragraph (4),  
9           before January 1, 2002, a standard health plan may  
10          impose a limitation or exclusion of benefits relating  
11          to treatment of a condition based on the fact that  
12          the condition preexisted the effective date of the  
13          plan with respect to an individual if—

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

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

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

23                (D) the limitation or exclusion does not re-  
24                late to pregnancy.

1           (2) CONTINUOUS COVERAGE.—A standard  
2 health plan shall provide that if an individual under  
3 such plan is in a period of continuous coverage with  
4 respect to particular services as of the date of enroll-  
5 ment under such plan, any period of exclusion of  
6 coverage with respect to a preexisting condition as  
7 permitted under paragraph (1) shall be prohibited.

8           (3) DEFINITIONS.—As used in this subsection:

9           (A) PERIOD OF CONTINUOUS COVERAGE.—

10           The term “period of continuous coverage”  
11 means, with respect to particular services, the  
12 period beginning on the date an individual is  
13 enrolled under a standard health plan or an  
14 equivalent health care program which provides  
15 benefits with respect to such services and ends  
16 on the date the individual is not so enrolled for  
17 a continuous period of more than 3 months.

18           (B) PREEXISTING CONDITION.—The term  
19 “preexisting condition” means, with respect to  
20 coverage under a standard health plan, a condi-  
21 tion which was diagnosed, or which was treated,  
22 within the 3-month period ending on the day  
23 before the first date of such coverage (without  
24 regard to any waiting period).

1           (4) NO EXCLUSION DURING AMNESTY PERIOD  
2 OR WITH RESPECT TO A SUBSIDY-ELIGIBLE INDI-  
3 VIDUAL.—This subsection shall not apply—

4           (A) during the first annual open enroll-  
5 ment period specified by the appropriate certi-  
6 fying authority under section 1503, and

7           (B) with respect to the enrollment of an  
8 individual eligible for a premium subsidy under  
9 subtitle A of title VI.

10 (c) APPLICATION OF INTERIM STANDARD.—

11           (1) IN GENERAL.—During the interim standard  
12 application period, a health plan sponsor may only  
13 offer a health plan in a State if such plan meets the  
14 standard specified in paragraph (2).

15           (2) SPECIFIED STANDARDS.—

16           (A) EXCLUSION.—The standards specified  
17 in subsection (b) by substituting—

18           (i) “6-month” for “3-month” in para-  
19 graph (1)(A), and

20           (ii) “major medical insurance plan or  
21 other plan offering coverage similar to the  
22 benefits included in the standard benefits  
23 package as established under subtitle C”  
24 for “standard health plan”.

1           (B) COVERAGE.—A self-insured health  
2 plan may not reduce or limit coverage of any  
3 condition or course of treatment that is ex-  
4 pected to cost more than \$2,500 during any 12-  
5 month period.

6           (3) INTERIM STANDARDS APPLICATION PE-  
7 RIOD.—The interim standards application period  
8 is—

9           (A) in the case of the standard specified in  
10 paragraph (2)(A), on or after January 1, 1995,  
11 and before January 1, 1997, and

12           (B) in the case of the standard specified in  
13 paragraph (2)(B), on or after August 1, 1994,  
14 and before January 1, 1997.

15           (4) APPLICATION OF RULES.—Paragraphs (4),  
16 (5), and (6) of section 1111(e) shall apply to this  
17 subsection.

18 **SEC. 1115. BENEFITS.**

19           (a) IN GENERAL.—A standard health plan shall offer  
20 to all enrollees in the plan the standard benefits package  
21 or the alternative standard benefits package established  
22 under subtitle C.

23           (b) ALTERNATIVE STANDARD BENEFITS PACK-  
24 AGE.—

1           (1) IN GENERAL.—A carrier may only offer a  
2           standard health plan with an alternative standard  
3           benefits package in a community rating area if such  
4           carrier also offers a standard health plan with a  
5           standard benefits package in such area.

6           (2) INCLUSION IN RISK ADJUSTMENT AND RE-  
7           INSURANCE PROGRAMS.—Any standard health plan  
8           with an alternative standard benefits packages shall  
9           be included in any reinsurance or risk adjustment  
10          program under section 1117 operating in the com-  
11          munity rating area in which such plan is offered.

12          (3) OFFER PROHIBITED IF MANDATES RE-  
13          QUIRED.—A carrier may not offer an alternative  
14          benefits package in a participating State and any  
15          community rating area in such State with respect to  
16          which the requirements of title X have become effec-  
17          tive.

18 **SEC. 1116. COMMUNITY RATING REQUIREMENTS.**

19          (a) APPLICABILITY.—Except as provided in sub-  
20          section (e), the provisions of this section shall apply to  
21          community-rated standard health plans.

22          (b) STANDARD PREMIUMS WITH RESPECT TO COM-  
23          MUNITY-RATED INDIVIDUALS.—Subject to subsection (d),  
24          each community-rated standard health plan shall establish  
25          within each community rating area in which the plan is

1 to be offered a standard premium for individual enroll-  
2 ment for the standard benefits package and the alternative  
3 standard benefits package established under subtitle C.

4 (c) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-  
5 ING AREAS.—

6 (1) IN GENERAL.—Subject to paragraph (2),  
7 the standard premium described in subsection (b)  
8 for all community-rated individuals within a commu-  
9 nity rating area shall be the same.

10 (2) APPLICATION TO ENROLLEES.—

11 (A) IN GENERAL.—The premium charged  
12 for coverage in a standard health plan shall be  
13 the product of—

14 (i) the standard premium (established  
15 under paragraph (1));

16 (ii) in the case of enrollment other  
17 than individual enrollment, the family ad-  
18 justment factor specified under subpara-  
19 graph (B); and

20 (iii) the age adjustment factor (speci-  
21 fied under subparagraph (C)).

22 (B) FAMILY ADJUSTMENT FACTOR.—The  
23 Secretary, in consultation with the NAIC, shall  
24 develop a family adjustment factor that reflects  
25 the relative actuarial costs of benefit packages

1 based on the applicable family enrollment (as  
2 compared with such costs for individual enroll-  
3 ment).

4 (C) AGE ADJUSTMENT FACTOR.—The Sec-  
5 retary, in consultation with the NAIC, shall  
6 specify, within 6 months of the date of the en-  
7 actment of this Act, uniform age categories and  
8 rating increments for age adjustment factors  
9 that reflect the relative actuarial costs of ben-  
10 efit packages among enrollees. The highest age  
11 adjustment factor may not exceed twice the  
12 lowest age adjustment factor for individuals 18  
13 to 65 years of age. The Secretary shall also  
14 provide for the gradual phaseout of age adjust-  
15 ment factors by January 1, 2002.

16 (d) LOWER PREMIUM THROUGH PURCHASING CO-  
17 OPERATIVES.—Notwithstanding any other provision of  
18 this section, no premium may be charged to a community-  
19 rated individual by a community-rated standard health  
20 plan in a community rating area which is not the same  
21 premium negotiated for such plan offered through any  
22 purchasing cooperative in such area.

23 (e) EXPERIENCE RATING.—

1           (1) APPLICABILITY.—The provisions of this  
2 subsection shall apply to experience-rated standard  
3 health plans.

4           (2) RATING.—For purposes of applying this  
5 section to experience-rated employers, the employees  
6 of the employer involved shall constitute the commu-  
7 nity with respect to the determination of the pre-  
8 mium.

9           (3) PREMIUMS.—An experience-rated standard  
10 health plan may not vary the premium imposed with  
11 respect to experience-rated individuals enrolled in  
12 the plan, except as may be allowed under this sec-  
13 tion with respect to geographic and family coverage  
14 factors (as determined by the Secretary of Labor)  
15 under the plan.

16 **SEC. 1117. RISK ADJUSTMENT AND REINSURANCE.**

17           (a) IN GENERAL.—Except as provided in subsection  
18 (b), each standard health plan shall participate in a stand-  
19 ard health plan risk adjustment program and a reinsur-  
20 ance program implemented by the State in accordance  
21 with section 1504.

22           (b) MULTISTATE PLANS.—Each multistate self-in-  
23 sured standard health plan shall participate in a reinsur-  
24 ance program developed by the Secretary of Labor under  
25 section 1482.

1 **SEC. 1118. FINANCIAL SOLVENCY REQUIREMENTS AND**  
2 **CONSUMER PROTECTION AGAINST PRO-**  
3 **VIDER CLAIMS.**

4 (a) SOLVENCY PROTECTION.—Each standard health  
5 plan shall meet financial solvency requirements to assure  
6 protection of enrollees with respect to potential insolvency.  
7 Each standard health plan shall meet requirements relat-  
8 ing to capital and solvency established by the Secretary  
9 under section 1401(h).

10 (b) PROTECTION AGAINST PROVIDER CLAIMS.—In  
11 the case of a failure of a standard health plan to make  
12 payments with respect to the standard benefits covered  
13 under the plan for any reason, an individual who is en-  
14 rolled under the plan is not liable to any health care pro-  
15 vider with respect to the provision of health services within  
16 such set of benefits for payments in excess of the amount  
17 for which the enrollee would have been liable if the plan  
18 were to have made payments in a timely manner.

19 **PART 3—DELIVERY SYSTEM REFORM**

20 **SEC. 1121. PROHIBITION OF DISCRIMINATION.**

21 (a) IN GENERAL.—Each standard health plan shall  
22 comply with the antidiscrimination requirements of section  
23 1602.

24 (b) ADDITIONAL ANTIDISCRIMINATION REQUIRE-  
25 MENTS.—

1           (1) IN GENERAL.—No standard health plan  
2           may discriminate on the basis of the provider’s sta-  
3           tus as a member of a health care profession for the  
4           purposes of selecting among providers of health serv-  
5           ices for participation in a provider network, but only  
6           if the State authorizes members of that profession to  
7           render the services in question and such services are  
8           covered in the standard benefits package established  
9           under subtitle C.

10          (2) RULE OF CONSTRUCTION.—Nothing in  
11          paragraph (1)(B) shall be construed as requiring  
12          any standard health plan to:

13                 (A) include in a network any individual  
14                 provider;

15                 (B) establish any defined ratio of different  
16                 categories of health professionals; or

17                 (C) establish any specific utilization review  
18                 or internal quality standards other than that re-  
19                 quired in other provisions of this Act.

20 **SEC. 1122. QUALITY ASSURANCE STANDARDS.**

21          (a) IN GENERAL.—Each standard health plan shall  
22          comply with the plan performance standards in accordance  
23          with subtitle A of title V. Each standard health plan shall  
24          establish procedures, including ongoing quality improve-  
25          ment procedures, to ensure that the health care services

1 provided to enrollees under the plan will be provided under  
2 reasonable standards of quality of care consistent with  
3 prevailing professionally recognized standards of medical  
4 practice and the quality standards established under sub-  
5 title A of title V.

6 (b) INTERNAL QUALITY ASSURANCE PROGRAM.—  
7 Each standard health plan shall establish, and commu-  
8 nicate to its enrollees and its providers, an ongoing inter-  
9 nal program, including periodic reporting, to monitor and  
10 evaluate the quality and cost effectiveness of its health  
11 care services, pursuant to standards established by the  
12 National Quality Council.

13 **SEC. 1123. CONSUMER GRIEVANCE PROCESS.**

14 Each standard health plan shall demonstrate to the  
15 appropriate certifying authority the capability to admin-  
16 ister the plan in a manner which ensures due process for  
17 all enrollees under rules established by the Secretary.

18 **SEC. 1124. HEALTH SECURITY CARDS.**

19 Each standard health plan shall issue a health secu-  
20 rity card to each individual enrolled in such plan in accord-  
21 ance with subtitle B of title V and regulations promul-  
22 gated by the Secretary.

23 **SEC. 1125. INFORMATION AND MARKETING STANDARDS.**

24 (a) IN GENERAL.—Each standard health plan shall  
25 provide information to the participating State and each

1 purchasing cooperative through which such plan is offered  
2 in accordance with sections 1401(d) and 5009, other ap-  
3 plicable information requirements of this Act, and rules  
4 promulgated by the Secretary.

5 (b) **MARKETING METHODS; ADVERTISING MATE-**  
6 **RIALS.**—A standard health plan may utilize direct mar-  
7 keting, agency, or other arrangements to distribute health  
8 plan information, subject to applicable fair marketing  
9 practices laws and standards established by the State or  
10 by the Secretary, including standards to prevent selective  
11 marketing. All advertising, promotional materials, and  
12 other communications with health plan members and the  
13 general public must be factually accurate and responsive  
14 to the needs of served populations. A standard health plan  
15 may not distribute marketing materials to an area smaller  
16 than the entire community rating area of the plan.

17 (c) **PAYMENT OF AGENT COMMISSIONS.**—A standard  
18 health plan—

19 (1) may pay a commission or other remunera-  
20 tion to an agent or broker in marketing the plan to  
21 individuals or groups, but

22 (2) may not vary such remuneration based, di-  
23 rectly or indirectly, on the anticipated or actual  
24 claims experience associated with the group or indi-  
25 viduals to which the plan was sold.

1 (d) MATERIALS IN APPROPRIATE LANGUAGES.—In  
2 the case of a community rating area that includes a sig-  
3 nificant number or proportion of residents with limited  
4 English proficiency, each standard health plan in such  
5 area shall provide all materials under this Act at an appro-  
6 priate reading level and in the native languages of such  
7 residents, as appropriate.

8 **SEC. 1126. INFORMATION REGARDING A PATIENT'S RIGHT**  
9 **TO SELF-DETERMINATION IN HEALTH CARE**  
10 **SERVICES.**

11 (a) IN GENERAL.—Each standard health plan shall  
12 provide written information to each individual enrolling in  
13 such plan of such individual's right under State law  
14 (whether statutory or as recognized by the courts of the  
15 State) to make decisions concerning medical care, includ-  
16 ing the right to accept or refuse medical treatment and  
17 the right to formulate advance directives (as defined in  
18 section 1866(f)(3) of the Social Security Act (42 U.S.C.  
19 1395cc(f)(3))), and the written policies of the standard  
20 health plan with respect to such right.

21 (b) PROMOTION OF SHARED DECISION MAKING.—  
22 Each standard health plan shall promote shared decision  
23 making by assuring that patients are appropriately in-  
24 formed about health care treatment options.

1 **SEC. 1127. CONTRACTS WITH PURCHASING COOPERATIVES.**

2 (a) **CONTRACTS WITH COOPERATIVES.**—A commu-  
3 nity-rated standard health plan provided by a carrier shall  
4 enter into contracts with each purchasing cooperative  
5 seeking such a contract in the community rating area  
6 served by the plan.

7 (b) **PRICING.**—No community-rated standard health  
8 plan shall offer a rate to a purchasing cooperative in the  
9 community rating area served by the plan that is more  
10 than the premium rate determined under section 1116.  
11 Such a plan may charge a marketing fee as specified  
12 under section 1324(b)(1).

13 **SEC. 1128. HEALTH PLAN ARRANGEMENTS WITH PRO-**  
14 **VIDERS.**

15 (a) **PROVIDERS OUTSIDE AREA.**—A State may not  
16 limit the ability of any plan to contract with a provider  
17 of health services located outside of the geographic bound-  
18 aries of a community rating area or the State.

19 (b) **TREATMENT OF COST-SHARING.**—Each standard  
20 health plan which provides the standard benefits package  
21 shall include in its payments to providers such additional  
22 reimbursements as may be necessary to reflect cost-shar-  
23 ing reductions to which individuals are entitled under sub-  
24 title A of title VI.

25 (c) **PROVIDER VERIFICATION.**—Each standard health  
26 plan shall ensure that all health care providers reimbursed

1 by the plan are authorized under State law to provide ap-  
2 plicable services. Each standard health plan shall—

3 (1) verify the credentials of practitioners and  
4 facilities;

5 (2) ensure that all providers meet applicable  
6 State licensing and certification standards;

7 (3) ensure that each health care provider par-  
8 ticipating in the plan annually discloses information  
9 regarding operations, ownership, finances, and work-  
10 force necessary to evaluate the providers compliance  
11 with this Act;

12 (4) oversee the quality and performance of par-  
13 ticipating providers, consistent with section 1122;  
14 and

15 (5) investigate and resolve consumer complaints  
16 against participating providers.

17 (d) REQUIREMENTS FOR NONNETWORK PLANS.—

18 (1) IN GENERAL.—Each standard health plan  
19 shall demonstrate, based on standards established by  
20 the Secretary, arrangements with a sufficient num-  
21 ber, distribution, and variety of qualified health pro-  
22 fessionals that will accept the plan's payment rates  
23 in full to ensure that all nonnetwork items and serv-  
24 ices covered by the standard benefits package estab-  
25 lished under subtitle C are available and accessible

1 to all enrollees throughout the community rating  
2 area with reasonable promptness and in a manner  
3 which assures continuity.

4 (2) DEFINITIONS RELATING TO NONNETWORK  
5 PLANS.—For purposes of this Act:

6 (A) NONNETWORK PLAN DEFINED.—The  
7 term “nonnetwork plan” means a standard  
8 health plan that does not utilize a provider net-  
9 work (as defined in subsection (e)(5)(B)).

10 (B) NONNETWORK ITEMS AND SERV-  
11 ICES.—The term “nonnetwork items and serv-  
12 ices” means items or services provided to an in-  
13 dividual enrolled under a standard health plan  
14 by a health care provider who is not a member  
15 of a provider network of the plan.

16 (e) REQUIREMENTS FOR NETWORK PLANS.—

17 (1) AGREEMENTS.—Each standard health plan  
18 shall enter into agreements or have such other ar-  
19 rangements with a sufficient number, distribution,  
20 and variety of qualified health professionals within  
21 the network that will accept the plan’s payment  
22 rates as payments in full to ensure that all services  
23 covered by the standard benefit package established  
24 under subtitle C are available and accessible to all  
25 enrollees throughout the health plan service area (es-

1        tablished under section 1502(d)) with reasonable  
2        promptness and in a manner which assure con-  
3        tinuity.

4            (2) GATEKEEPER.—With respect to each stand-  
5        ard health plan that utilizes a gatekeeper or similar  
6        process to approve health care services, such plan  
7        shall ensure that such gatekeeper or process does  
8        not create an undue burden for enrollees with com-  
9        plex or chronic health conditions and shall ensure  
10       access to relevant specialists for the continued care  
11       of such enrollees when medically indicated. In cases  
12       of a patient with a severe, complex, or chronic health  
13       condition, such plan shall determine, in conjunction  
14       with the enrollee and the enrollee’s primary care  
15       provider, whether it is medically necessary or appro-  
16       priate to use a specialist or a care coordinator from  
17       an interdisciplinary team as the gatekeeper or in the  
18       health care approval process.

19            (3) CONTINUED CARE.—Each standard health  
20        plan shall develop and implement mechanisms for  
21        coordinating the delivery of care among different  
22        providers so as to enhance continuity of care for the  
23        patient.

24            (4) ELIGIBLE CENTERS OF SPECIALIZED  
25        TREATMENT EXPERTISE.—

1           (A) IN GENERAL.—Each standard health  
2 plan must demonstrate that adults, children,  
3 and individuals with disabilities have access to  
4 specialized treatment expertise when medically  
5 indicated by meeting evaluation criteria estab-  
6 lished by the Secretary. In establishing such  
7 criteria, the Secretary may consider a process  
8 by which a standard health plan could be  
9 deemed to meet such evaluation criteria if such  
10 plan demonstrates referrals to designated cen-  
11 ters of specialized care when medically nec-  
12 essary or appropriate, informs enrollees of the  
13 availability of referral care, and ensures compli-  
14 ance with section 1123.

15           (B) ELIGIBLE CENTERS.—The Secretary  
16 shall establish criteria for designating centers of  
17 specialized care and shall designate eligible cen-  
18 ters based on such criteria. The criteria shall  
19 include requirements for staff credentials and  
20 experience, and requirements for measured out-  
21 comes in the diagnosis and treatment of pa-  
22 tients. The Secretary shall develop additional  
23 criteria for outcomes of specialized treatment as  
24 research findings become available. To be des-

1           ignated as a center of specialized care, a center  
2 shall—

3                   (i) attract patients from outside the  
4                   center's local geographic region, from  
5                   across the State or the Nation; and

6                   (ii) either sponsor, participate in, or  
7                   have medical staff who participate in peer-  
8                   reviewed research.

9           (C) LIMITATION.—A State may not estab-  
10           lish rules or policies that require or encourage  
11           standard health plans to give preference to cen-  
12           ters of specialized treatment expertise within  
13           the State or within the community rating area.  
14           A standard health plan shall not prohibit an  
15           academic health center, teaching hospital, or  
16           other center for specialized care with which it  
17           contracts from contracting with one or more  
18           other plans.

19           (D) SPECIALIZED TREATMENT EXPER-  
20           TISE.—For purposes of this paragraph, the  
21           term “specialized treatment expertise”, with re-  
22           spect to the treatment of a health condition by  
23           an eligible center, means expertise in diagnosing  
24           and treating unusual diseases or conditions, di-  
25           agnosing and treating diseases or conditions

1           which are unusually difficult to diagnose or  
2           treat, and providing other specialized health  
3           care.

4           (5) DEFINITIONS RELATING TO NETWORK  
5           PLANS.—For purposes of this Act:

6                   (A) NETWORK PLAN DEFINED.—The term  
7                   “network plan” means a standard health plan  
8                   that utilizes a provider network.

9                   (B) PROVIDER NETWORK DEFINED.—The  
10                   term “provider network” means, with respect to  
11                   a standard health plan, providers that have en-  
12                   tered into an agreement with the plan under  
13                   which such providers are obligated to provide  
14                   items and services in the standard benefits  
15                   package established under subtitle C to individ-  
16                   uals enrolled in the plan, or have an agreement  
17                   to provide services on a fee-for-service basis.

18                   (C) NETWORK ITEMS AND SERVICES.—The  
19                   term “network items and services” means items  
20                   or services provided to an individual enrolled  
21                   under a standard health plan by a health care  
22                   provider who is a member of a provider network  
23                   of the plan.

24           (f) EMERGENCY AND URGENT CARE SERVICES.—

1           (1) IN GENERAL.—Each standard health plan  
2 shall cover emergency and urgent care services pro-  
3 vided to enrollees, without regard to whether or not  
4 the provider furnishing such services has a contrac-  
5 tual (or other) arrangement with the plan to provide  
6 items or services to enrollees of the plan and in the  
7 case of emergency services without regard to prior  
8 authorization.

9           (2) PAYMENT AMOUNTS.—In the case of emer-  
10 gency and urgent care provided to an enrollee out-  
11 side of a standard health plan’s community rating  
12 area, the payment amounts of the plan shall be  
13 based on the applicable fee schedule described in  
14 subsection (g).

15 (g) APPLICATION OF PLAN FEE SCHEDULE.—

16           (1) IN GENERAL.—Subject to paragraph (2),  
17 each standard health plan that provides for payment  
18 for services on a fee-for-service basis and has not es-  
19 tablished an agreement or contractual arrangement  
20 with providers specifying a basis for payment shall  
21 make such payment to such providers under a fee  
22 schedule established by the plan.

23           (2) RULE OF CONSTRUCTION.—Nothing in the  
24 paragraph (1) shall be construed to prevent a stand-  
25 ard health plan from providing for a different basis

1 or level of payment than the fee schedule established  
2 under such paragraph as part of a contractual  
3 agreement with participating providers under the  
4 plan.

5 (h) PHYSICIAN PARTICIPATION PROGRAM; REQUIRE-  
6 MENT OF DIRECT BILLING.—

7 (1) PHYSICIAN PARTICIPATION PROGRAM.—

8 (A) IN GENERAL.—Each standard health  
9 plan shall establish a program under which par-  
10 ticipating physicians shall agree to accept the  
11 plan's payment schedule as payment in full, and  
12 agree not to charge patients more than the  
13 cost-sharing required by such plan. Each such  
14 plan shall make available the list of partici-  
15 pating physicians to enrollees and prospective  
16 enrollees.

17 (B) COVERAGE UNDER AGREEMENTS WITH  
18 PLANS.—The agreements or other arrange-  
19 ments entered into under subsection (e)(1) be-  
20 tween a standard health plan and the health  
21 care providers providing the standard benefits  
22 package established under subtitle C to individ-  
23 uals enrolled with the plan shall prohibit a pro-  
24 vider from engaging in balance billing described  
25 in subparagraph (A).

1 (2) DIRECT BILLING.—

2 (A) IN GENERAL.—A provider may not  
3 charge or collect from an enrollee amounts that  
4 are payable by the standard health plan (includ-  
5 ing any cost-sharing reduction assistance pay-  
6 able by the plan) and shall submit charges to  
7 such plan in accordance with any applicable re-  
8 quirements of subtitle B of title V (relating to  
9 health information systems).

10 (B) PROHIBITION.—An individual or entity  
11 that performs clinical laboratory services may  
12 not present or cause to be presented, a claim,  
13 bill, or demand for payment to any person other  
14 than the individual receiving such services, or to  
15 the standard health plan of the individual, ex-  
16 cept that the Secretary may by regulation es-  
17 tablish appropriate exceptions to the require-  
18 ment of this subparagraph.

19 (3) PROHIBITION OF BALANCE BILLING OF  
20 TAXES.—Any agreement entered into between a  
21 standard health plan and a provider shall prohibit  
22 the provider from charging patients the amount of  
23 any tax recovered from the provider under section  
24 4518 of the Internal Revenue Code of 1986.

1           (4) RULE OF CONSTRUCTION.—Nothing in this  
2 Act shall be construed to—

3           (A) require or force an individual to re-  
4 ceive health care solely through the individual’s  
5 standard health plan; or

6           (B) prohibit any individual from privately  
7 contracting with any health care provider and  
8 paying for the treatment or service provider by  
9 such provider on a cash basis or any other basis  
10 as agreed to between the individual and the  
11 provider.

12       (i) RELATION TO DETENTION.—A standard health  
13 plan is not required to provide any reimbursement to any  
14 detention facility for services performed in that facility for  
15 detainees in the facility.

16 **SEC. 1129. UTILIZATION MANAGEMENT PROTOCOLS AND**  
17 **PHYSICIAN INCENTIVE PLANS.**

18       (a) REQUIRING CONSUMER DISCLOSURE.—Each  
19 standard health plan shall disclose upon request to enroll-  
20 ees (and prospective enrollees) and to participating pro-  
21 viders (and prospective providers), the protocols and fi-  
22 nancial incentives used by the plan, including utilization  
23 management protocols and physician incentive plans for  
24 controlling utilization and costs, while protecting propri-

1 etary business information to the extent specified by the  
2 Secretary.

3 (b) UTILIZATION MANAGEMENT.—The utilization re-  
4 view and management activities of each standard health  
5 plan, provided either directly or through contract, shall  
6 meet the following standards as defined by the Secretary:

7 (1) PERSONNEL.—All review determinations  
8 shall be made by health professionals who are li-  
9 censed, certified, or otherwise credentialed and who  
10 are qualified to review utilization of the treatment  
11 being sought.

12 (2) REVIEW PROCESS.—Each standard health  
13 plan shall base utilization management on current  
14 scientific knowledge, stress the efficient delivery of  
15 health care and quality outcomes, rely primarily on  
16 evaluating and comparing practice patterns rather  
17 than routine case-by-case review, be consistent and  
18 timely in application, and have a process for making  
19 review determinations for urgent and emergency  
20 care 24 hours a day.

21 (3) NO FINANCIAL INCENTIVE.—Utilization  
22 management by each standard health plan may not  
23 create financial incentives for reviewers or providers  
24 to reduce or limit medically necessary or appropriate  
25 services.

1 (c) PHYSICIAN INCENTIVE PLANS.—A standard  
 2 health plan may not operate a physician incentive plan un-  
 3 less such incentive plan meets the requirements of section  
 4 1876(i)(8)(A) of the Social Security Act (42 U.S.C.  
 5 1395mm(i)(8)(A)).

6 **PART 4—SUPPLEMENTAL HEALTH BENEFITS**  
 7 **PLANS**

8 **SEC. 1141. SUPPLEMENTAL HEALTH BENEFITS PLANS.**

9 (a) TREATMENT OF SUPPLEMENTAL HEALTH BENE-  
 10 FITS PLANS.—

11 (1) IN GENERAL.—Nothing in this Act may be  
 12 construed as preventing a standard health plan  
 13 sponsor from offering and pricing (in a manner that  
 14 is separate from the offering and pricing of the  
 15 standard health plans offered by such sponsor in the  
 16 community rating area) supplemental health benefits  
 17 plans pursuant to the State certification plan, the  
 18 requirements of this section, and regulations promul-  
 19 gated by the Secretary.

20 (2) PLANS DEFINED.—In this Act:

21 (A) SUPPLEMENTAL HEALTH BENEFITS  
 22 PLAN.—The term “supplemental health benefits  
 23 plan” means a supplemental services plan or a  
 24 cost-sharing plan.

1 (B) SUPPLEMENTAL SERVICES PLAN.—

2 The term “supplemental services plan” means a  
3 health plan which provides—

4 (i) coverage for services and items not  
5 included in the standard benefits package  
6 established under subtitle C,

7 (ii) coverage for items and services in-  
8 cluded in such package but not covered be-  
9 cause of a limitation in amount, duration,  
10 or scope of benefits, or

11 (iii) both.

12 (C) COST-SHARING PLAN.—The term  
13 “cost-sharing plan” means a health plan which  
14 provides coverage for deductibles and coinsur-  
15 ance imposed as part of the standard benefits  
16 package established under subtitle C.

17 (b) REQUIREMENTS FOR SUPPLEMENTAL SERVICES  
18 PLANS.—

19 (1) APPLICATION OF CERTAIN HEALTH PLAN  
20 STANDARDS.—

21 (A) IN GENERAL.—The standards specified  
22 in subparagraph (B) shall apply with respect to  
23 each supplemental services plan in the same  
24 manner as such standards apply with respect to  
25 a certified standard health plan.

1 (B) SPECIFIED STANDARDS.—The stand-  
2 ards specified in this subparagraph are as fol-  
3 lows:

4 (i) Section 1111 (relating to guaran-  
5 teed issue, availability, and renewability).

6 (ii) Section 1112 (relating to enroll-  
7 ment).

8 (iii) Section 1114 (relating to non-  
9 discrimination based on health status).

10 (iv) Section 1116 (relating to rating  
11 limitations for community-rated market).

12 (2) NO DUPLICATIVE HEALTH BENEFITS.—A  
13 standard health plan sponsor or any other entity  
14 may not offer any supplemental services plan that—

15 (A) duplicates the standard benefits pack-  
16 age established under subtitle C, or

17 (B) duplicates any coverage provided under  
18 the medicare program to any medicare-eligible  
19 individual.

20 (3) RESTRICTIONS ON MARKETING ABUSES.—

21 Not later than May 1, 1995, the Secretary shall de-  
22 velop minimum standards that prohibit marketing  
23 practices by standard health plan sponsors and other  
24 entities offering supplemental services plans that in-  
25 volve—

1 (A) providing monetary incentives for, or  
2 tying or otherwise conditioning, the sale of the  
3 plan to enrollees in a certified standard health  
4 plan of the sponsor or entity;

5 (B) linking in any manner to the plan's  
6 standard benefits package; or

7 (C) using or disclosing to any party infor-  
8 mation about the health status or claims experi-  
9 ence of participants in a certified standard  
10 health plan for the purpose of marketing a sup-  
11 plemental services plan.

12 (c) REQUIREMENTS FOR COST-SHARING PLANS.—

13 (1) RULES FOR OFFERING OF POLICIES.—A  
14 cost-sharing plan may be offered to an individual  
15 only if—

16 (A) the plan is offered by the standard  
17 health plan in which the individual is enrolled;

18 (B) the standard health plan offers the  
19 plan to all individuals enrolled in the standard  
20 health plan;

21 (C) the individual is not enrolled in an al-  
22 ternative benefits package; and

23 (D) the plan is offered only during the en-  
24 rollment periods for standard health plans spec-  
25 ified in section 1112.

1           (2) PROHIBITION OF COVERAGE OF COPAY-  
2           MENTS.—A cost-sharing plan may not provide any  
3           benefits relating to any copayments established  
4           under subtitle C.

5           (3) EQUIVALENT COVERAGE FOR ALL SERV-  
6           ICES.—A cost-sharing plan shall provide coverage  
7           for items and services in the standard benefits pack-  
8           age to the same extent as the plan provides coverage  
9           for all items and services in the package.

10          (4) REQUIREMENTS FOR PRICING.—

11           (A) IN GENERAL.—The price of any cost-  
12           sharing plan shall—

13                   (i) be the same for each individual or  
14                   class of family to whom the plan is offered;

15                   (ii) include any expected increase in  
16                   utilization resulting from the purchase of  
17                   the plan by individuals enrolled in the  
18                   standard health plan; and

19                   (iii) not result in a loss-ratio of less  
20                   than 90 percent.

21           (B) LOSS-RATIO DEFINED.—In subpara-  
22           graph (A)(iii), a “loss-ratio” is the ratio of the  
23           premium returned to the consumer in payout  
24           relative to the total premium collected.

1           **Subtitle C—Benefits and Cost-**  
2                                   **Sharing**

3           **PART 1—STANDARD BENEFITS PACKAGES**

4   **SEC. 1201. GENERAL DESCRIPTION OF STANDARD BENE-**  
5                                   **FITS PACKAGES.**

6           (a) STANDARD BENEFITS PACKAGE.—For purposes  
7 of this title, a standard benefits package is a benefits  
8 package that—

9                   (1)(A) provides all of the items and services  
10           under the categories of health care items and serv-  
11           ices described in section 1202; and

12                   (B) provides for at least one of the 3 cost-shar-  
13           ing schedules established under section 1213(c)(2)  
14           by the National Health Benefits Board established  
15           under section 1211 (referred to in this part as the  
16           “Board”) for such a package; and

17                   (2) has an actuarial value that is equivalent to  
18           the actuarial value of the benefits package provided  
19           by the Blue Cross/Blue Shield Standard Option  
20           under the Federal Employees Health Benefits Pro-  
21           gram as in effect during 1994, adjusted for an aver-  
22           age population and adjusted for the particular cost-  
23           sharing schedule provided for in the package.

1 (b) ALTERNATIVE STANDARD BENEFITS PACK-  
 2 AGE.—For purposes of this title, an alternative standard  
 3 benefits package is a benefits package that—

4 (1)(A) provides all of the items and services  
 5 under the categories of health care items and serv-  
 6 ices described in section 1202; and

7 (B) provides for the very high deductible cost-  
 8 sharing schedule established under section  
 9 1213(c)(3) by the Board for such a package; and

10 (2) has an actuarial value that is less than the  
 11 actuarial value of the benefits package provided by  
 12 the Blue Cross/Blue Shield Standard Option under  
 13 the Federal Employees Health Benefits Program as  
 14 in effect during 1994, adjusted for an average popu-  
 15 lation.

16 (c) ACTUARIAL VALUES.—The Board shall determine  
 17 the actuarial values referred to in subsections (a)(2) and  
 18 (b)(2).

19 **SEC. 1202. DESCRIPTION OF CATEGORIES OF ITEMS AND**  
 20 **SERVICES.**

21 (a) IN GENERAL.—The categories of health care  
 22 items and services described in this section are the fol-  
 23 lowing, as defined by the Board under section 1213(a):

1           (1) HOSPITAL SERVICES.—The hospital (as de-  
2           fined in section 1203(7)) services described in this  
3           paragraph include the following:

4                   (A) Inpatient hospital services.

5                   (B) Outpatient hospital services.

6                   (C) 24-hour a day hospital emergency serv-  
7           ices.

8           (2) HEALTH PROFESSIONAL SERVICES.—The  
9           items and services described in this paragraph are—

10                   (A) health professional services (as defined  
11           in section 1203(3)), including consultations,  
12           that are provided in a home, office, or other  
13           ambulatory care setting, or an institutional set-  
14           ting; and

15                   (B) services and supplies (including drugs  
16           and biologicals which cannot be self-adminis-  
17           tered) furnished as incident to such health pro-  
18           fessional services.

19           (3) EMERGENCY AND AMBULATORY MEDICAL  
20           AND SURGICAL SERVICES.—The items and services  
21           described in this paragraph are 24-hour a day emer-  
22           gency services and ambulatory medical or surgical  
23           services provided in a facility that is legally author-  
24           ized to provide such services in the State in which  
25           such services are provided.

1           (4) CLINICAL PREVENTIVE SERVICES.—The  
2 items and services described in this paragraph are  
3 clinical preventive services, including services for  
4 high risk populations, age-appropriate immuniza-  
5 tions, tests, and clinician visits furnished consistent  
6 with any periodicity schedule specified by the Board  
7 under section 1213(a)(2)(B).

8           (5) MENTAL ILLNESS AND SUBSTANCE ABUSE  
9 SERVICES.—The items and services described in this  
10 paragraph are mental illness and substance abuse  
11 services, including inpatient, outpatient, residential  
12 non-hospital, and intensive non-residential services,  
13 for the treatment of mental illness and substance  
14 abuse disorders (as defined in section 1203(9)).

15           (6) FAMILY PLANNING SERVICES AND SERVICES  
16 FOR PREGNANT WOMEN.—The services described in  
17 this section include the following items and services:

18                   (A) Voluntary comprehensive family plan-  
19 ning services, including counseling and edu-  
20 cation.

21                   (B) Contraceptive drugs and devices that  
22 are subject to approval by the Secretary under  
23 the Federal Food, Drug, and Cosmetic Act.

24                   (C) Services for pregnant women.

1           (7) HOSPICE CARE.—The hospice care de-  
2           scribed in this paragraph is items and services pro-  
3           vided for end of life care (as defined in section  
4           1203(6)).

5           (8) HOME HEALTH CARE.—

6           (A) IN GENERAL.—The home health care  
7           described in this paragraph is home health care  
8           (as defined in section 1203(4)) and home infu-  
9           sion drug therapy services (as defined in section  
10          1203(5)).

11          (B) LIMITATIONS.—Coverage for home  
12          health care is subject to the following limita-  
13          tions:

14               (i) INPATIENT TREATMENT ALTER-  
15               NATIVE.—Such care is covered only as an  
16               alternative to inpatient treatment in a hos-  
17               pital, skilled nursing facility (as defined in  
18               section 1203(15)), or rehabilitation facility  
19               (as defined in section 1203(14)) after an  
20               illness, injury, disorder, or other health  
21               condition.

22               (ii) REEVALUATION.—At the end of  
23               each 60-day period of home health care,  
24               the need for continued care shall be re-  
25               evaluated by the person who is primarily

1 responsible for providing the home health  
2 care. Additional periods of care are covered  
3 only if such person determines that the re-  
4 quirement in clause (i) is satisfied.

5 (9) EXTENDED CARE SERVICES—

6 (A) IN GENERAL.—The extended care serv-  
7 ices described in this section are the items and  
8 services described in section 1861(h) of the So-  
9 cial Security Act, when provided to an inpatient  
10 of a skilled nursing facility or a rehabilitation  
11 facility.

12 (B) LIMITATIONS.—Extended care services  
13 are covered only as an alternative to receiving  
14 inpatient hospital services as a result of an ill-  
15 ness, injury, disorder, or other health condition.

16 (10) AMBULANCE SERVICES.—

17 (A) IN GENERAL.—The ambulance services  
18 described in this paragraph are covered only  
19 when indicated by the medical condition of the  
20 individual receiving such services. Such services  
21 include the following:

22 (i) Ground transportation by ambu-  
23 lance.

24 (ii) Air or water transportation by an  
25 aircraft or vessel equipped for transporting

1 an injured or sick individual in cases in  
2 which there is no other method of trans-  
3 portation or where use of another method  
4 of transportation is contra-indicated by the  
5 medical condition of such individual.

6 (11) OUTPATIENT LABORATORY, RADIOLOGY,  
7 AND DIAGNOSTIC SERVICES.—The items and services  
8 described in this paragraph are laboratory, radi-  
9 ology, and diagnostic services provided upon pre-  
10 scription to individuals who are not inpatients of a  
11 hospital, hospice, skilled nursing facility, or rehabili-  
12 tation facility.

13 (12) OUTPATIENT PRESCRIPTION DRUGS.—The  
14 items described in this paragraph are the following  
15 used for a medically accepted indication (as defined  
16 in section 1203(8)):

17 (A) Outpatient prescription drugs.

18 (B) Blood clotting factors (as defined in  
19 section 1203(1)).

20 (C) Drugs used for home infusion therapy.

21 (D) Biologicals.

22 (E) Accessories and supplies used directly  
23 with the items described in subparagraphs (A)  
24 through (D).

1           (13) OUTPATIENT REHABILITATION SERV-  
2           ICES.—

3           (A) IN GENERAL.—The outpatient rehabili-  
4           tation services described in this paragraph  
5           are—

6                     (i) outpatient occupational therapy;

7                     (ii) outpatient physical therapy;

8                     (iii) outpatient respiratory therapy;

9                     and

10                    (iv) outpatient speech-language pa-  
11                    thology services and outpatient audiology  
12                    services.

13           (B) LIMITATIONS.—Coverage for out-  
14           patient rehabilitation services is subject to the  
15           following limitations:

16                    (i) SERVICE LIMITATION.—Such serv-  
17                    ices include only items or services used to  
18                    restore or maintain functional capacity or  
19                    prevent or minimize limitations on physical  
20                    and cognitive functions as a result of an  
21                    illness, injury, disorder, or other health  
22                    condition, including attaining new func-  
23                    tional abilities at an age-appropriate rate.

24                    (ii) REEVALUATION.—At the end of  
25                    each 60-day period of outpatient rehabili-

1           tation services, the need for continued  
2           services shall be reevaluated by the person  
3           who is primarily responsible for providing  
4           the services. Additional periods of services  
5           are covered only if such person determines  
6           that the requirement of paragraph (1) is  
7           satisfied.

8           (14) DURABLE MEDICAL EQUIPMENT AND  
9           PROSTHETIC AND ORTHOTIC DEVICES.—

10           (A) IN GENERAL.—The items and services  
11           described in this paragraph are—

12                   (i) durable medical equipment (as de-  
13                   fined in section 1203(2);

14                   (ii) prosthetic devices (as defined in  
15                   section 1203(12);

16                   (iii) orthotics (as defined in section  
17                   1203(10)) and prosthetics (as defined in  
18                   section 1203(11)); and

19                   (iv) accessories and supplies used di-  
20                   rectly with the equipment or devices de-  
21                   scribed in clauses (i) through (iv).

22           (B) REPAIR, MAINTENANCE, ETC.—The  
23           items and services described in this paragraph  
24           include the following with respect to the equip-

1 ment and devices described in subparagraph

2 (A):

3 (i) Repair and maintenance of such  
4 equipment or devices.

5 (ii) Replacement of such equipment or  
6 devices when required due to loss, irrep-  
7 arable damage, wear, or because of a  
8 change in the patient's condition.

9 (iii) Fitting and training for the use  
10 of such equipment or devices.

11 (15) VISION CARE, HEARING AIDS, AND DENTAL  
12 CARE.—

13 (A) IN GENERAL.—The items described in  
14 this paragraph are the vision care described in  
15 subparagraph (B), dental care described in sub-  
16 paragraph (C), and hearing care described in  
17 subparagraph (D).

18 (B) VISION CARE.—The vision care de-  
19 scribed in this subparagraph is routine eye ex-  
20 aminations, diagnosis, and treatment for defects  
21 in vision furnished to individuals who are under  
22 22 years of age, including eyeglasses and con-  
23 tact lenses furnished according to a periodicity  
24 schedule established by the Board.

25 (C) DENTAL CARE.—

1 (i) INDIVIDUALS UNDER 22.—The  
2 dental care described in this subparagraph  
3 shall include the following, as specified by  
4 the Board, furnished to individuals who  
5 are under 22 years of age:

6 (I) Emergency dental treatment.

7 (II) Prevention and diagnosis of  
8 dental disease.

9 (III) Treatment of dental dis-  
10 ease.

11 (IV) Space maintenance proce-  
12 dures to prevent orthodontic complica-  
13 tions.

14 (V) Interceptive orthodontic  
15 treatment to prevent severe malocclu-  
16 sion.

17 (ii) INDIVIDUALS OVER 22.—The den-  
18 tal care described in this subparagraph for  
19 individuals who are over 22 years of age is  
20 emergency dental treatment, as specified  
21 by the Board.

22 (D) HEARING CARE.—The hearing care  
23 items and services described in this paragraph  
24 are the following when furnished to an indi-  
25 vidual who is under 22 years of age:

1 (i) Routine ear examinations and di-  
2 agnosis for defects in hearing as part of a  
3 physician visit.

4 (ii) Hearing aids when recommended  
5 by a physician or audiologist.

6 (16) INVESTIGATIONAL TREATMENTS.—The  
7 items and services described in this paragraph are  
8 items and services required to provide patient care  
9 pursuant to the design of a qualified investigational  
10 treatment (as defined in section 1203(13)).

11 (b) LIMITATION.—

12 (1) IN GENERAL.—Items and services under the  
13 categories described in subsection (a) shall be fur-  
14 nished to health plan enrollees when medically nec-  
15 essary or appropriate.

16 (2) DEFINITION.—For purposes of this subtitle,  
17 the term “medically necessary or appropriate” when  
18 referring to an item or service means an item or  
19 service intended to maintain or improve the biologi-  
20 cal, psychological, or functional condition of a health  
21 plan enrollee or to prevent or mitigate an adverse  
22 health outcome to an enrollee.

23 **SEC. 1203. DEFINITIONS.**

24 For purposes of this subtitle:

1           (1) BLOOD CLOTTING FACTORS.—The term  
2 “blood clotting factors” has the meaning given such  
3 term in section 1861(s)(2)(I) of the Social Security  
4 Act.

5           (2) DURABLE MEDICAL EQUIPMENT.—The term  
6 “durable medical equipment” has the meaning given  
7 such term in section 1861(n) of the Social Security  
8 Act.

9           (3) HEALTH PROFESSIONAL SERVICES.—The  
10 term “health professional services” means profes-  
11 sional services that—

12                   (A) are lawfully provided by a physician; or

13                   (B) would be described in subparagraph

14           (A) if provided by a physician, but are provided  
15 by another person who is legally authorized to  
16 provide such services in the State in which the  
17 services are provided.

18           (4) HOME HEALTH CARE.—The term “home  
19 health care” means the items and services described  
20 in section 1861(m) of the Social Security Act.

21           (5) HOME INFUSION DRUG THERAPY SERV-  
22 ICES.—The term “home infusion drug therapy serv-  
23 ices” means the home infusion drug therapy services  
24 described in section 1861(ll) of the Social Security  
25 Act.

1           (6) HOSPICE CARE.—The term “hospice care”  
2 means the items and services described in paragraph  
3 (1) of section 1861(dd) of the Social Security Act,  
4 except that in applying such section for purposes of  
5 this paragraph—

6                   (A) paragraphs (4)(B) and (5) shall be  
7 disregarded; and

8                   (B) all references to the Secretary of  
9 Health and Human Services shall be treated as  
10 references to the Board.

11           (7) HOSPITAL.—The term “hospital” has the  
12 meaning given such term in section 1861(e) of the  
13 Social Security Act, except that such term shall in-  
14 clude a facility operated by the uniformed services,  
15 the Department of Veterans Affairs, and the Indian  
16 Health Service that is primarily engaged in pro-  
17 viding services to inpatients that are equivalent to  
18 the services provided by a hospital defined in such  
19 section 1861(e).

20           (8) MEDICALLY ACCEPTED INDICATION.—The  
21 term “medically accepted indication” means with re-  
22 spect to the use of a drug, any use which has been  
23 approved by the Food and Drug Administration for  
24 the drug, and includes another use of the drug if—

1 (A) the drug has been approved by the  
2 Food and Drug Administration; and

3 (B) such use is supported by one or more  
4 citations which are included (or approved for  
5 inclusion) in one or more of the following com-  
6 pendia: the American Hospital Formulary Serv-  
7 ice-Drug Information, the American Medical  
8 Association Drug Evaluations, the United  
9 States Pharmacopoeia-Drug Information, and  
10 other authoritative compendia as identified by  
11 the Secretary.

12 (9) MENTAL ILLNESS AND SUBSTANCE ABUSE  
13 DISORDERS.—The term “mental illness and sub-  
14 stance abuse disorder” means a mental or substance  
15 abuse disorder listed in the Diagnostic and Statis-  
16 tical Manual of Mental Disorders, Fourth Edition,  
17 or the International Classification of Diseases, 9th  
18 Revision, the Clinical Modification, Third Edition, or  
19 revised versions of such manuals or texts.

20 (10) ORTHOTICS.—The term “orthotics” in-  
21 cludes—

22 (A) an accessory or supply used directly  
23 with a prosthetic device to achieve therapeutic  
24 benefits and proper functioning; and

25 (B) leg, arm, back, and neck braces.

1           (11) PROSTHETICS.—The term “prosthetics”  
2 includes artificial legs, arms, and eyes.

3           (12) PROSTHETIC DEVICES.—The term “pros-  
4 thetic devices” means devices that replace all or part  
5 of the function of a body organ.

6           (13) QUALIFIED INVESTIGATIONAL TREAT-  
7 MENT.—The term “qualified investigational treat-  
8 ment” means an investigational treatment that is  
9 part of a peer-reviewed and approved research pro-  
10 gram (as defined by the Secretary) or research trials  
11 approved by the Secretary, the Directors of the Na-  
12 tional Institutes of Health, the Commissioner of the  
13 Food and Drug Administration, the Secretary of  
14 Veterans Affairs, the Secretary of Defense, or a  
15 qualified nongovernmental research entity as defined  
16 in guidelines of the National Institutes of Health, in-  
17 cluding guidelines for cancer center support grants  
18 designated by the National Cancer Institute.

19           (14) REHABILITATION FACILITY.—The term  
20 “rehabilitation facility” means an institution (or a  
21 distinct part of an institution) which is established  
22 and operated for the purpose of providing diagnostic,  
23 therapeutic, and rehabilitation services to individuals  
24 for rehabilitation from illness, injury, disorder, or  
25 other health condition. An entity qualifying as a hos-

1       pital for as defined in paragraph (7) may also qual-  
 2       ify as a rehabilitation facility for the purposes of  
 3       section 1202(a)(9).

4               (15) SKILLED NURSING FACILITY.—The term  
 5       “skilled nursing facility” means an institution (or a  
 6       distinct part of an institution) which is primarily en-  
 7       gaged in providing to residents—

8                       (A) skilled nursing care and related serv-  
 9                       ices for residents who require medical or nurs-  
 10                      ing care; or

11                     (B) rehabilitation services to residents for  
 12                     rehabilitation from illness, injury, disorder, or  
 13                     other health condition.

14       **PART 2—NATIONAL HEALTH BENEFITS BOARD**

15       **SEC. 1211. CREATION OF NATIONAL HEALTH BENEFITS**  
 16                       **BOARD; MEMBERSHIP.**

17       (a) IN GENERAL.—There is hereby established a Na-  
 18       tional Health Benefits Board (referred to in this part as  
 19       the “Board”).

20       (b) COMPOSITION.—The Board is composed of 7  
 21       members appointed by the President, by and with the ad-  
 22       vice and consent of the Senate. No more than 4 members  
 23       of the Board may be affiliated with the same political  
 24       party. Members shall be appointed not later than 90 days  
 25       after the date of the enactment of this title.

1 (c) CHAIR.—The President shall designate one of the  
2 members of the Board as chair.

3 (d) TERMS.—

4 (1) IN GENERAL.—Except as provided in para-  
5 graph (2), the term of each member of the Board  
6 is 6 years and begins when the term of the prede-  
7 cessor of that member ends.

8 (2) INITIAL TERMS.—The initial terms of the  
9 members of the Board first taking office after the  
10 date of the enactment of this title, shall expire as  
11 designated by the President, two at the end of two  
12 years, two at the end of four years, and three at the  
13 end of six years.

14 (3) CONTINUATION IN OFFICE.—Upon the expi-  
15 ration of a term of office, a member shall continue  
16 to serve until a successor is appointed and qualified.

17 (e) VACANCIES.—

18 (1) IN GENERAL.—If a vacancy occurs, other  
19 than by expiration of term, a successor shall be ap-  
20 pointed by the President, by and with the consent of  
21 the Senate, to fill such vacancy. The appointment  
22 shall be for the remainder of the term of the prede-  
23 cessor.

24 (2) NO IMPAIRMENT OF FUNCTION.—A vacancy  
25 in the membership of the Board does not impair the

1 authority of the remaining members to exercise all  
2 of the powers of the Board.

3 (3) ACTING CHAIR.—The Board may designate  
4 a member to act as chair during any period in which  
5 there is no chair designated by the President.

6 (f) MEETINGS; QUORUM.—

7 (1) MEETINGS.—The chair shall preside at  
8 meetings of the Board, and in the absence of the  
9 chair, the Board shall elect a member to act as chair  
10 pro tempore.

11 (2) FREQUENCY.—The Board shall meet not  
12 less frequently than 4 times each year.

13 (3) QUORUM.—Four members of the Board  
14 shall constitute a quorum thereof.

15 **SEC. 1212. QUALIFICATIONS OF BOARD MEMBERS.**

16 (a) CITIZENSHIP.—Each member of the Board shall  
17 be a citizen of the United States.

18 (b) BASIS OF SELECTION.—Board members shall be  
19 selected on the basis of their experience and expertise in  
20 relevant subjects, including the practice of medicine, nurs-  
21 ing, or other clinical practices, health care financing and  
22 delivery, State health systems, consumer protection, busi-  
23 ness, law, and delivery of care to vulnerable populations.

24 (c) PAY AND TRAVEL EXPENSES.—

25 (1) PAY.—

1 (A) CHAIR.—The chair of the Board shall  
2 be paid at a rate equal to the daily equivalent  
3 of the minimum annual rate of basic pay pay-  
4 able for level II of the Executive Schedule  
5 under section 5315 of title 5, United States  
6 Code, for each day (including travel time) dur-  
7 ing which the chair is engaged in the actual  
8 performance of duties vested in the Board.

9 (B) MEMBERS.—Each member of the  
10 Board shall be paid at a rate equal to the daily  
11 equivalent of the minimum annual rate of basic  
12 pay payable for level III of the Executive  
13 Schedule under section 5315 of title 5, United  
14 States Code, for each day (including travel  
15 time) during which the member is engaged in  
16 the actual performance of duties vested in the  
17 Board.

18 (2) TRAVEL EXPENSES.—Members of the  
19 Board shall receive travel expenses, including per  
20 diem in lieu of subsistence, in accordance with sec-  
21 tions 5702 and 5703 of title 5, United States Code.

22 **SEC. 1213. GENERAL DUTIES AND RESPONSIBILITIES.**

23 (a) CLARIFICATION AND REFINEMENT OF ITEMS  
24 AND SERVICES.—

1           (1) IN GENERAL.—The Board shall promulgate  
2           such regulations or establish such guidelines as may  
3           be necessary to clarify and refine the items and serv-  
4           ices under the categories of health care items and  
5           services described in section 1202 in accordance with  
6           the requirements of subsections (a)(2) and (b)(2) of  
7           section 1201.

8           (2) SCHEDULES FOR ITEMS AND SERVICES.—

9           (A) IN GENERAL.—The Board shall estab-  
10          lish and update periodicity schedules for the  
11          items and services in the categories of health  
12          care items and services described in section  
13          1202.

14          (B) SPECIAL RULE WITH RESPECT TO  
15          CLINICAL PREVENTIVE SERVICES.—With re-  
16          spect to clinical preventive services, the  
17          Board—

18                 (i) shall specify and define specific  
19                 items and services as clinical preventive  
20                 services and shall establish and update a  
21                 periodicity schedule for such items and  
22                 services; and

23                 (ii) in specifying clinical preventive  
24                 services and establishing and updating pe-  
25                 riodicity schedules under clause (i), the

1 Board shall consult with experts in clinical  
2 preventive services, including the U.S. Pre-  
3 ventive Services Task Force, the Advisory  
4 Committee on Immunization Practices, the  
5 American College of Obstetricians and  
6 Gynecologists, and the American Academy  
7 of Pediatrics.

8 (3) MENTAL ILLNESS AND SUBSTANCE ABUSE  
9 SERVICES.—

10 (A) PARITY.—

11 (i) IN GENERAL.—The Board shall  
12 design mental illness and substance abuse  
13 services so as to achieve parity with serv-  
14 ices for other medical conditions. Except as  
15 provided in clause (iii), day or visit limits  
16 or cost-sharing requirements may not be  
17 applied to mental illness and substance  
18 abuse services that are not applied to serv-  
19 ices for other medical conditions.

20 (ii) PARITY DEFINED.—For purposes  
21 of this subparagraph, the term “parity”  
22 means comprehensive, coverage for all  
23 medically necessary or appropriate mental  
24 illness and substance abuse services in in-

1 patient, outpatient, residential, and inten-  
2 sive non-residential settings.

3 (iii) SPECIAL RULE.—

4 (I) EFFECT ON OTHER BENE-  
5 FITS.—If the Board determines that  
6 parity of mental illness and substance  
7 abuse services with services for other  
8 medical conditions cannot be achieved  
9 without imposing unduly burdensome  
10 cost-sharing requirements on other  
11 services, the Board may design mental  
12 illness and substance abuse services  
13 such that they include the following  
14 limits:

15 (aa) Inpatient hospital care  
16 may be limited, but in the case of  
17 mental illness the limit may not  
18 be set at a level below 30 days  
19 per year, and in the case of sub-  
20 stance abuse services the limit  
21 may not be set at a level below  
22 the level sufficient to provide de-  
23 toxification services.

24 (bb) After the first 5 visits  
25 for outpatient adult psycho-

1 therapy, the coinsurance for such  
2 services may be set at a level  
3 higher than the coinsurance for  
4 other services, but no higher than  
5 a 50 percent coinsurance level.

6 (cc) Consistent with the  
7 process described in section  
8 3510, the Board shall ensure  
9 that parity for mental illness and  
10 substance abuse services with  
11 services for other medical condi-  
12 tions is established no later than  
13 January 1, 2001.

14 (II) LEGISLATIVE PROPOSAL.—If  
15 the Board finds that establishing par-  
16 ity for mental illness and substance  
17 abuse services with services for other  
18 medical conditions cannot be achieved  
19 by January 1, 2001, without imposing  
20 unduly burdensome cost-sharing on all  
21 services, the Board shall develop a  
22 legislative proposal for an extension of  
23 such date. Not later than January 1,  
24 2000, the Board shall submit to the  
25 Congress an implementing bill which

1 contains such statutory provisions as  
2 are necessary or appropriate to imple-  
3 ment the legislative proposal devel-  
4 oped under the preceding sentence.

5 (B) MANAGEMENT OF SERVICES.—

6 (i) IN GENERAL.—The Board shall  
7 develop standards for the appropriate man-  
8 agement of mental illness and substance  
9 abuse services. Such standards shall in-  
10 clude quality managed care techniques.

11 (ii) QUALITY MANAGED CARE.—For  
12 purposes of clause (i), the term “quality  
13 managed care” refers to the administration  
14 of benefits through methods of central in-  
15 take, preauthorization, and utilization re-  
16 view under circumstances that protect indi-  
17 viduals from unwarranted denial of serv-  
18 ices.

19 (C) SETTINGS.—The Board shall give pri-  
20 ority to ensuring that mental illness and sub-  
21 stance abuse services are provided in the least  
22 restrictive setting that is clinically appropriate  
23 and encouraging the use of outpatient and in-  
24 tensive nonresidential treatments to the great-  
25 est extent possible.

1 (b) DETERMINING MEDICAL NECESSITY OR APPRO-  
2 PRIATENESS.—

3 (1) IN GENERAL.—The Board shall be author-  
4 ized to establish—

5 (A) criteria for determinations of medical  
6 necessity or appropriateness;

7 (B) procedures for determinations of med-  
8 ical necessity or appropriateness; and

9 (C) regulations or guidelines to be used in  
10 determining whether an item or service under  
11 the categories of health care items and services  
12 described in section 1202 is medically necessary  
13 or appropriate.

14 (2) REQUIREMENTS.—The Board shall include  
15 the following in establishing criteria, procedures, and  
16 regulations under this subsection:

17 (A) SPECIAL RULES WITH RESPECT TO EN-  
18 ROLLEES UNDER 22 YEARS OF AGE.—In making  
19 any determination with respect to medical ne-  
20 cessity or appropriateness with respect to an  
21 enrollee under 22 years of age, the Board shall  
22 consider whether the item or service is—

23 (i) is appropriate for the age and  
24 health status of the enrollee;

1 (ii) will prevent or ameliorate the ef-  
2 fects of a condition, illness, injury, or dis-  
3 order;

4 (iii) will aid the overall physical and  
5 mental growth and development of the en-  
6 rollee; or

7 (iv) will assist in achieving or main-  
8 taining maximum functional capacity in  
9 performing daily activities.

10 This subparagraph shall apply to all items and  
11 services under the categories of health care  
12 items and services described in section 1202 as  
13 clarified and refined by the Board under sub-  
14 section (a).

15 (B) CONSULTATIONS WITH EXPERT AU-  
16 THORITIES.—The Board shall consider the  
17 opinions of experts from academia, medical spe-  
18 cialty groups, industry, and government in es-  
19 tablishing criteria, procedures, and regulations  
20 with regard to medical necessity or appropriate-  
21 ness.

22 (C) RECOMMENDATIONS TO SECRETARY.—  
23 In the absence of sufficient evidence to develop  
24 regulations with respect to any particular cov-  
25 erage determination, the Board shall rec-

1           commend to the Secretary specific areas for  
2           which priorities should be given to undertake  
3           clinical trials or establish practice guidelines.

4           (3) HEALTH PLAN REQUIREMENTS.—The regu-  
5           lations established by the Board under this sub-  
6           section shall provide that health plans shall—

7                   (A) in making any determination with re-  
8                   spect to medical necessity or appropriateness,  
9                   consider the criteria and procedures established  
10                  by the Board under this subsection;

11                  (B) be guided by—

12                          (i) the initial determination of medical  
13                          necessity or appropriateness with respect  
14                          to an item or service made by an enrollee  
15                          and the health professional furnishing such  
16                          item or service; and

17                          (ii) available scientific evidence; and

18                  (C) if a health plan has developed a treat-  
19                  ment guideline or utilization protocol, or has  
20                  made a general coverage determination, the  
21                  plan shall—

22                          (i) provide a copy of, and a written  
23                          statement of the basis for, the guideline,  
24                          protocol, or determination at least 60 days  
25                          prior to the effective date of such guide-

1 line, protocol, or determination, to each af-  
2 fected provider with which the plan has a  
3 contract and the government entity which  
4 certifies the plan;

5 (ii) provide any or all of such informa-  
6 tion upon request to enrollees, potential  
7 enrollees, or other interested parties, in-  
8 cluding provider groups and specialty orga-  
9 nizations; and

10 (iii) revise such guidelines, protocols,  
11 or determinations periodically, or, if new  
12 scientific evidence becomes available, as  
13 soon as possible after such evidence is  
14 available.

15 (c) COST-SHARING.—The Board shall establish cost-  
16 sharing schedules to be provided by health plans providing  
17 a standard benefits package or an alternative standard  
18 benefits package. In establishing such cost-sharing sched-  
19 ules, the Board shall meet the following requirements:

20 (1) ANNUAL BASIS.—The Board shall review  
21 and update cost-sharing schedules as determined ap-  
22 propriate by the Board, but on at least an annual  
23 basis.

24 (2) PLANS PROVIDING STANDARD BENEFITS  
25 PACKAGE.—

1           (A) IN GENERAL.—The Board shall estab-  
2           lish 3 cost-sharing schedules for health plans  
3           providing the standard benefits package which  
4           permit a variety of delivery system options, in-  
5           cluding fee-for-service, preferred provider orga-  
6           nizations, point of service, and managed care.  
7           Such cost-sharing schedules shall consist of—

8                       (i) a low cost-sharing schedule;

9                       (ii) a high cost-sharing schedule; and

10                      (iii) a combination cost-sharing sched-

11           ule.

12           (B) ACTUARIAL VALUE OF HIGH COST-  
13           SHARING SCHEDULE.—A standard benefit pack-  
14           age that provides for the cost-sharing schedule  
15           established by the Board under this paragraph  
16           that has the lowest actuarial value relative to  
17           the actuarial values of all other cost-sharing  
18           schedules established by the Board under this  
19           paragraph, shall have an actuarial value that is  
20           equivalent to the actuarial value of the benefits  
21           package provided by the Blue Cross/Blue Shield  
22           Standard Option under the Federal Employees  
23           Health Benefits Program as in effect during  
24           1994, adjusted for an average population (as  
25           determined by the Board).

1           (3) PLANS PROVIDING ALTERNATIVE STANDARD  
2 BENEFITS PACKAGE.—The Board shall establish  
3 only one very high deductible cost-sharing schedule  
4 for health plans providing the alternative standard  
5 benefits package. Such cost-sharing schedule shall  
6 provide for a higher deductible than any deductible  
7 under a schedule established for health plans pro-  
8 viding a standard benefits package.

9           (4) CLINICAL PREVENTIVE SERVICES.—No  
10 cost-sharing schedule established by the Board may  
11 include cost-sharing for clinical preventive services  
12 and prenatal care.

13           (5) COST-SHARING RULES.—Cost-sharing  
14 schedules established by the Board may include co-  
15 payments, coinsurance, deductibles, and out-of-pock-  
16 et limits. The copayments, coinsurance, deductibles  
17 and out-of-pocket limits on cost-sharing for a year  
18 under the schedules shall be applied based upon ex-  
19 penses incurred for covered items and services fur-  
20 nished in the year.

21           (6) LIFETIME LIMITS.—No cost-sharing sched-  
22 ule established by the Board may include lifetime  
23 limits.

24           (d) LEGISLATIVE PROPOSALS ON ACTUARIAL  
25 EQUIVALENCE AND HEALTH SERVICE CATEGORIES.—

1           (1) IN GENERAL.—The Board may develop leg-  
2           islative proposals for modifications to the actuarial  
3           equivalence provisions of section 1201 and the cat-  
4           egories of health care items and services under sec-  
5           tion 1202.

6           (2) IMPLEMENTING BILL.—The Board shall  
7           submit to the Congress an implementing bill which  
8           contains such statutory provisions as are necessary  
9           or appropriate to implement the legislative proposals  
10          developed under paragraph (1).

11         (e) REPORTS.—

12           (1) DENTAL CARE.—The Board shall undertake  
13          a study to determine the costs of providing—

14                   (A) preventive dental care to all adults;

15                   (B) restorative dental care to all adults;

16                   and

17                   (C) preventive dental care to adults with  
18                   developmental, cognitive, and other mental dis-  
19                   abilities.

20          Not later than July 1, 1996, the Board shall pre-  
21          pare and submit to the Secretary and the Congress,  
22          a report concerning such study.

23           (2) IN VITRO FERTILIZATION.—The Board shall  
24          undertake a study to determine the costs of pro-  
25          viding coverage for in vitro fertilization in the stand-

1       ard benefits package. Not later than July 1, 1996,  
2       the Board shall prepare and submit to the Secretary  
3       and the Congress, a report concerning such study.

4       (f) OTHER REQUIREMENTS.—The Board shall satisfy  
5       any other requirements imposed on the Board under this  
6       title.

7       **SEC. 1214. POWERS.**

8       (a) EXECUTIVE DIRECTOR; STAFF.—

9               (1) EXECUTIVE DIRECTOR.—

10                       (A) IN GENERAL.—The Board shall, with-  
11                       out regard to section 5311(b) of title 5, United  
12                       States Code, appoint an Executive Director.

13                       (B) PAY.—The Executive Director shall be  
14                       paid at a rate equivalent to a rate for the Sen-  
15                       ior Executive Service.

16               (2) STAFF.—

17                       (A) IN GENERAL.—Subject to subpara-  
18                       graphs (B) and (C), the Executive Director,  
19                       with the approval of the Board, may appoint  
20                       and fix the pay of additional personnel.

21                       (B) PAY.—The Executive Director may  
22                       make such appointments without regard to the  
23                       provisions of title 5, United States Code, gov-  
24                       erning appointments in the competitive service,  
25                       and any personnel so appointed may be paid

1 without regard to the provisions of chapter 51  
2 and subchapter III of chapter 53 of such title,  
3 relating to classification and General Schedule  
4 pay rates, except that an individual so ap-  
5 pointed may not receive pay in excess of 120  
6 percent of the annual rate of basic pay payable  
7 for GS-15 of the General Schedule.

8 (C) DETAILED PERSONNEL.—Upon re-  
9 quest of the Executive Director, the head of any  
10 Federal department or agency may detail any  
11 of the personnel of that department or agency  
12 to the Board to assist the Board in carrying out  
13 its duties under this Act.

14 (b) CONTRACT AUTHORITY.—To the extent provided  
15 in advance in appropriations Acts, the Board may contract  
16 with any person (including an agency of the Federal Gov-  
17 ernment) for studies and analysis as required to execute  
18 its functions. Any employee of the Executive Branch may  
19 be detailed to the Board to assist the Board in carrying  
20 out its duties.

21 (c) CONSULTATIONS WITH EXPERTS.—The Board  
22 may consult with any outside expert individuals or groups  
23 that the Board determines appropriate in performing its  
24 duties under section 1213. The Board may establish advi-  
25 sory committees.

1 (d) ACCESS TO INFORMATION.—The Board may se-  
2 cure directly from any department or agency of the United  
3 States information necessary to enable it to carry out its  
4 functions, to the extent such information is otherwise  
5 available to a department or agency of the United States.  
6 Upon request of the chair, the head of that department  
7 or agency shall furnish that information to the Board.

8 (e) DELEGATION OF AUTHORITY.—Except as other-  
9 wise provided, the Board may delegate any function to  
10 such officers and employees as the Board may designate  
11 and may authorize such successive redelegations of such  
12 functions with the Board as the Board deems to be nec-  
13 essary or appropriate. No delegation of functions by the  
14 Board shall relieve the Board of responsibility for the ad-  
15 ministration of such functions.

16 (f) RULEMAKING.—The Board is authorized to estab-  
17 lish such rules as may be necessary to carry out this sub-  
18 title.

19 **SEC. 1215. FUNDING.**

20 (a) AUTHORIZATION OF APPROPRIATIONS.—There  
21 are authorized to be appropriated to the Board  
22 \$5,000,000 for each year and such additional sums as may  
23 be necessary to carry out the purposes of this part.

24 (b) SUBMISSION OF BUDGET.—Under the procedures  
25 of chapter 11 of title 31, United States Code, the budget

1 for the Board for a fiscal year shall be reviewed by the  
2 Director of the Office of Management and Budget and  
3 submitted to the Congress as part of the President's sub-  
4 mission of the Budget of the United States for the fiscal  
5 year.

6 **SEC. 1216. APPLICABILITY OF FEDERAL ADVISORY COM-**  
7 **MITTEE ACT.**

8 The Federal Advisory Committee Act (5 U.S.C. App.)  
9 shall not apply to the Board.

10 **SEC. 1217. CONGRESSIONAL CONSIDERATION OF BOARD**  
11 **PROPOSALS.**

12 (a) IN GENERAL.—Any implementing bill described  
13 in section 1213 shall be considered by Congress under the  
14 procedures for consideration described in subsection (b).

15 (b) CONGRESSIONAL CONSIDERATION.—

16 (1) RULES OF HOUSE OF REPRESENTATIVES  
17 AND SENATE.—This subsection is enacted by Con-  
18 gress—

19 (A) as an exercise of the rulemaking power  
20 of the House of Representatives and the Sen-  
21 ate, respectively, and as such is deemed a part  
22 of the rules of each House, respectively, but ap-  
23 plicable only with respect to the procedure to be  
24 followed in that House in the case of an imple-  
25 menting bill described in subsection (a), and su-

1           persedes other rules only to the extent that  
2           such rules are inconsistent therewith; and

3                   (B) with full recognition of the constitu-  
4           tional right of either House to change the rules  
5           (so far as relating to the procedure of that  
6           House) at any time, in the same manner and  
7           to the same extent as in the case of any other  
8           rule of that House.

9           (2) INTRODUCTION AND REFERRAL.—On the  
10          day on which the implementing bill described in sub-  
11          section (a) is transmitted to the House of Represent-  
12          atives and the Senate, such bill shall be introduced  
13          (by request) in the House of Representatives by the  
14          Majority Leader of the House, for himself or herself  
15          and the Minority Leader of the House, or by Mem-  
16          bers of the House designated by the Majority Leader  
17          and Minority Leader of the House and shall be in-  
18          troduced (by request) in the Senate by the Majority  
19          Leader of the Senate, for himself or herself and the  
20          Minority Leader of the Senate, or by Members of  
21          the Senate designated by the Majority Leader and  
22          Minority Leader of the Senate. If either House is  
23          not in session on the day on which the implementing  
24          bill is transmitted, the bill shall be introduced in the  
25          House, as provided in the preceding sentence, on the

1 first day thereafter on which the House is in session.

2 The implementing bill introduced in the House of  
3 Representatives and the Senate shall be referred to  
4 the appropriate committees of each House.

5 (3) AMENDMENTS PROHIBITED.—No amend-  
6 ment to an implementing bill shall be in order in ei-  
7 ther the House of Representatives or the Senate and  
8 no motion to suspend the application of this sub-  
9 section shall be in order in either House, nor shall  
10 it be in order in either House for the Presiding Offi-  
11 cer to entertain a request to suspend the application  
12 of this subsection by unanimous consent.

13 (4) PERIOD FOR COMMITTEE AND FLOOR CON-  
14 sideration.—

15 (A) IN GENERAL.—Except as provided in  
16 subparagraph (B), if the committee or commit-  
17 tees of either House to which an implementing  
18 bill has been referred have not reported it at  
19 the close of the 45th day after its introduction,  
20 such committee or committees shall be auto-  
21 matically discharged from further consideration  
22 of the implementing bill and it shall be placed  
23 on the appropriate calendar. A vote on final  
24 passage of the implementing bill shall be taken  
25 in each House on or before the close of the

1 45th day after the implementing bill is reported  
2 by the committees or committee of that House  
3 to which it was referred, or after such com-  
4 mittee or committees have been discharged  
5 from further consideration of the implementing  
6 bill. If prior to the passage by one House of an  
7 implementing bill of that House, that House re-  
8 ceives the same implementing bill from the  
9 other House then—

10 (i) the procedure in that House shall  
11 be the same as if no implementing bill had  
12 been received from the other House; but

13 (ii) the vote on final passage shall be  
14 on the implementing bill of the other  
15 House.

16 (B) COMPUTATION OF DAYS.—For pur-  
17 poses of subparagraph (A), in computing a  
18 number of days in either House, there shall be  
19 excluded—

20 (i) the days on which either House is  
21 not in session because of an adjournment  
22 of more than 3 days to a day certain, or  
23 an adjournment of the Congress sine die;  
24 and

1 (ii) any Saturday and Sunday not ex-  
2 cluded under clause (i) when either House  
3 is not in session.

4 (5) FLOOR CONSIDERATION IN THE HOUSE OF  
5 REPRESENTATIVES.—

6 (A) MOTION TO PROCEED.—A motion in  
7 the House of Representatives to proceed to the  
8 consideration of an implementing bill shall be  
9 highly privileged and not debatable. An amend-  
10 ment to the motion shall not be in order, nor  
11 shall it be in order to move to reconsider the  
12 vote by which the motion is agreed to or dis-  
13 agreed to.

14 (B) DEBATE.—Debate in the House of  
15 Representatives on an implementing bill shall  
16 be limited to not more than 20 hours, which  
17 shall be divided equally between those favoring  
18 and those opposing the bill. A motion further to  
19 limit debate shall not be debatable. It shall not  
20 be in order to move to recommit an imple-  
21 menting bill or to move to reconsider the vote  
22 by which an implementing bill is agreed to or  
23 disagreed to.

24 (C) MOTION TO POSTPONE.—Motions to  
25 postpone, made in the House of Representatives

1 with respect to the consideration of an imple-  
2 menting bill, and motions to proceed to the con-  
3 sideration of other business, shall be decided  
4 without debate.

5 (D) APPEALS.—All appeals from the deci-  
6 sions of the Chair relating to the application of  
7 the Rules of the House of Representatives to  
8 the procedure relating to an implementing bill  
9 shall be decided without debate.

10 (E) GENERAL RULES APPLY.—Except to  
11 the extent specifically provided in the preceding  
12 provisions of this paragraph, consideration of  
13 an implementing bill shall be governed by the  
14 Rules of the House of Representatives applica-  
15 ble to other bills and resolutions in similar cir-  
16 cumstances.

17 (6) FLOOR CONSIDERATION IN THE SENATE.—

18 (A) MOTION TO PROCEED.—A motion in  
19 the Senate to proceed to the consideration of an  
20 implementing bill shall be privileged and not de-  
21 batable. An amendment to the motion shall not  
22 be in order, nor shall it be in order to move to  
23 reconsider the vote by which the motion is  
24 agreed to or disagreed to.

1           (B) GENERAL DEBATE.—Debate in the  
2           Senate on an implementing bill, and all debat-  
3           able motions and appeals in connection there-  
4           with, shall be limited to not more than 20  
5           hours. The time shall be equally divided be-  
6           tween, and controlled by, the Majority Leader  
7           and the Minority Leader or their designees.

8           (C) DEBATE OF MOTIONS AND APPEALS.—  
9           Debate in the Senate on any debatable motion  
10          or appeal in connection with an implementing  
11          bill shall be limited to not more than one hour,  
12          to be equally divided between, and controlled  
13          by, the mover and the manager of the imple-  
14          menting bill, except that in the event the man-  
15          ager of the implementing bill is in favor of any  
16          such motion or appeal, the time in opposition  
17          thereto, shall be controlled by the Minority  
18          Leader or his designee. Such leaders, or either  
19          of them, may, from time under their control on  
20          the passage of an implementing bill, allot addi-  
21          tional time to any Senator during the consider-  
22          ation of any debatable motion or appeal.

23          (D) OTHER MOTIONS.—A motion in the  
24          Senate to further limit debate is not debatable.

1           A motion to recommit an implementing bill is  
2           not in order.

### 3   **Subtitle D—Access to Health Plans**

#### 4       **PART 1—ACCESS THROUGH EMPLOYERS**

##### 5   **SEC. 1301. GENERAL EMPLOYER RESPONSIBILITIES.**

6       (a) OFFER OF PLANS.—

7           (1) IN GENERAL.—Each employer—

8               (A) shall make available to each employee  
9               of the employer the opportunity—

10                   (i) in the case of an experienced-rated  
11                   employer, to enroll through the employer in  
12                   one of at least 3 certified experience-rated  
13                   standard health plans which provide the  
14                   standard benefits package established  
15                   under subtitle C, including, if available, a  
16                   high cost-sharing plan, a combination cost-  
17                   sharing plan, and a low cost-sharing plan  
18                   as established under such subtitle; or

19                   (ii) in the case of a community-rated  
20                   employer—

21                       (I) to enroll in any community-  
22                       rated plan offered through a pur-  
23                       chasing cooperative operating in the  
24                       community rating area in which such  
25                       employer is located, and if such coop-

1           erative is not a purchasing cooperative  
2           described in section 1341, then also  
3           through a cooperative so described;  
4           and

5                   (II) at the option of the em-  
6           ployer, to enroll through the employer  
7           in one of at least 3 certified commu-  
8           nity-rated standard health plans  
9           which provide the standard benefits  
10          package established under subtitle C,  
11          including, if available, a high cost-  
12          sharing plan, a combination cost-shar-  
13          ing plan, and a low cost-sharing plan  
14          as established under such subtitle;  
15          and

16                   (B) shall provide, upon request, payroll  
17          withholding of the employee's premiums.

18                   (2) WAIVER OF REQUIREMENT.—The Governor  
19          of a participating State (or, the Secretary of Labor,  
20          in the case of sponsors of multistate self-insured  
21          health plans) may waive the requirement under  
22          paragraph (1) for any employer in a rural area of  
23          such State which demonstrates an insufficient popu-  
24          lation density to support 3 types of certified stand-  
25          ard health plans. Such an employer shall at least

1 offer a high cost-sharing plan as established under  
2 subtitle C.

3 (3) PROHIBITION ON OFFERING OF ALTER-  
4 NATIVE PACKAGE.—No employer may offer an alter-  
5 native standard benefits package established under  
6 subtitle C.

7 (b) FORWARDING OF INFORMATION.—

8 (1) INFORMATION REGARDING PLANS.—An em-  
9 ployer must provide each employee of such em-  
10 ployer—

11 (A) with information provided by the State  
12 under section 1508 regarding all certified  
13 standard health plans offered in the community  
14 rating area in which the employer is located,  
15 and

16 (B) if the employer knows that an em-  
17 ployee resides in another community rating  
18 area, information regarding how to obtain infor-  
19 mation on certified standard health plans of-  
20 fered to residents of such other community rat-  
21 ing area.

22 (2) INFORMATION REGARDING EMPLOYEES.—  
23 An employer shall forward the name and address  
24 (and any other necessary identifying information

1 specified by the Secretary) of each employee enroll-  
2 ing through the employer—

3 (A) to the certified standard health plan in  
4 which such employee is enrolling, or

5 (B) to the purchasing cooperative (if any)  
6 through which such employee is enrolling.

7 **SEC. 1302. AUDITING OF RECORDS.**

8 Each employer shall maintain such records, and pro-  
9 vide the participating State for the area in which the em-  
10 ployer maintains its principal place of employment (as  
11 specified by the Secretary of Labor) with access to such  
12 records, as may be necessary to verify and audit the infor-  
13 mation reported under this Act.

14 **SEC. 1303. PROHIBITION OF CERTAIN EMPLOYER DISCRIMI-  
15 NATION.**

16 (a) **IN GENERAL.**—No employer may discriminate  
17 with respect to an employee on the basis of the family sta-  
18 tus of the employee or on the basis of the class of family  
19 enrollment selected with respect to the employee.

20 (b) **OTHER PROHIBITIONS.**—For the prohibition of  
21 other employer discriminatory practices, see section 4522  
22 of the Internal Revenue Code of 1986.

1 **SEC. 1304. PROHIBITION ON SELF-INSURING COST-SHAR-**  
2 **ING BENEFITS.**

3 A community-rated employer (and an experience-  
4 rated employer with respect to employees who are commu-  
5 nity-rated eligible individuals) may provide benefits to em-  
6 ployees that consist of the benefits included in a cost-shar-  
7 ing plan (as defined in section 1141(a)(2)(C)) only  
8 through a contribution toward the purchase of a cost-shar-  
9 ing plan which is funded primarily through insurance.

10 **SEC. 1305. RESPONSIBILITIES IN SINGLE-PAYER STATES.**

11 In the case of an individual who resides in a single-  
12 payer State and an employer with respect to employees  
13 who reside in such a State, the responsibilities of such in-  
14 dividual and employer under such system shall supersede  
15 the obligations of the individual and employer under this  
16 subtitle.

17 **SEC. 1306. DEVELOPMENT OF LARGE EMPLOYER PUR-**  
18 **CHASING GROUPS.**

19 (a) IN GENERAL.—Nothing in this title shall be con-  
20 strued as prohibiting 2 or more experience-rated employ-  
21 ers from joining together to purchase insurance for their  
22 employees, except that each such employer shall be respon-  
23 sible for meeting the employer's requirements under this  
24 title with respect to its employees.

25 (b) RULES BY SECRETARY.—The Secretary of Labor  
26 shall provide rules for large employer purchasing groups

1 similar to the rules applicable to purchasing cooperatives,  
 2 including rules regarding fiduciary responsibilities and fi-  
 3 nancial management.

4 (c) NO USE OF PURCHASING COOPERATIVES.—An  
 5 experience-rated employer shall be ineligible to purchase  
 6 health insurance through a purchasing cooperative, except  
 7 with respect to health insurance for individuals described  
 8 in paragraphs (1) and (2) of section 1307(d).

9 **SEC. 1307. RULES GOVERNING LITIGATION INVOLVING RE-**  
 10 **TIREE HEALTH BENEFITS.**

11 (a) MAINTENANCE OF BENEFITS.—

12 (1) IN GENERAL.—If—

13 (A) retiree health benefits or plan or plan  
 14 sponsor payments in connection with such bene-  
 15 fits are to be or have been terminated or re-  
 16 duced under an employee welfare benefit plan;  
 17 and

18 (B) an action is brought by any participant  
 19 or beneficiary to enjoin or otherwise modify  
 20 such termination or reduction,

21 the court without requirement of any additional  
 22 showing shall promptly order the plan and plan  
 23 sponsor to maintain the retiree health benefits and  
 24 payments at the level in effect immediately before  
 25 the termination or reduction while the action is

1 pending in any court. No security or other under-  
2 taking shall be required of any participant or bene-  
3 ficiary as a condition for issuance of such relief. An  
4 order requiring such maintenance of benefits may be  
5 refused or dissolved only upon determination by the  
6 court, on the basis of clear and convincing evidence,  
7 that the action is clearly without merit.

8 (2) MODIFICATIONS.—Nothing in this section  
9 shall preclude a court from modifying the obligation  
10 of a plan or plan sponsor to the extent retiree bene-  
11 fits are otherwise being paid.

12 (b) BURDEN OF PROOF.—In addition to the relief au-  
13 thorized in subsection (a) or otherwise available, if, in any  
14 action described in subsection (a), the terms of the em-  
15 ployee welfare benefit plan summary plan description or  
16 other materials distributed to employees at the time of a  
17 participant's retirement or disability are silent or are am-  
18 biguous, either on their face or after consideration of ex-  
19 trinsic evidence, as to whether retiree health benefits and  
20 payments may be terminated or reduced for a participant  
21 and his or her beneficiaries after the participant's retire-  
22 ment or disability, then the benefits and payments shall  
23 not be terminated or reduced for the participant and his  
24 or her beneficiaries unless the plan or plan sponsor estab-  
25 lishes by a preponderance of the evidence that the sum-

1 mary plan description and other materials about retiree  
2 benefits—

3 (1) were distributed to the participant at least  
4 90 days in advance of retirement or disability;

5 (2) did not promise retiree health benefits for  
6 the lifetime of the participant and his or her spouse;  
7 and

8 (3) clearly and specifically disclosed that the  
9 plan allowed such termination or reduction as to the  
10 participant after the time of his or her retirement or  
11 disability.

12 The disclosure described in paragraph (3) must have been  
13 made prominently and in language which can be under-  
14 stood by the average plan participant.

15 (c) REPRESENTATION.—Notwithstanding any other  
16 provision of law, an employee representative of any retired  
17 employee or the employee’s spouse or dependents may—

18 (1) bring an action described in this section on  
19 behalf of such employee, spouse, or dependents; or

20 (2) appear in such an action on behalf of such  
21 employee, spouse or dependents.

22 (d) RETIREE HEALTH BENEFITS.—For the purposes  
23 of this section, the term “retiree health benefits” means  
24 health benefits (including coverage) which are provided  
25 to—

1           (1) retired or disabled employees who, imme-  
 2           diately before the termination or reduction, are enti-  
 3           tled to receive such benefits upon retirement or be-  
 4           coming disabled; and

5           (2) their spouses and dependents.

6           (e) EFFECTIVE DATE.—The amendments made by  
 7 this section shall apply to actions relating to terminations  
 8 or reductions of retiree health benefits which are pending  
 9 or brought, on or after July 20, 1993.

10 **SEC. 1308. ENFORCEMENT.**

11           In the case of a person that violates a requirement  
 12 of this subtitle, the Secretary of Labor may impose a civil  
 13 money penalty, in an amount not to exceed \$10,000, for  
 14 each violation with respect to each individual.

15 **PART 2—ACCESS THROUGH HEALTH INSURANCE**

16 **PURCHASING COOPERATIVES**

17 **Subpart A—General Requirements**

18 **SEC. 1321. ORGANIZATION AND OPERATION.**

19           (a) DESIGNATION OF COOPERATIVES.—A State shall  
 20 certify health insurance purchasing cooperatives (in this  
 21 Act referred to as “purchasing cooperatives”) in accord-  
 22 ance with this part. Each cooperative shall be chartered  
 23 under State law and operated as a not-for-profit corpora-  
 24 tion.

25           (b) BOARD OF DIRECTORS.—

1           (1) IN GENERAL.—Each cooperative shall be  
2           governed by a Board of Directors to be composed of  
3           representatives of community-rated employers, com-  
4           munity-rated employees, and community-rated indi-  
5           viduals as elected by the members of the purchasing  
6           cooperative.

7           (2) INITIAL BOARD.—The initial Board of Di-  
8           rectors of a purchasing cooperative shall be com-  
9           posed of members selected by the sponsoring entity  
10          of the cooperative. Subsequent members of the  
11          Board of Directors shall be elected as provided for  
12          under paragraph (1) after being nominated by a  
13          nominating committee appointed by the preceding  
14          Board of Directors.

15          (c) ESTABLISHMENT BY STATE OR LOCAL GOVERN-  
16          MENT.—A State or local government may establish or  
17          sponsor a purchasing cooperative to serve a community  
18          rating area. The Secretary shall establish special rules  
19          concerning the legal and governing structure of a State  
20          or local government purchasing cooperative.

21          (d) MEMBERSHIP.—A purchasing cooperative shall  
22          accept all community-rated employers, community-rated  
23          employees, and community-rated individuals residing with-  
24          in the area served by the cooperative as members if such  
25          employers, employees, or individuals request such mem-

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

4 (e) PROHIBITION.—An insurer may not form or un-  
5 derwrite a purchasing cooperative but may administer  
6 such a cooperative.

7 (f) DUTIES OF COOPERATIVES.—Each purchasing  
8 cooperative shall—

9 (1) negotiate (regarding premiums and mar-  
10 keting fees) with and enter into agreements with  
11 standard health plans under section 1323;

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

14 (3) enroll community-rated employees and com-  
15 munity-rated individuals in standard health plans;

16 (4) collect premiums and make payments to  
17 standard health plans on behalf of community-rated  
18 employers and community-rated individuals;

19 (5) provide for coordination with other pur-  
20 chasing cooperatives;

21 (6) provide comparative information to the pub-  
22 lic and the participating State on standard health  
23 plans offered through the purchasing cooperative  
24 from information provided by the plans under sec-  
25 tion 1125;

1           (7) have the capability of accepting data from  
2           standard health plans as required under subtitle B  
3           of title V;

4           (8) comply with such fiduciary responsibility, fi-  
5           nancial management, and administrative require-  
6           ments as the Secretary may establish; and

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

9           (g) LIMITATION ON ACTIVITIES.—A cooperative shall  
10          not—

11           (1) perform any activity (including review, ap-  
12           proval, or enforcement) relating to payment rates for  
13           providers;

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

17           (3) assume insurance risk; or

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

21           (h) RULES OF CONSTRUCTION.—

22           (1) MULTIPLE COOPERATIVES.—Noting in this  
23           section shall be construed to prevent a State from  
24           certifying or establishing more than one purchasing  
25           cooperative in a community rating area.

1 (2) EXCLUSIVE COOPERATIVE.—

2 (A) IN GENERAL.—Nothing in this section  
3 shall be construed as requiring a State to cer-  
4 tify or establish more than one purchasing co-  
5 operative serving a community rating area.

6 (B) SPECIAL RULES.—If a State chooses  
7 to certify only one purchasing cooperative in a  
8 community rating area, then such cooperative  
9 (other than a cooperative established under sec-  
10 tion 1341) may not negotiate regarding pre-  
11 miums as described in subsection (f)(1) and,  
12 notwithstanding section 1323(a)(1), shall enter  
13 into an agreement with each standard health  
14 plan operating in the area which desires such  
15 an agreement.

16 (3) SINGLE ORGANIZATION SERVING MULTIPLE  
17 COMMUNITY RATING AREAS.—Nothing in this sec-  
18 tion shall be construed as preventing a single not-  
19 for-profit corporation from being the purchasing co-  
20 operative for more than one community rating area.

21 (4) VOLUNTARY PARTICIPATION.—Nothing in  
22 this section shall be construed as requiring any com-  
23 munity-rated individual, community-rated employee,  
24 or community-rated employer to purchase a stand-  
25 ard health plan exclusively through a cooperative.

1 **SEC. 1322. MEMBERSHIP.**

2 (a) IN GENERAL.—A purchasing cooperative shall  
3 offer all community-rated individuals and community-  
4 rated employees residing within the community rating  
5 area served by the cooperative the opportunity to enroll  
6 in any standard health plan that has entered into an  
7 agreement with the cooperative under section 1323.

8 (b) ENROLLMENT PROCESS.—A purchasing coopera-  
9 tive shall establish an enrollment process in accordance  
10 with rules established by the Secretary.

11 (c) COORDINATION AMONG PURCHASING COOPERA-  
12 TIVES.—Each participating State shall establish rules con-  
13 sistent with this section for coordination among pur-  
14 chasing cooperatives in cases in which community-rated  
15 employers are located in one community rating area and  
16 their community-rated employees reside in a different  
17 community rating area.

18 **SEC. 1323. AGREEMENTS WITH STANDARD HEALTH PLANS.**

19 (a) AGREEMENTS.—

20 (1) IN GENERAL.—Except as provided in para-  
21 graph (2), each purchasing cooperative for a commu-  
22 nity rating area may enter into an agreement under  
23 this section with any standard health plan that the  
24 purchasing cooperative desires to be made available  
25 through such purchasing cooperative.

26 (2) MINIMUM REQUIREMENT.—

1 (A) IN GENERAL.—Except as provided in  
2 subparagraph (B), each purchasing cooperative  
3 shall enter into an agreement under paragraph  
4 (1) with at least 3 types of standard health  
5 plans which provide the standard benefits pack-  
6 age established under subtitle C, including, if  
7 available, a high cost-sharing plan, a combina-  
8 tion cost-sharing plan, and a low cost-sharing  
9 plan as established under such subtitle.

10 (B) WAIVER OF REQUIREMENT.—The Gov-  
11 ernor of a participating State may waive the re-  
12 quirement under subparagraph (A), in a man-  
13 ner consistent with section 1301(a)(2)), for any  
14 purchasing cooperative in a rural area of such  
15 State which demonstrates an insufficient popu-  
16 lation density to support 3 types of standard  
17 health plans. Such a purchasing cooperative  
18 shall at least offer a high cost-sharing plan as  
19 established under such subtitle.

20 (3) LIMITATION.—A purchasing cooperative  
21 may not enter into an agreement under this section  
22 with a standard health plan unless such plan is cer-  
23 tified by the State under subtitle E.

24 (4) TERMINATION OF AGREEMENT.—An agree-  
25 ment under paragraph (1) shall remain in effect for

1 a 12-month period. The State shall establish a pro-  
2 cess for the termination of agreements entered into  
3 under this section and a process for appealing such  
4 termination under this paragraph. In accordance  
5 with rules established by the State—

6 (A) a cooperative may terminate an agree-  
7 ment with a standard health plan if the health  
8 plan's certification for the community rating  
9 area involved is terminated or if the health plan  
10 fails to fulfill the requirements of the agree-  
11 ment; and

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

17 (b) RECEIPT OF GROSS PREMIUMS.—

18 (1) IN GENERAL.—A purchasing cooperative  
19 may require that a standard health plan with which  
20 such cooperative has an agreement under this sec-  
21 tion provide for the payment of premiums directly to  
22 the cooperative in accordance with rules promulgated  
23 by the Secretary.

24 (2) FORWARDING OF PREMIUMS.—A pur-  
25 chasing cooperative that requires direct payment of

1 premiums under paragraph (1) shall forward to the  
2 standard health plan the amounts collected on the  
3 behalf of the enrollees in such plan in accordance  
4 with the State program of reinsurance and risk ad-  
5 justment.

6 (3) CERTIFIED STANDARD HEALTH PLANS RE-  
7 TAIN RISK OF NONPAYMENT.—Nothing in this sub-  
8 section shall be construed as placing upon a pur-  
9 chasing cooperative any risk associated with the fail-  
10 ure of individuals and employers to make prompt  
11 payment of premiums (other than the portion of the  
12 premium representing the purchasing cooperative  
13 administrative fee under section 1324(a)).

14 **SEC. 1324. MEMBERSHIP AND MARKETING FEES.**

15 (a) COOPERATIVE FEES.—A purchasing cooperative  
16 shall charge members a uniform membership fee to cover  
17 the cost of activities undertaken by the cooperative (in-  
18 cluding all administrative costs incurred by the coopera-  
19 tive).

20 (b) MARKETING FEES.—

21 (1) IN GENERAL.—A purchasing cooperative  
22 shall charge members a separate marketing fee  
23 which a standard health plan may charge to cover  
24 the cost of marketing and administrative activities  
25 undertaken by such plan in such cooperative.

1           (2) NEGOTIATION.—A purchasing cooperative  
2 and a standard health plan shall negotiate the mar-  
3 keting fee. Such negotiated fee shall not be binding  
4 on such health plan with respect to other purchasing  
5 cooperatives through which the plan is offered.

6           (3) LIMITATION.—In no case shall a marketing  
7 fee assessed by a standard health plan offered out-  
8 side of a purchasing cooperative be lower than the  
9 weighted average of the marketing fees negotiated  
10 with all purchasing cooperatives for the community  
11 rating area involved.

12       (c) DISCLOSURE AND MULTIPLE COOPERATIVES.—

13           (1) DISCLOSURE.—A purchasing cooperative  
14 shall, prior to the time of enrollment, publish the  
15 membership fee of such cooperative and the mar-  
16 keting fees for each standard health plan offered  
17 through the cooperative. Such fees shall be cal-  
18 culated and identified as separate charges from the  
19 premium charged by the standard health plans of-  
20 fered by the purchasing cooperative.

21           (2) SUBMISSIONS TO STATE.—

22           (A) IN GENERAL.—Each purchasing coop-  
23 erative in a community rating area shall provide  
24 the State with information on the fees described

1 in paragraph (1) under rules developed by the  
2 State.

3 (B) DOCUMENTATION.—Pursuant to regu-  
4 lations issued by the Secretary, standard health  
5 plans shall submit actuarial data and such  
6 other documentation as the State may require  
7 in order to verify the basis for variation in mar-  
8 keting fees across cooperatives and other insur-  
9 ance distribution sources. States shall use such  
10 information in order to make a determination  
11 that each plan’s marketing fees are based on le-  
12 gitimate variation in marketing and distribution  
13 costs across alternative distribution sources.

14 (3) MULTIPLE COOPERATIVES.—In community  
15 rating areas in which States have certified multiple  
16 purchasing cooperatives, such cooperatives may com-  
17 pete for members on the basis of the fees described  
18 in this section.

19 **Subpart B—Community-Rated Employers**

20 **SEC. 1331. DUTIES OF PURCHASING COOPERATIVES.**

21 (a) IN GENERAL.—A purchasing cooperative for a  
22 community rating area shall offer to enter into an agree-  
23 ment under this section with each community-rated em-  
24 ployer that employs individuals in the community rating  
25 area and that desires to join the cooperative. An agree-

1 ment between such an employer and a cooperative shall  
2 include provisions consistent with the requirements of this  
3 subtitle.

4 (b) ELECTION OF ENROLLMENT.—

5 (1) IN GENERAL.—An employee of a commu-  
6 nity-rated employer may select coverage under any  
7 of the standard health plans offered through a pur-  
8 chasing cooperative of which the employer is a mem-  
9 ber.

10 (2) ENROLLMENT OUTSIDE THE COOPERA-  
11 TIVE.—An employee of a community-rated employer  
12 may elect to enroll in a plan offered through the  
13 purchasing cooperative with which the employer has  
14 entered into an agreement or directly with a stand-  
15 ard health plan selected by the employer (if such  
16 plan is not offered by the cooperative selected by the  
17 employer). A community-rated employee not residing  
18 in the community rating area served by the pur-  
19 chasing cooperative selected by the employer shall  
20 enroll in a standard health plan consistent with rules  
21 promulgated by the Secretary. The purchasing coop-  
22 erative selected by the employer shall be responsible  
23 for forwarding premium payments to the appropriate  
24 plan or cooperative for each community-rated em-



1 rated individuals residing within that area at the  
2 community-rated premium established under section  
3 1116.

4 (2) FEDERAL EMPLOYEES AND ANNUITANTS.—  
5 Until the date of universal coverage, any Federal  
6 employee or annuitant shall obtain coverage under  
7 any FEHBP plan offered through such a purchasing  
8 cooperative in the community rating area in which  
9 such employee or annuitant resides at the rate es-  
10 tablished under chapter 89 of title 5, United States  
11 Code, for such plan.

12 (3) OFFER OF NATIONAL PLANS.—Each pur-  
13 chasing cooperative joined or established under para-  
14 graph (1) shall, not later than January 1, 1998,  
15 offer to community-rated individuals covered by such  
16 cooperative all national FEHBP plans (including  
17 employee organization plans) under rules established  
18 by the Office of Personnel Management.

19 (b) AGREEMENTS WITH PURCHASING COOPERA-  
20 TIVES.—

21 (1) IN GENERAL.—The Office of Personnel  
22 Management shall make every effort to enter into an  
23 agreement with a purchasing cooperative in each  
24 community rating area in the United States to carry  
25 out its responsibilities under this section.

1           (2) ESTABLISHMENT BY OPM.—If no pur-  
2           chasing cooperative exists in an area or if the Office  
3           of Personnel Management is unsuccessful in reach-  
4           ing such an agreement, the Office of Personnel Man-  
5           agement shall establish and administer a purchasing  
6           cooperative in such area. Such cooperative shall  
7           meet all the requirements of this part except rules  
8           regarding governance and fiduciary responsibility.

9           (3) DESIGNATION AS PURCHASING COOPERA-  
10          TIVE.—All FEHBP eligible employees residing in  
11          the community rating area served by a cooperative  
12          described in paragraph 1 or (2) shall enroll in a  
13          standard health plan through such cooperative.

14          (c) REQUIREMENT OF OPM.—

15               (1) IN GENERAL.—The Office of Personnel  
16               Management is hereby authorized to take such ac-  
17               tions as are appropriate to fulfill its responsibilities  
18               under this subpart.

19               (2) RATE BLENDING.—The Office of Personnel  
20               Management shall implement rules to blend during  
21               the period before the date of universal coverage the  
22               premiums for FEHBP plans offered through pur-  
23               chasing cooperatives to Federal employees and com-  
24               munity-rated individuals in each community rating  
25               area.

1 (d) AMENDMENTS TO TITLE 5.—

2 (1) IN GENERAL.—Chapter 89 of title 5, United  
3 States Code, is amended by adding at the end the  
4 following new section:

5 **“§ 8915. Relationship to the Health Security Act**

6 “(a) The provisions of this chapter shall be subject  
7 to the provisions of the Health Security Act, to the extent  
8 of any inconsistency between such provisions.

9 “(b) Individuals who are not Federal employees or  
10 annuitants and who are enrolled in a health benefits plan  
11 pursuant to section 1341 of the Health Security Act shall  
12 for all administrative purposes be treated separately from  
13 Federal employees and annuitants enrolled under this  
14 chapter.

15 “(c) No provision of the Health Security Act shall  
16 be construed to authorize the payment or deposit of any  
17 monies from or into the Employees Health Benefits  
18 Fund.”.

19 (2) CONFORMING AMENDMENT.—Section 8914  
20 of title 5, United States Code, is amended by strik-  
21 ing out “Any provision of law” and inserting in lieu  
22 thereof “Except for the provisions of the Health Se-  
23 curity Act, any provision of law”.

24 (3) TECHNICAL AMENDMENT.—The table of  
25 sections for chapter 89 of title 5, United States

1 Code, is amended by adding after the item relating  
2 to section 8914 the following new item:

“8915. Relationship to the Health Security Act.”.

3 **SEC. 1342. SPECIAL RULES FOR FEHBP SUPPLEMENTAL**  
4 **PLANS.**

5 (a) DEVELOPMENT.—The Office of Personnel Man-  
6 agement shall develop FEHBP supplemental health ben-  
7 efit plans. The Office of Personnel Management shall meet  
8 and confer with representatives of Federal employees and  
9 annuitants regarding the supplemental services plans and  
10 the cost-sharing plans to be offered (including premium  
11 contributions, if any, to be made by the Federal Govern-  
12 ment with respect to such plans for Federal employees and  
13 annuitants) through a process to be established by the Na-  
14 tional Partnership Council.

15 (b) OFFERING.—The Federal Government shall offer  
16 FEHBP supplemental health benefit plans developed in  
17 accordance with subsection (a) and cost-sharing plans as  
18 provided in section 1141 to Federal employees, annu-  
19 itants, and any other community-rated individual.

20 **SEC. 1343. DEFINITIONS.**

21 For purposes of this subpart:

22 (1) ANNUITANT.—The term “annuitant” means  
23 an “annuitant” as defined by section 8901 of title  
24 5, United States Code.

1           (2) FEHBP.—The term “FEHBP” means the  
2 health insurance program under chapter 89 of title  
3 5, United States Code.

4           (3) FEDERAL EMPLOYEE.—The term “Federal  
5 employee” means an “employee” as defined by sec-  
6 tion 8901 of title 5, United States Code.

7       **PART 3—TREATMENT OF ASSOCIATION PLANS**

8       **SEC. 1351. RULES RELATING TO MULTIPLE EMPLOYER**  
9                               **WELFARE ARRANGEMENTS.**

10       (a) GENERAL RULE.—A multiple employer welfare  
11 arrangement—

12           (1) shall meet all requirements of this Act ap-  
13 plicable to standard health plans, and

14           (2) may elect to be treated as a health insur-  
15 ance purchasing cooperative if it meets the require-  
16 ments of part 2 and other applicable requirements of  
17 this Act.

18       (b) TREATMENT FOR RATING PURPOSE.—

19           (1) IN GENERAL.—Except as provided in para-  
20 graph (2), a plan to which subsection (a) applies  
21 shall be treated as a community-rated plan and shall  
22 meet all requirements of this Act applicable to a  
23 community-rated plan.

24           (2) EXPERIENCE-RATED PLAN.—A plan shall  
25 be treated as an experience-rated plan only if the

1       only participants in the plan are experience-rated in-  
2       dividuals.

3       (c) COORDINATION WITH ERISA.—Section 514(b) of  
4 the Employee Retirement Income Security Act of 1974  
5 (29 U.S.C. 1144(b)) is amended by striking paragraph  
6 (6).

7       (d) MULTIPLE EMPLOYER WELFARE ARRANGE-  
8 MENT.—For purposes of this section, the term “multiple  
9 employer welfare arrangement” has the meaning given  
10 such term by section 3(40) of the Employer Retirement  
11 Income Security Act of 1974.

12 **SEC. 1352. ASSOCIATION PLANS.**

13       (a) GENERAL RULE.—Any health plan to which sec-  
14 tion 1351 does not apply which is maintained by an asso-  
15 ciation or similar entity shall meet all requirements of this  
16 Act applicable to standard health plans.

17       (b) TREATMENT FOR RATING PURPOSES.—

18           (1) IN GENERAL.—Except as provided in para-  
19 graph (2), a plan to which subsection (a) applies  
20 shall be treated as a community-rated plan and shall  
21 meet all requirements of this Act applicable to a  
22 community-rated plan.

23           (2) EXPERIENCE-RATED PLAN.—A plan shall  
24 be treated as an experience-rated plan only if the

1       only participants in the plan are experience-rated in-  
2       dividuals.

3                               **Subtitle E—Federal**  
4                               **Responsibilities**

5       **PART 1—SECRETARY OF HEALTH AND HUMAN**  
6                               **SERVICES**

7                               **Subpart A—General Duties**

8       **SEC. 1401. GENERAL DUTIES AND RESPONSIBILITIES.**

9       (a) **IN GENERAL.**—Except as otherwise specifically  
10       provided in this Act (or with respect to the administration  
11       of provisions in the Internal Revenue Code of 1986 or in  
12       the Employee Retirement Income Security Act of 1974),  
13       the Secretary of Health and Human Services shall admin-  
14       ister and implement all of the provisions of this Act.

15       (b) **COVERAGE AND FAMILIES.**—The Secretary shall  
16       develop and implement standards relating to the eligibility  
17       of individuals for coverage in applicable health plans under  
18       subtitle B and may provide such additional exceptions and  
19       special rules relating to the treatment of family members  
20       under section 1113 as the Secretary finds appropriate.

21       (c) **QUALITY MANAGEMENT AND IMPROVEMENT.**—  
22       The Secretary shall establish and have ultimate responsi-  
23       bility for a performance-based system of quality manage-  
24       ment and improvement as required by section 5001.

1 (d) INFORMATION SYSTEM AND INFORMATION RE-  
2 LATED FUNCTIONS.—

3 (1) IN GENERAL.—The Secretary shall—

4 (A) develop and implement standards to  
5 establish a national health information system  
6 to measure quality as required by title V;

7 (B) provide model format and content re-  
8 quirements for summary plan descriptions;

9 (C) provide model format and content re-  
10 quirements for comparative plan brochures  
11 under section 1125; and

12 (D) provide model format and content re-  
13 quirements for comparative purchasing coopera-  
14 tive brochures under section 1321.

15 (2) INFORMATION RELATED FUNCTIONS.—

16 (A) DESIGNATION.—The Secretary shall  
17 provide for the use of entities in the national  
18 health data network to perform information re-  
19 lated functions under this section with respect  
20 to employers, States, contracting entities, and  
21 purchasing cooperatives.

22 (B) FUNCTIONS.—The functions referred  
23 to in subparagraph (A) shall include—

24 (i) receipt of information submitted by  
25 employers under section 1301,

1 (ii) with respect to the information re-  
2 ceived, transmittal to the States, and

3 (iii) such other functions as the Sec-  
4 retary specifies.

5 (e) PARTICIPATING STATE REQUIREMENTS.—Con-  
6 sistent with the provisions of subtitle F, the Secretary  
7 shall—

8 (1) establish requirements for participating  
9 States,

10 (2) monitor State compliance with those re-  
11 quirements, and

12 (3) provide technical assistance,  
13 in a manner that ensures access to the standard benefit  
14 package for all eligible individuals.

15 (f) DEVELOPMENT OF PREMIUM AND AGE CLASS  
16 FACTORS.—The Secretary shall establish premium class  
17 and age class factors under subpart D.

18 (g) DEVELOPMENT OF REINSURANCE AND RISK-AD-  
19 JUSTMENT METHODOLOGY.—The Secretary shall develop  
20 a methodology for the reinsurance and risk-adjustment of  
21 premium payments to community-rated and experience-  
22 rated health plans in accordance with section 1504.

23 (h) FINANCIAL REQUIREMENTS.—

24 (1) IN GENERAL.—The Secretary shall establish  
25 minimum capital requirements and requirements for

1 guaranty funds and financial reporting and auditing  
2 standards under subpart F.

3 (2) FINANCIAL MANAGEMENT STANDARDS.—

4 The Secretary, in consultation with the Secretary of  
5 Labor, shall establish, for purposes of section 1118,  
6 standards relating to the management of finances,  
7 maintenance of records, accounting practices, audit-  
8 ing procedures, and financial reporting for States,  
9 consumer purchasing cooperatives and health plans.  
10 Such standards shall take into account current Fed-  
11 eral laws and regulations relating to fiduciary re-  
12 sponsibilities and financial management of funds.

13 (3) AUDITING STATE PERFORMANCE.—The

14 Secretary shall perform periodic financial and other  
15 audits of States to assure that such States are car-  
16 rying out their responsibilities under this Act con-  
17 sistent with this Act. Such audits shall include au-  
18 dits of State performance in the areas of—

19 (A) assuring enrollment of all community-  
20 rated individuals in health plans;

21 (B) management of premium and cost  
22 sharing discounts and reductions provided;

23 (C) financial management (including the  
24 financial activities of cooperatives and State-  
25 designated contracting entities); and

1 (D) assuring enforcement of the anti-  
2 discrimination provisions of this Act.

3 (i) STANDARDS FOR HEALTH PLAN GRIEVANCE PRO-  
4 CEDURES.—The Secretary shall establish standards for  
5 health plan grievance procedures that are used by enroll-  
6 ees in pursuing complaints.

7 (j) FIDUCIARY REQUIREMENTS.—The Secretary  
8 shall, in consultation with the Secretary of Labor, develop  
9 and promulgate fiduciary requirements for the manage-  
10 ment of funds by States, plans, cooperatives, and employ-  
11 ers.

12 (k) GUARANTY FUNDS.—The Secretary shall estab-  
13 lish standards for guaranty funds as provided for in sec-  
14 tion 1442.

15 (l) STANDARDS FOR UTILIZATION MANAGEMENT  
16 PROGRAMS.—

17 (1) IN GENERAL.—Not later than 12 months  
18 after the date of enactment of this Act, the Sec-  
19 retary, in consultation with interested parties which  
20 may include one or more accrediting organizations,  
21 shall promulgate uniform Federal standards for uti-  
22 lization management programs, to include the activi-  
23 ties described in section 1129.

24 (2) COMPLIANCE.—States shall ensure compli-  
25 ance with the Federal standards established under

1 paragraph (1), consistent with their role in certi-  
2 fying health plans.

3 (3) REVIEW AND UPDATE.—The Secretary shall  
4 periodically review and update utilization manage-  
5 ment standards to reflect appropriate policies and  
6 practices in health care delivery.

7 (m) COLLECTION ACTIVITIES.—The Secretary may  
8 provide (through contract or otherwise) for collection ac-  
9 tivities for the collection of amounts owed to States and  
10 purchasing cooperatives for health insurance coverage sub-  
11 ject to the provisions of this title.

12 **SEC. 1402. ANNUAL REPORT.**

13 (a) IN GENERAL.—The Secretary, in consultation  
14 with the National Health Benefits Board and the Health  
15 Care Cost and Coverage Commission, shall prepare and  
16 submit to the President and the Congress an annual re-  
17 port concerning the overall implementation of the new  
18 health care system under this Act.

19 (b) MATTERS TO BE INCLUDED.—The Secretary  
20 shall include in each annual report under this section the  
21 following:

22 (1) Information on Federal and State imple-  
23 mentation.

24 (2) Data related to quality improvement.

1           (3) Recommendations or changes in the admin-  
2           istration and regulation of laws related to health  
3           care financing, delivery, and coverage.

4 **SEC. 1403. ASSISTANCE WITH FAMILY COLLECTIONS.**

5           The Secretary shall provide States with such tech-  
6           nical and other assistance as may promote the efficient  
7           collection of other amounts owed by families under this  
8           Act.

9 **SEC. 1404. ADVISORY OPINIONS.**

10          (a) **IN GENERAL.**—Community- and provider-based  
11          plans, and individuals and organizations seeking to estab-  
12          lish such plans, shall be eligible to receive advisory opin-  
13          ions from appropriate Federal entities, including opinions  
14          concerning whether their arrangement complies with Fed-  
15          eral self-referral, fraud and abuse, and anti-trust laws.

16          (b) **REGULATIONS.**—The Secretary shall issue regula-  
17          tions setting forth the procedures for obtaining advisory  
18          opinions described in subsection (a).

19          (c) **TIMING OF OPINIONS.**—An advisory opinions  
20          shall be issued not later than 90 days after receipt of a  
21          request for such opinion from a plan.

22          (d) **FEEES.**—Applicants under this section shall pay  
23          a fee, the amount of which to be determined by the Sec-  
24          retary, to cover the costs of providing an opinion under  
25          this section.

1 **SEC. 1405. FUNDING.**

2       There are authorized to be appropriated to the Sec-  
3 retary, such sums as may be necessary to carry out this  
4 subpart for each of the fiscal years 1995 through 1999.

5 **Subpart B—Responsibilities Relating to Review and**  
6 **Approval of State Systems**

7 **SEC. 1411. FEDERAL REVIEW AND ACTION ON STATE SYS-**  
8 **TEMS.**

9       (a) APPROVAL OF STATE SYSTEMS BY SEC-  
10 RETARY.—

11           (1) IN GENERAL.—The Secretary shall approve  
12 a State health care system for which a plan is sub-  
13 mitted under section 1501(a) unless the Secretary  
14 determines that the system (as set forth in the plan)  
15 does not (or will not) meet the responsibilities for a  
16 participating State under this Act.

17           (2) REGULATIONS.—Not later than July 1,  
18 1995, the Secretary shall issue regulations, pre-  
19 scribing the requirements for State health care sys-  
20 tems under this title, except that in the case of a  
21 plan submitted under section 1501(a) before the  
22 date of issuance of such regulations, the Secretary  
23 shall take action on such document notwithstanding  
24 the fact that such regulations have not been issued.

25           (3) NO APPROVAL PERMITTED FOR YEARS  
26 PRIOR TO 1996.—Except as otherwise specifically

1 provided in this Act, the Secretary may not approve  
2 a State health care system under this subpart for  
3 any year prior to 1996.

4 (b) REVIEW OF COMPLETENESS OF PLANS.—

5 (1) IN GENERAL.—If a State submits a plan  
6 under subsection (a)(1), the Secretary shall notify  
7 the State, not later than 7 working days after the  
8 date of submission, whether or not the plan is com-  
9 plete and provides the Secretary with sufficient in-  
10 formation to approve or disapprove the document.

11 (2) ADDITIONAL INFORMATION ON INCOMPLETE  
12 PLAN.—If the Secretary notifies a State that the  
13 State's plan is not complete, the State shall be pro-  
14 vided such additional period (not to exceed 45 days)  
15 as the Secretary may by regulation establish in  
16 which to submit such additional information as the  
17 Secretary may require. Not later than 7 working  
18 days after the State submits the additional informa-  
19 tion, the Secretary shall notify the State respecting  
20 the completeness of the plan.

21 (c) ACTION ON COMPLETED DOCUMENTS.—

22 (1) IN GENERAL.—The Secretary shall make a  
23 determination (and notify the State) on whether the  
24 State's plan provides for the implementation of a

1 State system that meets the applicable requirements  
2 of this title—

3 (A) in the case of a State that did not re-  
4 quire an additional period described in sub-  
5 section (b)(2) to file a complete plan, not later  
6 than 90 days after notifying a State under sub-  
7 section (b) that the State’s plan is complete, or

8 (B) in the case of a State that required an  
9 additional period described in subsection (b)(2)  
10 to file a complete plan, not later than 90 days  
11 after notifying a State under subsection (b)  
12 that the State’s plan is complete.

13 (2) REVIEW OF COVERAGE AREA.—The Sec-  
14 retary shall review the State designation of commu-  
15 nity rating area boundaries to determine whether  
16 such boundaries comply with sections 1502 and  
17 1602, and in particular, the requirements of such  
18 sections concerning non-discrimination in the estab-  
19 lishment of coverage area boundaries.

20 (3) PLANS DEEMED APPROVED.—If the Sec-  
21 retary does not meet the applicable deadline for  
22 making a determination and providing notice under  
23 paragraph (1) with respect to a State’s plan, the  
24 Secretary shall be deemed to have approved the  
25 State’s plan for purposes of this Act.

1 (d) OPPORTUNITY TO RESPOND TO REJECTED  
2 PLAN.—

3 (1) IN GENERAL.—If (within the applicable  
4 deadline under subsection (e)(1)) the Secretary noti-  
5 fies a State that its plan does not provide for the  
6 implementation of a State system that meets the ap-  
7 plicable requirements of this title, the Secretary shall  
8 provide the State with a period of 60 days in which  
9 to submit such additional information and assur-  
10 ances as the Secretary may require.

11 (2) DEADLINE FOR RESPONSE.—Not later than  
12 30 days after receiving additional information and  
13 assurances under paragraph (1), the Secretary shall  
14 make a determination (and notify the State) on  
15 whether the State’s plan provides for the implemen-  
16 tation of a State system that meets the applicable  
17 requirements of this title.

18 (3) PLAN DEEMED APPROVED.—If the Sec-  
19 retary does not meet the deadline established under  
20 paragraph (2) with respect to a State, the Secretary  
21 shall be deemed to have approved the State’s plan  
22 for purposes of this Act.

23 (e) APPROVAL OF PREVIOUSLY TERMINATED  
24 STATES.—If the Secretary has approved a State system  
25 under this part for a year but subsequently terminated

1 the approval of the system under section 1412(b)(2), the  
2 Secretary shall approve the system for a succeeding year  
3 if the State—

4 (1) demonstrates to the satisfaction of the Sec-  
5 retary that the failure that formed the basis for the  
6 termination no longer exists, and

7 (2) provides reasonable assurances that the  
8 types of actions (or inactions) which formed the  
9 basis for such termination will not recur.

10 (f) REVISIONS TO STATE SYSTEM.—

11 (1) SUBMISSION.—A State may revise a system  
12 approved for a year under this section, except that  
13 such revision shall not take effect unless the State  
14 has submitted to the Secretary a document describ-  
15 ing such revision and the Secretary has approved  
16 such revision.

17 (2) ACTIONS ON REVISIONS.—Not later than 60  
18 days after a document is submitted under paragraph  
19 (1), the Secretary shall make a determination (and  
20 notify the State) on whether the implementation of  
21 the State system, as proposed to be revised, meets  
22 the applicable requirements of this title. If the Sec-  
23 retary fails to meet the requirement of the preceding  
24 sentence, the Secretary shall be deemed to have ap-

1 proved the implementation of the State system as  
2 proposed to be revised.

3 (3) REJECTION OF REVISIONS.—Subsection (d)  
4 shall apply to an amendment submitted under this  
5 subsection in the same manner as it applies to a  
6 completed plan submitted under subsection (b).

7 **SEC. 1412. FAILURE OF PARTICIPATING STATES TO MEET**  
8 **CONDITIONS FOR COMPLIANCE.**

9 (a) IN GENERAL.—In the case of a participating  
10 State, if the Secretary determines that the operation of  
11 the State system under this title fails to meet the applica-  
12 ble requirements of this Act, the Secretary shall apply  
13 against the State in accordance with subsection (b).

14 (b) TYPE OF SANCTION APPLICABLE.—The sanctions  
15 applicable under this section are as follows:

16 (1) If the Secretary determines that the State's  
17 failure does not substantially jeopardize the ability  
18 of eligible individuals in the State to obtain coverage  
19 for the standard benefit package, the Secretary shall  
20 reduce payments with respect to the State in accord-  
21 ance with section 1413.

22 (2) If the Secretary determines that the failure  
23 substantially jeopardizes the ability of eligible indi-  
24 viduals in the State to obtain coverage for the stand-  
25 ard benefit package—

1 (A) the Secretary shall terminate its ap-  
2 proval of the State system; and

3 (B) the Secretary shall assume the respon-  
4 sibilities described in section 1422.

5 (c) TERMINATION OF SANCTION.—A State against  
6 which a sanction is imposed under this section may submit  
7 information at any time to the Secretary to demonstrate  
8 that the failure that led to the imposition of the sanction  
9 has been corrected.

10 (d) PROTECTION OF ACCESS TO BENEFITS.—The  
11 Secretary shall take actions under this section with respect  
12 to a State only in a manner that assures the continuous  
13 coverage of eligible individuals enrolled in community-  
14 rated health plans.

15 **SEC. 1413. REDUCTION IN PAYMENTS FOR HEALTH PRO-**  
16 **GRAMS BY SECRETARY OF HEALTH AND**  
17 **HUMAN SERVICES.**

18 (a) IN GENERAL.—Upon a determination by the Sec-  
19 retary under section 1412(b)(1), the Secretary shall re-  
20 duce the amount of any of the payments described in sub-  
21 section (b) that would otherwise be made to individuals  
22 and entities in the State by such amount as the Secretary  
23 determines to be appropriate.

24 (b) PAYMENTS DESCRIBED.—The payments de-  
25 scribed in this subsection are as follows:

1           (1) Payments to academic health centers in the  
2 State under subtitle B of title III.

3           (2) Payments to individuals and entities in the  
4 State for health research activities under section 301  
5 and title IV of the Public Health Service Act.

6           (3) Payments to hospitals in the State under  
7 part 4 of subtitle E of title III (relating to payments  
8 to hospitals serving vulnerable populations).

9 **SEC. 1414. REVIEW OF FEDERAL DETERMINATIONS.**

10       Any State affected by a determination by the Sec-  
11 retary under this subpart may appeal such determination  
12 in accordance with section 5531.

13 **SEC. 1415. FEDERAL SUPPORT FOR STATE IMPLEMENTA-**  
14 **TION.**

15       (a) **PLANNING GRANTS.**—

16           (1) **IN GENERAL.**—Not later than 90 days after  
17 the date of enactment of this Act, the Secretary  
18 shall, to the extent amounts are appropriated, make  
19 available to each State a planning grant to assist the  
20 State in the development of a health care system  
21 necessary to enable the State to become a partici-  
22 pating State under this title.

23           (2) **FORMULA.**—The Secretary shall establish a  
24 formula for the distribution of funds made available  
25 under this subsection.

1           (3) AUTHORIZATION OF APPROPRIATIONS.—

2           There are authorized to be appropriated  
3           \$50,000,000 for each of the fiscal years 1995 and  
4           1996 for grants under this subsection.

5           (b) GRANTS FOR START-UP SUPPORT.—

6           (1) IN GENERAL.—The Secretary shall, to the  
7           extent amounts are appropriated, make available to  
8           States, upon their becoming participating States,  
9           grants to assist in the establishment of purchasing  
10          cooperatives.

11          (2) FORMULA.—The Secretary shall establish a  
12          formula for the distribution of funds made available  
13          under this subsection.

14          (3) STATE MATCHING FUNDS REQUIRED.—  
15          Funds are payable to a State under this subsection  
16          only if the State provides assurances, satisfactory to  
17          the Secretary, that amounts of State funds (at least  
18          equal to the amount made available under this sub-  
19          section) will be expended for the purposes described  
20          in paragraph (1).

21          (4) AUTHORIZATION OF APPROPRIATIONS.—

22          There are authorized to be appropriated  
23          \$313,000,000 for fiscal year 1996, \$625,000,000 for  
24          fiscal year 1997, and \$313,000,000 for fiscal year  
25          1998, for grants under this subsection.



1 **SEC. 1423. IMPOSITION OF SURCHARGE ON PREMIUMS**  
2 **UNDER FEDERALLY-OPERATED SYSTEM.**

3 If this subpart applies to a State for a calendar year,  
4 the premiums charged by community-rated health plans  
5 in the State shall be equal to premiums that would other-  
6 wise be charged, increased by 15 percent. Such 15 percent  
7 increase shall be used to reimburse the Secretary for any  
8 administrative or other expenses incurred as a result of  
9 establishing and operating the system in that State.

10 **SEC. 1424. RETURN TO STATE OPERATION.**

11 (a) APPLICATION PROCESS.—After the establishment  
12 and operation of a system by the Secretary in a State  
13 under section 1422, the State may at any time apply to  
14 the Secretary for the approval of a State system in accord-  
15 ance with the procedures described in section 1411.

16 (b) TIMING.—If the Secretary approves the system  
17 of a State for which the Secretary has operated a system  
18 under this subpart during a year, the Secretary shall ter-  
19 minate the operation of the system, and the State shall  
20 establish and operate its approved system, as of January  
21 1 of the first year beginning after the Secretary approves  
22 the State system. The termination of the Secretary's sys-  
23 tem and the operation of the State's system shall be con-  
24 ducted in a manner that assures the continuous coverage  
25 of eligible individuals in the State under community-rated  
26 health plans.

1       **Subpart D—Establishment of Class Factors for**  
2                                   **Charging Premiums**

3   **SEC. 1431. PREMIUM CLASS AND AGE CLASS FACTORS.**

4       (a) IN GENERAL.—For purposes of this title and title  
5 X, the Secretary shall establish premium class and age  
6 class factors in accordance with section 1113(c).

7       (b) CONDITIONS.—In establishing such factors, the  
8 factor for the class of individual enrollment shall be 1 and  
9 the factor for the couple-only class of family enrollment  
10 shall be 2.

11       **Subpart E—Risk Adjustment and Reinsurance**  
12                                   **Methodology for Payment of Plans**

13   **SEC. 1435. DEVELOPMENT OF A RISK ADJUSTMENT AND RE-**  
14                                   **INSURANCE METHODOLOGY.**

15       (a) ESTABLISHMENT.—The Secretary shall develop a  
16 risk adjustment and reinsurance methodology in accord-  
17 ance with section 1504.

18       (b) RESEARCH AND DEMONSTRATION.—The Sec-  
19 retary shall conduct and support research and demonstra-  
20 tion projects to develop and improve, on a continuing  
21 basis, the risk adjustment and reinsurance methodology  
22 under this subpart.

23       (c) TECHNICAL ASSISTANCE.—The Secretary shall  
24 provide technical assistance to States in implementing the  
25 methodology developed under this subpart.



1           (1) IN GENERAL.—States shall consider alter-  
2       native financial instruments and methods for  
3       community- and provider-based plans (as defined in  
4       paragraph (2)) to meet the capital and solvency  
5       standards developed in accordance with this section.  
6       Provisions made for such plans shall ensure the fis-  
7       cal integrity and financial solvency of such plans.

8           (2) ELIGIBLE PLANS.—Plans eligible for special  
9       consideration by States must be offered by public or  
10      not-for-profit entities that are owned, or in which a  
11      majority share of the plan’s investment is held by—

12           (A) health care providers who practice in  
13      the plan;

14           (B) individuals who live in the area, or  
15      not-for-profit organizations located in the area  
16      serviced by the plan;

17           (C) a combination of individuals and orga-  
18      nizations described in subparagraphs (A) and  
19      (B); or

20           (D) organizations located outside the serv-  
21      ice area which provide for control over local op-  
22      erations by individuals described in subpara-  
23      graphs (A) or (B).

24           (e) DEVELOPMENT OF STANDARDS BY NAIC.—The  
25      Secretary may request the National Association of Insur-

1   ance Commissioners to develop model standards for the  
2   additional capital requirements described in subsection (c)  
3   and to present such standards to the Secretary not later  
4   than July 1, 1995. The Secretary may accept such stand-  
5   ards as the standards to be applied under subsection (c)  
6   or modify the standards in any appropriate manner.

7   **SEC. 1442. STANDARD FOR GUARANTY FUNDS.**

8       (a) **IN GENERAL.**—In consultation with the States,  
9   the Secretary shall establish standards for guaranty funds  
10  established by States for community-rated health plans.

11       (b) **GUARANTY FUND STANDARDS.**—The standards  
12  established under subsection (a) for a guaranty fund shall  
13  include the following:

14           (1) Each fund must have a method to generate  
15       sufficient resources to pay health providers and oth-  
16       ers in the case of a failure of a health plan in order  
17       to meet obligations with respect to—

18               (A) services rendered by the health plan  
19       for the standard benefit package, including any  
20       supplemental coverage for cost sharing provided  
21       by the health plan, and

22               (B) services rendered prior to health plan  
23       insolvency and services to patients after the in-  
24       solvency but prior to their enrollment in other  
25       health plans.

1           (2) Each fund shall be liable for all claims  
2           against the plan by health care providers with re-  
3           spect to their provision of items and services covered  
4           under the standard benefit package to enrollees of  
5           the failed plan. Such claims, in full, shall take pri-  
6           ority over all other claims. The fund is liable, to the  
7           extent and in the manner provided in accordance  
8           with rules established by the Secretary, for other  
9           claims, including other claims of such providers and  
10          the claims of contractors, employees, governments,  
11          or any other claimants.

12           (3) The fund stands as a creditor for any pay-  
13          ments owed the plan to the extent of the payments  
14          made by the fund for obligations of the plan.

15           (4) The fund has authority to borrow against  
16          future assessments in order to meet the obligations  
17          of failed plans participating in the fund.

18                           **Subpart G—Open Enrollment**

19   **SEC. 1445. PERIODS OF AUTHORIZED CHANGES IN ENROLL-**  
20                           **MENT.**

21          The Secretary shall specify periods of enrollment in  
22          accordance with section 1112(c).

23   **SEC. 1446. DISTRIBUTION OF COMPARATIVE INFORMATION.**

24          The Secretary shall specify a period of time prior to  
25          open enrollment during which States must provide for the

1 distribution to community-rated individuals enrollment  
2 materials and comparative information on health plans  
3 and purchasing cooperatives.

4 **PART 2—ESSENTIAL COMMUNITY PROVIDERS**

5 **SEC. 1461. CERTIFICATION.**

6 For purposes of this Act, the Secretary shall certify  
7 as an “essential community provider” any health care pro-  
8 vider or organization that—

9 (1) is within any of the categories of providers  
10 and organizations specified in section 1462(a), or

11 (2) meets the standards for certification under  
12 section 1463(a).

13 **SEC. 1462. CATEGORIES OF PROVIDERS AUTOMATICALLY**  
14 **CERTIFIED.**

15 (a) IN GENERAL.—The categories of providers and  
16 organizations, including subrecipients, specified in this  
17 subsection are as follows:

18 (1) CATEGORY 1 ENTITIES.—The following enti-  
19 ties shall be considered category 1 entities:

20 (A) Covered entities as defined in section  
21 340B(a)(4) of the Public Health Service Act  
22 (42 U.S.C. 256b(a)(4)), except that subsections  
23 (a)(4)(L)(iii) and (a)(7) of such section shall  
24 not apply.

1 (B) School health services centers under  
2 title III.

3 (C) Public or nonprofit hospitals—

4 (i) that meet the criteria for public  
5 hospitals which are eligible entities under  
6 section 340B of the Public Health Service  
7 Act in any cost reporting period in the 3-  
8 year period prior to the date of enactment  
9 of this Act, except that subsection  
10 (a)(4)(L)(iii) of such section shall not  
11 apply; or

12 (ii) meeting alternative criteria devel-  
13 oped by the Secretary after the date of en-  
14 actment of this Act which are comparable  
15 to the criteria utilized in determining eligi-  
16 bility under such section 340B;

17 (D) Public and private, nonprofit mental  
18 health and substance abuse providers receiving  
19 funds under title V or XIX of the Public Health  
20 Service Act.

21 (E) Runaway homeless youth centers or  
22 transitional living programs for homeless youth  
23 providing health services under the Runaway  
24 Homeless Youth Act of 1974 (42 U.S.C. 5701  
25 et seq.).

1 (F) Public or nonprofit maternal and child  
2 health providers that receive funding under title  
3 V of the Social Security Act.

4 (G) Rural health clinics as defined under  
5 section 1861(aa)(2) of the Social Security Act.

6 (H) Programs of the Indian Health Service  
7 (as defined in section 8302(3)).

8 (2) CATEGORY 2 ENTITIES.—The following enti-  
9 ties shall be considered category 2 entities:

10 (A) Medicare dependent small rural hos-  
11 pitals under section 1886(d)(8)(iii) of the Social  
12 Security Act.

13 (B) Children’s hospitals meeting com-  
14 parable criteria determined appropriate by the  
15 Secretary.

16 (b) STUDY OF FEDERALLY CERTIFIED RURAL  
17 HEALTH CLINICS.—The Secretary shall conduct an eval-  
18 uation of the Rural Health Clinics program as defined in  
19 section 1861(aa)(2) of the Social Security Act to examine  
20 the causes of the growth in the program and the charac-  
21 teristics of providers certified as rural health clinics and  
22 the characteristics of the population served by rural health  
23 clinics to ensure that the program meets the needs of rural  
24 underserved communities. The Secretary shall report the  
25 findings of such evaluation, together with any rec-

1 ommended changes in the rural health clinics program, to  
2 the Congress not later than January 1, 1996.

3 **SEC. 1463. STANDARDS FOR ADDITIONAL PROVIDERS.**

4 (a) STANDARDS.—The Secretary shall publish stand-  
5 ards for the certification of additional categories of health  
6 care providers and organizations as essential community  
7 providers, including the categories described in subsection  
8 (b). Such a health care provider or organization shall not  
9 be certified unless the Secretary determines, under such  
10 standards, that health plans operating in the area served  
11 by the applicant would not otherwise be able to assure ade-  
12 quate access to items and services included in the standard  
13 benefit package if such a provider was not so certified.

14 (b) CATEGORIES TO BE INCLUDED.—The categories  
15 described in this subsection are as follows:

16 (1) CERTAIN HEALTH PROFESSIONALS.—A  
17 health professional who—

18 (A) for at least 20 hours per week—

19 (i) is located in an area (or areas)  
20 designated as a health professional short-  
21 age area (under section 332 of the Public  
22 Health Service Act) or serves a population  
23 (or populations) designated as a medically  
24 underserved population (under section 330  
25 of the Public Health Service Act); or

1 (ii)(I) is located or provides services in  
2 a neighborhood or community whose resi-  
3 dents are at risk of underservice; and

4 (II) is available to patients at such lo-  
5 cation on evenings and weekends; and

6 (B) if the health professional is a physi-  
7 cian—

8 (i) is licensed to practice in the juris-  
9 diction; and

10 (ii) is either—

11 (I) granted privileges to practice  
12 at one or more hospitals; or

13 (II) has a consultation and refer-  
14 ral arrangement with one or more  
15 physicians who are granted privileges  
16 to practice at one or more hospitals.

17 (2) INSTITUTIONAL PROVIDERS.—Public and  
18 private nonprofit hospitals and other public and non-  
19 profit institutional health care providers, including  
20 family planning clinics, located in health professional  
21 shortage areas (as defined under section 332 of the  
22 Public Health Service Act) or receiving funding  
23 under subtitle E of title III of this Act).

24 (3) OTHER PROVIDERS.—

1 (A) IN GENERAL.—Other public and pri-  
2 vate nonprofit agencies and organizations  
3 that—

4 (i) are located in such an area or pro-  
5 viding health services to such a population,  
6 and

7 (ii) provide health care and services  
8 essential to residents of such an area or  
9 such populations.

10 (B) NONPROFIT HOSPITALS.—Nonprofit  
11 hospitals with a minimum of 200 beds, located  
12 in urban areas where—

13 (i) the cumulative total of its services  
14 provided to individuals who are entitled to  
15 benefits under title XVIII of the Social Se-  
16 curity Act or under a State plan under  
17 title XIX of such Act equals a minimum of  
18 65 percent; and

19 (ii) a minimum of 20 percent of its  
20 services are provided to individuals eligible  
21 for assistance under such title XIX.

22 **SEC. 1464. CERTIFICATION PROCESS; REVIEW; TERMI-**  
23 **NATION OF CERTIFICATIONS.**

24 (a) CERTIFICATION PROCESS.—

1           (1) PUBLICATION OF PROCEDURES.—The Sec-  
2           retary shall publish, not later than 6 months after  
3           the date of the enactment of this Act, the procedures  
4           to be used by health care professionals, providers,  
5           agencies, and organizations seeking certification  
6           under this subpart, including the form and manner  
7           in which an application for such certification is to be  
8           made.

9           (2) TIMELY DETERMINATION.—The Secretary  
10          shall make a determination upon such an application  
11          not later than 60 days (or 15 days in the case of  
12          a certification for an entity described in section  
13          1462) after the date the complete application has  
14          been submitted. The determination on an application  
15          for certification of an entity described in section  
16          1462 shall only involve the verification that the enti-  
17          ty is an entity described in such section.

18          (b) REVIEW OF CERTIFICATIONS.—The Secretary  
19          shall periodically review whether professionals, providers,  
20          agencies, and organizations certified under this subpart  
21          continue to meet the requirements for such certification.

22          (c) TERMINATION OR DENIAL OF CERTIFICATION.—

23                (1) PRELIMINARY FINDING.—If the Secretary  
24                preliminarily finds that an entity seeking certifi-  
25                cation under this section does not meet the require-

1       ments for such certification or such an entity cer-  
2       tified under this subpart fails to continue to meet  
3       the requirements for such certification, the Secretary  
4       shall notify the entity of such preliminary finding  
5       and permit the entity an opportunity, under subtitle  
6       C of title V, to rebut such findings.

7               (2) FINAL DETERMINATION.—If, after such op-  
8       portunity, the Secretary continues to find that such  
9       an entity continues to fail to meet such require-  
10      ments, the Secretary shall terminate the certification  
11      and shall notify the entity and the State of such ter-  
12      mination and the effective date of the termination.

13 **SEC. 1465. NOTIFICATION OF PARTICIPATING STATES.**

14       (a) IN GENERAL.—Not less often than annually the  
15      Secretary shall notify each participating State of essential  
16      community providers that have been certified under this  
17      subpart.

18       (b) CONTENTS.—Such notice shall include sufficient  
19      information to permit each State to notify health plans  
20      of the identity of each entity certified as an essential com-  
21      munity provider, including—

22               (1) the location of the provider within each  
23      plan’s service area,

24               (2) the health services furnished by the pro-  
25      vider, and

1           (3) other information necessary for health plans  
2           to carry out this subpart.

3 **SEC. 1466. HEALTH PLAN REQUIREMENT.**

4           (a) IN GENERAL.—

5           (1) CATEGORY 1 ENTITIES.—With respect to  
6           each essential community provider described in sec-  
7           tion 1462(a)(1) (other than a provider of school  
8           health services) that makes an election under sub-  
9           section (d), that serves the health plan service area  
10          of such health plan, and that requests participation  
11          under this section, a health plan shall either—

12                   (A) enter into a written provider participa-  
13                   tion agreement (described in subsection (b))  
14                   with such providers, or

15                   (B) enter into a written agreement under  
16                   which the plan shall make payments to such  
17                   provider in accordance with subsection (c).

18          (2) CATEGORY 2 ENTITIES.—

19                   (A) IN GENERAL.—With respect to at least  
20                   one essential community provider described in  
21                   subparagraph (A) and at least one essential  
22                   community provider described in subparagraph  
23                   (B) of section 1462(a)(2), that makes an elec-  
24                   tion under subsection (d), that serves the health  
25                   plan service area of such health plan, and that

1 requests participation under this section, a  
2 health plan shall either—

3 (i) enter into a written provider par-  
4 ticipation agreement (described in sub-  
5 section (b)) with such providers, or

6 (ii) enter into a written agreement  
7 under which the plan shall make payments  
8 to such provider in accordance with sub-  
9 section (c).

10 (B) EXCEPTION.—A State, as part of the  
11 State plan under section 1501(a), may submit  
12 to the Secretary for approval a request that the  
13 Secretary permit the State to—

14 (i) require health plans operating in  
15 certain community rating areas in the  
16 State to contract with more than one es-  
17 sential community provider of each type  
18 referred to in subparagraph (A), based on  
19 geographic proximity, cultural and lan-  
20 guage needs, capacity to meet the needs of  
21 enrollees, or other factors determined rel-  
22 evant by the State; and

23 (ii) establish additional types of essen-  
24 tial community providers under section

1           1462(a)(2) that a health plan must con-  
2           tract with under subparagraph (A).

3           (C) DISCRETION OF SECRETARY.—With  
4           respect to a State request under subparagraph  
5           (B), the Secretary shall—

6                     (i) approve such request; or

7                     (ii) require the designation of such ad-  
8                     ditional essential community providers in  
9                     the State as the Secretary determines nec-  
10                    essary.

11          (b) PARTICIPATION AGREEMENT.—A participation  
12          agreement between a health plan and an electing essential  
13          community provider under this subsection shall provide  
14          that the health plan agrees to treat the provider in accord-  
15          ance with terms and conditions the same as those that  
16          are applicable to other providers participating in the  
17          health plan with respect to each of the following:

18                    (1) The scope of services for which payment is  
19                    made by the plan to the provider.

20                    (2) The rate of payment for covered care and  
21                    services.

22                    (3) The availability of financial incentives to  
23                    participating providers.

24                    (4) Limitations on financial risk provided to  
25                    other participating providers.

1           (5) Assignment of enrollees to participating  
2 providers.

3           (6) Access by the provider's patients to pro-  
4 viders in medical specialties or subspecialties partici-  
5 pating in the plan.

6           (c) PAYMENTS FOR PROVIDERS WITHOUT PARTICI-  
7 PATION AGREEMENTS.—

8           (1) IN GENERAL.—Payment in accordance with  
9 this subsection is payment based, as elected by the  
10 electing essential community provider, either—

11           (A) on the fee schedule developed by the  
12 State; or

13           (B) on payment methodologies and rates  
14 used under the applicable Medicare payment  
15 methodology and rates (or the most closely ap-  
16 plicable methodology under such program as  
17 the Secretary specifies in regulations).

18           (2) SPECIAL RULE FOR FEDERALLY QUALIFIED  
19 HEALTH CENTERS.—With respect to each federally  
20 qualified health center (as such term is defined in  
21 section 1861(aa) of the Social Security Act) that is  
22 an essential community provider, a health plan shall  
23 make payments based on the reasonable cost rates  
24 applicable under section 1833(a)(3) of the Social Se-

1 curity Act, except that the federally qualified health  
2 center may accept other payment amounts.

3 (3) NO APPLICATION OF GATE-KEEPER LIMITA-  
4 TIONS.—Payment in accordance with this subsection  
5 may be subject to utilization review, but may not be  
6 subject to otherwise applicable gatekeeper require-  
7 ments under the plan.

8 (d) ELECTION.—

9 (1) IN GENERAL.—In this part, the term “elect-  
10 ing essential community provider” means, with re-  
11 spect to a health plan, an essential community pro-  
12 vider certified under this subpart that elects under  
13 this subpart to apply to the health plan.

14 (2) FORM OF ELECTION.—An election under  
15 this subsection shall be made in a form and manner  
16 specified by the Secretary, and shall include notice  
17 to the health plan involved. Such an election may be  
18 made annually with respect to a health plan, except  
19 that the plan and provider may agree to make such  
20 an election on a more frequent basis.

21 (e) SPECIAL RULE FOR PROVIDERS OF SCHOOL  
22 HEALTH SERVICES.—A health plan shall pay, to each pro-  
23 vider of school health services located in the plan’s service  
24 area, an amount determined by the Secretary for such  
25 services furnished to enrollees of the plan.

1 **SEC. 1467. RECOMMENDATION ON CONTINUATION OF RE-**  
2 **QUIREMENT.**

3 (a) STUDIES.—In order to prepare recommendations  
4 under subsection (b), the Secretary shall conduct studies  
5 regarding essential community providers, including studies  
6 that assess—

7 (1) the definition of essential community pro-  
8 vider,

9 (2) the sufficiency of the funding levels for pro-  
10 viders, including the special rule for federally quali-  
11 fied health centers under section 1466(c)(2), for  
12 both covered and uncovered benefits under this Act,

13 (3) the effects of contracting requirements re-  
14 lating to such providers on such providers, health  
15 plans, and enrollees,

16 (4) the impact of the payment rules for such  
17 providers, and

18 (5) the impact of national health reform on  
19 such providers.

20 (b) RECOMMENDATIONS TO AND CONSIDERATION BY  
21 CONGRESS.—

22 (1) IN GENERAL.—Not later than 5 years after  
23 the date of enactment of this Act, the Secretary  
24 shall submit to Congress, specific recommendations  
25 concerning whether, and to what extent, section  
26 1466 should continue to apply to some or all essen-

1 tial community providers. Such recommendations  
2 may include a description of the particular types of  
3 such providers and circumstances under which such  
4 section should continue to apply.

5 (2) JOINT RESOLUTION AND CONSIDERATION  
6 BY CONGRESS.—

7 (A) IN GENERAL.—The recommendations  
8 under paragraph (1) shall be implemented un-  
9 less a joint resolution (described in subpara-  
10 graph (B)) disapproving such recommendations  
11 is enacted in accordance with the provisions of  
12 subparagraph (C), before the end of the 45-day  
13 period beginning on the date on which such rec-  
14 ommendations were submitted. For purposes of  
15 applying the preceding sentence and subpara-  
16 graphs (B) and (C), the days on which either  
17 House of Congress is not in session because of  
18 an adjournment of more than three days to a  
19 day certain shall be excluded in the computa-  
20 tion of a period.

21 (B) JOINT RESOLUTION OF DIS-  
22 APPROVAL.—A joint resolution described in this  
23 subparagraph means only a joint resolution  
24 which is introduced within the 10-day period  
25 beginning on the date on which the Secretary

1 submits recommendations under paragraph (1)  
2 and—

3 (i) which does not have a preamble;

4 (ii) the matter after the resolving  
5 clause of which is as follows: “That Con-  
6 gress disapproves the recommendations of  
7 the Secretary of Health and Human Serv-  
8 ices concerning the extension of certain es-  
9 sential community provider provisions, as  
10 submitted by the Secretary on  
11 \_\_\_\_\_.”, the blank space being  
12 filled in with the appropriate date; and

13 (iii) the title of which is as follows:

14 “Joint resolution disapproving rec-  
15 ommendations of the Secretary of Health  
16 and Human Services concerning the exten-  
17 sion of certain essential community pro-  
18 vider provisions, as submitted by the Sec-  
19 retary on \_\_\_\_\_.”, the blank  
20 space being filled in with the appropriate  
21 date.

22 (C) PROCEDURES FOR CONSIDERATION OF  
23 RESOLUTION OF DISAPPROVAL.—Subject to  
24 subparagraph (D), the provisions of section  
25 2908 (other than subsection (a)) of the Defense

1 Base Closure and Realignment Act of 1990  
2 shall apply to the consideration of a joint reso-  
3 lution described in subparagraph (B) in the  
4 same manner as such provisions apply to a joint  
5 resolution described in section 2908(a) of such  
6 Act.

7 (D) SPECIAL RULES.—For purposes of ap-  
8 plying subparagraph (C) with respect to such  
9 provisions—

10 (i) any reference to the Committee on  
11 Armed Services of the House of Represent-  
12 atives shall be deemed a reference to an  
13 appropriate Committee of the House of  
14 Representatives (specified by the Speaker  
15 of the House of Representatives at the  
16 time of submission of recommendations  
17 under paragraph (1)) and any reference to  
18 the Committee on Armed Services of the  
19 Senate shall be deemed a reference to an  
20 appropriate Committee of the Senate  
21 (specified by the Majority Leader of the  
22 Senate at the time of submission of rec-  
23 ommendations under paragraph (1)); and

24 (ii) any reference to the date on which  
25 the President transmits a report shall be

1           deemed a reference to the date on which  
2           the Secretary submits a recommendation  
3           under paragraph (1).

4 **SEC. 1468. DEFINITIONS.**

5       As used in subpart:

6           (1) CHILDREN'S HOSPITAL.—The term “chil-  
7       dren's hospital” means those hospitals whose inpa-  
8       tients are certified by the Secretary or the State to  
9       be predominantly under the age of 18.

10          (2) HEALTH PROFESSIONAL.—The term  
11       “health professional” means a physician, nurse,  
12       nurse practitioner, certified nurse midwife, physician  
13       assistant, psychologist, dentist, pharmacist, chiro-  
14       practor, clinical social worker, and other health care  
15       professional recognized by the Secretary.

16          (3) SUBRECIPIENT.—The term “subrecipient”  
17       means, with respect to a recipient of a grant under  
18       a particular authority, an entity that—

19               (A) is receiving funding from such a grant  
20               under a contract with the principal recipient of  
21               such a grant, and

22               (B) meets the requirements established to  
23               be a recipient of such a grant.

1       **PART 3—SPECIFIC RESPONSIBILITIES OF**  
2                   **SECRETARY OF LABOR.**

3   **SEC. 1481. RESPONSIBILITIES OF SECRETARY OF LABOR.**

4       (a) IN GENERAL.—The Secretary of Labor is respon-  
5   sible—

6           (1) under subtitle D, for the enforcement of re-  
7       quirements applicable to employers (including re-  
8       quirements relating to payment of premiums under  
9       title X if applicable) and the administration of large  
10      employer purchasing groups;

11          (2) for the temporary assumption of the oper-  
12      ation of self-insured employer sponsored health plans  
13      that are insolvent;

14          (3) for carrying out any other responsibilities  
15      assigned to the Secretary under this Act; and

16          (4) for administering title I of the Employee  
17      Retirement Income Security Act of 1974 as it re-  
18      lates to group health plans maintained by large em-  
19      ployer purchasing groups.

20      (b) AGREEMENTS WITH STATES.—The Secretary of  
21      Labor may enter into agreements with States in order to  
22      enforce responsibilities of employers and large employer  
23      purchasing groups, and requirements of employer spon-  
24      sored health plans, under subtitle B of title I of the Em-  
25      ployee Retirement Income Security Act of 1974.

1           (c) CONSULTATION.—In carrying out activities under  
2 this Act with respect to large employer purchasing groups,  
3 employer sponsored health plans, and employers, the Sec-  
4 retary of Labor shall consult with the Secretary of Health  
5 and Human Services.

6           (d) GUARANTY FUNDS.—

7               (1) IN GENERAL.—The Secretary of Labor shall  
8 establish standards for guaranty funds to be estab-  
9 lished by a State with respect to a self-insured plan  
10 operating wholly within the State.

11              (2) MULTISTATE PLANS.—The Secretary of  
12 Labor shall establish and administer a guaranty  
13 fund with respect to multistate self-insured plans.

14           (e) EMPLOYER-RELATED REQUIREMENTS.—

15               (1) IN GENERAL.—The Secretary of Labor, in  
16 consultation with the Secretary, shall be responsible  
17 for assuring that employers—

18                   (A) make payments of any employer pre-  
19 miums (and withhold and make payment of the  
20 family share of premiums with respect to quali-  
21 fying employees) and provide discounts to em-  
22 ployees as required under this Act, including  
23 auditing of collection activities with respect to  
24 such payments,

1 (B) submit timely reports as required  
2 under this Act, and

3 (C) otherwise comply with requirements  
4 imposed on employers under this Act.

5 (2) AUDIT AND SIMILAR AUTHORITIES.—The  
6 Secretary of Labor—

7 (A) may carry out such audits (directly or  
8 through contract) and such investigations of  
9 employers and States and large employer pur-  
10 chasing groups,

11 (B) may exercise such authorities under  
12 section 504 of Employee Retirement Income Se-  
13 curity Act of 1974 (in relation to activities  
14 under this Act),

15 (C) may provide (through contract or oth-  
16 erwise) for such collection activities (in relation  
17 to amounts owed to large employer purchasing  
18 groups, and for the benefit of such groups), and

19 (D) may impose such civil penalties in ac-  
20 cordance with this Act,

21 as may be necessary to carry out such Secretary's  
22 responsibilities under this section.

23 (3) AUDITING OF EMPLOYER PAYMENTS.—

24 (A) IN GENERAL.—Each State is respon-  
25 sible for auditing the records of community-

1 rated employers to assure that employer pay-  
2 ments (including the payment of amounts with-  
3 held) were made in the appropriate amount as  
4 provided under subtitle B of title X.

5 (B) EMPLOYERS WITH EMPLOYEES RESID-  
6 ING IN DIFFERENT COMMUNITY-RATING  
7 AREAS.—In the case of a community-rated em-  
8 ployer which has employees who reside in more  
9 than one community rating area in more than  
10 one State, the Secretary of Labor, in consulta-  
11 tion with the Secretary, shall establish a proc-  
12 ess for the coordination of State auditing activi-  
13 ties among the States involved.

14 (C) APPEAL.—In the case of an audit con-  
15 ducted by a State on an employer under this  
16 paragraph, an employer or other State that is  
17 aggrieved by the determination in the audit is  
18 entitled to review of such audit by the Secretary  
19 of Labor in a manner to be provided by such  
20 Secretary.

21 (f) AUTHORITY.—The Secretary of Labor is author-  
22 ized to issue such regulations as may be necessary to carry  
23 out section 1305 and responsibilities of the Secretary  
24 under this Act.

1 **SEC. 1482. FEDERAL ROLE WITH RESPECT TO MULTISTATE**  
2 **SELF-INSURED HEALTH PLANS.**

3 (a) IN GENERAL.—In the case of a multistate self-  
4 insured health plan or a multistate self-insured supple-  
5 mental health benefits plan, the Secretary of Labor shall  
6 be responsible for certifying such plans and carrying out  
7 activities under this title in the same manner as a partici-  
8 pating State would carry out activities under this title with  
9 respect to a standard health plan.

10 (b) SELF-INSURED PLAN STANDARDS.—The Sec-  
11 retary of Labor shall develop and publish standards appli-  
12 cable to self-insured plans offered by large employers. The  
13 Secretary shall develop and publish such standards by not  
14 later than the date that is 6 months after the date of en-  
15 actment of this Act. Such standards shall be the certified  
16 standard health plan standards applicable to self-insured  
17 plans under this title.

18 (c) DETERMINATION OF MULTISTATE STATUS.—For  
19 purposes of this Act, a self-insured health plan or a self-  
20 insured supplemental health benefits plan shall be consid-  
21 ered a multistate health plan if established or maintained  
22 by an experience-rated employer which has a substantial  
23 number of employees enrolled in such plan in each of 2  
24 or more States (as determined by the Secretary of Labor).

1 **SEC. 1483. ASSISTANCE WITH EMPLOYER COLLECTIONS.**

2       The Secretary of Labor shall provide States with such  
3 technical and other assistance as may promote the effi-  
4 cient collection of all amounts owed under this Act by em-  
5 ployers.

6 **SEC. 1484. PENALTIES FOR FAILURE OF LARGE EMPLOYER**  
7 **PURCHASING GROUPS TO MEET REQUIRE-**  
8 **MENTS.**

9       If the Secretary of Labor finds that a large employer  
10 purchasing group has failed substantially to meet the ap-  
11 plicable requirements of subtitle D, the Secretary shall im-  
12 pose a civil money penalty of not to exceed \$10,000 for  
13 each such violation.

14 **SEC. 1485. APPLICABILITY OF ERISA ENFORCEMENT MECH-**  
15 **ANISMS FOR ENFORCEMENT OF CERTAIN RE-**  
16 **QUIREMENTS.**

17       The provisions of sections 502 (relating to civil en-  
18 forcement), 504 (relating to investigative authority) and  
19 506 (relating to criminal enforcement) of the Employee  
20 Retirement Income Security Act of 1974 shall apply to  
21 enforcement by the Secretary of Labor of the applicable  
22 requirements for large group purchasers in the same man-  
23 ner and to same extent as such provisions apply to en-  
24 forcement of title I of such Act.

1 **SEC. 1486. WORKPLACE WELLNESS PROGRAM.**

2 (a) IN GENERAL.—The Secretary shall develop cer-  
3 tification criteria for workplace wellness programs.

4 (b) APPLICATION OF SECTION.—Any health plan  
5 may offer a uniform premium discount, not to exceed 5  
6 percent, to employers maintaining certified workplace  
7 wellness programs.

8 **PART 4—OFFICE OF RURAL HEALTH POLICY**

9 **SEC. 1491. OFFICE OF RURAL HEALTH POLICY.**

10 (a) APPOINTMENT OF ASSISTANT SECRETARY.—

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

13 (A) by striking “by a Director, who shall  
14 advise the Secretary” and inserting “by an As-  
15 sistant Secretary for Rural Health (in this sec-  
16 tion referred to as the ‘Assistant Secretary’),  
17 who shall report directly to the Secretary”; and

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

22 (2) CONFORMING AMENDMENTS.—(A) Section  
23 711(b) of the Social Security Act (42 U.S.C. 912(b))  
24 is amended by striking “the Director” and inserting  
25 “the Assistant Secretary”.

1           (B) Section 338J(a) of the Public Health Serv-  
2           ice Act (42 U.S.C. 254r(a)) is amended by striking  
3           “Director of the Office of Rural Health Policy” and  
4           inserting “Assistant Secretary for Rural Health”.

5           (C) Section 464T(b) of the Public Health Serv-  
6           ice Act (42 U.S.C. 285p–2(b)) is amended in the  
7           matter preceding paragraph (1) by striking “Direc-  
8           tor of the Office of Rural Health Policy” and insert-  
9           ing “Assistant Secretary for Rural Health”.

10          (D) Section 6213 of the Omnibus Budget Rec-  
11          onciliation Act of 1989 (42 U.S.C. 1395x note) is  
12          amended in subsection (e)(1) by striking “Director  
13          of the Office of Rural Health Policy” and inserting  
14          “Assistant Secretary for Rural Health”.

15          (E) Section 403 of the Ryan White Comprehen-  
16          sive AIDS Resources Emergency Act of 1990 (42  
17          U.S.C. 300ff–11 note) is amended in the matter pre-  
18          ceding paragraph (1) of subsection (a) by striking  
19          “Director of the Office of Rural Health Policy” and  
20          inserting “Assistant Secretary for Rural Health”.

21          (3) AMENDMENT TO THE EXECUTIVE SCHED-  
22          ULE.—Section 5315 of title 5, United States Code,  
23          is amended by striking “Assistant Secretaries of  
24          Health and Human Services (5)” and inserting “As-

1       sistant Secretaries of Health and Human Services  
2       (6)”.

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

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

## 12       **Subtitle F—Participating State** 13       **Responsibilities**

### 14       **PART 1—GENERAL RESPONSIBILITIES**

#### 15       **SEC. 1501. STATE PLAN AND CERTIFICATION OF STANDARD** 16       **HEALTH PLANS AND SUPPLEMENTAL** 17       **HEALTH BENEFITS PLANS.**

18       (a) STATE PLAN.—

19           (1) IN GENERAL.—For purposes of the ap-  
20 proval of a State health care system by the Sec-  
21 retary under section 1411, a State is a “parti-  
22 cipating State” if the State meets the applicable re-  
23 quirements of this subtitle.

24           (2) SUBMISSION OF PLAN.—In order to be ap-  
25 proved as a participating State under section 1411,

1 a State shall submit to the Secretary a State plan  
2 (in a form and manner specified by the Secretary)  
3 that describes the State health care system that the  
4 State is establishing (or has established).

5 (3) DEADLINE.—If a State is not a partici-  
6 pating State with a State health care system in op-  
7 eration by January 1, 1997, the provisions of sub-  
8 part C of part 1 of subtitle E (relating to respon-  
9 sibilities in absence of State systems) shall take ef-  
10 fect.

11 (4) SUBMISSION OF INFORMATION SUBSEQUENT  
12 TO APPROVAL.—A State approved as a participating  
13 State under section 1411 shall submit to the Sec-  
14 retary an annual update to the State health care  
15 system not later than February 15 of each year fol-  
16 lowing the first year for which the State is a partici-  
17 pating State. The update shall contain—

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

22 (B) such information as the Secretary may  
23 require to determine that the State operated  
24 the system during the previous year in accord-

1           ance with the Secretary's approval of the sys-  
2           tem for such previous year.

3           (b) HEALTH PLAN ACCREDITATION, CERTIFICATION  
4 AND ENFORCEMENT PROGRAM.—

5           (1) ESTABLISHMENT.—The Secretary shall es-  
6           tablish a program for the accreditation, certification  
7           and enforcement of health plan standards by States  
8           (hereafter referred to in this subsection as the “ACE  
9           program”). Under such program, the Secretary  
10          shall—

11           (A) develop guidelines for the accredita-  
12          tion, certification and enforcement of standards  
13          for certified standard health plans;

14           (B) approve State ACE programs as meet-  
15          ing such guidelines; and

16           (C) monitor the compliance of States with  
17          such guidelines.

18          (2) PROGRAM ELEMENTS.—The guidelines re-  
19          ferred to in paragraph (1) shall include the following  
20          components:

21           (A) CERTIFICATION.—State certification,  
22          and recertification not less frequently than once  
23          during each 3-year period, of standard health  
24          plans determined by the State to be in compli-  
25          ance with the standards established under sub-

1 title B and with the regulations promulgated by  
2 the Secretary concerning such standards.

3 (B) DISENROLLMENT DATA.—State review  
4 of enrollee disenrollment from each standard  
5 health plan to determine whether there is a pat-  
6 tern of disenrollment that does not reflect the  
7 distribution of such plans' reenrolling member-  
8 ship.

9 (C) MONITORING.—State monitoring of  
10 the performance of each standard health plan  
11 to ensure that such plans continue to meet the  
12 criteria for certification.

13 (3) STATE PROGRAMS.—Each participating  
14 State shall develop accreditation, certification and  
15 enforcement programs in accordance with the guide-  
16 lines established by the Secretary under paragraph  
17 (1).

18 (4) USE OF PRIVATE ORGANIZATIONS.—

19 (A) IN GENERAL.—A State may utilize pri-  
20 vate accreditation organizations to review the  
21 compliance by standard health plans with spe-  
22 cific standards with which such organizations  
23 have demonstrated expertise. A State may use  
24 such reviews as the basis for determining plan  
25 compliance with such standards. The Secretary

1 shall approve eligible accreditation organiza-  
2 tions and promulgate regulations prohibiting  
3 conflicts of interest in the use of such bodies by  
4 States.

5 (B) LIMITATIONS.—The use of private ac-  
6 creditation organizations by a State under sub-  
7 paragraph (A) shall not relieve such State of its  
8 obligations under this subsection. In no case  
9 shall a State delegate enforcement authority or  
10 enforcement responsibilities to private organiza-  
11 tions.

12 (5) ENFORCEMENT.—A State ACE program  
13 shall establish a process for imposing sanctions on  
14 standard health plans that fail to comply with the  
15 standards established under this title. Such sanc-  
16 tions may include—

17 (A) limiting or prohibiting new member en-  
18 rollment;

19 (B) permitting existing members to  
20 disenroll from the health plan without penalty;

21 (C) State operation of a health plan to  
22 provide transitional access;

23 (D) the imposition of civil monetary pen-  
24 alties in accordance with this Act;

1 (E) requiring that a plan follow a correc-  
2 tive action plan developed by the State; and

3 (F) decertification or denial of recertifi-  
4 cation, but only after the plan has been pro-  
5 vided a reasonable opportunity to comply with  
6 such standards.

7 (6) MULTI-STATE PLANS.—The Secretary of  
8 Labor, in consultation with the Secretary, shall  
9 carry out all certification and enforcement activities  
10 described in this subsection with respect to  
11 multistate self-insured plans.

12 (c) OTHER STATE DUTIES.—A participating State  
13 shall—

14 (1) certify each purchasing cooperative that  
15 meets the requirements of part 2 of subtitle D; and

16 (5) administer the State subsidies as provided  
17 for in title VI.

18 (d) EFFECTIVE DATE.—Subsection (b) shall apply to  
19 standard health plans and supplemental health benefits  
20 plans sold, issued, or renewed on or after January 1,  
21 1997.

22 **SEC. 1502. COMMUNITY RATING AREAS AND HEALTH PLAN**  
23 **SERVICE AREAS.**

24 (a) IN GENERAL.—In accordance with this section,  
25 each participating State shall, subject to approval by the

1 Secretary, provide for the division of the State into 1 or  
2 more community rating areas.

3 (b) MULTIPLE AREAS.—With respect to a community  
4 rating area—

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

8 (2) the number of individuals residing within  
9 such an area may not be less than 250,000; and

10 (3) no area incorporated in a community rating  
11 area may be incorporated into another such area.

12 (c) BOUNDARIES.—

13 (1) IN GENERAL.—In establishing boundaries  
14 for community rating areas, a participating State  
15 shall comply with the antidiscrimination require-  
16 ments of section 1602.

17 (2) COORDINATING MULTIPLE COMMUNITY RAT-  
18 ING AREAS.—Nothing in this section shall be con-  
19 strued as preventing a participating State from co-  
20 ordinating the activities of one or more community  
21 rating areas in the State.

22 (3) INTERSTATE COMMUNITY RATING AREAS.—  
23 Community rating areas with respect to interstate  
24 areas shall be established in accordance with rules  
25 established by the Secretary.

1 (4) COORDINATION IN MULTI-STATE AREAS.—

2 One or more participating States may coordinate  
3 their operations in contiguous community rating  
4 areas. Such coordination may include, the following  
5 activities, adoption of joint operating rules, con-  
6 tracting with standard health plans, enforcement ac-  
7 tivities, and establishment of fee schedules for health  
8 providers.

9 (d) HEALTH PLAN SERVICE AREAS.—

10 (1) IN GENERAL.—Pursuant to guidelines de-  
11 veloped under paragraph (2), each State shall des-  
12 ignate, by not later than January 1, 19\_\_\_\_, health  
13 plan service areas.

14 (2) GUIDELINES.—The State shall designate  
15 one or more health plan service areas within each  
16 community rating area in the State, that—

17 (A) prevent discrimination in accordance  
18 with section 1602; and

19 (B) do not cross community rating area  
20 boundaries.

21 **SEC. 1503. OPEN ENROLLMENT PERIODS.**

22 Each participating State, based on rules and proce-  
23 dures established by the Secretary, shall specify a uniform,  
24 annual open enrollment period for each community rating  
25 area during which all eligible individuals are permitted the

1 opportunity to change enrollment among the standard  
2 health plans offered to such individuals in such area under  
3 this Act. The initial annual open enrollment period shall  
4 be for a period of 90 days.

5 **SEC. 1504. RISK ADJUSTMENT PROGRAM.**

6 (a) REQUIREMENT FOR IMPLEMENTATION.—In ac-  
7 cordance with rules established by the Secretary, each  
8 State shall implement a risk adjustment methodology de-  
9 veloped by the Secretary under subsection (d).

10 (b) STATE RISK ADJUSTMENT ORGANIZATION.—  
11 Each State shall establish a State risk adjustment organi-  
12 zation to carry out the adjustments required under the  
13 methodology implemented by the State under subsection  
14 (a) and make payments in accordance with subsection (c).  
15 Such organization shall meet standards established by the  
16 Secretary relating to organizational structure, operation,  
17 fiduciary responsibilities and financial management.

18 (c) ADJUSTMENTS AND PAYMENTS.—

19 (1) CLASSES OF PURCHASERS.—The Secretary  
20 shall specify classes of individual health plan pur-  
21 chasers whose expected expenditures are signifi-  
22 cantly higher than those of employed individuals cov-  
23 ered under community-rated plans.

24 (2) ESTIMATES.—The Secretary shall annually  
25 estimate the amount by which the expected expendi-

1       tures related to specified high-cost community-rated  
2       individual health plan purchasers (as specified by  
3       the Secretary under the methodologies developed  
4       under subsection (a)) for the year involved will ex-  
5       ceed the expected average expenditures for other  
6       community-rated health plan enrollees. Based on  
7       such estimates, the Secretary shall develop a per  
8       capita adjustment amount with respect to each com-  
9       munity rating area.

10           (3) PAYMENTS.—

11           (A) IN GENERAL.—The State risk adjust-  
12           ment organization shall, using the methodolo-  
13           gies developed by the Secretary under sub-  
14           section (a), apply the per capita adjustment  
15           amount to community-rated and experience-  
16           rated (and multistate plans under subparagraph  
17           (C)) health plans offered within each commu-  
18           nity rating area in the State.

19           (B) STANDARD PLANS.—Standard health  
20           plans subject to an assessment under subpara-  
21           graph (A) shall make payments to the State  
22           risk adjustment organization for the State in  
23           which such plans provide coverage.

24           (C) MULTISTATE PLANS.—A multistate  
25           community-rated or experience-rated plan that

1 is subject to an assessment under subparagraph  
2 (A) shall make payments to a single State risk  
3 adjustment organization and provide such orga-  
4 nization with information concerning the geo-  
5 graphic distribution of the enrollees in such  
6 plan. Such organization shall determine the  
7 amount of such payments that are applicable to  
8 each community-rating area and distribute such  
9 amounts to the appropriate State risk adjust-  
10 ment organization.

11 (D) DISTRIBUTION.—State risk adjust-  
12 ment organizations shall distribute amounts col-  
13 lected under this paragraph to community-rated  
14 or experience-rated health plans that are deter-  
15 mined to have expenditures for items and serv-  
16 ices provided to enrolled individuals that are  
17 greater than the average expenditures for en-  
18 rollees in standard health plans. The amounts  
19 of such distributions shall be based on the  
20 methodology applied by the organization in-  
21 volved.

22 (d) DEVELOPMENT OF METHODOLOGIES.—

23 (1) IN GENERAL.—Not later than  
24 \_\_\_\_\_, the Secretary, in consultation  
25 with an advisory committee established by the Sec-

1       retary, shall develop a risk adjustment and reinsur-  
2       ance methodology for use by States in accordance  
3       with this section.

4               (2) METHODOLOGY.—

5               (A) PURPOSES.—The risk adjustment  
6       methodology developed under paragraph (1)  
7       shall—

8               (i) ensure that assessments imposed  
9       on or payments provided to standard  
10      health plans reflect the expected relative  
11      utilization and expenditures for covered  
12      items and services by the enrollees of each  
13      plan compared to the average utilization  
14      and expenditures for all eligible individ-  
15      uals, and

16              (ii) protect standard health plans that  
17      enroll a disproportionate share of eligible  
18      individuals with respect to whom expected  
19      utilization of health care services (included  
20      in the benefit package) and expected  
21      health care expenditures for such services  
22      are greater than the average level of such  
23      utilization and expenditures for eligible in-  
24      dividuals.

1 (B) FACTORS TO BE CONSIDERED.—The  
2 methodology shall take into account the fol-  
3 lowing factors:

4 (i) Demographic characteristics.

5 (ii) Health status, including prior use  
6 of health services.

7 (iii) Geographic area of residence.

8 (iv) Socio-economic status.

9 (v) The cost sharing of the plan.

10 (vi) Any other factors determined by  
11 the Secretary to be material to the pur-  
12 poses described in subparagraph (A).

13 (3) SPECIAL CONSIDERATION FOR MENTAL ILL-  
14 NESS AND MENTAL RETARDATION.—In developing  
15 the methodology under this section, the Secretary  
16 shall give consideration to the unique problems of  
17 adjusting payments relating to health plans with re-  
18 spect to individuals with mental illness and mental  
19 retardation.

20 (4) MANDATORY REINSURANCE.—

21 (A) IN GENERAL.—The methodology devel-  
22 oped under this section shall include a system  
23 of mandatory reinsurance as a component of  
24 the risk adjustment methodology.

1 (B) REINSURANCE SYSTEM.—The Sec-  
2 retary, in developing the methodology for a  
3 mandatory reinsurance system under subpara-  
4 graph (A), shall—

5 (i) provide for standard health plans  
6 to make payments to state-established re-  
7 insurance programs for the purpose of re-  
8 insuring all or part of the health care ex-  
9 penditures for items and services included  
10 in the standard benefit package for classes  
11 of high-cost individual health plan pur-  
12 chasers (as specified by the Secretary) or  
13 specific high-cost treatments or diagnosis;  
14 and

15 (ii) specify the manner of creation,  
16 structure, and operation of the system in  
17 each State, including—

18 (I) the manner (which may be  
19 prospective or retrospective) in which  
20 standard health plans make payments  
21 to the system, and

22 (II) the type and level of reinsur-  
23 ance coverage provided by the system.

24 (5) COST-SHARING ADJUSTMENT.—The stand-  
25 ards developed by the Secretary under this sub-

1 section shall include a cost-sharing adjustment  
2 mechanism to adjust for losses among all standard  
3 health plans, except multistate self-insured health  
4 plans, resulting from the reduced cost-sharing obli-  
5 gations of individuals receiving assistance as is pro-  
6 vided under the program described in subtitle A of  
7 title VI.

8 (6) CONFIDENTIALITY OF INFORMATION.—The  
9 methodology shall be developed under this section in  
10 a manner that is consistent with privacy standards  
11 promulgated under title V. In developing such stand-  
12 ards, the Secretary shall take into account any po-  
13 tential need of States for certain individually identi-  
14 fiable health information in order to carry out risk-  
15 adjustment and reinsurance activities under this  
16 Act, but only to the minimum extent necessary to  
17 carry out such activities and with protections pro-  
18 vided to minimize the identification of the individ-  
19 uals to whom the information relates.

20 **SEC. 1505. GUARANTY FUNDS.**

21 A State, in accordance with the standards established  
22 by the Secretary under section 1442, shall establish a  
23 State guaranty fund with respect to community-rated  
24 plans offered in such State. The State shall establish a

1 separate guaranty fund with respect to self-insured plans  
2 operating in the State in accordance with section 1481.

3 **SEC. 1506. ENROLLMENT ACTIVITIES.**

4 (a) PROVIDER-BASED ENROLLMENT MECHA-  
5 NISMS.—The Secretary shall promulgate rules regarding  
6 the establishment by each participating State, in accord-  
7 ance with section 6006, of provider-based enrollment  
8 mechanisms for individuals seeking care who are not en-  
9 rolled in a standard health plan. Such rules shall include  
10 provisions requiring standard health plans to pay pro-  
11 viders for care delivered to individuals prior to the individ-  
12 ual's enrollment in the plan and be consistent with section  
13 1114.

14 (b) COORDINATION OF ENROLLMENT ACTIVITIES.—  
15 Each participating State shall coordinate its activities, in-  
16 cluding plan enrollment and disenrollment activities, with  
17 other States in a manner specified by the Secretary that  
18 ensures continuous, nonduplicative coverage of commu-  
19 nity-rated and experience-rated individuals in standard  
20 health plans and that minimizes administrative procedures  
21 and paperwork.

22 **SEC. 1507. RURAL AND MEDICALLY UNDERSERVED AREAS.**

23 (a) IN GENERAL.—If, in accordance with appropriate  
24 rules established by the Secretary, a State determines that  
25 there is inadequate access in the provision of health serv-

1 ices by standard health plans in any area of a State, the  
2 State may authorize—

3 (1) a standard health plan to be the only stand-  
4 ard health plan in the area; or

5 (2) two or more standard health plans to take  
6 joint action to develop and implement a program.

7 (b) **MEDICALLY UNDERSERVED AREA DEFINED.**—

8 For purposes of this subtitle the term “medically under-  
9 served area” means an urban or rural area designated by  
10 the Secretary as an area with a shortage of health profes-  
11 sional or of health services or facilities.

12 **SEC. 1508. PUBLIC ACCESS SITES.**

13 (a) **DESIGNATION.**—A State shall designate public  
14 access sites within each community rating area through  
15 which residents of such areas can obtain consumer infor-  
16 mation concerning health plans and purchasing coopera-  
17 tives offered in such areas. Such sites shall be designated  
18 in a manner that ensures access to such information by  
19 health care consumers.

20 (b) **INFORMATION.**—A State shall, through the public  
21 access sites designated under subsection (a) and using the  
22 information provided to the State under sections 1125 and  
23 1321(f)(6), prepare and make available information, in a  
24 comparative form, concerning standard health plans cer-  
25 tified by the State and purchasing cooperatives operating

1 in the State. The State shall provide such materials to  
2 employers located within the State.

3 **SEC. 1509. REQUIREMENTS RELATING TO POSSESSIONS OF**  
4 **THE UNITED STATES.**

5 (a) IN GENERAL.—A possession of the United States  
6 shall be a participating State meeting the requirements  
7 of this Act only if there is an agreement in effect between  
8 the United States and such possession pursuant to  
9 which—

10 (1) the laws of such possession impose a part  
11 B premium recapture assessment (as defined in sub-  
12 section (b));

13 (2) nothing in any provision of law, including  
14 the law of such possession, permits such possession  
15 to reduce or remit in any way, directly or indirectly,  
16 any liability to such possession by reason of such as-  
17 sessment;

18 (3) any amount received in the Treasury of  
19 such possession by reason of such assessment shall  
20 be paid (at such time and in such manner as the  
21 Secretary of the Treasury shall prescribe) to the  
22 Federal Supplementary Medical Insurance Trust  
23 Fund;

24 (4) such assessment is coordinated with the as-  
25 sessment imposed by section 59B of the Internal

1 Revenue Code of 1986 such that, for any period, an  
2 individual would be required to pay (in the aggre-  
3 gate) not more than the applicable amount for such  
4 period; and

5 (5) the possession complies with such other re-  
6 quirements as may be prescribed by the Secretary  
7 and the Secretary of the Treasury to carry out the  
8 purposes of this paragraph, including requirements  
9 prescribing the information individuals to whom  
10 such assessment may apply shall furnish to the Sec-  
11 retary and the Secretary of the Treasury.

12 (b) QUALIFIED PART B PREMIUM RECAPTURE AS-  
13 SESSMENT.—In subsection (a), the term “qualified medi-  
14 care part B premium recapture assessment” means an as-  
15 sessment imposed and collected by such a possession that  
16 is—

17 (1) equivalent to the assessment imposed under  
18 section 59B of the Internal Revenue Code of 1986;  
19 and

20 (2) imposed on all individuals who are bona fide  
21 residents of the possession, to the extent such indi-  
22 viduals have not paid the assessment imposed under  
23 such section 59B to the United States by reason of  
24 subsection (d)(5) of such section.

1 **SEC. 1510. RIGHT OF RECOVERY OF CERTAIN TAXES**  
2 **AGAINST PROVIDERS.**

3 Each participating State shall provide that issuers  
4 and plan sponsors of certified standard health plans shall  
5 have the right of recovery against providers described in  
6 section 4518 of the Internal Revenue Code of 1986 and  
7 shall provide methods of enforcing such right.

8 **PART 2—TREATMENT OF STATE LAWS**

9 **SEC. 1511. PREEMPTION OF CERTAIN STATE LAWS RELAT-**  
10 **ING TO HEALTH PLANS.**

11 (a) **LAWS RESTRICTING PLANS OTHER THAN FEE-**  
12 **FOR-SERVICE PLANS.**—Except as may otherwise be pro-  
13 vided in this section, no State law shall apply to any serv-  
14 ices provided under a health plan that is not a fee-for-  
15 service plan (or a fee-for-service component of a plan) if  
16 such law has the effect of prohibiting or otherwise restrict-  
17 ing plans from—

18 (1) limiting the number and type of health care  
19 providers who participate in the plan;

20 (2) requiring enrollees to obtain health services  
21 (other than emergency services) from participating  
22 providers or from providers authorized by the plan;

23 (3) requiring enrollees to obtain a referral for  
24 treatment by a specialized physician or health insti-  
25 tution;

1 (4) establishing different payment rates for par-  
 2 ticipating providers and providers outside the plan;

3 (5) creating incentives to encourage the use of  
 4 participating providers; or

5 (6) requiring the use of single-source suppliers  
 6 for pharmacy, non-serviced medical equipment, and  
 7 other health products and services.

8 (b) PREEMPTION OF STATE CORPORATE PRACTICE  
 9 ACTS.—Any State law related to the corporate practice  
 10 of medicine and to provider ownership of health plans or  
 11 other providers shall not apply to arrangements between  
 12 health plans that are not fee-for-service plans and their  
 13 participating providers.

14 **SEC. 1512. OVERRIDE OF RESTRICTIVE STATE PRACTICE**  
 15 **LAWS.**

16 (a) **OVERRIDE.**—

17 (1) **IN GENERAL.**—No State may, through li-  
 18 censure or otherwise, restrict the practice of any  
 19 class of practitioners beyond that which is justified  
 20 by the education and training of such practitioners.

21 (2) **DEFINITION.**—As used in this section, the  
 22 term “practitioner” means—

23 (A) a nurse practitioner;

24 (B) a certified nurse midwife;

25 (C) a nurse anesthetist;

1 (D) a clinical nurse specialist; and  
2 (E) a physicians assistant;  
3 that has been awarded a master's degree  
4 or postmaster's certificate following the comple-  
5 tion of an accredited training program that pre-  
6 pares individuals in advanced practitioner spe-  
7 cialties and that is authorized by the State to  
8 practice as such a practitioner.

9 (b) REGULATIONS.—The Secretary shall promulgate  
10 regulations to implement subsection (a) and shall ensure  
11 that appropriate technical assistance is available to States  
12 for the purpose of complying with this section.

### 13 **PART 3—STATE FLEXIBILITY**

#### 14 **Subpart A—Existing State Laws**

#### 15 **SEC. 1521. CONTINUANCE OF EXISTING FEDERAL LAW** 16 **WAIVERS.**

17 Nothing in this Act shall preempt any feature of a  
18 State health care system operating under a waiver granted  
19 before the date of the enactment of this Act under titles  
20 XVIII or XIX of the Social Security Act (42 U.S.C. 1395  
21 et seq. or 1396 et seq.) or the Employee Retirement In-  
22 come Security Act of 1974 (29 U.S.C. 1001 et seq.).

#### 23 **SEC. 1522. HAWAII PREPAID HEALTH CARE ACT.**

24 (a) ERISA WAIVER.—

1           (1) IN GENERAL.—Section 514(b)(5) of the  
2 Employee Retirement Income Security Act of 1974  
3 (29 U.S.C. 1144(b)(5)) is amended to read as fol-  
4 lows:

5           “(5)(A) Except as provided in subparagraphs  
6 (B) and (C), subsection (a) shall not apply to the  
7 Hawaii Prepaid Health Care Act (Haw. Rev. Stat.  
8 §§ 393–1 through 393–51).

9           “(B) Nothing in subparagraph (A) shall be con-  
10 strued to exempt from subsection (a) any State tax  
11 law relating to employee benefits plans.

12           “(C) If the Secretary of Labor notifies the Gov-  
13 ernor of the State of Hawaii that as the result of  
14 an amendment to the Hawaii Prepaid Health Care  
15 Act enacted after the date of the enactment of this  
16 paragraph—

17           “(i) the proportion of the population with  
18 health care coverage under such Act is less than  
19 such proportion on such date, or

20           “(ii) the level of benefit coverage provided  
21 under such Act is less than the actuarial equiv-  
22 alent of such level of coverage on such date,  
23 subparagraph (A) shall not apply with respect to the  
24 application of such amendment to such Act after the  
25 date of such notification.”.

1           (2) EFFECTIVE DATE.—The amendment made  
2 by paragraph (1) shall take effect on the date of the  
3 enactment of this Act.

4           (b) HSA WAIVER.—

5           (1) IN GENERAL.—The Secretary shall, at the  
6 request of the Governor of the State of Hawaii and  
7 in accordance with this section, grant a waiver to  
8 the State from the requirements of this Act (other  
9 than the requirements specified in paragraph (3)).

10          (2) SCOPE OF WAIVER.—The waiver granted  
11 under paragraph (1) shall exempt—

12           (A) the State of Hawaii;

13           (B) health plans offered within the State;

14           and

15           (C) health plan participants, including em-  
16 ployers, employees, residents, and health plan  
17 sponsors within the State,

18 from requirements otherwise applicable to the State  
19 and such plans and participants.

20          (3) REQUIRED COMPLIANCE OF OTHER RE-  
21 QUIREMENTS.—The waiver shall initially be granted  
22 under paragraph (1) if the State of Hawaii dem-  
23 onstrates to the Secretary that the State main-  
24 tains—

1           (A) a requirement that employers make  
2 premium contributions comparable to the re-  
3 quirements of this Act;

4           (B) a comprehensive benefit package (in-  
5 cluding cost sharing) that is comparable with  
6 the requirements of subtitle B of this title;

7           (C) a percentage of State population with  
8 health care coverage that is not less than the  
9 national average;

10          (D) a quality control mechanism and data  
11 system that are comparable to the applicable re-  
12 quirements of title V; and

13          (E) health care cost containment con-  
14 sistent with the provisions of this Act.

15          (4) WAIVER PERIOD.—The waiver initially  
16 granted under paragraph (1) shall extend for the pe-  
17 riod during which the State of Hawaii continues to  
18 comply with the requirements specified in paragraph  
19 (3). The Secretary may require the State, every 5  
20 years, to demonstrate to the Secretary the State's  
21 continued compliance with such requirements.

22          (5) PROCEDURE IN THE EVENT OF NON-COM-  
23 PLIANCE.—

24           (A) NOTICE.—If, at any time after grant-  
25 ing a waiver under paragraph (1), the Secretary

1 finds that the State of Hawaii is not meeting  
2 the requirements specified in paragraph (3), the  
3 Secretary shall notify the State of the Sec-  
4 retary's findings.

5 (B) OPPORTUNITY TO CONTEST.—The  
6 State may contest the Secretary's findings  
7 under the procedures provided under section  
8 5231.

9 (C) OPPORTUNITY FOR CORRECTION.—

10 (i) FINDINGS NOT CONTESTED.—If  
11 the State does not contest the Secretary's  
12 findings within the 30-day period begin-  
13 ning on the date of receipt of a notice of  
14 such findings, the State shall have—

15 (I) a 90-day period beginning on  
16 such date to show a good faith effort  
17 to remedy the non-compliance, and

18 (II) an additional 12-month pe-  
19 riod to take such actions as may be  
20 required to bring the State into com-  
21 pliance with the requirements speci-  
22 fied in paragraph (3).

23 (ii) CONTESTED FINDINGS.—If the  
24 State contests the Secretary's findings

1           within such 30-day period but such find-  
2           ings are upheld, the State shall have—

3                   (I) a 90-day period beginning on  
4                   the date of final adjudication to show  
5                   a good faith effort to remedy the non-  
6                   compliance, and

7                   (II) an additional 12-month pe-  
8                   riod to take such actions as may be  
9                   required to bring the State into com-  
10                  pliance with the requirements speci-  
11                  fied in paragraph (3).

12           (D) TERMINATION.—If the State fails to  
13           demonstrate a good faith effort under subpara-  
14           graph (C)(i)(I) or (C)(ii)(I) or to take actions  
15           under subparagraph (C)(i)(II) or (C)(ii)(II)  
16           within the time period specified, the Secretary  
17           may revoke the waiver granted in paragraph  
18           (1).

19           (6) COOPERATIVE AGREEMENT WITH THE SEC-  
20           RETARY.—The Secretary shall enter into cooperative  
21           agreements with appropriate officials of the State of  
22           Hawaii—

23                   (A) to develop standards and reporting re-  
24                   quirements necessary for the issuance and

1 maintenance of the State's waiver under para-  
2 graph (1); and

3 (B) otherwise to effectuate the provisions  
4 of this subsection.

5 (7) ELIGIBILITY FOR FEDERAL FUNDS PRO-  
6 VIDED TO PARTICIPATING STATES.—Nothing in this  
7 subsection shall preclude the eligibility of the State  
8 of Hawaii to participate in any public health initia-  
9 tive, grant, or financial aid program under this Act  
10 (including the medicaid program under title XIX of  
11 the Social Security Act), or the sharing of revenue  
12 resulting from the amendments made by title VII,  
13 designed to implement the purpose of this Act. The  
14 Secretary shall work with appropriate officials of the  
15 State of Hawaii to develop comparable, alternative  
16 standards to govern the State's entitlement under  
17 title XI.

18 **SEC. 1523. ALTERNATIVE STATE PROVIDER PAYMENT SYS-**  
19 **TEMS.**

20 Notwithstanding any other provision of law, if a hos-  
21 pital reimbursement system operated by a State meets the  
22 requirements of section 1814(b) of the Social Security Act  
23 (42 U.S.C. 1395f(b)) and has been approved by the Sec-  
24 retary and in continuous operation since July 1, 1977, the  
25 payment rates and methodologies required under the sys-

1 tem for services provided in the State shall apply to all  
2 purchasers and payers, including those under employee  
3 welfare benefit plans authorized under the Employee Re-  
4 tirement Income Security Act of 1974 (29 U.S.C. 1001  
5 et seq.), workers' compensation programs under State law,  
6 the Federal Employees' Compensation Act under chapter  
7 81 of title 5, United States Code, and Federal employee  
8 health benefit plans under chapter 89 of title 5, United  
9 States Code.

10 **SEC. 1524. ALTERNATIVE STATE HOSPITAL SERVICES PAY-**  
11 **MENT SYSTEMS.**

12 (a) IN GENERAL.—No State shall be prevented from  
13 enforcing—

14 (1) a State system described in subsection (b),

15 or

16 (2) a State system described in subsection (c),  
17 by any provision of the Employee Retirement Income Se-  
18 curity Act of 1974 (29 U.S.C. 1001 et seq.) or chapter  
19 81 or 89 of title 5, United States Code.

20 (b) REIMBURSEMENT CONTROL SYSTEM.—A State  
21 system is described in this subsection if it is a State reim-  
22 bursement control system in operation before the date of  
23 the enactment of this Act which—

24 (1) applies to substantially all non-Federal  
25 acute care hospitals in the State, and

1           (2) regulates substantially all rates of payment  
2           (including maximum charges) in the State for inpa-  
3           tient hospital services, except payments made under  
4           title XVIII of the Social Security Act (42 U.S.C.  
5           1395 et seq.).

6           (c) HEALTH INSURANCE REFORM SYSTEM.—A State  
7           system is described in this subsection if it is a State health  
8           insurance reform system in operation before the date of  
9           the enactment of this Act which requires any insurer (in-  
10          cluding a health maintenance organization) to comply with  
11          requirements governing open enrollment and community  
12          rating, including premium adjustments or other health  
13          care assessments, for the purpose of risk adjustment.

14          (d) EFFECTIVE DATES.—

15               (1) SUBSECTION (b).—In the case of a State  
16               system described in subsection (b), the provisions of  
17               this section shall apply before, on, and after the date  
18               of the enactment of this Act.

19               (2) SUBSECTION (c).—In the case of a State  
20               system described in subsection (c), the provisions of  
21               this section shall apply before, on, and after the date  
22               of the enactment of this Act, and before the effective  
23               date of section 1116 of this Act.

1     **Subpart B—Requirements for State Single-Payer**  
2                                   **Systems**

3     **SEC. 1531. SINGLE-PAYER SYSTEM DESCRIBED.**

4             The Secretary shall approve an application of a State  
5 to operate a single-payer system if the Secretary finds that  
6 the system—

7             (1) meets the requirements of section 1532; and

8             (2)(A) in the case of a system offered through-  
9 out a State, meets the requirements for a Statewide  
10 single-payer system under section 1533; or

11            (B) in the case of a system offered in a single  
12 community rating area of a State, meets the require-  
13 ments for an area specific single-payer system under  
14 section 1534.

15     **SEC. 1532. GENERAL REQUIREMENTS FOR SINGLE-PAYER**  
16                                   **SYSTEMS.**

17             Each single-payer system shall meet the following re-  
18 quirements:

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

23             (2) OPERATION BY STATE.—The system is op-  
24 erated by the State or a designated agency of the  
25 State.

26             (3) ENROLLMENT OF INDIVIDUALS.—

1 (A) MANDATORY ENROLLMENT OF ALL  
2 COMMUNITY-RATED INDIVIDUALS.—The system  
3 shall provide for the enrollment of all commu-  
4 nity-rated individuals residing in the State (or,  
5 in the case of an area-specific single-payer sys-  
6 tem, in the community rating area) who are not  
7 medicare-eligible individuals.

8 (B) OPTIONAL ENROLLMENT OF MEDI-  
9 CARE-ELIGIBLE INDIVIDUALS.—At the option of  
10 the State and if the Secretary has approved an  
11 application submitted by the State, the system  
12 may provide for the enrollment of medicare-eli-  
13 gible individuals residing in the State (or, in the  
14 case of an area-specific single-payer system, in  
15 the community rating area).

16 (C) OPTIONAL ENROLLMENT OF EXPERI-  
17 ENCE-RATED INDIVIDUALS.—

18 (i) IN GENERAL.—Except as provided  
19 in clause (ii), at the option of the State, a  
20 single-payer system may provide for the  
21 enrollment of experience-rated individuals  
22 residing in the State (or, in the case of an  
23 area-specific single-payer system, in the  
24 community rating area).

1                   (ii) PARTICIPATION BY CERTAIN  
2                   MULTISTATE PLANS.—The system shall  
3                   not require participation by any experi-  
4                   ence-rated individual who is enrolled in a  
5                   certified multistate self-insured standard  
6                   health plan which is a multiemployer plan  
7                   described in section 1013(10), or which is  
8                   sponsored by an experience-rated employer  
9                   sponsor with at least 5,000 full-time em-  
10                  ployees.

11                 (D) OPTIONS INCLUDED IN STATE SYSTEM  
12                 DOCUMENT.—A State may not exercise any of  
13                 the options described in subparagraphs (B) or  
14                 (C) for a year unless the State included a de-  
15                 scription of the option in the submission of its  
16                 system document to the Secretary for the year  
17                 under section 1501(a).

18                 (E) EXCLUSION OF CERTAIN INDIVID-  
19                 UALS.—A single-payer system may not require  
20                 the enrollment of veterans, active duty military  
21                 personnel, and American Indians.

22                 (4) DIRECT PAYMENT TO PROVIDERS.—

23                 (A) IN GENERAL.—With respect to pro-  
24                 viders who furnish items and services included  
25                 in the standard benefits package established

1 under subtitle C to individuals enrolled in the  
2 system, the State shall make payments directly,  
3 or through fiscal intermediaries, to such pro-  
4 viders and assume (subject to subparagraph  
5 (B)) all financial risk associated with making  
6 such payments.

7 (B) CAPITATED PAYMENTS PERMITTED.—  
8 Nothing in subparagraph (A) shall be construed  
9 to prohibit providers furnishing items and serv-  
10 ices under the system from receiving payments  
11 on a capitated, at-risk basis based on prospec-  
12 tively determined rates.

13 (5) PROVISION OF STANDARD BENEFITS PACK-  
14 AGE.—

15 (A) IN GENERAL.—The system shall pro-  
16 vide for coverage of the standard benefits pack-  
17 age established under subtitle C, including the  
18 cost-sharing provided under the package (sub-  
19 ject to subparagraph (B)), to all individuals en-  
20 rolled in the system.

21 (B) IMPOSITION OF REDUCED COST-SHAR-  
22 ING.—The system may decrease the cost-shar-  
23 ing otherwise provided in the standard benefits  
24 package established under subtitle C with re-  
25 spect to any individuals enrolled in the system

1 or any class of services included in the package,  
2 so long as the system does not increase the  
3 cost-sharing otherwise imposed with respect to  
4 any other individuals or services.

5 (6) COST CONTAINMENT.—The system shall  
6 provide for mechanisms to ensure, in a manner sat-  
7 isfactory to the Secretary, that—

8 (A) the rate of growth in health care  
9 spending will not be higher than the target es-  
10 tablished under this Act;

11 (B) the expenditures described in subpara-  
12 graph (A) are computed and effectively mon-  
13 itored;

14 (C) automatic, mandatory, nondis-  
15 cretionary reductions in payments to health  
16 care providers will be imposed to the extent re-  
17 quired to assure that such per capita expendi-  
18 tures do not exceed the applicable target re-  
19 ferred to in subparagraph (A); and

20 (D) Federal payments to a single payer  
21 State or health care coverage area shall be lim-  
22 ited to the payments that would have been  
23 made in the absence of the implementation of  
24 the single payer system.

1           (7) FEDERAL PAYMENTS.—The system shall  
2 provide for mechanisms to ensure, in a manner sat-  
3 isfactory to the Secretary, that Federal payments to  
4 a single-payer State or community rating area shall  
5 be limited to the payments that would have been  
6 made in the absence of the implementation of the  
7 single-payer system.

8           (8) REQUIREMENTS GENERALLY APPLICABLE  
9 TO STANDARD HEALTH PLANS.—The system shall  
10 meet the requirements applicable to a standard  
11 health plan, except that—

12           (A) the system does not have the authority  
13 provided to standard health plans under section  
14 1111(b)(3) (relating to permissible limitations  
15 on the enrollment of community-rated eligible  
16 individuals on the basis of limits on the plan’s  
17 capacity); and

18           (B) the system is not required to meet the  
19 requirements of sections 1116 (relating to rat-  
20 ing limitations for community-rated market),  
21 1123(a) (relating to plan solvency), and section  
22 1125 (relating to restrictions on the marketing  
23 of plan materials).

1 **SEC. 1533. SPECIAL RULES FOR STATES OPERATING STATE-**  
2 **WIDE SINGLE-PAYER SYSTEM.**

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

5 (1) the State shall operate the system through-  
6 out the State; and

7 (2) except as provided in subsection (b), the  
8 State shall meet the requirements for participating  
9 States under part 1.

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

15 (1) **ESTABLISHMENT OF COMMUNITY RATING**  
16 **AND SERVICE AREAS.**—The requirements of sections  
17 1502(a) (relating to the establishment of community  
18 rating areas) and 1502(b) (relating to the designa-  
19 tion of health plan service areas).

20 (2) **OTHER REFERENCES INAPPLICABLE.**—Any  
21 requirement which the Secretary determines is not  
22 appropriate to apply to a State single-payer system.

23 (c) **FINANCING.**—

24 (1) **IN GENERAL.**—A State operating a State-  
25 wide single-payer system shall provide for the financ-  
26 ing of the system using, at least in part, a payroll-

1 based financing system that requires employers to  
2 pay at least the amount that the employers would be  
3 required to pay if the employers were subject to the  
4 requirements of title X (determined without regard  
5 to any effective date).

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

9 (d) SINGLE-PAYER STATE DEFINED.—In this title,  
10 the term “single-payer State” means a State with a State-  
11 wide single-payer system in effect that has been approved  
12 by the Secretary in accordance with this part.

13 **SEC. 1534. SPECIAL RULES FOR COMMUNITY RATING AREA-**  
14 **SPECIFIC SINGLE-PAYER SYSTEMS.**

15 (a) IN GENERAL.—In the case of a State operating  
16 a community rating area specific single-payer system, ex-  
17 cept as provided in subsection (b), the State shall meet  
18 the requirements for participating States under part 1.

19 (b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR  
20 PARTICIPATING STATES.—

21 (1) ESTABLISHMENT OF SERVICE AREAS.—The  
22 requirement of section 1502(b) (relating to the des-  
23 ignation of health plan service areas).

24 (2) OTHER REFERENCES INAPPLICABLE.—Any  
25 requirement which the Secretary determines is not

1 appropriate to apply to a community rating area  
2 specific single-payer system.

3 **Subpart C—Early Implementation of Comprehensive**  
4 **State Programs**

5 **SEC. 1541. EARLY IMPLEMENTATION OF COMPREHENSIVE**  
6 **STATE PROGRAMS**

7 (a) APPLICATION.—

8 (1) IN GENERAL.—In accordance with this sec-  
9 tion, each State desiring to implement the reform  
10 standards established in this Act before the applica-  
11 ble effective date for such standards, may submit an  
12 application to the Secretary of Health and Human  
13 Services and the Secretary of Labor to request ap-  
14 proval of a State comprehensive health care reform  
15 program established under State law which meets  
16 the requirements specified in subsection (b).

17 (2) ESTABLISHMENT OF CRITERIA.—The Secre-  
18 taries shall establish not later than January 1, 1995,  
19 criteria for—

20 (A) the approval of such applications, and

21 (B) the continuing review of such State  
22 programs consistent with the provisions of sub-  
23 part B of part 1.

24 (3) EXPEDITED PROCEDURE.—The Secretaries  
25 shall establish an expedited procedure for the consid-

1       eration and disposition of applications under this  
2       subsection. The procedure established by the Secre-  
3       taries shall provide that such consideration and dis-  
4       position be completed within 90 days, and that if the  
5       application is approved, multistate employers be no-  
6       tified of such approval.

7       (b) REQUIREMENTS SPECIFIED.—The State program  
8       shall be consistent with the reform standards established  
9       in this Act and the interim and final (if any) regulations  
10      promulgated by the Secretaries, including—

11           (1) a standardized benefits package meeting the  
12           requirements established under subtitle C, or in the  
13           event such requirements have not been fully promul-  
14           gated on the date of the application, the require-  
15           ments for a qualified health maintenance organiza-  
16           tion (as defined in section 1310(d) of the Public  
17           Health Service Act (42 U.S.C. 300e-9(d));

18           (2) insurance reforms and rating requirements  
19           as specified under part 2 of subtitle B;

20           (3) standards for health plans as specified  
21           under part 3 of subtitle B;

22           (4) the recognition of, and standards for, pur-  
23           chasing cooperatives, as specified in part 2 of sub-  
24           title D;

1           (5) compliance with the data collection and pri-  
2           vacy procedures established under subtitle B of title  
3           V;

4           (6) uniform administrative procedures as speci-  
5           fied in section 1126;

6           (7) the imposition of employer and individual  
7           responsibilities as specified in part 1 of subtitle D  
8           and title X (determined without regard to any effec-  
9           tive date);

10          (8) the establishment of the subsidy program  
11          under this Act; and

12          (9) health care cost containment under this  
13          Act.

14          (c) QUALIFICATION FOR FEDERAL FUNDS.—For  
15          purposes of this Act, a State with an approved State pro-  
16          gram under this section shall be considered a participating  
17          State and shall maintain such status if such State meets  
18          the requirements of this Act as such provisions become  
19          effective.

20          (d) EMPLOYER CERTIFICATION PROCESS.—In the  
21          case of any multistate self-insured health plan, certifi-  
22          cation by the plan to the Secretary of Labor that such  
23          plan is in compliance with the applicable Federal stand-  
24          ards described in subsection (b) shall satisfy compliance  
25          with any State program approved under this section.

1 (e) FUNDING.—The Secretary of Health and Human  
 2 Services shall pay over to each State with an approved  
 3 application under this section for each calendar quarter  
 4 ending before 1997 an amount equal to the estimated de-  
 5 crease in Federal expenditures (net of any estimated de-  
 6 crease in Federal revenues) for such quarter with respect  
 7 to such State resulting from the implementation of the  
 8 State comprehensive health care reform program.

9 **Subtitle G—Miscellaneous**  
 10 **Provisions**

11 **SEC. 1601. PROVISION OF ITEMS OR SERVICES CONTRARY**  
 12 **TO RELIGIOUS BELIEF OR MORAL CONVIC-**  
 13 **TION.**

14 A health professional or a health facility may not be  
 15 required to provide an item or service in the standard ben-  
 16 efit package if the professional or facility objects to doing  
 17 so on the basis of a religious belief or moral conviction.

18 **SEC. 1602. ANTIDISCRIMINATION.**

19 (a) IN GENERAL.—The Secretary of Health and  
 20 Human Services, and any State, health plan, purchasing  
 21 cooperative, employer, health program or activity receiving  
 22 Federal financial assistance, or other entity subject to this  
 23 Act, shall not directly or through contractual arrange-  
 24 ments—

1           (1) deny or limit access to or the availability of  
2 health care services, or otherwise discriminate in  
3 connection with the provision of health care services;  
4 or

5           (2) limit, segregate, or classify an individual in  
6 any way which would deprive or tend to deprive such  
7 individual of health care services, or otherwise ad-  
8 versely affect his or her access to health care serv-  
9 ices;

10 on the basis of race, national origin, sex, religion, lan-  
11 guage, income, age, sexual orientation, disability, health  
12 status, or anticipated need for health services.

13       (b) APPLICATION OF SECTION TO SPECIFIC AC-  
14 TIONS.—This section shall apply to, but is not limited to,  
15 the following actions:

16           (1) The establishing of boundaries for commu-  
17 nity rating areas under section 1502, the enrollment  
18 of individuals in a health care plan or the marketing  
19 of a health care plan, and the selection of providers  
20 or the setting of the terms or conditions under which  
21 providers participate in a health care plan or pro-  
22 vider network.

23           (2) The determination of the scope of services  
24 provided by a health care plan, and the providing of

1 such services and determining of the site or location  
2 of health care facilities.

3 (c) REGULATIONS.—Not later than 1 year after the  
4 date of the enactment of this Act, the Secretary of Health  
5 and Human Services shall issue regulations to carry out  
6 this section.

7 (d) EFFECT ON OTHER LAWS. Nothing in this Act  
8 shall be construed to limit the scope of, or the availability  
9 of relief under, any other Federal or State law prohibiting  
10 discrimination or providing relief therefore.

11 **TITLE II—NEW BENEFITS**  
12 **Subtitle A—Coverage of Outpatient**  
13 **Prescription Drugs in Medicare**

14 **SEC. 2000. REFERENCES IN SUBTITLE.**

15 (a) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
16 cept as otherwise specifically provided, whenever in this  
17 subtitle an amendment is expressed in terms of an amend-  
18 ment to or repeal of a section or other provision, the ref-  
19 erence shall be considered to be made to that section or  
20 other provision of the Social Security Act.

21 (b) REFERENCES TO OBRA.—In this title, the terms  
22 “OBRA–1986”, “OBRA–1987”, “OBRA–1989”,  
23 “OBRA–1990”, and “OBRA–1993” refer to the Omnibus  
24 Budget Reconciliation Act of 1986 (Public Law 99–509),  
25 the Omnibus Budget Reconciliation Act of 1987 (Public

1 Law 100–203), the Omnibus Budget Reconciliation Act  
2 of 1989 (Public Law 101–239), the Omnibus Budget Rec-  
3 onciliation Act of 1990 (Public Law 101–508), and the  
4 Omnibus Budget Reconciliation Act of 1993 (Public Law  
5 103–66), respectively.

6 **PART 1—COVERAGE OF OUTPATIENT**

7 **PRESCRIPTION DRUGS**

8 **SEC. 2001. COVERAGE OF OUTPATIENT PRESCRIPTION**  
9 **DRUGS.**

10 (a) COVERED OUTPATIENT DRUGS AS MEDICAL AND  
11 OTHER HEALTH SERVICES.—Section 1861(s)(2)(J) (42  
12 U.S.C. 1395x(s)(2)(J)) is amended to read as follows:

13 “(J) covered outpatient drugs;”.

14 (b) DEFINITION OF COVERED OUTPATIENT DRUG.—  
15 Section 1861(t) (42 U.S.C. 1395x(t)) is amended—

16 (1) in the heading, by adding at the end the fol-  
17 lowing: “; Covered Outpatient Drugs”;

18 (2) in paragraph (1)—

19 (A) by striking “paragraph (2)” and in-  
20 serting “the succeeding paragraphs of this sub-  
21 section”, and

22 (B) by striking the period at the end and  
23 inserting “, but only if used for a medically ac-  
24 cepted indication.”; and

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

3           “(2) Except as otherwise provided in paragraph (3),  
4 the term ‘covered outpatient drug’ means any of the fol-  
5 lowing products used for a medically accepted indication:

6           “(A) A drug which may be dispensed only upon  
7 prescription and—

8           “(i) which is approved for safety and effec-  
9 tiveness as a prescription drug under section  
10 505 or 507 of the Federal Food, Drug, and  
11 Cosmetic Act or which is approved under sec-  
12 tion 505(j) of such Act;

13           “(ii)(I) which was commercially used or  
14 sold in the United States before the date of the  
15 enactment of the Drug Amendments of 1962 or  
16 which is identical, similar, or related (within the  
17 meaning of section 310.6(b)(1) of title 21 of the  
18 Code of Federal Regulations) to such a drug,  
19 and (II) which has not been the subject of a  
20 final determination by the Secretary that it is  
21 a ‘new drug’ (within the meaning of section  
22 201(p) of the Federal Food, Drug, and Cos-  
23 metic Act) or an action brought by the Sec-  
24 retary under section 301, 302(a), or 304(a) of

1 such Act to enforce section 502(f) or 505(a) of  
2 such Act; or

3 “(iii)(I) which is described in section  
4 107(c)(3) of the Drug Amendments of 1962  
5 and for which the Secretary has determined  
6 there is a compelling justification for its med-  
7 ical need, or is identical, similar, or related  
8 (within the meaning of section 310.6(b)(1) of  
9 title 21 of the Code of Federal Regulations) to  
10 such a drug, and (II) for which the Secretary  
11 has not issued a notice of an opportunity for a  
12 hearing under section 505(e) of the Federal  
13 Food, Drug, and Cosmetic Act on a proposed  
14 order of the Secretary to withdraw approval of  
15 an application for such drug under such section  
16 because the Secretary has determined that the  
17 drug is less than effective for all conditions of  
18 use prescribed, recommended, or suggested in  
19 its labeling.

20 “(B) A biological product which—

21 “(i) may only be dispensed upon prescrip-  
22 tion,

23 “(ii) is licensed under section 351 of the  
24 Public Health Service Act, and

1           “(iii) is produced at an establishment li-  
2           censed under such section to produce such  
3           product.

4           “(C) Insulin certified under section 506 of the  
5           Federal Food, Drug, and Cosmetic Act.

6           “(D) Enteral nutrients (but only if provided as  
7           a covered home infusion drug).

8           “(3) The term ‘covered outpatient drug’ does not in-  
9           clude any product—

10           “(A) which is administered through infusion in  
11           a setting described in paragraph (5)(A)(ii) unless  
12           the product is a covered home infusion drug;

13           “(B) when furnished as part of, or as incident  
14           to, any other item or service for which payment may  
15           be made under this title (other than physicians’  
16           services or services which would be physicians’ serv-  
17           ices if furnished by a physician); or

18           “(C) which is listed under paragraph (2) of sec-  
19           tion 1927(d) (other than subparagraph (I) or (J) of  
20           such paragraph) as a drug which may be excluded  
21           from coverage under a State plan under title XIX  
22           and which the Secretary elects to exclude from cov-  
23           erage under part B.

24           “(4) For purposes of this subsection, the term ‘medi-  
25           cally accepted indication’, with respect to the use of an

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

4           “(A) the drug has been approved by the Food  
5           and Drug Administration; and

6           “(B)(i) such use is supported by one or more  
7           citations which are included (or approved for inclu-  
8           sion) in one or more of the following compendia: the  
9           American Hospital Formulary Service-Drug Infor-  
10          mation, the American Medical Association Drug  
11          Evaluations, the United States Pharmacopoeia-Drug  
12          Information, and other authoritative compendia as  
13          identified by the Secretary, unless the Secretary has  
14          determined that the use is not medically appropriate  
15          or the use is identified as not indicated in one or  
16          more such compendia, or

17          “(ii) the carrier involved determines, based  
18          upon guidance provided by the Secretary to carriers  
19          for determining accepted uses of drugs, that such  
20          use is medically accepted based on supportive clinical  
21          evidence in peer reviewed medical literature appear-  
22          ing in publications which have been identified for  
23          purposes of this clause by the Secretary.

1 The Secretary may revise the list of compendia in sub-  
2 paragraph (B)(i) designated as appropriate for identifying  
3 medically accepted indications for drugs.

4 “(5)(A) For purposes of this subsection, the term  
5 ‘covered home infusion drug’ means a covered outpatient  
6 drug dispensed to an individual that—

7 “(i) is administered intravenously,  
8 subcutaneously, or epidurally, using an access device  
9 that is inserted into the body and an infusion device  
10 to control the rate of flow of the drug (or through  
11 other means of administration determined by the  
12 Secretary);

13 “(ii) is administered—

14 “(I) in the individual’s home,

15 “(II) in an institution used as the individ-  
16 ual’s home, but only if the drug is administered  
17 during an inpatient day for which payment is  
18 not made to the institution under part A for in-  
19 patient or extended care services furnished to  
20 the individual, or

21 “(III) in a facility other than the individ-  
22 ual’s home if the administration of the drug at  
23 the facility is determined by the Secretary to be  
24 cost-effective (in accordance with such criteria  
25 as the Secretary may establish); and

1           “(iii) with respect to a drug furnished in a  
2           home setting—

3                   “(I) is an antibiotic drug and the Sec-  
4                   retary has not determined, for the specific drug  
5                   or the indication to which the drug is applied,  
6                   that the drug cannot generally be administered  
7                   safely and effectively in such a setting, or

8                   “(II) is not an antibiotic drug and the Sec-  
9                   retary has determined, for the specific drug or  
10                  the indication to which the drug is applied, that  
11                  the drug can generally be administered safely  
12                  and effectively in such a setting.

13           “(B) Not later than January 1, 1999, (and periodi-  
14           cally thereafter), the Secretary shall publish a list of the  
15           drugs, and indications for such drugs, that are covered  
16           home infusion drugs, with respect to which home infusion  
17           drug therapy may be provided under this title.”.

18           (c) CONFORMING AMENDMENTS REPEALING SEPA-  
19           RATE COVERAGE OF CERTAIN DRUGS AND PRODUCTS.—

20           (1) Effective January 1, 1999, section 1861(s)(2) (42  
21           U.S.C. 1395x(s)(2)) is amended—

22                   (A) in subparagraph (A), by striking “(includ-  
23                   ing drugs” and all that follows through “self-admin-  
24                   istered)”;

25                   (B) by striking subparagraphs (G) and (I);

1 (C) by adding “and” at the end of subpara-  
2 graph (M); and

3 (D) by striking subparagraphs (O), (P), and  
4 (Q).

5 (2) Effective January 1, 1999, section 1861 (42  
6 U.S.C. 1395x) is amended by striking the subsection (jj)  
7 added by section 4156(a)(2) of OBRA–1990.

8 (3) Effective January 1, 1999, section 1881(b) (42  
9 U.S.C. 1395rr(b)) is amended—

10 (A) in the first sentence of paragraph (1)—

11 (i) by striking “, (B)” and inserting “, and  
12 (B)”, and

13 (ii) by striking “, and (C)” and all that  
14 follows and inserting a period; and

15 (B) in paragraph (11)—

16 (i) by striking “(11)(A)” and inserting  
17 “(11)”, and

18 (ii) by striking subparagraphs (B) and (C).

19 **SEC. 2002. PAYMENT RULES AND RELATED REQUIREMENTS**  
20 **FOR COVERED OUTPATIENT DRUGS.**

21 (a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m)  
22 is amended by inserting after subsection (c) the following  
23 new subsection:

24 “(d) PAYMENT FOR AND CERTAIN REQUIREMENTS  
25 CONCERNING COVERED OUTPATIENT DRUGS.—

1 “(1) DEDUCTIBLE.—

2 “(A) IN GENERAL.—Payment shall be  
3 made under paragraph (2) only for expenses in-  
4 curred by an individual for a covered outpatient  
5 drug during a calendar year after the individual  
6 has incurred expenses in the year for such  
7 drugs (during a period in which the individual  
8 is entitled to benefits under this part) equal to  
9 the deductible amount for that year.

10 “(B) DEDUCTIBLE AMOUNT.—

11 “(i) For purposes of subparagraph  
12 (A), the deductible amount is—

13 “(I) for 1999, an amount equal  
14 to the amount determined under  
15 clause (ii)(I);

16 “(II) for 2000, the amount  
17 (rounded to the nearest dollar) that  
18 the Secretary estimates will ensure  
19 that the percentage of individuals cov-  
20 ered under this part (other than indi-  
21 viduals enrolled with an eligible orga-  
22 nization under section 1876, an orga-  
23 nization described in section  
24 1833(a)(1)(A), or a medicare drug  
25 benefit plan under section 1851) dur-

1           ing the year who will incur expenses  
2           for covered outpatient drugs equal to  
3           or greater than such amount will be  
4           the same as the percentage for the  
5           previous year;

6                   “(III) for 2001, an amount equal  
7           to the amount determined under  
8           clause (ii)(II); and

9                   “(IV) for any succeeding year,  
10          the amount (rounded to the nearest  
11          dollar) that the Secretary estimates  
12          will ensure that the percentage of in-  
13          dividuals covered under this part  
14          (other than individuals enrolled with  
15          an eligible organization under section  
16          1876, an organization described in  
17          section 1833(a)(1)(A), or a medicare  
18          drug benefit plan under section 1851)  
19          during the year who will incur ex-  
20          penses for covered outpatient drugs  
21          equal to or greater than such amount  
22          will be the same as the percentage for  
23          the previous year.

24                   “(ii) For purposes of clause (i), the  
25          amount determined under this clause is—

1           “(I) in 1999, an amount deter-  
2           mined by the Secretary such that the  
3           amount so determined will result in  
4           projected incurred spending and ad-  
5           ministrative costs (net of projected re-  
6           bates under section 1851 and any  
7           portion of the part B premium attrib-  
8           utable to the covered outpatient drug  
9           benefit) for providing payment under  
10          this title for covered outpatient drugs  
11          that would be equal to a spending tar-  
12          get equal to \$13,500,000,000; and

13           “(II) in 2001, an amount deter-  
14          mined by the Secretary (based on ac-  
15          tual experience) that the Secretary es-  
16          timates will ensure that the percent-  
17          age of individuals covered under this  
18          part (other than individuals enrolled  
19          with an eligible organization under  
20          section 1876, an organization de-  
21          scribed in section 1833(a)(1)(A), or a  
22          medicare drug benefit plan under sec-  
23          tion 1851) during the year who will  
24          incur expenses for covered outpatient  
25          drugs equal to or greater than such

1 amount will be the same as the per-  
2 centage that would have incurred such  
3 expenses had actual experience in  
4 such incurred spending and adminis-  
5 trative costs (described in subclause  
6 (I)) for 1999 been equal to the spend-  
7 ing target for 1999 (described in sub-  
8 clause (I)).

9 “(iii) The Secretary shall promulgate  
10 the deductible amount for 1999 and each  
11 succeeding year not later than October 1  
12 of the previous year.

13 “(2) PAYMENT AMOUNT.—

14 “(A) IN GENERAL.—Subject to the deduct-  
15 ible established under paragraph (1), the  
16 amount payable under this part for a covered  
17 outpatient drug furnished to an individual dur-  
18 ing a calendar year shall be equal to—

19 “(i) 80 percent of the payment basis  
20 described in paragraph (3), in the case of  
21 an individual who has not incurred ex-  
22 penses for covered outpatient drugs during  
23 the year (including the deductible imposed  
24 under paragraph (1)) in excess of the out-

1 of-pocket limit for the year under subpara-  
2 graph (B); and

3 “(ii) 100 percent of the payment basis  
4 described in paragraph (3), in the case of  
5 any other individual.

6 “(B) OUT-OF-POCKET LIMIT DE-  
7 SCRIBED.—

8 “(i) For purposes of subparagraph  
9 (A), the out-of-pocket limit for a year is  
10 equal to—

11 “(I) for 1999, \$1275; and

12 “(II) for any succeeding year, the  
13 amount (rounded to the nearest dol-  
14 lar) that the Secretary estimates will  
15 ensure that the percentage of the av-  
16 erage number of individuals covered  
17 under this part (other than individ-  
18 uals enrolled with an eligible organiza-  
19 tion under section 1876 or an organi-  
20 zation described in section  
21 1833(a)(1)(A)) during the year who  
22 will incur expenses for covered out-  
23 patient drugs equal to or greater than  
24 such amount will be the same as the  
25 percentage for the previous year.

1                   “(ii) The Secretary shall promulgate  
2                   the out-of-pocket limit for 1999 and each  
3                   succeeding year not later than October 1  
4                   of the previous year.

5                   “(3) PAYMENT BASIS.—For purposes of para-  
6                   graph (2), the payment basis is the lesser of—

7                   “(A) the actual charge for a covered out-  
8                   patient drug, or

9                   “(B) the applicable payment limit estab-  
10                  lished under paragraph (4).

11                  “(4) PAYMENT LIMITS.—

12                  “(A) PAYMENT LIMIT FOR SINGLE SOURCE  
13                  DRUGS AND MULTIPLE SOURCE DRUGS WITH  
14                  RESTRICTIVE PRESCRIPTIONS.—In the case of a  
15                  covered outpatient drug that is a multiple  
16                  source drug which has a restrictive prescription,  
17                  or that is single source drug, the payment limit  
18                  for a payment calculation period is equal to the  
19                  amount of the administrative allowance (estab-  
20                  lished under paragraph (5)) plus the product of  
21                  the number of dosage units dispensed and the  
22                  per unit estimated acquisition cost for the drug  
23                  product (determined under subparagraph (C))  
24                  for the period.

1           “(B) PAYMENT LIMIT FOR MULTIPLE  
2 SOURCE DRUGS WITHOUT RESTRICTIVE PRE-  
3 SCRIPTIONS.—In the case of a drug that is a  
4 multiple source drug which does not have a re-  
5 strictive prescription, the payment limit for a  
6 payment calculation period is equal to the  
7 amount of the administrative allowance (estab-  
8 lished under paragraph (5)) plus the product of  
9 the number of dosage units dispensed and the  
10 unweighted median of the unit estimated acqui-  
11 sition cost (determined under subparagraph  
12 (C)) for the drug products for the period.

13           “(C) DETERMINATION OF UNIT PRICE.—

14           “(i) IN GENERAL.—The Secretary  
15 shall determine, for the dispensing or pro-  
16 viding of a covered outpatient drug prod-  
17 uct in the payment calculation period, the  
18 estimated acquisition cost for the drug  
19 product. With respect to any covered out-  
20 patient drug product, the estimated acqui-  
21 sition cost, may not exceed 93 percent of  
22 the published average wholesale price for  
23 the drug, as determined one month prior  
24 to the beginning of the payment calcula-  
25 tion period.

1           “(ii) COMPLIANCE WITH REQUEST  
2           FOR INFORMATION.—If a wholesaler or di-  
3           rect seller of a covered outpatient drug re-  
4           fuses, after being requested by the Sec-  
5           retary, to provide price information re-  
6           quested to carry out clause (i), or delib-  
7           erately provides information that is false,  
8           the Secretary may impose a civil money  
9           penalty of not to exceed \$10,000 for each  
10          such refusal or provision of false informa-  
11          tion. The provisions of section 1128A  
12          (other than subsections (a) and (b)) shall  
13          apply to civil money penalties under the  
14          previous sentence in the same manner as  
15          they apply to a penalty or proceeding  
16          under section 1128A(a). Information gath-  
17          ered pursuant to clause (i) shall not be dis-  
18          closed except as the Secretary determines  
19          to be necessary to carry out the purposes  
20          of this part and to permit the Comptroller  
21          General and the Director of the Congres-  
22          sional Budget Office to review the informa-  
23          tion provided.

24           “(5) ADMINISTRATIVE ALLOWANCE FOR PUR-  
25          POSES OF PAYMENT LIMIT.—

1           “(A) IN GENERAL.—Except as provided in  
2 subparagraphs (B) and (C), the administrative  
3 allowance established under this paragraph is—

4                   “(i) for 1999, an amount equal to \$5;

5                   and

6                   “(ii) for each succeeding year, the  
7 amount for the previous year, adjusted by  
8 the percentage change in the consumer  
9 price index for all urban consumers (U.S.  
10 city average) for the 12-month period end-  
11 ing with June of that previous year.

12           “(B) NO DISPENSING FEE FOR CERTAIN  
13 DRUGS AND PRODUCTS.—No administrative al-  
14 lowance may be provided under this paragraph  
15 with respect to any of the following covered out-  
16 patient drugs:

17                   “(i) Erythropoietin provided to dialy-  
18 sis patients.

19                   “(ii) Drugs and biologicals provided  
20 as an incident to a physician’s service or to  
21 a service which would be a physician’s  
22 service if furnished by a physician.

23                   “(iii) Covered home infusion drugs.

24           “(6) MAIL ORDER PHARMACY OPTION.—

1           “(A) ESTABLISHMENT OF MAIL ORDER OP-  
2           TION.—The Secretary may establish a competi-  
3           tive bidding process to award contracts to mail  
4           order pharmacies for the provision of covered  
5           outpatient drugs that are maintenance drugs to  
6           individuals who opt to receive such drugs  
7           through the mail order pharmacies. The pay-  
8           ment amount for a covered outpatient drug  
9           under this section to a mail order pharmacy  
10          under such a contract shall be equal to the  
11          amount bid by such plan under this subpara-  
12          graph instead of the payment limit determined  
13          in accordance with paragraph (4).

14          “(B) SHARING OF SAVINGS.—To the ex-  
15          tent that payment is made under this section  
16          for maintenance drugs that are provided  
17          through a mail order pharmacy pursuant to  
18          subparagraph (A), an individual that opts to re-  
19          ceive such drugs from such pharmacy shall re-  
20          ceive from the Secretary a rebate or a contribu-  
21          tion toward the individual’s cost sharing in an  
22          amount equal to 25 percent of the excess of the  
23          payment limit determined in accordance with  
24          paragraph (4) over the amount charged by the  
25          mail order pharmacy for such drug.

1           “(7) ASSURING APPROPRIATE PRESCRIBING  
2           AND DISPENSING PRACTICES.—

3           “(A) IN GENERAL.—The Secretary shall  
4           develop a program to—

5                   “(i) provide on-line prospective review  
6                   of prescriptions on a 24-hour basis (in ac-  
7                   cordance with subparagraph (B)) and ret-  
8                   rospective review of claims;

9                   “(ii) establish standards for coun-  
10                  seling individuals to whom covered out-  
11                  patient drugs are prescribed; and

12                  “(iii) identify (and to educate physi-  
13                  cians, patients, and pharmacists con-  
14                  cerning)—

15                   “(I) instances or patterns of un-  
16                   necessary or inappropriate prescribing  
17                   or dispensing practices for covered  
18                   outpatient drugs,

19                   “(II) instances or patterns of  
20                   substandard care with respect to such  
21                   drugs,

22                   “(III) potential adverse reactions,  
23                   and

24                   “(IV) appropriate use of generic  
25                   products.

1 “(B) PROSPECTIVE REVIEW.—

2 “(i) IN GENERAL.—The program  
3 under this paragraph shall provide for on-  
4 line prospective review of each covered out-  
5 patient drug prescribed for a patient be-  
6 fore the prescription is filled or the drug is  
7 furnished, including screening for potential  
8 drug therapy problems due to therapeutic  
9 duplication, drug-to-drug interactions, and  
10 incorrect drug dosage or duration of drug  
11 treatment.

12 “(ii) DISCUSSION OF APPROPRIATE  
13 USE.—In conducting prospective review  
14 under this subparagraph, any individual or  
15 entity that dispenses a covered outpatient  
16 drug shall offer to discuss with the patient  
17 to whom the drug is furnished or the pa-  
18 tient’s caregiver (in person if practicable,  
19 or through access to a toll-free telephone  
20 service) information regarding the appro-  
21 priate use of the drug, potential inter-  
22 actions between the drug and other drugs  
23 dispensed to the individual, and such other  
24 matters as the Secretary may require.

1           “(iii) ADDITIONAL DUTIES.—In car-  
2 rying out this subparagraph, the Secretary  
3 shall—

4           “(I) develop public domain soft-  
5 ware which could be used by carriers  
6 and pharmacies to provide the on-line  
7 prospective review; and

8           “(II) study the feasibility and de-  
9 sirability of requiring patient diag-  
10 nosis codes on prescriptions and to  
11 the extent that the Secretary finds  
12 such a requirement to be feasible and  
13 desirable, to implement such a re-  
14 quirement to be effective on and after  
15 January 1, 2000.

16           “(C) PRIOR AUTHORIZATION.—

17           “(i) DEVELOPMENT OF LIST OF MIS-  
18 USED DRUGS.—The Secretary shall develop  
19 (and periodically) update a list of covered  
20 outpatient drugs which the Secretary has  
21 determined, based on data collected, may  
22 be subject to misuse or inappropriate use.  
23 The Secretary shall provide a means for  
24 manufacturers to appeal an initial decision  
25 to include a drug on the list.

1           “(ii) PRIOR AUTHORIZATION FOR  
2 DRUGS ON LIST.—The Secretary shall es-  
3 tablish a process under which (subject to  
4 clause (iii)) the Secretary may require ad-  
5 vance approval for any covered outpatient  
6 drug included on the list developed under  
7 clause (i).

8           “(iii) RESTRICTIONS ON DENIAL OF  
9 APPROVAL.—The Secretary may not deny  
10 the approval of a drug under the process  
11 established under clause (ii) before its dis-  
12 pensing unless the process—

13                 “(I) provides responses by tele-  
14 phone or other telecommunication de-  
15 vice within 24 hours of a request for  
16 prior authorization; and

17                 “(II) provides for the dispensing  
18 of at least a 72-hour supply of a cov-  
19 ered outpatient prescription drug in  
20 emergency situations (as defined by  
21 the Secretary).

22           “(iv) EXPANSION TO OTHER  
23 DRUGS.—If the rate of growth of payments  
24 under this part for covered outpatient  
25 drugs exceeds the average rate of growth

1           for parts A and B expenditures and the  
2           Secretary finds such action to be feasible  
3           and desirable, the Secretary may require  
4           advance approval under this subparagraph  
5           for the dispensing of a covered outpatient  
6           drug in cases where a more cost-effective  
7           therapeutically or generically equivalent  
8           drug is available.

9           “(D) DRUG USE REVIEW.—As part of the  
10          program established under subparagraph (A),  
11          the Secretary shall provide for a drug use re-  
12          view program to provide for the ongoing peri-  
13          odic examination of claims data and other  
14          records on covered outpatient drugs furnished  
15          to patients under this title in order to identify  
16          patterns of fraud, abuse, gross overuse, or inap-  
17          propriate or medically unnecessary care among  
18          physicians, pharmacists, and patients.

19          “(E) ADOPTION OF MEDICAID PRO-  
20          GRAMS.—To the extent considered appropriate  
21          by the Secretary, the program developed under  
22          this paragraph with respect to drugs furnished  
23          in a State may include elements applicable to  
24          the furnishing of covered outpatient drugs

1 under the State medicaid program under sec-  
2 tion 1927.

3 “(8) BILLING REQUIREMENTS.—

4 “(A) MANDATORY ASSIGNMENT.—(i) Pay-  
5 ment under this part for a covered outpatient  
6 drug may only be made on an assignment-re-  
7 lated basis.

8 “(ii) Except for deductible, coinsurance, or  
9 copayment amounts applicable under this part,  
10 no person may bill or collect any amount from  
11 an individual enrolled under this part or other  
12 person for a covered outpatient drug for which  
13 payment may be made under this part, and no  
14 such individual or person is liable for payment  
15 of any amounts billed in violation of this clause.  
16 If a person knowingly and willfully bills or col-  
17 lects an amount in violation of the previous sen-  
18 tence, the Secretary may apply sanctions  
19 against such person in accordance with section  
20 1842(j)(2). Paragraph (4) of section 1842(j)  
21 shall apply in this clause in the same manner  
22 as such paragraph applies to such section.

23 “(B) USE OF ELECTRONIC SYSTEM.—The  
24 Secretary shall establish, by not later than Jan-  
25 uary 1, 1998, a point-of-sale electronic system

1 for use by carriers and pharmacies in the sub-  
2 mission of information respecting covered out-  
3 patient drugs dispensed to medicare bene-  
4 ficiaries under this part. Such system shall be  
5 consistent with the standards established by the  
6 National Council of Prescription Drug Pro-  
7 grams.

8 “(9) REQUIRING PHARMACY SUPPLIER NUM-  
9 BERS.—

10 “(A) IN GENERAL.—Payment may not be  
11 made under this part with respect to a covered  
12 outpatient drug dispensed by a pharmacy unless  
13 the entity has obtained a supplier number from  
14 the Secretary.

15 “(B) STANDARDS FOR ISSUING SUPPLIER  
16 NUMBERS.—The Secretary may not issue a sup-  
17 plier number to an entity for purposes of sub-  
18 paragraph (A) unless the entity demonstrates to  
19 the Secretary that it will maintain patient  
20 records (in accordance with such standards as  
21 the Secretary may impose) and meet the other  
22 applicable requirements of this subsection and  
23 section 1848(g).

24 “(10) STUDY ON PHARMACEUTICAL CARE SERV-  
25 ICES.—The Secretary shall conduct a study to de-

1       velop, in consultation with actively practicing phar-  
2       macists, a payment methodology (to be in addition  
3       to the administrative allowance established under  
4       paragraph (5)) which is based upon and reflects the  
5       reasonable charges for varying levels of pharmacist  
6       services, including patient consultations provided to  
7       individuals under this section. The Secretary shall  
8       submit a report, including such recommendations as  
9       the Secretary determines to be appropriate, to Con-  
10      gress on the methodology developed under this para-  
11      graph not later than September 30, 1998.

12           “(11) DEFINITIONS.—In this subsection:

13                   “(A) MULTIPLE AND SINGLE SOURCE  
14                   DRUGS.—The terms ‘multiple source drug’ and  
15                   ‘single source drug’ have the meanings given  
16                   those terms under section 1927(k)(7), except  
17                   that the reference in such section to a ‘covered  
18                   outpatient drug’ shall be considered a reference  
19                   to a covered outpatient drug under this part.

20                   “(B) RESTRICTIVE PRESCRIPTION.—A  
21                   drug has a ‘restrictive prescription’ only if—

22                           “(i) in the case of a written prescrip-  
23                           tion, the prescription for the drug indi-  
24                           cates, in the handwriting of the physician  
25                           or other person prescribing the drug and

1 with an appropriate phrase (such as ‘brand  
2 medically necessary’) recognized by the  
3 Secretary, that a particular drug product  
4 must be dispensed, or

5 “(ii) in the case of a prescription  
6 issued by telephone—

7 “(I) the physician or other per-  
8 son prescribing the drug (through use  
9 of such an appropriate phrase) states  
10 that a particular drug product must  
11 be dispensed, and

12 “(II) the physician or other per-  
13 son submits to the pharmacy involved,  
14 within 30 days after the date of the  
15 telephone prescription, a written con-  
16 firmation which is in the handwriting  
17 of the physician or other person pre-  
18 scribing the drug and which indicates  
19 with such appropriate phrase that the  
20 particular drug product was required  
21 to have been dispensed.

22 “(C) PAYMENT CALCULATION PERIOD.—

23 The term ‘payment calculation period’ means a  
24 calendar year.”.

1 (b) REQUIRING PHARMACIES TO SUBMIT CLAIMS.—  
2 Section 1848(g)(4) (42 U.S.C. 1395w-4(g)(4)) is amend-  
3 ed—

4 (1) in the heading—

5 (A) by striking “PHYSICIAN”, and

6 (B) by inserting “BY PHYSICIANS AND  
7 SUPPLIERS” after “CLAIMS”;

8 (2) in the matter in subparagraph (A) pre-  
9 ceding clause (i)—

10 (A) by striking “For services furnished on  
11 or after September 1, 1990, within 1 year” and  
12 inserting “Within 1 year (or 90 days in the  
13 case of covered outpatient drugs)”,

14 (B) by striking “a service” and inserting  
15 “an item or service”, and

16 (C) by inserting “or of providing a covered  
17 outpatient drug,” after “basis,”; and

18 (3) in subparagraph (A)(i), by inserting “item  
19 or” before “service”.

20 (c) SPECIAL RULES FOR CARRIERS.—

21 (1) USE OF REGIONAL CARRIERS.—Section  
22 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by  
23 adding at the end the following:

24 “(D) With respect to activities related to covered out-  
25 patient drugs, the Secretary may enter into contracts with

1 carriers under this section to perform the activities on a  
2 regional basis.”.

3 (2) ADDITIONAL FUNCTIONS.—Section  
4 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

5 (A) by striking “and” at the end of sub-  
6 paragraph (H);

7 (B) by adding “and” at the end of sub-  
8 paragraph (L);

9 (C) by redesignating subparagraph (L) as  
10 subparagraph (I); and

11 (D) by inserting after subparagraph (I) (as  
12 so redesignated) the following new subpara-  
13 graphs:

14 “(J) if it makes determinations or payments  
15 with respect to covered outpatient drugs, will—

16 “(i) receive information transmitted under  
17 the electronic system established under section  
18 1834(d)(8)(B), and

19 “(ii) respond to requests by pharmacies  
20 (and individuals entitled to benefits under this  
21 part) as to whether or not such an individual  
22 has met the prescription drug deductible estab-  
23 lished under section 1834(d)(1)(A) for a year;  
24 and

1           “(K) will enter into such contracts with organi-  
2           zations described in subsection (f)(3) as the Sec-  
3           retary determines may be necessary to implement  
4           and operate (and for related functions with respect  
5           to) the electronic system established under section  
6           1834(d)(8)(B) for covered outpatient drugs under  
7           this part;”.

8           (3) PAYMENT ON OTHER THAN A COST  
9           BASIS.—Section 1842(c)(1)(A) (42 U.S.C.  
10          1395u(c)(1)(A)) is amended—

11                   (A) by inserting “(i)” after “(c)(1)(A)”,

12                   (B) in the first sentence, by inserting “,  
13                   except as otherwise provided in clause (ii),”  
14                   after “under this part, and”, and

15                   (C) by adding at the end the following:

16           “(ii) To the extent that a contract under this section  
17           provides for activities related to covered outpatient drugs,  
18           the Secretary may provide for payment for those activities  
19           based on any method of payment determined by the Sec-  
20           retary to be appropriate.”.

21           (4) BATCH PROMPT PROCESSING OF CLAIMS.—

22           Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

23                   (A) in paragraphs (2)(A) and (3)(A), by  
24                   striking “Each” and inserting “Except as pro-  
25                   vided in paragraph (4), each”;

1 (B) by adding at the end the following new  
2 paragraph:

3 “(4)(A) Each contract under this section which pro-  
4 vides for the disbursement of funds, as described in sub-  
5 section (a)(1)(B), with respect to claims for payment for  
6 covered outpatient drugs shall provide for a payment cycle  
7 under which each carrier will, on a monthly basis, make  
8 a payment with respect to all claims which were received  
9 and approved for payment in the period since the most  
10 recent date on which such a payment was made with re-  
11 spect to the participating pharmacy or individual submit-  
12 ting the claim.

13 “(B) If payment is not issued, mailed, or otherwise  
14 transmitted within 5 days of when such a payment is re-  
15 quired to be made under subparagraph (A), interest shall  
16 be paid at the rate used for purposes of section 3902(a)  
17 of title 31, United States Code (relating to interest pen-  
18 alties for failure to make prompt payments) for the period  
19 beginning on the day after such 5-day period and ending  
20 on the date on which payment is made.”.

21 (5) USE OF OTHER ENTITIES FOR COVERED  
22 OUTPATIENT DRUGS.—Section 1842(f) (42 U.S.C.  
23 1395u(f)) is amended—

24 (A) by striking “and” at the end of para-  
25 graph (1),

1 (B) by striking the period at the end of  
2 paragraph (2) and inserting “; and”, and

3 (C) by adding at the end the following:

4 “(3) with respect to activities related to covered  
5 outpatient drugs, any other private entity which the  
6 Secretary determines is qualified to conduct such ac-  
7 tivities.”.

8 (6) DESIGNATED CARRIERS TO PROCESS  
9 CLAIMS OF RAILROAD RETIREES.—Section 1842(g)  
10 (42 U.S.C. 1395u(g)) is amended by inserting  
11 “(other than functions related to covered outpatient  
12 drugs)” after “functions”.

13 (e) CONFORMING AMENDMENTS.—

14 (1)(A) Section 1833(a)(1) (42 U.S.C.  
15 1395l(a)(1)) is amended—

16 (i) by striking “and” at the end of clause  
17 (O), and

18 (ii) by inserting before the semicolon at the  
19 end the following: “, and (Q) with respect to  
20 covered outpatient drugs, the amounts paid  
21 shall be as prescribed by section 1834(d)”.

22 (B) Section 1833(a)(2) (42 U.S.C. 1395l(a)(2))  
23 is amended in the matter preceding subparagraph  
24 (A) by inserting “, except for covered outpatient  
25 drugs,” after “and (I) of such section”.

1           (2) Section 1833(b)(2) (42 U.S.C. 1395l(b)(2))  
2           is amended by inserting “or with respect to covered  
3           outpatient drugs” before the comma.

4           (3) The first sentence of section 1842(h)(2) (42  
5           U.S.C. 1395u(h)(2)) is amended by inserting  
6           “(other than a carrier described in subsection  
7           (f)(3))” after “Each carrier”.

8           (4) The first sentence of section 1866(a)(2)(A)  
9           (42 U.S.C. 1395cc(a)(2)(A)) is amended—

10           (A) in clause (i), by inserting “section  
11           1834(d),” after “section 1833(b),” and

12           (B) in clause (ii), by inserting “, other  
13           than for covered outpatient drugs,” after “pro-  
14           vider)”.

15 **SEC. 2003. MEDICARE REBATES FOR COVERED OUT-**  
16 **PATIENT DRUGS.**

17           (a) IN GENERAL.—Part B of title XVIII is amended  
18 by adding at the end the following new section:

19           “REBATES FOR COVERED OUTPATIENT DRUGS  
20           “Sec. 1850. (a) REQUIREMENT FOR REBATE AGREE-  
21 MENT.—In order for payment to be available under this  
22 part for covered outpatient drugs of a manufacturer dis-  
23 pensed or provided on or after January 1, 1999, the man-  
24 ufacturer must have entered into and have in effect a re-  
25 bate agreement with the Secretary meeting the require-

1 ments of subsection (b), and an agreement to give equal  
2 access to discounts in accordance with subsection (e).

3 “(b) TERMS, IMPLEMENTATION, AND ENFORCEMENT  
4 OF REBATE AGREEMENT.—

5 “(1) PERIODIC REBATES.—

6 “(A) IN GENERAL.—A rebate agreement  
7 under this section shall require the manufac-  
8 turer to pay to the Secretary for each calendar  
9 quarter, not later than 30 days after the date  
10 of receipt of the information described in para-  
11 graph (2) for such quarter, a rebate in an  
12 amount determined under subsection (c) for all  
13 covered outpatient drugs of the manufacturer  
14 described in subparagraph (B).

15 “(B) DRUGS INCLUDED IN QUARTERLY  
16 REBATE CALCULATION.—Drugs subject to re-  
17 bate with respect to a calendar quarter are  
18 drugs which are dispensed or provided during  
19 such quarter to individuals (other than individ-  
20 uals enrolled with an entity with a contract  
21 under section 1876 or a medicare drug benefit  
22 plan with a contract under section 1851) eligi-  
23 ble for benefits under this part, as reported to  
24 the Secretary.

1           “(2) INFORMATION FURNISHED TO MANUFAC-  
2           TURERS.—

3           “(A) IN GENERAL.—The Secretary shall  
4           report to each manufacturer, not later than 60  
5           days after the end of each calendar quarter, in-  
6           formation on the total number, for each covered  
7           outpatient drug, of units of each dosage form,  
8           strength, and package size dispensed or pro-  
9           vided under the plan during the quarter, on the  
10          basis of the data reported to the Secretary de-  
11          scribed in paragraph (1)(B).

12          “(B) AUDIT.—The Comptroller General  
13          may audit the records of the Secretary to the  
14          extent necessary to determine the accuracy of  
15          reports by the Secretary pursuant to subpara-  
16          graph (A). Adjustments to rebates shall be  
17          made to the extent determined necessary by the  
18          audit to reflect actual units of drugs dispensed.

19          “(3) PROVISION OF PRICE INFORMATION BY  
20          MANUFACTURER.—

21          “(A) QUARTERLY PRICING INFORMA-  
22          TION.—Each manufacturer with an agreement  
23          in effect under this section shall report to the  
24          Secretary, not later than 30 days after the last  
25          day of each calendar quarter, on the average

1 manufacturer retail price and the average man-  
2 ufacturer non-retail price for each dosage form  
3 and strength of each covered outpatient drug  
4 for the quarter.

5 “(B) BASE QUARTER PRICES.—Each man-  
6 ufacturer of a covered outpatient drug with an  
7 agreement under this section shall report to the  
8 Secretary, by not later than 30 days after the  
9 effective date of such agreement (or, if later, 30  
10 days after the end of the base quarter), the av-  
11 erage manufacturer retail price, for such base  
12 quarter, for each dosage form and strength of  
13 each such covered drug.

14 “(C) VERIFICATION OF AVERAGE MANU-  
15 FACTURER PRICE.—The Secretary may inspect  
16 the records of manufacturers, and survey whole-  
17 salers, pharmacies, and institutional purchasers  
18 of drugs, as necessary to verify prices reported  
19 under subparagraph (A).

20 “(D) PENALTIES.—

21 “(i) CIVIL MONEY PENALTIES.—The  
22 Secretary may impose a civil money pen-  
23 alty on a manufacturer with an agreement  
24 under this section—

1           “(I) for failure to provide infor-  
2           mation required under subparagraph  
3           (A) on a timely basis, in an amount  
4           up to \$10,000 per day of delay;

5           “(II) for refusal to provide infor-  
6           mation about charges or prices re-  
7           quested by the Secretary for purposes  
8           of verification pursuant to subpara-  
9           graph (C), in an amount up to  
10          \$100,000; and

11          “(III) for provision, pursuant to  
12          subparagraph (A) or (B), of informa-  
13          tion that the manufacturer knows or  
14          should know is false, in an amount up  
15          to \$100,000 per item of information.

16          Such civil money penalties are in addition  
17          to any other penalties prescribed by law.  
18          The provisions of section 1128A (other  
19          than subsections (a) (with respect to  
20          amounts of penalties or additional assess-  
21          ments) and (b)) shall apply to a civil  
22          money penalty under this subparagraph in  
23          the same manner as such provisions apply  
24          to a penalty or proceeding under section  
25          1128A(a).

1           “(ii) TERMINATION OF AGREE-  
2           MENT.—If a manufacturer with an agree-  
3           ment under this section has not provided  
4           information required under subparagraph  
5           (A) or (B) within 90 days of the deadline  
6           imposed, the Secretary may suspend the  
7           agreement with respect to covered out-  
8           patient drugs dispensed after the end of  
9           such 90-day period and until the date such  
10          information is reported (but in no case  
11          shall a suspension be for less than 30  
12          days).

13          “(4) LENGTH OF AGREEMENT.—

14                 “(A) IN GENERAL.—A rebate agreement  
15                 shall be effective for an initial period of not less  
16                 than one year and shall be automatically re-  
17                 newed for a period of not less than one year un-  
18                 less terminated under subparagraph (B).

19                 “(B) TERMINATION.—

20                         “(i) BY THE SECRETARY.—The Sec-  
21                         retary may provide for termination of a re-  
22                         bate agreement for violation of the require-  
23                         ments of the agreement or other good  
24                         cause shown. Such termination shall not be  
25                         effective earlier than 60 days after the

1 date of notice of such termination. The  
2 Secretary shall afford a manufacturer an  
3 opportunity for a hearing concerning such  
4 termination, but such hearing shall not  
5 delay the effective date of the termination.

6 “(ii) BY A MANUFACTURER.—A man-  
7 ufacturer may terminate a rebate agree-  
8 ment under this section for any reason.  
9 Any such termination shall not be effective  
10 until the calendar quarter beginning at  
11 least 60 days after the date the manufac-  
12 turer provides notice to the Secretary.

13 “(iii) EFFECTIVE DATE OF TERMI-  
14 NATION.—Any termination under this sub-  
15 paragraph shall not affect rebates due  
16 under the agreement before the effective  
17 date of its termination.

18 “(iv) NOTICE TO PHARMACIES.—In  
19 the case of a termination under this sub-  
20 paragraph, the Secretary shall notify phar-  
21 macies and physician organizations not less  
22 than 30 days before the effective date of  
23 such termination.

24 “(c) AMOUNT OF REBATE.—

1           “(1) BASE REBATE.—Each manufacturer shall  
2 remit a basic rebate to the Secretary for each cal-  
3 endar quarter in an amount, with respect to each  
4 dosage form and strength of a covered outpatient  
5 drug, equal to the product of—

6           “(A) the total number of units subject to  
7 rebate for such quarter, as described in sub-  
8 section (b)(1)(B); and

9           “(B)(i) in the case of a single-source drug  
10 or innovator-multiple source drug, 15 percent of  
11 the average manufacturer retail price, or

12           “(ii) in the case of a noninnovator-multiple  
13 source drug furnished over-the-counter, insulin  
14 or an enteral nutrient, 6 percent (or the appli-  
15 cable percent if the Secretary implements the  
16 sliding scale developed in accordance with para-  
17 graph (4)) of the average manufacturer retail  
18 price.

19           “(2) ADDITIONAL REBATE.—Each manufac-  
20 turer shall remit to the Secretary, for each calendar  
21 quarter, an additional rebate for each dosage form  
22 and strength of a single-source or innovator-mul-  
23 tiple-source drug, in an amount equal to—

1           “(A) the total number of units subject to  
2 rebate for such quarter, as described in sub-  
3 section (b)(1)(B), multiplied by

4           “(B) the amount, if any, by which the av-  
5 erage manufacturer retail price for such drugs  
6 of the manufacturer exceeds the average manu-  
7 facturer retail price for the base quarter, in-  
8 creased by the percentage increase in the Con-  
9 sumer Price Index for all urban consumers  
10 (U.S. average) from the end of such base quar-  
11 ter to the month before the beginning of such  
12 calendar quarter.

13           “(3) DEPOSIT OF REBATES.—The Secretary  
14 shall deposit rebates under this section in the Fed-  
15 eral Supplementary Medical Insurance Trust Fund  
16 established under section 1841.

17           “(4) APPLICABLE PERCENT.—

18           “(A) NONINNOVATOR MULTIPLE SOURCE  
19 DRUG.—

20           “(i) IN GENERAL.—For purposes of  
21 this subparagraph, the Secretary may de-  
22 velop and implement a sliding scale to de-  
23 termine the applicable percent for rebates  
24 based on the relationship between the aver-  
25 age manufacturer retail price of the non-

1 innovator-multiple source drug furnished  
2 over-the-counter and the average manufac-  
3 turer retail price of the equivalent inno-  
4 vator drug (except as provided in subpara-  
5 graph (B)) .

6 “(ii) SLIDING SCALE DESCRIBED.—  
7 The sliding scale developed by the Sec-  
8 retary under clause (i) shall—

9 “(I) require that the applicable  
10 percent be not less than 2 percent and  
11 not be greater than 15 percent; and

12 “(II) ensure that the total level  
13 of rebates collected under such a slid-  
14 ing scale would be equivalent to a flat  
15 6 percent rebate on such drugs.

16 “(B) ENTERAL NUTRIENTS AND INSU-  
17 LIN.—For purposes of this subparagraph, the  
18 applicable percent for enteral nutrients and in-  
19 sulin under the sliding scale would be equal to  
20 6 percent.

21 “(d) CONFIDENTIALITY OF INFORMATION.—Notwith-  
22 standing any other provision of law, information disclosed  
23 by a manufacturer under this section is confidential and  
24 shall not be disclosed by the Secretary (or a carrier), ex-  
25 cept—

1           “(A) as the Secretary determines to be nec-  
2           essary to carry out this section,

3           “(B) to permit the Comptroller General to re-  
4           view the information provided, and

5           “(C) to permit the Director of the Congres-  
6           sional Budget Office to review the information pro-  
7           vided.

8           “(e) DEFINITIONS.—For purposes of this section—

9           “(1)    AVERAGE    MANUFACTURER    RETAIL  
10          PRICE.—The term ‘average manufacturer retail  
11          price’ means, with respect to a covered outpatient  
12          drug of a manufacturer for a calendar quarter, the  
13          average price (inclusive of discounts for cash pay-  
14          ment, prompt payment, volume purchases, and re-  
15          bates (other than rebates under this section), but ex-  
16          clusive of nominal prices) paid to the manufacturer  
17          for the drug in the United States for drugs distrib-  
18          uted to the retail pharmacy class of trade.

19          “(2)    AVERAGE    MANUFACTURER    NON-RETAIL  
20          PRICE.—The term ‘average manufacturer non-retail  
21          price’ means, with respect to a covered outpatient  
22          drug of a manufacturer for a calendar quarter, the  
23          weighted average price (inclusive of discounts for  
24          cash payment, prompt payment, volume purchases,  
25          and rebates (other than rebates under this section),

1 but exclusive of nominal prices) paid to the manu-  
2 facturer for the drug in the United States by hos-  
3 pitals and other institutional purchasers that pur-  
4 chase drugs for institutional use and not for resale.

5 “(3) BASE QUARTER.—The term ‘base quarter’  
6 means, with respect to a covered outpatient drug of  
7 a manufacturer, the calendar quarter beginning  
8 April 1, 1993, or (if later) the first full calendar  
9 quarter during which the drug was marketed in the  
10 United States.

11 “(4) DRUG.—The terms ‘innovator multiple  
12 source drug’, ‘noninnovator multiple source drug’,  
13 and ‘single source drug’ have the meanings given  
14 those terms under section 1927(k)(7), except that  
15 the reference in such section to a ‘covered outpatient  
16 drug’ shall be considered a reference to a covered  
17 outpatient drug under this part.

18 “(5) MANUFACTURER.—The term ‘manufac-  
19 turer’ means, with respect to a covered outpatient  
20 drug—

21 “(A) the entity whose National Drug Code  
22 number (as issued pursuant to section 510(e) of  
23 the Federal Food, Drug, and Cosmetic Act) ap-  
24 pears on the labeling of the drug; or

1           “(B) if the number described in subpara-  
2           graph (A) does not appear on the labeling of  
3           the drug, the person named as the applicant in  
4           a human drug application (in the case of a new  
5           drug) or the product license application (in the  
6           case of a biological product) for such drug ap-  
7           proved by the Food and Drug Administration.”.

8           (b) EXCLUSIONS FROM COVERAGE.—Section  
9 1862(a) (42 U.S.C. 1395y(a)) is amended—

10           (1) by striking “and” at the end of paragraph  
11           (15),

12           (2) by striking the period at the end of para-  
13           graph (16) and inserting “; or”, and

14           (3) by inserting after paragraph (16) the fol-  
15           lowing new paragraph:

16           “(17) consisting of a covered outpatient drug  
17           (as described in section 1861(t)) furnished during a  
18           year for which the drug’s manufacturer does not  
19           have in effect a rebate agreement with the Secretary  
20           that meets the requirements of section 1850 for the  
21           year.”.

22 **SEC. 2004. PRESCRIPTION DRUG PAYMENT REVIEW COM-**  
23 **MISSION.**

24           Part B of title XVIII is amended by inserting after  
25           section 1846 the following new section:

1 “PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

2 “SEC. 1847. (a)(1) The Director of the Congressional  
3 Office of Technology Assessment (in this section referred  
4 to as the ‘Director’ and the ‘Office’, respectively) shall  
5 provide for the appointment of a Prescription Drug Pay-  
6 ment Review Commission (in this section referred to as  
7 the ‘Commission’), to be composed of individuals with ex-  
8 pertise in the provision and financing of covered out-  
9 patient drugs appointed by the Director (without regard  
10 to the provisions of title 5, United States Code, governing  
11 appointments in the competitive service).

12 “(2) The Commission shall consist of 11 individuals.  
13 Members of the Commission shall first be appointed by  
14 no later than January 1, 1996, for a term of 3 years, ex-  
15 cept that the Director may provide initially for such short-  
16 er terms as will insure that (on a continuing basis) the  
17 terms of no more than 4 members expire in any one year.

18 “(3) The membership of the Commission shall in-  
19 clude recognized experts in the fields of health care eco-  
20 nomics, medicine, pharmacology, pharmacy, and prescrip-  
21 tion drug reimbursement, as well as at least one individual  
22 who is a medicare beneficiary, one individual representing  
23 a research-based pharmaceutical company, and one indi-  
24 vidual representing a biotechnology company.

1       “(b)(1) The Commission shall submit to Congress an  
2 annual report no later than May 1 of each year, beginning  
3 with 1997—

4               “(A) concerning the implementation and  
5 the operation of the coverage of covered out-  
6 patient drugs under this part, including rec-  
7 ommendations to Congress on changes to the  
8 program to improve access to prescription  
9 drugs, the quality of prescription drug care, and  
10 program efficiencies;

11              “(B) reviewing the process of contracting  
12 with medicare drug benefits plans under section  
13 1851;

14              “(C) concerning the fiscal soundness of the  
15 furnishing of covered outpatient drugs under  
16 this part;

17              “(D) concerning the appropriateness, fair-  
18 ness and effectiveness of the rebate structure  
19 under section 1850; and

20              “(E) concerning the advisability of devel-  
21 oping a review process to exempt small manu-  
22 facturers of single source or innovator multiple  
23 source drugs from rebates under section 1850  
24 based on the manufacturer’s sales and the his-  
25 toric pricing of the manufacturer’s products.

1 “(c) Section 1845(c)(1) shall apply to the Commis-  
2 sion in the same manner as it applies to the Physician  
3 Payment Review Commission.

4 “(d) There are authorized to be appropriated such  
5 sums as may be necessary to carry out the provisions of  
6 this section. Such sums shall be payable from the Federal  
7 Supplementary Medical Insurance Trust Fund.”.

8 **SEC. 2005. COVERAGE OF HOME INFUSION DRUG THERAPY**  
9 **SERVICES.**

10 (a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C.  
11 1395k(a)(2)(A)) is amended by inserting “and home infu-  
12 sion drug therapy services” before the semicolon.

13 (b) HOME INFUSION DRUG THERAPY SERVICES DE-  
14 FINED.—Section 1861 (42 U.S.C. 1395x) is amended—

15 (1) by redesignating the subsection (jj) inserted  
16 by section 4156(a)(2) of the Omnibus Budget Rec-  
17 onciliation Act of 1990 as subsection (kk); and

18 (2) by inserting after such subsection the fol-  
19 lowing new subsection:

20 “Home Infusion Drug Therapy Services

21 “(ll)(1) The term ‘home infusion drug therapy serv-  
22 ices’ means the items and services described in paragraph  
23 (2) furnished to an individual who is under the care of  
24 a physician—

1           “(A) in a setting described in subsection  
2           (t)(5)(A)(ii),

3           “(B) by a qualified home infusion drug therapy  
4           provider (as defined in paragraph (3)) or by others  
5           under arrangements with them made by that pro-  
6           vider, and

7           “(C) under a plan established and periodically  
8           reviewed by a physician.

9           “(2) The items and services described in this para-  
10          graph are such nursing, pharmacy, and related services  
11          (including medical supplies, intravenous fluids, delivery,  
12          and equipment) as are necessary to conduct safely and ef-  
13          fectively a drug regimen through use of a covered home  
14          infusion drug (as defined in subsection (t)(5)), but do not  
15          include such covered home infusion drugs.

16          “(3) The term ‘qualified home infusion drug therapy  
17          provider’ means any entity that the Secretary determines  
18          meets the following requirements (or, in the case of a  
19          home health agency or an entity with respect to which the  
20          only items and services described in paragraph (2) fur-  
21          nished by the entity are enteral nutrition therapy services,  
22          meets any of the following requirements which the Sec-  
23          retary considers appropriate):

24                  “(A) The entity is capable of providing nursing  
25                  or pharmacy services and providing or arranging for

1 the other items and services described in paragraph  
2 (2) and covered home infusion drugs.

3 “(B) The entity maintains clinical records on  
4 all patients.

5 “(C) The entity adheres to written protocols  
6 and policies with respect to the provision of items  
7 and services.

8 “(D) The entity makes services available (as  
9 needed) seven days a week on a 24-hour basis.

10 “(E) The entity coordinates all services with  
11 the patient’s physician.

12 “(F) The entity conducts a quality assessment  
13 and assurance program, including drug regimen re-  
14 view and coordination of patient care.

15 “(G) The entity assures that only trained per-  
16 sonnel provide covered home infusion drugs (and any  
17 other service for which training is required to pro-  
18 vide the service safely).

19 “(H) The entity assumes responsibility for the  
20 quality of services provided by others under arrange-  
21 ments with the entity.

22 “(I) In the case of an entity in any State in  
23 which State or applicable local law provides for the  
24 licensing of entities of this nature, the entity (i) is  
25 licensed pursuant to such law, or (ii) is approved, by

1 the agency of such State or locality responsible for  
2 licensing entities of this nature, as meeting the  
3 standards established for such licensing.

4 “(J) The entity meets such other requirements  
5 as the Secretary may determine are necessary to as-  
6 sure the safe and effective provision of home infu-  
7 sion drug therapy services and the efficient adminis-  
8 tration of the home infusion drug therapy benefit.”.

9 (c) PAYMENT.—

10 (1) IN GENERAL.—Section 1833 (42 U.S.C.  
11 1395l) is amended—

12 (A) in subsection (a)(2)(B), by striking “or  
13 (E)” and inserting “(E), or (F)”,

14 (B) in subsection (a)(2)(D), by striking  
15 “and” at the end,

16 (C) in subsection (a)(2)(E), by striking the  
17 semicolon and inserting “; and”,

18 (D) by inserting after subsection (a)(2)(E)  
19 the following new subparagraph:

20 “(F) with respect to home infusion drug  
21 therapy services, the amounts described in sec-  
22 tion 1834(j);”, and

23 (E) in the first sentence of subsection (b),  
24 by striking “services, (3)” and inserting “serv-

1           ices and home infusion drug therapy services,  
2           (3)”.

3           (2) AMOUNT DESCRIBED.—Section 1834 is  
4           amended by adding at the end the following new  
5           subsection:

6           “(j) HOME INFUSION DRUG THERAPY SERVICES.—

7                 “(1) IN GENERAL.—With respect to home infu-  
8           sion drug therapy services, payment under this part  
9           shall be made in an amount equal to the lesser of  
10          the actual charges for such services or the fee sched-  
11          ule established under paragraph (2).

12           “(2) ESTABLISHMENT OF FEE SCHEDULE.—

13                 “(A) IN GENERAL.—The Secretary shall  
14           establish by regulation before the beginning of  
15           1999 and each succeeding year a fee schedule  
16           for home infusion drug therapy services for  
17           which payment is made under this part. A fee  
18           schedule established under this subsection shall  
19           be on a per diem basis.

20                 “(B) ADJUSTMENT FOR SERVICES FUR-  
21           NISHED BY INSTITUTIONS.—The fee schedule  
22           established by the Secretary under subpara-  
23           graph (A) shall provide for adjustments in the  
24           case of home infusion drug therapy services for  
25           which payment is made under this part that are

1 furnished by a provider of services to avoid du-  
2 plicative payments under this title for the serv-  
3 ice costs associated with such services.”.

4 (d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C.  
5 1395n(a)(2)) is amended—

6 (1) by striking “and” at the end of subpara-  
7 graph (E),

8 (2) by striking the period at the end of sub-  
9 paragraph (F) and inserting “; and”, and

10 (3) by inserting after subparagraph (F) the fol-  
11 lowing:

12 “(G) in the case of home infusion drug  
13 therapy services, (i) such services are or were  
14 required because the individual needed such  
15 services for the administration of a covered  
16 home infusion drug, (ii) a plan for furnishing  
17 such services has been established and is re-  
18 viewed periodically by a physician, and (iii)  
19 such services are or were furnished while the in-  
20 dividual is or was under the care of a physi-  
21 cian.”.

22 (e) CERTIFICATION OF HOME INFUSION DRUG  
23 THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR  
24 NONCOMPLIANCE.—

1           (1) TREATMENT AS PROVIDER OF SERVICES.—  
2           Section 1861(u) (42 U.S.C. 1395x(u)) is amended  
3           by inserting “home infusion drug therapy provider,”  
4           after “hospice program,”.

5           (2) CONSULTATION WITH STATE AGENCIES AND  
6           OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C.  
7           1395z) is amended by striking “and (dd)(2)” and  
8           inserting “(dd)(2), and (ll)(3)”.

9           (3) USE OF STATE AGENCIES IN DETERMINING  
10          COMPLIANCE.—Section 1864(a) (42 U.S.C.  
11          1395aa(a)) is amended—

12                   (A) in the first sentence, by striking “an  
13                   agency is a hospice program” and inserting “an  
14                   agency or entity is a hospice program or a  
15                   home infusion drug therapy provider,”; and

16                   (B) in the second sentence—

17                           (i) by striking “institution or agency”  
18                           and inserting “institution, agency, or enti-  
19                           ty”, and

20                           (ii) by striking “or hospice program”  
21                           and inserting “hospice program, or home  
22                           infusion drug therapy provider”.

23          (4) APPLICATION OF INTERMEDIATE SANC-  
24          TIONS.—Section 1846 (42 U.S.C. 1395w-2) is  
25          amended—

1 (A) in the heading, by adding “AND FOR  
2 QUALIFIED HOME INFUSION DRUG THERAPY  
3 PROVIDERS” at the end,

4 (B) in subsection (a), by inserting “or that  
5 a qualified home infusion drug therapy provider  
6 that is certified for participation under this title  
7 no longer substantially meets the requirements  
8 of section 1861(l)(3)” after “under this part”,  
9 and

10 (C) in subsection (b)(2)(A)(iv), by insert-  
11 ing “or home infusion drug therapy services”  
12 after “clinical diagnostic laboratory tests”.

13 (f) USE OF REGIONAL INTERMEDIARIES IN ADMINIS-  
14 TRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h)  
15 is amended by adding at the end the following new sub-  
16 section:

17 “(k) With respect to carrying out functions relating  
18 to payment for home infusion drug therapy services and  
19 covered home infusion drugs, the Secretary may enter into  
20 contracts with agencies or organizations under this section  
21 to perform such functions on a regional basis.”.

22 (g) CONFORMING AMENDMENTS.—(1) Section  
23 1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended  
24 by striking “, except that” and all that follows through  
25 “equipment”.

1       (2) Section 1861(n) (42 U.S.C. 1395x(n)) is amend-  
2 ed by adding at the end the following: “Such term does  
3 not include any home infusion drug therapy services de-  
4 scribed in section 1861(ll) or any covered outpatient drug  
5 used as a supply related to the furnishing of an item of  
6 durable medical equipment.”.

7       (3) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is  
8 amended by inserting after “dental” the following: “de-  
9 vices or enteral and parenteral nutrients, supplies, and  
10 equipment”.

11       (h) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to items and services furnished on  
13 or after January 1, 1999.

14 **SEC. 2006. MEDICARE DRUG BENEFIT PLANS.**

15       (a) IN GENERAL.—Part B of title XVIII of the Social  
16 Security Act (42 U.S.C. 1395 et seq.), as amended by sec-  
17 tion 2003, is further amended by adding at the end the  
18 following new section:

19 **“SEC. 1851. MEDICARE DRUG BENEFIT PLANS.**

20       “(a) IN GENERAL.—

21               “(1) GENERAL PERMISSION TO CONTRACT.—

22       The Secretary may enter into contracts with medi-  
23 care drug benefit plans in a State for the provision  
24 of covered outpatient drugs (as defined in section  
25 1861(t)(2)) (except as provided in subsection

1 (i)(3)(G)) to individuals entitled to benefits under  
2 part A and enrolled under part B if the plan meets  
3 the requirements of this section with respect to indi-  
4 viduals enrolled under this section.

5 “(2) ENTITIES ELIGIBLE TO ENTER INTO A  
6 CONTRACT.—The Secretary may enter into a con-  
7 tract under this section with a medicare drug benefit  
8 plan that is—

9 “(A) a certified standard health plan but  
10 only if such plan has not entered into a con-  
11 tract with the Secretary under section 1876;

12 “(B) a network of chain and independent  
13 pharmacy providers;

14 “(C) a pharmacy benefit management com-  
15 pany; or

16 “(D) any other entity that the Secretary  
17 determines is appropriate.

18 “(3) AVAILABILITY OF PLANS.—

19 “(A) IN GENERAL.—Every individual enti-  
20 tled to benefits under part A and enrolled under  
21 part B shall be eligible to enroll under this sec-  
22 tion with any medicare drug benefit plan with  
23 a contract under this section which serves the  
24 State in which the individual resides.

1           “(B) ENROLLMENT BY AN INDIVIDUAL.—

2           In accordance with the enrollment periods es-  
3           tablished under subsection (e)(1), an individual  
4           may enroll under this section with a medicare  
5           drug benefit plan with a contract under this  
6           section only through a third party designated  
7           by the Secretary in regulations and the indi-  
8           vidual may only terminate enrollment in accord-  
9           ance with subsection (e)(2).

10           “(C) INFORMATION DISTRIBUTED BY THE  
11           SECRETARY.—

12           “(i) IN GENERAL.—The Secretary  
13           shall develop and distribute comparative  
14           materials to individuals eligible to enroll  
15           under this section regarding all medicare  
16           drug benefit plans with contracts under  
17           this section, the availability of payment for  
18           covered outpatient drugs under section  
19           1834(d), and the availability of covered  
20           outpatient drugs to enrollees of entities  
21           with contracts under section 1876. The  
22           Secretary shall include in such comparative  
23           materials that each medicare drug benefit  
24           plan with a contract under this section is  
25           authorized by law to terminate or refuse to

1 renew the contract, and that termination  
2 or nonrenewal of the contract may result  
3 in termination of the enrollments of indi-  
4 viduals enrolled with the plan under this  
5 section.

6 “(ii) PROVISION OF INFORMATION BY  
7 THE PLAN.—Each medicare drug benefit  
8 plan with a contract under this section  
9 shall collect and provide such standard in-  
10 formation as the Secretary shall prescribe  
11 by regulation as necessary to evaluate the  
12 performance and quality of such plan, in-  
13 cluding enrollee satisfaction, and to com-  
14 pare such performance and quality with  
15 competing plans.

16 “(4) PAYMENTS.—

17 “(A) PAYMENTS IN LIEU OF NORMAL PAY-  
18 MENTS.—Payments under a contract to a medi-  
19 care drug benefit plan under this section shall  
20 be instead of the amounts which (in the absence  
21 of the contract) would be otherwise payable,  
22 pursuant to section 1834, for covered out-  
23 patient drugs furnished by or through the plan  
24 to individuals enrolled with the plan under this  
25 section.

1           “(B) SOURCE OF PAYMENT.—The payment  
2           to a medicare drug benefit plan under this sec-  
3           tion for individuals enrolled under this section  
4           with the plan and entitled to benefits under  
5           part A and enrolled under part B shall be made  
6           from the Federal Supplementary Medical Insur-  
7           ance Trust Fund.

8           “(5) DEFINITIONS.—

9           “(A) SERVICE AREA.—The term ‘health  
10          plan service area’ means a health plan service  
11          area designated by the State under section  
12          1502(d) of the Health Security Act.

13          “(B) CERTIFIED STANDARD HEALTH  
14          PLAN.—The term ‘certified standard health  
15          plan’ has the meaning given such term in sec-  
16          tion 1011(2) of the Health Security Act.

17          “(b) PAYMENT RULES UNDER CONTRACTS.—

18          “(1) IN GENERAL.—

19          “(A) PAYMENTS.—With respect to any cal-  
20          endar year, each medicare drug benefit plan  
21          with a contract under this section shall receive  
22          a payment under this title with respect to each  
23          individual enrolled with the plan for each month  
24          such individual is enrolled equal to the applica-  
25          ble monthly percentage of the lesser of—

1           “(i) 95 percent of the fee for service  
2           component determined under paragraph  
3           (2)(B)(i) adjusted by the rate factor deter-  
4           mined under subparagraph (C) for the  
5           class of such individual; or

6           “(ii) the medicare drug benefit plan  
7           component determined under paragraph  
8           (2)(B)(ii) for the plan’s service area ad-  
9           justed by the rate factor determined under  
10          subparagraph (C) for the class of such in-  
11          dividual.

12          “(B) APPLICABLE MONTHLY PERCENT-  
13          AGE.—For purposes of subparagraph (A), the  
14          Secretary shall annually set the applicable  
15          monthly percentage for each month of the cal-  
16          endar year. Such percentage for a month shall  
17          be equal to the Secretary’s estimate of the pro-  
18          portion of the total covered outpatient drug  
19          benefit incurred in such month under section  
20          1834 to the total covered outpatient drug ben-  
21          efit incurred for such year under section 1834.

22          “(C) DETERMINATION OF CLASSES OF IN-  
23          DIVIDUALS AND RATE FACTORS FOR SUCH  
24          CLASSES.—

1           “(i) DETERMINATION OF CLASSES.—

2           For purposes of this section, the Secretary  
3           shall define appropriate classes of individ-  
4           uals based on such factors as the Secretary  
5           determines to be appropriate.

6           “(ii) RATE FACTORS.—The Secretary  
7           shall annually determine the rate factors  
8           for each class of individuals defined in  
9           clause (i) reflecting the differences in the  
10          average per capita spending for providing  
11          covered outpatient drug coverage under  
12          part B among individuals in such classes.

13          “(2) DETERMINATION OF PAYMENT RATE.—

14                 “(A) DETERMINATION BY SECRETARY.—

15                 The Secretary shall annually determine under  
16                 subparagraph (B), and shall announce (in a  
17                 manner intended to provide notice to interested  
18                 parties) not later than October 1 before the cal-  
19                 endar year concerned, the payment for each  
20                 service area.

21                 “(B) FORMULAS FOR DETERMINING PAY-  
22                 MENT AMOUNTS.—

23                         “(i) FEE-FOR-SERVICE        COMPO-  
24                         NENT.—The amount determined under  
25                         this clause is the projected average annual

1 per capita drug fee-for-service costs (as de-  
2 fined in subparagraph (D)) for covered  
3 outpatient drugs for the service area for  
4 individuals not enrolled in medicare drug  
5 benefit plans with contracts under this sec-  
6 tion or entities with contracts under sec-  
7 tion 1876, adjusted by the factor described  
8 in clause (ii)(I).

9 “(ii) MEDICARE DRUG BENEFIT PLAN  
10 COMPONENT.—The medicare drug benefit  
11 plan component determined under this  
12 clause is the sum of the following amounts  
13 determined with respect to each medicare  
14 drug benefit plan—

15 “(I) the amount of the uniform  
16 annual premium submitted by the  
17 plan to the Secretary under subpara-  
18 graph (C), adjusted by a factor deter-  
19 mined by the Secretary to normalize  
20 the difference in the distribution of in-  
21 dividuals projected to be enrolled in  
22 the plan among the various classes of  
23 individuals defined by the Secretary to  
24 the national distribution of all individ-

1 uals in the program under this title  
2 among such classes; multiplied by

3 “(II) a fraction (expressed as a  
4 percentage), the numerator of which  
5 is the number of all individuals en-  
6 rolled in the plan (as projected by the  
7 plan using either historical experience  
8 or some other methodology developed  
9 by the Secretary), and the denomi-  
10 nator of which is the number of all in-  
11 dividuals enrolled in all medicare drug  
12 benefit plans in the service area.

13 “(C) UNIFORM ANNUAL PREMIUMS; PRE-  
14 MIUM FOR ADDITIONAL SERVICES.—

15 “(i) IN GENERAL.—Each medicare  
16 drug benefit plan shall, not later than Au-  
17 gust 1 of each year, submit to the Sec-  
18 retary a bid for the next calendar year for  
19 each service area with respect to which the  
20 plan proposes to serve under a contract  
21 under this section. A bid with respect to a  
22 service area shall include the following:

23 “(I) UNIFORM ANNUAL PRE-  
24 MIUM.—A statement of the uniform  
25 annual premium amount that the plan

1 intends to charge for individuals en-  
2 rolled under this section with the  
3 plan.

4 “(II) PREMIUM FOR SUPPLE-  
5 MENTAL PLAN.—A statement of the  
6 fixed monthly premium amount that  
7 the plan intends to charge for each  
8 supplemental plan offering additional  
9 cost-sharing benefits.

10 “(ii) NOTICE BEFORE BID SUBMIS-  
11 SIONS.—At least 45 days before the date  
12 for submitting bids under clause (i) for a  
13 year, the Secretary shall provide for notice  
14 to medicare drug benefit plans of—

15 “(I) proposed changes to be  
16 made in the methodology or benefit  
17 coverage assumptions from the meth-  
18 odology and assumptions used in the  
19 previous calendar year and shall pro-  
20 vide such plans an opportunity to  
21 comment on such proposed changes;

22 “(II) the applicable monthly per-  
23 centage for each month of the cal-  
24 endar year as determined by the Sec-  
25 retary under paragraph (1)(B); and

1                   “(III) the rate factors for such  
2                   calendar year determined under para-  
3                   graph (1)(C).

4                   “(D) PROJECTED AVERAGE ANNUAL PER  
5                   CAPITA FEE-FOR-SERVICE COSTS.—

6                   “(i) IN GENERAL.—For purposes of  
7                   subparagraph (B), the term ‘projected av-  
8                   erage annual per capita drug fee-for-serv-  
9                   ice costs’ means, with respect to a service  
10                  area, the annual amount that the Sec-  
11                  retary estimates in advance would be pay-  
12                  able in any contract year for providing  
13                  payment for covered outpatient drugs for  
14                  individuals enrolled under part B (includ-  
15                  ing administrative costs incurred by orga-  
16                  nizations described in section 1842), if the  
17                  services were to be furnished by other than  
18                  a medicare drug benefit plan with a con-  
19                  tract under this section or by an entities  
20                  with a contract under section 1876.

21                  “(ii) BASIS FOR ESTIMATES.—The es-  
22                  timate made by the Secretary under clause  
23                  (i) shall be made on the basis of actual ex-  
24                  perience of the service area or, if the Sec-  
25                  retary determines that the data in that

1 service area are inadequate to make an ac-  
2 curate estimate, the Secretary may use the  
3 actual experience of a similar area, with  
4 appropriate adjustments to assure actu-  
5 arial equivalence, including adjustments  
6 the Secretary may determine appropriate  
7 to adjust for demographics, health status,  
8 and the presence of specific medical condi-  
9 tions. For the first 2 years that contracts  
10 are entered into under this section, the  
11 Secretary shall base such estimates on the  
12 best available data.

13 “(3) PAYMENT RULES.—

14 “(A) AMOUNT OF PREMIUM.—

15 “(i) STANDARD PACKAGE.—Each  
16 medicare drug benefit plan with a contract  
17 under this section must provide to individ-  
18 uals enrolled with the plan under this sec-  
19 tion, for each month of the duration of  
20 such enrollment during each contract pe-  
21 riod, the coverage described in subsection  
22 (d) for the lesser of—

23 “(I) the applicable monthly per-  
24 centage of the uniform annual pre-

1 mium amount submitted under para-  
2 graph (2)(C)(i)(I); or

3 “(II) the applicable monthly per-  
4 centage of the amount described in  
5 subsection (b)(1)(A).

6 “(ii) SUPPLEMENTAL PLAN.—

7 “(I) IN GENERAL.—Each medi-  
8 care drug benefit plan with a contract  
9 under this section must provide to in-  
10 dividuals enrolled with the plan under  
11 this section, for the duration of such  
12 enrollment during each contract pe-  
13 riod, a fixed monthly premium for the  
14 supplemental plan described in para-  
15 graph (2)(C)(i)(II) equal to the pre-  
16 mium amount determined by the plan  
17 under such paragraph. An individual  
18 that elects to enroll in the supple-  
19 mental plan shall be responsible for  
20 paying to the plan the fixed monthly  
21 premium amount described in the pre-  
22 ceding sentence.

23 “(II) PAYMENT GREATER THAN  
24 FIXED MONTHLY PREMIUM.—If, with  
25 respect to any individual enrolled in a

1 medicare drug benefit plan with a  
2 contract under this section, the  
3 amount paid to the plan under sub-  
4 section (b)(1)(A) exceeds the applica-  
5 ble monthly percentage of the uniform  
6 annual premium amount submitted  
7 under paragraph (2)(C)(i)(I), the plan  
8 shall apply such excess to a premium  
9 for any supplemental policy described  
10 in paragraph (2)(C)(ii) that the indi-  
11 vidual may elect. If the individual  
12 does not elect such a policy, the medi-  
13 care drug benefit plan shall pay such  
14 excess to the Secretary for deposit in  
15 the Federal Supplementary Medical  
16 Insurance Trust Fund.

17 “(B) MONTHLY PAYMENTS.—

18 “(i) IN GENERAL.—The Secretary  
19 shall make monthly payments in advance  
20 and in accordance with the rate deter-  
21 mined under paragraph (1)(A) to each  
22 medicare drug benefit plan with a contract  
23 under this section for each individual en-  
24 rolled with the plan under this section.

1           “(ii) ADJUSTMENTS.—The amount of  
2           payment under this subparagraph may be  
3           retroactively adjusted to take into account  
4           any difference between the actual number  
5           of individuals enrolled in the plan under  
6           this section and the number of such indi-  
7           viduals estimated to be so enrolled in de-  
8           termining the amount of the advance pay-  
9           ment.

10           “(iii) PAYMENT TO PLAN ONLY.—If  
11           an individual is enrolled under this section  
12           with a medicare drug benefit plan with a  
13           contract under this section, only the plan  
14           shall be entitled to receive payments from  
15           the Secretary under this title for covered  
16           outpatient drugs furnished to the indi-  
17           vidual.

18           “(d) COVERAGE OF BENEFITS.—

19           “(1) DRUGS PROVIDED.—A medicare drug ben-  
20           efit plan with a contract under this section must  
21           provide to individuals enrolled in the plan under this  
22           section covered outpatient drugs (as defined in sec-  
23           tion 1861(t)(2)), except as provided in subsection  
24           (i)(3)(G).

1           “(2) PROVISION OF MEDICALLY NECESSARY  
2 CARE.—Each medicare drug benefit plan with a con-  
3 tract under this section must—

4           “(A) make the covered outpatient drugs  
5 described in paragraph (1)—

6           “(i) available and accessible to en-  
7 rolled individuals within the State with  
8 reasonable promptness and in a manner  
9 which assures continuity, and

10           “(ii) when medically necessary, avail-  
11 able and accessible twenty-four hours a  
12 day and seven days a week, and

13           “(B) provide for reimbursement with re-  
14 spect to drugs which are described in subpara-  
15 graph (A) and which are provided to such an  
16 individual other than through the plan, if—

17           “(i) the drugs were medically nec-  
18 essary and immediately required because of  
19 an unforeseen illness, injury, or condition,  
20 and

21           “(ii) it was not reasonable given the  
22 circumstances to obtain the drugs through  
23 the plan.

24           “(3) COST-SHARING.—Each medicare drug ben-  
25 efit plan with a contract under this section must

1 provide to individuals enrolled under this section  
2 with respect to the drugs described in paragraph  
3 (1), cost-sharing requirements that are the same as  
4 the cost-sharing requirements for covered outpatient  
5 drug under section 1834, except that the deductible  
6 for a medicare drug benefit plan shall be reduced by  
7 an amount determined by the Secretary such that  
8 the cost-sharing of the plan is equal to 95 percent  
9 of the actuarial value of the cost sharing require-  
10 ments under section 1834.

11 “(4) COST-SHARING FOR SUPPLEMENTAL  
12 PLANS.—A supplemental plan may not have cost-  
13 sharing that applies differential cost-sharing based  
14 on the therapeutic class of drug prescribed or other  
15 cost-sharing structures that the Secretary deter-  
16 mines would be likely to discourage enrollment by in-  
17 dividuals with medical conditions that require exten-  
18 sive use of prescription drugs.

19 “(5) ACTUARIAL EQUIVALENCE OF STANDARD  
20 PLAN AND SUPPLEMENTAL PLAN.—The premium  
21 charged to an individual enrolled under this section  
22 for a supplemental policy that eliminates or reduces  
23 the cost-sharing requirement imposed on such indi-  
24 vidual and the actuarial value of any remaining cost-  
25 sharing requirement under the plan shall not exceed

1 95 percent of the actuarial value of the cost-sharing  
2 requirements under section 1834.

3 “(e) ENROLLMENT.—

4 “(1) ENROLLMENT PERIODS.—Each medicare  
5 drug benefit plan with a contract under this section  
6 must have a uniform open enrollment period (which  
7 shall be the period specified by the Secretary under  
8 section 1876(c)(3)(A)(i)), for the enrollment of indi-  
9 viduals under this section, of at least 30 days dura-  
10 tion every year. The plan must also have additional  
11 enrollment periods in accordance with the enrollment  
12 periods required under clauses (ii), (iii), and (iv) of  
13 section 1876(c)(3)(A).

14 “(2) TERMINATION.—An individual may only  
15 terminate an individual’s enrollment with a medicare  
16 drug benefit plan during an open enrollment period  
17 described in paragraph (1).

18 “(3) NONDISCRIMINATION.—The medicare drug  
19 benefit plan must provide assurances to the Sec-  
20 retary that it will not discriminate against any indi-  
21 vidual because of the individual’s health status, re-  
22 quirements for covered outpatient drugs, claims ex-  
23 perience, medical history, or other factors that are  
24 generally related to the need for covered outpatient

1 drugs and that it will notify each individual of such  
2 fact at the time of the individual's enrollment.

3 “(4) NOTICE OF RIGHTS, ETC.—Each medicare  
4 drug benefit plan with a contract under this section  
5 shall provide each enrollee, at the time of enrollment  
6 and not less frequently than annually thereafter, an  
7 explanation of the enrollee's rights under this sec-  
8 tion, including an explanation of—

9 “(A) the enrollee's rights to benefits from  
10 the plan,

11 “(B) the restrictions on payments under  
12 this title for covered outpatient drugs furnished  
13 other than by or through the plan,

14 “(C) out-of-plan coverage provided by the  
15 plan, and

16 “(D) appeal rights of enrollees.

17 “(f) MEMBERSHIP REQUIREMENTS.—

18 “(1) NON-MEDICARE REQUIREMENT.—

19 “(A) IN GENERAL.—Each entity with a  
20 contract under this section shall provide at that  
21 at least 1/2 of the individuals who are provided  
22 with drug coverage by the entity are individuals  
23 who are not enrolled in a medicare drug benefit  
24 plan under this section.

1           “(B) SUSPENSION OF ENROLLMENT.—If  
2           the Secretary determines that a medicare drug  
3           benefit plan with a contract under this section  
4           has failed to comply with the requirements of  
5           this subsection, the Secretary may provide for  
6           the suspension of enrollment of individuals  
7           under this section or of payment to the plan  
8           under this section for individuals newly enrolled  
9           with the plan, after the date the Secretary noti-  
10          fies the plan of such noncompliance.

11          “(2) 5000 INDIVIDUALS.—Each medicare drug  
12          benefit plan with a contract under this section shall  
13          provide covered outpatient drug coverage to at least  
14          5000 individuals, except that the Secretary may  
15          enter into such a contract with a medicare drug ben-  
16          efit plan that has fewer enrollees if the plan pri-  
17          marily serves members residing outside of urbanized  
18          areas.

19          “(g) PAYMENT RULES FOR PLANS.—

20          “(1) SUBROGATION RIGHTS.—Notwithstanding  
21          any other provision of law, the medicare drug benefit  
22          plan may, (in the case of the provision of covered  
23          outpatient drugs to an individual enrolled under this  
24          section for a drug for which the member is entitled  
25          to benefits under a workmen’s compensation law or

1 plan of the United States or a State, under an auto-  
2 mobile or liability insurance policy or plan, including  
3 a self-insured plan, under no fault insurance, or  
4 under a primary plan (as defined in section  
5 1862(b)(2)(A)) charge or authorize the provider of  
6 such services to charge, in accordance with the  
7 charges allowed under such law or policy—

8 “(A) the insurance carrier, employer, or  
9 other entity which under such law, plan, or pol-  
10 icy is to pay for the provision of such services,  
11 or

12 “(B) such enrollee to the extent that the  
13 enrollee has been paid under such law, plan, or  
14 policy for such services.

15 “(2) PROMPT PAYMENT REQUIREMENT.—

16 “(A) IN GENERAL.—A contract under this  
17 section shall require the medicare drug benefit  
18 plan to provide prompt payment (consistent  
19 with the provisions of section 1842(c)(4)) of  
20 claims submitted for covered outpatient drugs  
21 furnished to individuals pursuant to such con-  
22 tract, if the drugs are not furnished under a  
23 contract between the plan and the provider or  
24 supplier.

1           “(B) FAILURE.—In the case of a plan  
2           which the Secretary determines, after notice  
3           and opportunity for a hearing, has failed to  
4           make payments of amounts in compliance with  
5           subparagraph (A), the Secretary may provide  
6           for direct payment of the amounts owed to pro-  
7           viders and suppliers for such covered services  
8           furnished to individuals enrolled under this sec-  
9           tion under the contract. If the Secretary pro-  
10          vides for such direct payments, the Secretary  
11          shall provide for an appropriate reduction in  
12          the amount of payments otherwise made to the  
13          plan under this section to reflect the amount of  
14          the Secretary’s payments (and costs incurred by  
15          the Secretary in making such payments).

16          “(h) DURATION, TERMINATION, EFFECTIVE DATE,  
17          AND TERMS OF CONTRACT; POWERS AND DUTIES OF  
18          SECRETARY.—

19                 “(1) DURATION AND TERMINATION.—

20                 “(A) IN GENERAL.—Except as provided in  
21                 subparagraph (B), each contract under this sec-  
22                 tion shall be for a term of at least one year, as  
23                 determined by the Secretary, and may be made  
24                 automatically renewable from term to term in  
25                 the absence of notice by either party of inten-

1           tion to terminate at the end of the current  
2           term.

3           “(B) EXCEPTION.—The Secretary may  
4           terminate a contract at any time (after such  
5           reasonable notice and opportunity for hearing  
6           to the medicare drug benefit plan involved as  
7           the Secretary may provide in regulations), if the  
8           Secretary finds that the plan—

9                   “(i) has failed substantially to carry  
10                   out the contract,

11                   “(ii) is carrying out the contract in a  
12                   manner inconsistent with the efficient and  
13                   effective administration of this section, or

14                   “(iii) no longer substantially complies  
15                   with the requirements of this section.

16           “(2) EFFECTIVE DATE.—The effective date of  
17           any contract executed pursuant to this section shall  
18           be specified in the contract.

19           “(3) TERMS.—Each contract under this sec-  
20           tion—

21                   “(A) shall provide that the Secretary, or  
22                   any person or organization designated by the  
23                   Secretary—

24                   “(i) shall have the right to inspect or  
25                   otherwise evaluate—

1                   “(I) the quality, appropriateness,  
2                   and timeliness of drugs provided  
3                   under the contract, and

4                   “(II) the facilities of the organi-  
5                   zation when there is reasonable evi-  
6                   dence of some need for such inspec-  
7                   tion, and

8                   “(ii) shall have the right to audit and  
9                   inspect any books and records of the medi-  
10                  care drug benefit plan that pertain—

11                  “(I) to the ability of the plan to  
12                  bear the risk of potential financial  
13                  losses, or

14                  “(II) to drugs provided or deter-  
15                  minations of amounts payable under  
16                  the contract;

17                  “(B) shall require the plan with a contract  
18                  to provide (and pay for) written notice in ad-  
19                  vance of the contract’s termination, as well as  
20                  a description of alternatives for obtaining bene-  
21                  fits under this title, to each individual enrolled  
22                  under this section with the plan;

23                  “(C)(i) shall require the plan to comply  
24                  with subsections (a) and (c) of section 1318 of  
25                  the Public Health Service Act (relating to dis-

1 closure of certain financial information) and  
2 with the requirement of section 1301(c)(8) of  
3 such Act (relating to liability arrangements to  
4 protect members);

5 “(ii) shall require the plan to provide and  
6 supply information determined appropriate by  
7 the Secretary in the manner determined appro-  
8 priate by the Secretary; and

9 “(iii) shall require the plan to notify the  
10 Secretary of loans and other special financial  
11 arrangements which are made between the plan  
12 and subcontractors, affiliates, and related par-  
13 ties; and

14 “(D) shall contain such other terms and  
15 conditions not inconsistent with this section (in-  
16 cluding requiring the organization to provide  
17 the Secretary with such information) as the  
18 Secretary may find necessary and appropriate.

19 “(4) PERIOD OF DISQUALIFICATION.—The Sec-  
20 retary may not enter into a contract with a medicare  
21 drug benefit plan if a previous contract with that  
22 plan under this section was terminated at the re-  
23 quest of the plan within the preceding 5-year period  
24 or if the plan submits a bid under subsection  
25 (b)(2)(C) and does not enter into a contract, except

1 in circumstances which warrant special consider-  
2 ation, as determined by the Secretary.

3 “(5) DISREGARD OF CERTAIN INCONSISTENT  
4 LAWS, ETC.—The authority vested in the Secretary  
5 by this section may be performed without regard to  
6 such provisions of law or regulations relating to the  
7 making, performance, amendment, or modification of  
8 contracts of the United States as the Secretary may  
9 determine to be inconsistent with the furtherance of  
10 the purpose of this title.

11 “(6) FINDINGS OF FAILURE.—

12 “(A) IN GENERAL.—If the Secretary deter-  
13 mines that medicare drug benefit plan with a  
14 contract under this section—

15 “(i) fails substantially to provide  
16 medically necessary covered outpatient  
17 drugs that are required (under law or  
18 under the contract) to be provided to an  
19 individual covered under the contract, if  
20 the failure has adversely affected (or has  
21 substantial likelihood of adversely affect-  
22 ing) the individual;

23 “(ii) imposes premiums on individuals  
24 enrolled under this section in excess of the  
25 premiums permitted;

1           “(iii) acts to expel or to refuse to re-  
2 enroll an individual in violation of the pro-  
3 visions of this section;

4           “(iv) engages in any practice that  
5 would reasonably be expected to have the  
6 effect of denying or discouraging enroll-  
7 ment (except as permitted by this section)  
8 by eligible individuals with the plan whose  
9 medical condition or history indicates a  
10 need for substantial future covered out-  
11 patient drugs;

12           “(v) misrepresents or falsifies infor-  
13 mation that is furnished—

14                 “(I) to the Secretary under this  
15 section, or

16                 “(II) to an individual or to any  
17 other entity under this section;

18           “(vi) employs or contracts with any  
19 individual or entity that is excluded from  
20 participation under this title under section  
21 1128 or 1128A for the provision of health  
22 care, utilization review, medical social  
23 work, or administrative services or employs  
24 or contracts with any entity for the provi-  
25 sion (directly or indirectly) through such

1 an excluded individual or entity of such  
2 services;  
3 the Secretary may provide, in addition to any  
4 other remedies authorized by law, for any of the  
5 remedies described in subparagraph (B).

6 “(B) REMEDIES.—The remedies described  
7 in this subparagraph are—

8 “(i) civil money penalties of not more  
9 than \$25,000 for each determination under  
10 subparagraph (A) or, with respect to a de-  
11 termination under clause (iv) or (v)(I) of  
12 such subparagraph, of not more than  
13 \$100,000 for each such determination,  
14 plus, with respect to a determination under  
15 subparagraph (A)(ii), double the excess  
16 amount charged in violation of such sub-  
17 paragraph (and the excess amount charged  
18 shall be deducted from the penalty and re-  
19 turned to the individual concerned), and  
20 plus, with respect to a determination under  
21 subparagraph (A)(iv), \$15,000 for each in-  
22 dividual not enrolled as a result of the  
23 practice involved,

24 “(ii) suspension of enrollment of indi-  
25 viduals under this section after the date

1           the Secretary notifies the plan of a deter-  
2           mination under subparagraph (A) and  
3           until the Secretary is satisfied that the  
4           basis for such determination has been cor-  
5           rected and is not likely to recur, or

6                   “(iii) suspension of payment to the  
7           plan under this section for individuals en-  
8           rolled after the date the Secretary notifies  
9           the plan of a determination under subpara-  
10          graph (A) and until the Secretary is satis-  
11          fied that the basis for such determination  
12          has been corrected and is not likely to  
13          recur.

14          The provisions of section 1128A (other than  
15          subsections (a) and (b)) shall apply to a civil  
16          money penalty under clause (i) in the same  
17          manner as they apply to a civil money penalty  
18          or proceeding under section 1128A(a).

19          “(i) OTHER GENERAL REQUIREMENTS ON PLANS.—

20                   “(1) GRIEVANCE PROCEDURES.—Each medi-  
21          care drug benefit plan with a contract under this  
22          section must provide meaningful procedures for  
23          hearing and resolving grievances between the plan  
24          (including any entity or individual through which the

1 plan provides health care services) and individuals  
2 enrolled with the plan under this section.

3 “(2) APPEALS.—An individual enrolled with a  
4 medicare drug benefit plan under this section who is  
5 dissatisfied by reason of the individual’s failure to  
6 receive any covered outpatient drug to which the in-  
7 dividual believes the individual is entitled and at no  
8 greater charge than the individual believes the indi-  
9 vidual is required to pay is entitled, if the amount  
10 in controversy is \$100 or more, to a hearing before  
11 the Secretary to the same extent as is provided in  
12 section 205(b), and in any such hearing the Sec-  
13 retary shall make the plan a party. If the amount  
14 in controversy is \$1,000 or more, the individual or  
15 plan shall, upon notifying the other party, be enti-  
16 tled to judicial review of the Secretary’s final deci-  
17 sion as provided in section 205(g), and both the in-  
18 dividual and the plan shall be entitled to be parties  
19 to that judicial review.

20 “(3) ADDITIONAL REQUIREMENTS.—Not later  
21 than January 1, 1998, the Secretary shall establish  
22 standards for additional requirements for medicare  
23 drug benefit plans with contracts under this section,  
24 that to the extent possible are consistent with the  
25 standards relating to eligible organizations that have

1 entered into risk contracts under section 1876, and  
2 which provide that a medicare drug benefit plan—

3 “(A) must demonstrate financial solvency;

4 “(B) must demonstrate the ability to pro-  
5 vide benefits to all potential enrollees through-  
6 out the State served by the plan;

7 “(C) must not engage in marketing or  
8 other practices designed to discourage or limit  
9 the issuance of a medicare outpatient drug cov-  
10 erage plan to any potential enrollee on the basis  
11 of health status, claims experience, medical his-  
12 tory, or other factors that are generally related  
13 to utilization of covered outpatient drugs;

14 “(D) must inform individuals eligible to  
15 enroll with the plan about the plan only in ac-  
16 cordance with procedures and conditions deter-  
17 mined by the Secretary and may not distribute  
18 promotional or informational material unless—

19 “(i) at least 45 days before its dis-  
20 tribution, the plan has submitted the mate-  
21 rial to the Secretary for review,

22 “(ii) the material is made available to  
23 all individuals eligible to enroll in the plan  
24 in the State served by the plan, and

1           “(iii) the Secretary has not dis-  
2           approved the distribution of the material  
3           due to a determination that in the Sec-  
4           retary’s discretion, the material is materi-  
5           ally inaccurate or misleading or otherwise  
6           makes a material misrepresentation;

7           “(E) must provide convenient access to  
8           pharmacies for individuals in each zip code re-  
9           gion of the State taking into account the special  
10          needs of individuals who are enrolled in part B;

11          “(F) in addition to the access described in  
12          subparagraph (E), may provide enrollees with a  
13          mail-order pharmacy option;

14          “(G) may establish a formulary system (to  
15          be maintained throughout the 1-year contract  
16          period) which ensures that—

17                 “(i) the formulary shall cover at least  
18                 one covered outpatient drug in each thera-  
19                 peutic class of drugs representing a unique  
20                 mechanism of action (as defined by the  
21                 Secretary); and

22                 “(ii) that any covered outpatient drug  
23                 excluded by the formulary is subject to a  
24                 prior authorization process in which the  
25                 plan may not deny approval of any drug

1           unless the plan complies with the process  
2           described in section 1834(d)(7)(C)(iii);

3           “(H) must disclose any special relation-  
4           ships or arrangements with drug manufactur-  
5           ers, including ownership arrangements, dis-  
6           tribution arrangements, or alliances;

7           “(I) must have standards to assure the ap-  
8           propriate use of outpatient prescription medica-  
9           tions, including a program of prospective and  
10          retrospective drug use review, consistent with  
11          standards under the drug use review program  
12          developed by the Secretary under section  
13          1834(d)(7), including for any mail order serv-  
14          ices operated or used by the plan; and

15          “(J) is able to process claims for out-  
16          patient prescription drugs under the program  
17          through an on-line real time point of sale sys-  
18          tem, and has developed a process for processing  
19          out-of-area claims.”.

20          (b) **EFFECTIVE DATE.**—The amendments made by  
21          this section shall be effective with respect to contracts en-  
22          tered into on or after January 1, 1999.

1 **SEC. 2007. PAYMENT FOR COVERED OUTPATIENT DRUG**  
2 **BENEFIT UNDER MEDICARE CONTRACTS**  
3 **WITH HMOS AND CMPS.**

4 (a) **IN GENERAL.**—In providing for payments for the  
5 covered outpatient drug benefit, as added by section 2001,  
6 to entities with risk contracts under section 1876 of the  
7 Social Security Act, the Secretary of Health and Human  
8 Services may base such payment on classes of enrollees  
9 or geographic factors that are different than the classes  
10 or geographic factors otherwise utilized for determining  
11 payment under such section.

12 (b) **EFFECTIVE DATE.**—This section shall apply to  
13 contracts entered into on or after January 1, 1999.

14 **SEC. 2008. MAINTENANCE OF EFFORT.**

15 (a) **MAINTENANCE OF EFFORT WITH RESPECT TO**  
16 **PRESCRIPTION DRUGS.**—Section 1862(b)(1) (42 U.S.C.  
17 1395y(b)(1)) is amended by adding at the end the fol-  
18 lowing new subparagraph:

19 “(F) **PRESCRIPTION DRUGS.**—

20 “(i) **IN GENERAL.**—A group health  
21 plan may not take into account that an in-  
22 dividual (or the individual’s spouse) who is  
23 covered under the plan by virtue of the in-  
24 dividual’s current retirement status with  
25 an employer may be eligible to receive cov-  
26 ered outpatient drug coverage under part

1 B, except that this subparagraph shall not  
2 prohibit a plan from taking into account  
3 that an individual is eligible to receive cov-  
4 ered outpatient drug coverage under part  
5 B on or after January 1, 2002. To the ex-  
6 tent that the group health plan furnishes  
7 prescription drugs pursuant to a collec-  
8 tively bargained agreement, this subpara-  
9 graph shall prohibit a plan from taking  
10 into account that an individual is eligible  
11 to receive covered outpatient drug coverage  
12 under part B for the greater of the period  
13 of the agreement or until January 1, 2002.

14 “(ii) CURRENT RETIREMENT STA-  
15 TUS.—An individual has ‘current retire-  
16 ment status’ with an employer if the indi-  
17 vidual no longer has current employment  
18 status due to the individual’s retirement  
19 from such employment status.”.

20 (b) EFFECTIVE DATE.—The amendment made by  
21 subsection (a) shall apply to group health plans offering  
22 prescription drug coverage on or after January 1, 1994.

1 **Subtitle B—Home and Community-**  
2 **Based Services**

3 **PART 1—HOME AND COMMUNITY-BASED**  
4 **SERVICES FOR INDIVIDUALS WITH DISABILITIES**

5 **SEC. 2101. STATE PROGRAMS FOR HOME AND COMMUNITY-**  
6 **BASED SERVICES FOR INDIVIDUALS WITH**  
7 **DISABILITIES.**

8 (a) **IN GENERAL.**—Each State that has a plan for  
9 home and community-based services for individuals with  
10 disabilities submitted to and approved by the Secretary  
11 under section 2102(b) is entitled to payment in accordance  
12 with section 2108.

13 (b) **ENTITLEMENT TO SERVICES.**—Nothing in this  
14 subtitle shall be construed to create a right to services for  
15 individuals or a requirement that a State with an approved  
16 plan expend the entire amount of funds to which it is enti-  
17 tled under this subtitle.

18 (c) **DESIGNATION OF AGENCY.**—Not later than 6  
19 months after the date of enactment of this subtitle, the  
20 Secretary shall designate an agency responsible for pro-  
21 gram administration under this subtitle.

22 **SEC. 2102. STATE PLANS.**

23 (a) **PLAN REQUIREMENTS.**—In order to be approved  
24 under subsection (b), a State plan for home and commu-

1 nity-based services for individuals with disabilities must  
2 meet the following requirements:

3 (1) STATE MAINTENANCE OF EFFORT.—

4 (A) IN GENERAL.—A State plan under this  
5 subtitle shall provide that the State will, during  
6 any fiscal year that the State is furnishing serv-  
7 ices under this subtitle, make expenditures of  
8 State funds in an amount equal to the State  
9 maintenance of effort amount for the year de-  
10 termined under subparagraph (B) for fur-  
11 nishing the services described in subparagraph  
12 (C) under the State plan under this subtitle  
13 and the State plan under title XIX of the Social  
14 Security Act.

15 (B) STATE MAINTENANCE OF EFFORT  
16 AMOUNT.—

17 (i) IN GENERAL.—The maintenance of  
18 effort amount for a State for a fiscal year  
19 is an amount equal to—

20 (I) for fiscal year 1998, the base  
21 amount for the State (as determined  
22 under clause (ii)) updated through the  
23 midpoint of fiscal year 1998 by the  
24 estimated percentage change in the  
25 consumer price index during the pe-

1           riod beginning on October 1, 1994  
2           and ending at that midpoint; and

3           (II) for succeeding fiscal years,  
4           an amount equal to the amount deter-  
5           mined under this clause for the pre-  
6           vious fiscal year updated through the  
7           midpoint of the year by the estimated  
8           percentage change in the consumer  
9           price index during the 12-month pe-  
10          riod ending at that midpoint, with ap-  
11          propriate adjustments to reflect pre-  
12          vious underestimations or overesti-  
13          mations under this clause in the pro-  
14          jected percentage change in the con-  
15          sumer price index.

16          (ii) STATE BASE AMOUNT.—The base  
17          amount for a State is an amount equal to  
18          the total expenditures from State funds  
19          made under the State plan under title XIX  
20          of the Social Security Act during fiscal  
21          year 1994 with respect to medical assist-  
22          ance consisting of the services described in  
23          subparagraph (C).

1 (C) MEDICAID SERVICES DESCRIBED.—

2 The services described in this subparagraph are  
3 the following:

4 (i) Personal care services (as de-  
5 scribed in section 1905(a)(24) of the Social  
6 Security Act).

7 (ii) Home or community-based serv-  
8 ices furnished under a waiver granted  
9 under subsection (c), (d), or (e) of section  
10 1915 of such Act.

11 (iii) Home and community care fur-  
12 nished to functionally disabled elderly indi-  
13 viduals under section 1929 of such Act.

14 (iv) Community supported living ar-  
15 rangements services under section 1930 of  
16 such Act.

17 (2) ELIGIBILITY.—

18 (A) IN GENERAL.—Except as provided in  
19 subparagraph (B), within the amounts provided  
20 by the State and under section 2108 for such  
21 plan, the plan shall provide that services under  
22 the plan will be available to individuals with dis-  
23 abilities (as defined in section 2103(a)) in the  
24 State.

1           (C) INITIAL SCREENING.—The plan shall  
2 provide a process for the initial screening of an  
3 individual who appears to have some reasonable  
4 likelihood of being an individual with disabili-  
5 ties. Any such process shall require the provi-  
6 sion of assistance to individuals who wish to  
7 apply but whose disability limits their ability to  
8 apply. The initial screening and the determina-  
9 tion of disability (as defined under section  
10 2103(b)(1)) shall be conducted by a public  
11 agency.

12           (D) RESTRICTIONS.—The plan may not  
13 limit the eligibility of individuals with disabili-  
14 ties based on—

- 15                   (i) income,  
16                   (ii) age,  
17                   (iii) residential setting (other than an  
18 institutional setting), or  
19                   (iv) other grounds specified by the  
20 Secretary.

21           (E) CONTINUATION OF SERVICES.—The  
22 plan must provide assurances that, in the case  
23 of an individual receiving medical assistance for  
24 home and community-based services under the  
25 State medicaid plan under title XIX of the So-

1           cial Security Act as of the date a State’s plan  
2           is approved under this subtitle, the State will  
3           continue to make available (either under this  
4           plan, under the State medicaid plan, or other-  
5           wise) to such individual an appropriate level of  
6           assistance for home and community-based serv-  
7           ices, taking into account the level of assistance  
8           provided as of such date and the individual’s  
9           need for home and community-based services.

10       (3) SERVICES.—

11           (A) NEEDS ASSESSMENT.—Not later than  
12           the end of the second year of implementation,  
13           the plan or its amendments shall include the re-  
14           sults of a statewide assessment of the needs of  
15           individuals with disabilities in a format required  
16           by the Secretary. The needs assessment shall  
17           include demographic data concerning the num-  
18           ber of individuals within each category of dis-  
19           ability described in this subtitle, and the serv-  
20           ices available to meet the needs of such individ-  
21           uals.

22           (B) SPECIFICATION.—Consistent with sec-  
23           tion 2104, the plan shall specify—

24                   (i) the services made available under  
25                   the plan,

1           (ii) the extent and manner in which  
2           such services are allocated and made avail-  
3           able to individuals with disabilities, and

4           (iii) the manner in which services  
5           under the plan are coordinated with each  
6           other and with health and long-term care  
7           services available outside the plan for indi-  
8           viduals with disabilities.

9           (C) TAKING INTO ACCOUNT INFORMAL  
10          CARE.—A State plan may take into account, in  
11          determining the amount and array of services  
12          made available to covered individuals with dis-  
13          abilities, the availability of informal care.

14          (D) ALLOCATION.—The State plan—

15           (i) shall specify how services under  
16           the plan will be allocated among covered  
17           individuals with disabilities,

18           (ii) shall attempt to meet the needs of  
19           individuals with a variety of disabilities  
20           within the limits of available funding,

21           (iii) shall include services that assist  
22           all categories of individuals with disabil-  
23           ities, regardless of their age or the nature  
24           of their disabling conditions,

1 (iv) shall demonstrate that services  
2 are allocated equitably, in accordance with  
3 the needs assessment required under sub-  
4 paragraph (A), and

5 (v) shall ensure that—

6 (I) the proportion of the popu-  
7 lation of low-income individuals with  
8 disabilities in the State that rep-  
9 resents individuals with disabilities  
10 who are provided home and commu-  
11 nity-based services either under the  
12 plan, under the State medicaid plan,  
13 or under both, is not less than,

14 (II) the proportion of the popu-  
15 lation of the State that represents in-  
16 dividuals who are low-income individ-  
17 uals.

18 (E) LIMITATION ON LICENSURE OR CER-  
19 TIFICATION.—The State may not subject con-  
20 sumer-directed providers of personal assistance  
21 services to licensure, certification, or other re-  
22 quirements which the Secretary finds not to be  
23 necessary for the health and safety of individ-  
24 uals with disabilities.

1 (F) CONSUMER CHOICE.—To the extent  
2 feasible, the State shall follow the choice of an  
3 individual with disabilities (or that individual’s  
4 designated representative who may be a family  
5 member) regarding which covered services to re-  
6 ceive and the providers who will provide such  
7 services.

8 (4) COST SHARING.—The plan shall impose cost  
9 sharing with respect to covered services in accord-  
10 ance with section 2105.

11 (5) TYPES OF PROVIDERS AND REQUIREMENTS  
12 FOR PARTICIPATION.—The plan shall specify—

13 (A) the types of service providers eligible  
14 to participate in the program under the plan,  
15 which shall include consumer-directed providers  
16 of personal assistance services, except that the  
17 plan—

18 (i) may not limit benefits to services  
19 provided by registered nurses or licensed  
20 practical nurses; and

21 (ii) may not limit benefits to services  
22 provided by agencies or providers certified  
23 under title XVIII; and

24 (B) any requirements for participation ap-  
25 plicable to each type of service provider.

## 1 (6) PROVIDER REIMBURSEMENT.—

2 (A) PAYMENT METHODS.—The plan shall  
3 specify the payment methods to be used to re-  
4 imburse providers for services furnished under  
5 the plan. Such methods may include retrospec-  
6 tive reimbursement on a fee-for-service basis,  
7 prepayment on a capitation basis, payment by  
8 cash or vouchers to individuals with disabilities,  
9 or any combination of these methods. In the  
10 case of payment to consumer-directed providers  
11 of personal assistance services, including pay-  
12 ment through the use of cash or vouchers, the  
13 plan shall specify how the plan will assure com-  
14 pliance with applicable employment tax and  
15 health care coverage provisions.

16 (B) PAYMENT RATES.—The plan shall  
17 specify the methods and criteria to be used to  
18 set payment rates for—

19 (i) agency administered services fur-  
20 nished under the plan; and

21 (ii) consumer-directed personal assist-  
22 ance services furnished under the plan, in-  
23 cluding cash payments or vouchers to indi-  
24 viduals with disabilities, except that such  
25 payments shall be adequate to cover

1 amounts required under applicable employ-  
2 ment tax and health care coverage provi-  
3 sions.

4 (C) PLAN PAYMENT AS PAYMENT IN  
5 FULL.—The plan shall restrict payment under  
6 the plan for covered services to those providers  
7 that agree to accept the payment under the  
8 plan (at the rates established pursuant to sub-  
9 paragraph (B)) and any cost sharing permitted  
10 or provided for under section 2105 as payment  
11 in full for services furnished under the plan.

12 (7) QUALITY ASSURANCE AND SAFEGUARDS.—  
13 The State plan shall provide for quality assurance  
14 and safeguards for applicants and beneficiaries in  
15 accordance with section 2106.

16 (8) ADVISORY GROUP.—The State plan shall—

17 (A) assure the establishment and mainte-  
18 nance of an advisory group under section  
19 2107(b), and

20 (B) include the documentation prepared by  
21 the group under section 2107(b)(4).

22 (9) ADMINISTRATION AND ACCESS.—

23 (A) STATE AGENCY.—The plan shall des-  
24 ignate a State agency or agencies to administer  
25 (or to supervise the administration of) the plan.

1 (B) COORDINATION.—The plan shall speci-  
2 fy how it will—

3 (i) coordinate services provided under  
4 the plan, including eligibility prescreening,  
5 service coordination, and referrals for indi-  
6 viduals with disabilities who are ineligible  
7 for services under this subtitle with the  
8 State medicaid plan under title XIX of the  
9 Social Security Act, titles V and XX of  
10 such Act, programs under the Older Amer-  
11 icans Act of 1965, programs under the De-  
12 velopmental Disabilities Assistance and  
13 Bill of Rights Act, the Individuals with  
14 Disabilities Education Act, and any other  
15 Federal or State programs that provide  
16 services or assistance targeted to individ-  
17 uals with disabilities; and

18 (ii) coordinate with health plans.

19 (C) ADMINISTRATIVE EXPENDITURES.—  
20 Effective beginning with fiscal year 2004, the  
21 plan shall contain assurances that not more  
22 than 10 percent of expenditures under the plan  
23 for all quarters in any fiscal year shall be for  
24 administrative costs.

1           (10) REPORTS AND INFORMATION TO SEC-  
2       RETARY; AUDITS.—The plan shall provide that the  
3       State will furnish to the Secretary—

4           (A) such reports, and will cooperate with  
5       such audits, as the Secretary determines are  
6       needed concerning the State's administration of  
7       its plan under this subtitle, including the proc-  
8       essing of claims under the plan, and

9           (B) such data and information as the Sec-  
10       retary may require in a uniform format as spec-  
11       ified by the Secretary.

12          (11) USE OF STATE FUNDS FOR MATCHING.—  
13       The plan shall provide assurances that Federal  
14       funds will not be used to provide for the State share  
15       of expenditures under this subtitle.

16          (12) HEALTH CARE WORKER REDEPLOY-  
17       MENT.—The plan shall provide for the following:

18           (A) Before initiating the process of imple-  
19       menting the State program under such plan,  
20       negotiations will be commenced with labor  
21       unions representing the employees of the af-  
22       fected hospitals or other facilities.

23           (B) Negotiations under subparagraph (A)  
24       will address the following:

1 (i) The impact of the implementation  
2 of the program upon the workforce.

3 (ii) Methods to redeploy workers to  
4 positions in the proposed system, in the  
5 case of workers affected by the program.

6 (C) The plan will provide evidence that  
7 there has been compliance with subparagraphs  
8 (A) and (B), including a description of the re-  
9 sults of the negotiations.

10 (13) TERMINOLOGY.—The plan shall adhere to  
11 uniform definitions of terms, as specified by the Sec-  
12 retary.

13 (b) APPROVAL OF PLANS.—The Secretary shall ap-  
14 prove a plan submitted by a State if the Secretary deter-  
15 mines that the plan—

16 (1) was developed by the State after a public  
17 comment period of not less than 30 days, and

18 (2) meets the requirements of subsection (a).

19 The approval of such a plan shall take effect as of the  
20 first day of the first fiscal year beginning after the date  
21 of such approval (except that any approval made before  
22 January 1, 1998, shall be effective as of January 1, 1998).

23 In order to budget funds allotted under this subtitle, the  
24 Secretary shall establish a deadline for the submission of  
25 such a plan before the beginning of a fiscal year as a con-

1 dition of its approval effective with that fiscal year. Any  
2 significant changes to the State plan shall be submitted  
3 to the Secretary in the form of plan amendments and shall  
4 be subject to approval by the Secretary.

5 (c) MONITORING.—The Secretary shall annually  
6 monitor the compliance of State plans with the require-  
7 ments of this subtitle according to specified performance  
8 standards. In accordance with section 2108(e), States that  
9 fail to comply with such requirements may be subject to  
10 a reduction in the Federal matching rates available to the  
11 State under section 2108(a) or the withholding of Federal  
12 funds for services or administration until such time as  
13 compliance is achieved.

14 (d) TECHNICAL ASSISTANCE.—The Secretary shall  
15 ensure the availability of ongoing technical assistance to  
16 States under this section. Such assistance shall include  
17 serving as a clearinghouse for information regarding suc-  
18 cessful practices in providing long-term care services.

19 (e) REGULATIONS.—The Secretary shall issue such  
20 regulations as may be appropriate to carry out this sub-  
21 title on a timely basis.

22 **SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.**

23 (a) IN GENERAL.—For purposes of this subtitle, the  
24 term ‘individual with disabilities’ means any individual

1 within one or more of the following categories of individ-  
2 uals:

3 (1) INDIVIDUALS REQUIRING HELP WITH AC-  
4 TIVITIES OF DAILY LIVING.—An individual of any  
5 age who—

6 (A) requires hands-on or standby assist-  
7 ance, supervision, or cueing (as defined in regu-  
8 lations) to perform three or more activities of  
9 daily living (as defined in subsection (d)), and

10 (B) is expected to require such assistance,  
11 supervision, or cueing over a period of at least  
12 90 days.

13 (2) INDIVIDUALS WITH SEVERE COGNITIVE OR  
14 MENTAL IMPAIRMENT.—An individual of any age—

15 (A) whose score, on a standard mental sta-  
16 tus protocol (or protocols) appropriate for  
17 measuring the individual's particular condition  
18 specified by the Secretary, indicates either se-  
19 vere cognitive impairment or severe mental im-  
20 pairment, or both;

21 (B) who—

22 (i) requires hands-on or standby as-  
23 sistance, supervision, or cueing with one or  
24 more activities of daily living;

1 (ii) requires hands-on or standby as-  
2 sistance, supervision, or cueing with at  
3 least such instrumental activity (or activi-  
4 ties) of daily living related to cognitive or  
5 mental impairment as the Secretary speci-  
6 fies; or

7 (iii) displays symptoms of one or more  
8 serious behavioral problems (that is on a  
9 list of such problems specified by the Sec-  
10 retary) which create a need for supervision  
11 to prevent harm to self or others; and

12 (C) who is expected to meet the require-  
13 ments of subparagraphs (A) and (B) over a pe-  
14 riod of at least 90 days.

15 Not later than 2 years after the date of enactment  
16 of this subtitle, the Secretary shall make rec-  
17 ommendations regarding the most appropriate dura-  
18 tion of disability under this paragraph.

19 (3) INDIVIDUALS WITH SEVERE OR PROFOUND  
20 MENTAL RETARDATION.—An individual of any age  
21 who has severe or profound mental retardation (as  
22 determined according to a protocol specified by the  
23 Secretary).

24 (4) YOUNG CHILDREN WITH SEVERE DISABIL-  
25 ITIES.—An individual under 6 years of age who—

1 (A) has a severe disability or chronic med-  
2 ical condition that limits functioning in a man-  
3 ner that is comparable in severity to the stand-  
4 ards established under paragraphs (1), (2), or  
5 (3), and

6 (B) is expected to have such a disability or  
7 condition and require such services over a pe-  
8 riod of at least 90 days.

9 (b) DETERMINATION.—

10 (1) IN GENERAL.—In formulating eligibility cri-  
11 teria under subsection (a), the Secretary shall estab-  
12 lish criteria for assessing the functional level of dis-  
13 ability among all categories of individuals with dis-  
14 abilities that are comparable in severity, regardless  
15 of the age or the nature of the disabling condition  
16 of the individual. The determination of whether an  
17 individual is an individual with disabilities shall be  
18 made by a public or nonprofit agency that is speci-  
19 fied under the State plan and that is not a provider  
20 of home and community-based services under this  
21 subtitle and by using a uniform protocol consisting  
22 of an initial screening and a determination of dis-  
23 ability specified by the Secretary. A State may not  
24 impose cost sharing with respect to a determination  
25 of disability. A State may collect additional informa-

1       tion, at the time of obtaining information to make  
2       such determination, in order to provide for the as-  
3       sessment and plan described in section 2104(b) or  
4       for other purposes.

5           (2) PERIODIC REASSESSMENT.—The determina-  
6       tion that an individual is an individual with disabil-  
7       ities shall be considered to be effective under the  
8       State plan for a period of not more than 6 months  
9       (or for such longer period in such cases as a signifi-  
10      cant change in an individual's condition that may af-  
11      fect such determination is unlikely). A reassessment  
12      shall be made if there is a significant change in an  
13      individual's condition that may affect such deter-  
14      mination.

15       (c) ELIGIBILITY CRITERIA.—The Secretary shall re-  
16      assess the validity of the eligibility criteria described in  
17      subsection (a) as new knowledge regarding the assess-  
18      ments of functional disabilities becomes available. The  
19      Secretary shall report to the Committees on Finance and  
20      Labor and Human Resources of the Senate and the Com-  
21      mittees on Ways and Means and Energy and Commerce  
22      of the House of Representatives on its findings under the  
23      preceding sentence as determined appropriate by the Sec-  
24      retary.

1 (d) ACTIVITY OF DAILY LIVING DEFINED.—For pur-  
 2 poses of this subtitle, the term ‘activity of daily living’  
 3 means any of the following: eating, toileting, dressing,  
 4 bathing, and transferring.

5 **SEC. 2104. HOME AND COMMUNITY-BASED SERVICES COV-  
 6 ERED UNDER STATE PLAN.**

7 (a) SPECIFICATION.—

8 (1) IN GENERAL.—Subject to the succeeding  
 9 provisions of this section, the State plan under this  
 10 subtitle shall specify—

11 (A) the home and community-based serv-  
 12 ices available under the plan to individuals with  
 13 disabilities (or to such categories of such indi-  
 14 viduals), and

15 (B) any limits with respect to such serv-  
 16 ices.

17 (2) FLEXIBILITY IN MEETING INDIVIDUAL  
 18 NEEDS.—Subject to subsection (e)(2), such services  
 19 may be delivered in an individual’s home, a range of  
 20 community residential arrangements, or outside the  
 21 home.

22 (b) REQUIREMENT FOR NEEDS ASSESSMENT AND  
 23 PLAN OF CARE.—

24 (1) IN GENERAL.—The State plan shall provide  
 25 for home and community-based services to an indi-

1 individual with disabilities only if the following require-  
2 ments are met:

3 (A) COMPREHENSIVE ASSESSMENT.—A

4 comprehensive assessment of an individual's  
5 need for home and community-based services  
6 (regardless of whether all need services are  
7 available under the plan) shall be made in ac-  
8 cordance with a uniform, comprehensive assess-  
9 ment tool that shall be used by a State under  
10 this paragraph with the approval of the Sec-  
11 retary. The Secretary shall provide guidance to  
12 the States with regard to the appropriate quali-  
13 fications for individuals who conduct com-  
14 prehensive assessments.

15 (B) INDIVIDUALIZED PLAN OF CARE.—An

16 individualized plan of care based on the assess-  
17 ment made under subparagraph (A) shall be de-  
18 veloped. A plan of care under this subparagraph  
19 shall—

20 (i) specify which services included  
21 under the individual plan will be provided  
22 under the State plan under this subtitle;

23 (ii) identify (to the extent possible)  
24 how the individual will be provided any

1 services specified under the plan of care  
2 and not provided under the State plan;

3 (iii) specify how the provision of serv-  
4 ices to the individual under the plan will be  
5 coordinated with the provision of other  
6 health care services to the individual; and

7 (iv) be reviewed and updated every 6  
8 months (or more frequently if there is a  
9 change in the individual's condition).

10 The State shall make reasonable efforts to iden-  
11 tify and arrange for services described in clause  
12 (ii). Nothing in this subsection shall be con-  
13 strued as requiring a State (under the State  
14 plan or otherwise) to provide all the services  
15 specified in such a plan.

16 (C) INVOLVEMENT OF INDIVIDUALS.—The  
17 individualized plan of care under subparagraph  
18 (B) for an individual with disabilities shall—

19 (i) be developed by qualified individ-  
20 uals (specified under the State plan);

21 (ii) be developed and implemented in  
22 close consultation with the individual (or  
23 the individual's designated representative);  
24 and

1 (iii) be approved by the individual (or  
2 the individual's designated representative).

3 (c) REQUIREMENT FOR CARE MANAGEMENT.—

4 (1) IN GENERAL.—The State shall make avail-  
5 able to each category of individuals with disabilities  
6 care management services that at a minimum in-  
7 clude—

8 (A) arrangements for the provision of such  
9 services, and

10 (B) monitoring of the delivery of services.

11 (2) CARE MANAGEMENT SERVICES.—

12 (A) IN GENERAL.—Except as provided in  
13 subparagraph (B), the care management serv-  
14 ices described in paragraph (1) shall be pro-  
15 vided by a public or private entity that is not  
16 providing home and community-based services  
17 under this subtitle.

18 (B) EXCEPTION.—A person who provides  
19 home and community-based services under this  
20 subtitle may provide care management services  
21 if—

22 (i) the State determines that there is  
23 an insufficient pool of entities willing to  
24 provide such services in an area due to a  
25 low population of individuals eligible for

1 home and community-based services under  
2 this subtitle residing in such area; and

3 (ii) the State plan specifies procedures  
4 that the State will implement in order to  
5 avoid conflicts of interest.

6 (d) MANDATORY COVERAGE OF PERSONAL ASSIST-  
7 ANCE SERVICES.—The State plan shall include, in the  
8 array of services made available to each category of indi-  
9 viduals with disabilities, both agency-administered and  
10 consumer-directed personal assistance services (as defined  
11 in subsection (h)).

12 (e) ADDITIONAL SERVICES.—

13 (1) TYPES OF SERVICES.—Subject to subsection  
14 (f), services available under a State plan under this  
15 subtitle may include any (or all) of the following:

16 (A) Homemaker and chore assistance.

17 (B) Home modifications.

18 (C) Respite services.

19 (D) Assistive devices, as defined in the  
20 Technology Related Assistance for Individuals  
21 with Disabilities Act.

22 (E) Adult day services.

23 (F) Habilitation and rehabilitation.

24 (G) Supported employment.

25 (H) Home health services.

1 (I) Transportation.

2 (J) Any other care or assistive services  
3 specified by the State and approved by the Sec-  
4 retary that will help individuals with disabilities  
5 to remain in their homes and communities.

6 (2) CRITERIA FOR SELECTION OF SERVICES.—

7 The State electing services under paragraph (1)  
8 shall specify in the State plan—

9 (A) the methods and standards used to se-  
10 lect the types, and the amount, duration, and  
11 scope, of services to be covered under the plan  
12 and to be available to each category of individ-  
13 uals with disabilities, and

14 (B) how the types, and the amount, dura-  
15 tion, and scope, of services specified, within the  
16 limits of available funding, provide substantial  
17 assistance in living independently to individuals  
18 within each of the categories of individuals with  
19 disabilities.

20 (f) EXCLUSIONS AND LIMITATIONS.—A State plan  
21 may not provide for coverage of—

22 (1) room and board,

23 (2) services furnished in a hospital, nursing fa-  
24 cility, intermediate care facility for the mentally re-

1       tarded, or other institutional setting specified by the  
2       Secretary, or

3             (3) items and services to the extent coverage is  
4       provided for the individual under a health plan or  
5       the medicare program.

6       (g) PAYMENT FOR SERVICES.—In order to pay for  
7 covered services, a State plan may provide for the use of—

8             (1) vouchers,

9             (2) cash payments directly to individuals with  
10 disabilities,

11            (3) capitation payments to health plans, and

12            (4) payment to providers.

13       (h) PERSONAL ASSISTANCE SERVICES.—

14            (1) IN GENERAL.—For purposes of this sub-  
15 title, the term “personal assistance services” means  
16 those services specified under the State plan as per-  
17 sonal assistance services and shall include at least  
18 hands-on and standby assistance, supervision, and  
19 cueing with activities of daily living, whether agency-  
20 administered or consumer-directed (as defined in  
21 paragraph (2)).

22            (2) CONSUMER-DIRECTED.—For purposes of  
23 this subtitle:

24                  (A) IN GENERAL.—The term “consumer-  
25 directed” means, with reference to personal as-

1 assistance services or the provider of such serv-  
2 ices, services that are provided by an individual  
3 who is selected and managed (and, at the op-  
4 tion of the service recipient, trained) by the in-  
5 dividual receiving the services.

6 (B) STATE RESPONSIBILITIES.—A State  
7 plan shall ensure that where services are pro-  
8 vided in a consumer-directed manner, the State  
9 shall create or contract with an entity, other  
10 than the consumer or the individual provider,  
11 to—

12 (i) inform both recipients and pro-  
13 viders of rights and responsibilities under  
14 all applicable Federal labor and tax law;  
15 and

16 (ii) assume responsibility for providing  
17 effective billing, payments for services, tax  
18 withholding, unemployment insurance, and  
19 workers' compensation coverage, and act  
20 as the employer of the home care provider.

21 (C) RIGHT OF CONSUMERS.—Notwith-  
22 standing the State responsibilities described in  
23 subparagraph (B), service recipients, and,  
24 where appropriate, their designated representa-  
25 tive, shall retain the right to independently se-

1           lect, hire, terminate, and direct (including man-  
2           age, train, schedule, and verify services pro-  
3           vided) the work of a home care provider.

4           (3) AGENCY ADMINISTERED.—For purposes of  
5           this subtitle, the term ‘agency-administered’ means,  
6           with respect to such services, services that are not  
7           consumer-directed.

8 **SEC. 2105. COST SHARING.**

9           (a) NO COST SHARING FOR POOREST.—

10           (1) IN GENERAL.—The State plan may not im-  
11           pose any cost sharing for individuals with income (as  
12           determined under subsection (d)) less than 150 per-  
13           cent of the official poverty level (referred to in para-  
14           graph (2)) applicable to a family of the size involved.

15           (2) OFFICIAL POVERTY LEVEL.—The term ‘ap-  
16           plicable poverty level’ means, for a family for a year,  
17           the official poverty line (as defined by the Office of  
18           Management and Budget, and revised annually in  
19           accordance with section 673(2) of the Omnibus  
20           Budget Reconciliation Act of 1981) applicable to a  
21           family of the size involved.

22           (b) SLIDING SCALE FOR REMAINDER.—

23           (1) REQUIRED COINSURANCE.—The State plan  
24           shall impose cost sharing in the form of coinsurance

1 (based on the amount paid under the State plan for  
2 a service)—

3 (A) at a rate of 10 percent for individuals  
4 with disabilities with income not less than 150  
5 percent, and less than 175 percent, of such offi-  
6 cial poverty line (as so applied);

7 (B) at a rate of 15 percent for such indi-  
8 viduals with income not less than 175 percent,  
9 and less than 225 percent, of such official pov-  
10 erty line (as so applied);

11 (C) at a rate of 25 percent for such indi-  
12 viduals with income not less than 225 percent,  
13 and less than 275 percent, of such official pov-  
14 erty line (as so applied);

15 (D) at a rate of 30 percent for such indi-  
16 viduals with income not less than 275 percent,  
17 and less than 325 percent, of such official pov-  
18 erty line (as so applied);

19 (E) at a rate of 35 percent for such indi-  
20 viduals with income not less than 325 percent,  
21 and less than 400 percent, of such official pov-  
22 erty line (as so applied); and

23 (F) at a rate of 40 percent for such indi-  
24 viduals with income equal to at least 400 per-  
25 cent of such official poverty line (as so applied).

1           (2) REQUIRED ANNUAL DEDUCTIBLE.—The  
2 State plan shall impose cost sharing in the form of  
3 an annual deductible—

4           (A) of \$100 for individuals with disabilities  
5 with income not less than 150 percent, and less  
6 than 175 percent, of such official poverty line  
7 (as so applied);

8           (B) of \$200 for such individuals with in-  
9 come not less than 175 percent, and less than  
10 225 percent, of such official poverty line (as so  
11 applied);

12           (C) of \$300 for such individuals with in-  
13 come not less than 225 percent, and less than  
14 275 percent, of such official poverty line (as so  
15 applied);

16           (D) of \$400 for such individuals with in-  
17 come not less than 275 percent, and less than  
18 325 percent, of such official poverty line (as so  
19 applied);

20           (E) of \$500 for such individuals with in-  
21 come not less than 325 percent, and less than  
22 400 percent, of such official poverty line (as so  
23 applied); and

1 (F) of \$600 for such individuals with in-  
2 come equal to at least 400 percent of such offi-  
3 cial poverty line (as so applied).

4 (c) RECOMMENDATION OF THE SECRETARY.—The  
5 Secretary shall make recommendations to the States as  
6 to how to reduce cost-sharing for individuals with extraor-  
7 dinary out-of-pocket costs for whom the cost-sharing pro-  
8 visions of this section could jeopardize their ability to take  
9 advantage of the services offered under this subtitle. The  
10 Secretary shall establish a methodology for reducing the  
11 cost-sharing burden for individuals with exceptionally high  
12 out-of-pocket costs under this subtitle.

13 (d) DETERMINATION OF INCOME FOR PURPOSES OF  
14 COST SHARING.—The State plan shall specify the process  
15 to be used to determine the income of an individual with  
16 disabilities for purposes of this section. Such standards  
17 shall include a uniform Federal definition of income and  
18 any allowable deductions from income.

19 **SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.**

20 (a) QUALITY ASSURANCE.—

21 (1) IN GENERAL.—The State plan shall specify  
22 how the State will ensure and monitor the quality of  
23 services, including—

24 (A) safeguarding the health and safety of  
25 individuals with disabilities,

1 (B) setting the minimum standards for  
2 agency providers and how such standards will  
3 be enforced,

4 (C) setting the minimum competency re-  
5 quirements for agency provider employees who  
6 provide direct services under this subtitle and  
7 how the competency of such employees will be  
8 enforced,

9 (D) obtaining meaningful consumer input,  
10 including consumer surveys that measure the  
11 extent to which participants receive the services  
12 described in the plan of care and participant  
13 satisfaction with such services,

14 (E) establishing a process to receive, inves-  
15 tigate, and resolve allegations of neglect and/or  
16 abuse,

17 (F) establishing optional training programs  
18 for individuals with disabilities in the use and  
19 direction of consumer directed providers of per-  
20 sonal assistance services,

21 (G) establishing an appeals procedure for  
22 eligibility denials and a grievance procedure for  
23 disagreements with the terms of an individual-  
24 ized plan of care,

1           (H) providing for participation in quality  
2 assurance activities, and

3           (I) specifying the role of the long-term care  
4 ombudsman (under the Older Americans Act of  
5 1965) and the Protection and Advocacy Agency  
6 (under the Developmental Disabilities Assist-  
7 ance and Bill of Rights Act) in assuring quality  
8 of services and protecting the rights of individ-  
9 uals with disabilities.

10           (2) ISSUANCE OF REGULATIONS.—Not later  
11 than 1 year after the date of enactment of this sub-  
12 title, the Secretary shall issue regulations imple-  
13 menting the quality provisions of this subsection.

14           (b) FEDERAL STANDARDS.—The State plan shall ad-  
15 here to Federal quality standards in the following areas:

16           (1) Case review of a specified sample of client  
17 records.

18           (2) The mandatory reporting of abuse, neglect,  
19 or exploitation.

20           (3) The development of a registry of provider  
21 agencies or home care workers and consumer di-  
22 rected providers of personal assistance services  
23 against whom any complaints have been sustained,  
24 which shall be available to the public.

1           (4) Sanctions to be imposed on States or pro-  
2           viders, including disqualification from the program,  
3           if minimum standards are not met.

4           (5) Surveys of client satisfaction.

5           (6) State optional training programs for infor-  
6           mal caregivers.

7           (c) CLIENT ADVOCACY.—

8           (1) IN GENERAL.—The State plan shall provide  
9           that the State will expend the amount allocated  
10          under section 2109(b)(2) for client advocacy activi-  
11          ties. The State may use such funds to augment the  
12          budgets of the long-term care ombudsman (under  
13          the Older Americans Act of 1965) and the Protec-  
14          tion and Advocacy Agency (under the Developmental  
15          Disabilities Assistance and Bill of Rights Act) or  
16          may establish a separate and independent client ad-  
17          vocacy office in accordance with paragraph (2) to  
18          administer a new program designed to advocate for  
19          client rights.

20          (2) CLIENT ADVOCACY OFFICE.—

21                (A) IN GENERAL.—A client advocacy office  
22                established under this paragraph shall—

23                    (i) identify, investigate, and resolve  
24                    complaints that—

1 (I) are made by, or on behalf of,  
2 clients; and

3 (II) relate to action, inaction, or  
4 decisions, that may adversely affect  
5 the health, safety, welfare, or rights of  
6 the clients (including the welfare and  
7 rights of the clients with respect to  
8 the appointment and activities of  
9 guardians and representative payees),  
10 of—

11 (aa) providers, or represent-  
12 atives of providers, of long-term  
13 care services;

14 (bb) public agencies; or

15 (cc) health and social service  
16 agencies;

17 (ii) provide services to assist the cli-  
18 ents in protecting the health, safety, wel-  
19 fare, and rights of the clients;

20 (iii) inform the clients about means of  
21 obtaining services provided by providers or  
22 agencies described in clause (i)(II) or serv-  
23 ices described in clause (ii);

24 (iv) ensure that the clients have reg-  
25 ular and timely access to the services pro-

1           vided through the office and that the cli-  
2           ents and complainants receive timely re-  
3           sponses from representatives of the office  
4           to complaints; and

5           (v) represent the interests of the cli-  
6           ents before governmental agencies and  
7           seek administrative, legal, and other rem-  
8           edies to protect the health, safety, welfare,  
9           and rights of the clients with regard to the  
10          provisions of this subtitle.

11          (B) CONTRACTS AND ARRANGEMENTS.—

12           (i) IN GENERAL.—Except as provided  
13           in clause (ii), the State agency may estab-  
14           lish and operate the office, and carry out  
15           the program, directly, or by contract or  
16           other arrangement with any public agency  
17           or nonprofit private organization.

18          (C) LICENSING AND CERTIFICATION ORGA-  
19          NIZATIONS; ASSOCIATIONS.—The State agency  
20          may not enter into the contract or other ar-  
21          rangement described in clause (i) with an agen-  
22          cy or organization that is responsible for licens-  
23          ing, certifying, or providing long-term care serv-  
24          ices in the State.

25          (d) SAFEGUARDS.—

1           (1) CONFIDENTIALITY.—The State plan shall  
2           provide safeguards which restrict the use or disclo-  
3           sure of information concerning applicants and bene-  
4           ficiaries to purposes directly connected with the ad-  
5           ministration of the plan.

6           (2) SAFEGUARDS AGAINST ABUSE.—The State  
7           plans shall provide safeguards against physical, emo-  
8           tional, or financial abuse or exploitation (specifically  
9           including appropriate safeguards in cases where pay-  
10          ment for program benefits is made by cash pay-  
11          ments or vouchers given directly to individuals with  
12          disabilities). All providers of services shall be re-  
13          quired to register with the State agency.

14          (3) REGULATIONS.—Not later than January 1,  
15          1998, the Secretary shall promulgate regulations  
16          with respect to the requirements on States under  
17          this subsection.

18          (e) SPECIFIED RIGHTS.—The State plan shall pro-  
19          vide that in furnishing home and community-based serv-  
20          ices under the plan the following individual rights are pro-  
21          tected:

22                (1) The right to be fully informed in advance,  
23                orally and in writing, of the care to be provided, to  
24                be fully informed in advance of any changes in care  
25                to be provided, and (except with respect to an indi-

1       vidual determined incompetent) to participate in  
2       planning care or changes in care.

3           (2) The right to—

4               (A) voice grievances with respect to serv-  
5               ices that are (or fail to be) furnished without  
6               discrimination or reprisal for voicing grievances,

7               (B) be told how to complain to State and  
8               local authorities, and

9               (C) prompt resolution of any grievances or  
10              complaints.

11          (3) The right to confidentiality of personal and  
12          clinical records and the right to have access to such  
13          records.

14          (4) The right to privacy and to have one's prop-  
15          erty treated with respect.

16          (5) The right to refuse all or part of any care  
17          and to be informed of the likely consequences of  
18          such refusal.

19          (6) The right to education or training for one-  
20          self and for members of one's family or household on  
21          the management of care.

22          (7) The right to be free from physical or mental  
23          abuse, corporal punishment, and any physical or  
24          chemical restraints imposed for purposes of dis-

1 cipline or convenience and not included in an indi-  
2 vidual's plan of care.

3 (8) The right to be fully informed orally and in  
4 writing of the individual's rights.

5 (9) The right to a free choice of providers.

6 (10) The right to direct provider activities when  
7 an individual is competent and willing to direct such  
8 activities.

9 **SEC. 2107. ADVISORY GROUPS.**

10 (a) FEDERAL ADVISORY GROUP.—

11 (1) ESTABLISHMENT.—The Secretary shall es-  
12 tablish an advisory group, to advise the Secretary  
13 and States on all aspects of the program under this  
14 subtitle.

15 (2) COMPOSITION.—The group shall be com-  
16 posed of individuals with disabilities and their rep-  
17 resentatives, providers, Federal and State officials,  
18 and local community implementing agencies. A ma-  
19 jority of its members shall be individuals with dis-  
20 abilities and their representatives.

21 (b) STATE ADVISORY GROUPS.—

22 (1) IN GENERAL.—Each State plan shall pro-  
23 vide for the establishment and maintenance of an  
24 advisory group to advise the State on all aspects of  
25 the State plan under this subtitle.

1           (2) COMPOSITION.—Members of each advisory  
2 group shall be appointed by the Governor (or other  
3 chief executive officer of the State) and shall include  
4 individuals with disabilities and their representa-  
5 tives, providers, State officials, and local community  
6 implementing agencies. A majority of its members  
7 shall be individuals with disabilities and their rep-  
8 resentatives. The members of the advisory group  
9 shall be selected from the those nominated as de-  
10 scribed in paragraph (3).

11           (3) SELECTION OF MEMBERS.—Each State  
12 shall establish a process whereby all residents of the  
13 State, including individuals with disabilities and  
14 their representatives, shall be given the opportunity  
15 to nominate members to the advisory group.

16           (4) PARTICULAR CONCERNS.—Each advisory  
17 group shall—

18                   (A) before the State plan is developed, ad-  
19 vise the State on guiding principles and values,  
20 policy directions, and specific components of the  
21 plan,

22                   (B) meet regularly with State officials in-  
23 volved in developing the plan, during the devel-  
24 opment phase, to review and comment on all as-  
25 pects of the plan,

1 (C) participate in the public hearings to  
2 help assure that public comments are addressed  
3 to the extent practicable,

4 (D) report to the Governor and make  
5 available to the public any differences between  
6 the group's recommendations and the plan,

7 (E) report to the Governor and make avail-  
8 able to the public specifically the degree to  
9 which the plan is consumer-directed, and

10 (F) meet regularly with officials of the des-  
11 ignated State agency (or agencies) to provide  
12 advice on all aspects of implementation and  
13 evaluation of the plan.

14 **SEC. 2108. PAYMENTS TO STATES.**

15 (a) IN GENERAL.—Subject to section 2102(a)(9)(C)  
16 (relating to limitation on payment for administrative  
17 costs), the Secretary, in accordance with the Cash Man-  
18 agement Improvement Act, shall authorize payment to  
19 each State with a plan approved under this subtitle, for  
20 each quarter (beginning on or after January 1, 1998),  
21 from its allotment under section 2109(b), an amount equal  
22 to—

23 (1)(A) if the amount demonstrated by State  
24 claims to have been expended during the year for  
25 home and community-based services under the plan

1 for individuals with disabilities does not exceed 20  
2 percent of the amount allotted to the State under  
3 section 2109(b), 100 percent of the amount dem-  
4 onstrated by State claims to have been expended  
5 during the quarter for such services for such individ-  
6 uals; or

7 (B) for the amount demonstrated by State  
8 claims to have been expended during the year for  
9 home and community-based services under the plan  
10 for individuals with disabilities that exceeds 20 per-  
11 cent of the amount allotted to the State under sec-  
12 tion 2109(b), the Federal home and community-  
13 based services matching percentage (as defined in  
14 subsection (b)) of such amount; plus

15 (2) an amount equal to 90 percent of the  
16 amount demonstrated by the State to have been ex-  
17 pended during the quarter for quality assurance ac-  
18 tivities under the plan; plus

19 (3) an amount equal to 90 percent of amount  
20 expended during the quarter under the plan for ac-  
21 tivities (including preliminary screening) relating to  
22 determination of eligibility and performance of needs  
23 assessment; plus

24 (4) an amount equal to 90 percent (or, begin-  
25 ning with quarters in fiscal year 2004, 75 percent)

1 of the amount expended during the quarter for the  
2 design, development, and installation of mechanical  
3 claims processing systems and for information re-  
4 trieval; plus

5 (5) an amount equal to 50 percent of the re-  
6 mainder of the amounts expended during the quar-  
7 ter as found necessary by the Secretary for the prop-  
8 er and efficient administration of the State plan.

9 (b) FEDERAL HOME AND COMMUNITY-BASED SERV-  
10 ICES MATCHING PERCENTAGE.—In subsection (a), the  
11 term ‘Federal home and community-based services match-  
12 ing percentage’ means, with respect to a State, the State’s  
13 Federal medical assistance percentage (as defined in sec-  
14 tion 1905(b) of the Social Security Act) increased by 15  
15 percentage points, except that the Federal home and com-  
16 munity-based services matching percentage shall in no  
17 case be more than 95 percent.

18 (c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE  
19 ADJUSTMENTS.—The method of computing and making  
20 payments under this section shall be as follows:

21 (1) The Secretary shall, prior to the beginning  
22 of each quarter, estimate the amount to be paid to  
23 the State under subsection (a) for such quarter,  
24 based on a report filed by the State containing its  
25 estimate of the total sum to be expended in such

1 quarter, and such other information as the Secretary  
2 may find necessary.

3 (2) From the allotment available therefore, the  
4 Secretary shall provide for payment of the amount  
5 so estimated, reduced or increased, as the case may  
6 be, by any sum (not previously adjusted under this  
7 section) by which the Secretary finds that the esti-  
8 mate of the amount to be paid the State for any  
9 prior period under this section was greater or less  
10 than the amount which should have been paid.

11 (d) APPLICATION OF RULES REGARDING LIMITA-  
12 TIONS ON PROVIDER-RELATED DONATIONS AND HEALTH  
13 CARE RELATED TAXES.—The provisions of section  
14 1903(w) of the Social Security Act shall apply to pay-  
15 ments to States under this section in the same manner  
16 as they apply to payments to States under section 1903(a)  
17 of such Act.

18 (e) FAILURE TO COMPLY WITH STATE PLAN.—If a  
19 State furnishing home and community-based services  
20 under this subtitle fails to comply with the State plan ap-  
21 proved under this subtitle, the Secretary may either re-  
22 duce the Federal matching rates available to the State  
23 under subsection (a) or withhold an amount of funds de-  
24 termined appropriate by the Secretary from any payment  
25 to the State under this section.

1 **SEC. 2109. APPROPRIATIONS; ALLOTMENTS TO STATES.**

2 (a) APPROPRIATIONS.—

3 (1) FISCAL YEARS 1998 THROUGH 2004.—Sub-  
4 ject to paragraph (5)(C), for purposes of this sub-  
5 title, the appropriation authorized under this subtitle  
6 for each of fiscal years 1998 through 2004 is the  
7 following:

8 (A) For fiscal year 1998, \$1,800,000,000.

9 (B) For fiscal year 1999, \$2,900,000,000.

10 (C) For fiscal year 2000, \$3,600,000,000.

11 (D) For fiscal year 2001, \$5,000,000,000.

12 (E) For fiscal year 2002, \$7,900,000,000.

13 (F) For fiscal year 2003,  
14 \$11,400,000,000.

15 (G) For fiscal year 2004,  
16 \$15,400,000,000.

17 (2) SUBSEQUENT FISCAL YEARS.—For pur-  
18 poses of this subtitle, the appropriation authorized  
19 for State plans under this subtitle for each fiscal  
20 year after fiscal year 2004 is the appropriation au-  
21 thorized under this subsection for the preceding fis-  
22 cal year multiplied by—

23 (A) a factor (described in paragraph (3))  
24 reflecting the change in the consumer price  
25 index for the fiscal year, and

1 (B) a factor (described in paragraph (4))  
2 reflecting the change in the number of individ-  
3 uals with disabilities for the fiscal year.

4 (3) CPI INCREASE FACTOR.—For purposes of  
5 paragraph (2)(A), the factor described in this para-  
6 graph for a fiscal year is the ratio of—

7 (A) the annual average index of the con-  
8 sumer price index for the preceding fiscal year,  
9 to—

10 (B) such index, as so measured, for the  
11 second preceding fiscal year.

12 (4) DISABLED POPULATION FACTOR.—For pur-  
13 poses of paragraph (2)(B), the factor described in  
14 this paragraph for a fiscal year is 100 percent plus  
15 (or minus) the percentage increase (or decrease)  
16 change in the disabled population of the United  
17 States (as determined for purposes of the most re-  
18 cent update under subsection (b)(3)(D)).

19 (5) ADDITIONAL FUNDS DUE TO MEDICAID  
20 OFFSETS.—

21 (A) IN GENERAL.—Each participating  
22 State must provide the Secretary with informa-  
23 tion concerning offsets and reductions in the  
24 medicaid program resulting from home and  
25 community-based services provided disabled in-

1 individuals under this subtitle, that would have  
2 been paid for such individuals under the State  
3 medicaid plan but for the provision of similar  
4 services under the program under this subtitle.  
5 At the time a State first submits its plan under  
6 this subtitle and before each subsequent fiscal  
7 year (through fiscal year 2004), the State also  
8 must provide the Secretary with such budgetary  
9 information (for each fiscal year through fiscal  
10 year 2004), as the Secretary determines to be  
11 necessary to carry out this paragraph.

12 (B) REPORTS.—Each State with a pro-  
13 gram under this subtitle shall submit such re-  
14 ports to the Secretary as the Secretary may re-  
15 quire in order to monitor compliance with sub-  
16 paragraph (A). The Secretary shall specify the  
17 format of such reports and establish uniform  
18 data reporting elements.

19 (C) ADJUSTMENTS TO APPROPRIATION.—

20 (i) IN GENERAL.—For each fiscal year  
21 (beginning with fiscal year 1998 and end-  
22 ing with fiscal year 2004) and based on a  
23 review of information submitted under sub-  
24 paragraph (A), the Secretary shall deter-  
25 mine the amount by which the appropria-

1           tion authorized under subsection (a) will  
2           increase. The amount of such increase for  
3           a fiscal year shall be limited to the reduc-  
4           tion in Federal expenditures of medical as-  
5           sistance (as determined by Secretary) that  
6           would have been made under part A of  
7           title XIX for home and community based  
8           services for disabled individuals but for the  
9           provision of similar services under the pro-  
10          gram under this subtitle.

11                   (ii) ANNUAL PUBLICATION.—The Sec-  
12           retary shall publish before the beginning of  
13           such fiscal year, the revised appropriation  
14           authorized under this subsection for such  
15           fiscal year.

16                   (D) CONSTRUCTION.—Nothing in this sub-  
17           section shall be construed as requiring States to  
18           determine eligibility for medical assistance  
19           under the State medicaid plan on behalf of indi-  
20           viduals receiving assistance under this subtitle.

21           (b) ALLOTMENTS TO STATES.—

22                   (1) IN GENERAL.—The Secretary shall allot the  
23           amounts available under the appropriation author-  
24           ized for the fiscal year (specified in subsection (a))  
25           to the States with plans approved under this subtitle

1 in accordance with an allocation formula developed  
2 by the Secretary which takes into account—

3 (A) the percentage of the total number of  
4 individuals with disabilities in all States that re-  
5 side in a particular State;

6 (B) the per capita costs of furnishing home  
7 and community-based services to individuals  
8 with disabilities in the State; and

9 (C) the percentage of all individuals with  
10 incomes at or below 150 percent of the official  
11 poverty line (as described in section 2105(a)(2))  
12 in all States that reside in a particular State.

13 (2) ALLOCATION FOR CLIENT ADVOCACY AC-  
14 TIVITIES.—Each State with a plan approved under  
15 this subtitle shall allocate one-half of one percent of  
16 the State's total allotment under paragraph (1) for  
17 client advocacy activities as described in section  
18 2106(c).

19 (3) NO DUPLICATE PAYMENT.—No payment  
20 may be made to a State under this section for any  
21 services provided to an individual to the extent that  
22 the State received payment for such services under  
23 section 1903(a) of the Social Security Act.

24 (4) REALLOCATIONS.—Any amounts allotted to  
25 States under this subsection for a year that are not

1       expended in such year shall remain available for  
2       State programs under this subtitle and may be re-  
3       allocated to States as the Secretary determines ap-  
4       propriate.

5       (c) STATE ENTITLEMENT.—This subtitle constitutes  
6       budget authority in advance of appropriations Acts, and  
7       represents the obligation of the Federal Government to  
8       provide for the payment to States of amounts described  
9       in subsection (a).

10   **SEC. 2110. FEDERAL EVALUATIONS.**

11       (a) IN GENERAL.—Not later than December 31,  
12       2003, December 31, 2006, and each December 31 there-  
13       after, the Secretary shall provide to Congress analytical  
14       reports that evaluate—

15               (1) the extent to which individuals with low in-  
16       comes and disabilities are equitably served;

17               (2) the adequacy and equity of service plans to  
18       individuals with similar levels of disability across  
19       States;

20               (3) the comparability of program participation  
21       across States, described by level and type of dis-  
22       ability; and

23               (4) the ability of service providers to sufficiently  
24       meet the demand for services.

1 (b) GERIATRIC ASSESSMENTS.—Not later than 18  
 2 months after the date of enactment of this part, the Sec-  
 3 retary shall report to Congress concerning the feasibility  
 4 of providing reimbursement under health plans and other  
 5 payers of health services for full geriatric assessment,  
 6 when recommended by a physician.

7 **PART 2—GRANTS RELATING TO THE DEVELOP-**  
 8 **MENT OF HOSPITAL LINKAGE PROGRAMS**

9 **SEC. 2111. INFORMATION AND TECHNICAL ASSISTANCE**  
 10 **GRANTS RELATING TO DEVELOPMENT OF**  
 11 **HOSPITAL LINKAGE PROGRAMS.**

12 (a) FINDINGS.—Congress finds that—

13 (1) demonstration programs and projects have  
 14 been developed to offer care management to hos-  
 15 pitalized individuals awaiting discharge who are in  
 16 need of long-term health care services that meet in-  
 17 dividual needs and preferences in home and commu-  
 18 nity-based settings as an alternative to long-term  
 19 nursing home care or institutional placement; and

20 (2) there is a need to disseminate information  
 21 and technical assistance to hospitals and State and  
 22 local community organizations regarding such pro-  
 23 grams and projects and to provide incentive grants  
 24 to State and local public and private agencies, in-  
 25 cluding area agencies on aging, to establish and ex-

1       pand programs that offer care management to indi-  
2       viduals awaiting discharge from acute care hospitals  
3       who are in need of long-term care so that services  
4       to meet individual needs and preferences can be ar-  
5       ranged in home and community-based settings as an  
6       alternative to long-term placement in nursing homes  
7       or other institutional settings.

8       (b) DISSEMINATION OF INFORMATION, TECHNICAL  
9       ASSISTANCE, AND INCENTIVE GRANTS TO ASSIST IN THE  
10       DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.—  
11       Part C of title III of the Public Health Service Act (42  
12       U.S.C. 248 et seq.) is amended by adding at the end there-  
13       of the following new section:

14       **“SEC. 327B. DISSEMINATION OF INFORMATION, TECHNICAL**  
15                       **ASSISTANCE AND INCENTIVE GRANTS TO AS-**  
16                       **SIST IN THE DEVELOPMENT OF HOSPITAL**  
17                       **LINKAGE PROGRAMS.**

18       “(a) DISSEMINATION OF INFORMATION.—The Sec-  
19       retary shall compile, evaluate, publish and disseminate to  
20       appropriate State and local officials and to private organi-  
21       zations and agencies that provide services to individuals  
22       in need of long-term health care services, such information  
23       and materials as may assist such entities in replicating  
24       successful programs that are aimed at offering care man-  
25       agement to hospitalized individuals who are in need of

1 long-term care so that services to meet individual needs  
2 and preferences can be arranged in home and community-  
3 based settings as an alternative to long-term nursing home  
4 placement. The Secretary may provide technical assistance  
5 to entities seeking to replicate such programs.

6       “(b) INCENTIVE GRANTS TO ASSIST IN THE DEVEL-  
7 OPMENT OF HOSPITAL LINKAGE PROGRAMS.—The Sec-  
8 retary shall establish a program under which incentive  
9 grants may be awarded to assist private and public agen-  
10 cies, including area agencies on aging, and organizations  
11 in developing and expanding programs and projects that  
12 facilitate the discharge of individuals in hospitals or other  
13 acute care facilities who are in need of long-term care serv-  
14 ices and placement of such individuals into home and com-  
15 munity-based settings.

16       “(c) ADMINISTRATIVE PROVISIONS.—

17               “(1) ELIGIBLE ENTITIES.—To be eligible to re-  
18 ceive a grant under subsection (b) an entity shall  
19 be—

20                       “(A)(i) a State agency as defined in sec-  
21 tion 102(43) of the Older Americans Act of  
22 1965; or

23                       “(ii) a State agency responsible for admin-  
24 istering home and community care programs  
25 under title XIX of the Social Security Act; or

1           “(B) if no State agency described in sub-  
2 paragraph (A) applies with respect to a par-  
3 ticular State, a public or nonprofit private enti-  
4 ty.

5           “(2) APPLICATIONS.—To be eligible to receive  
6 an incentive grant under subsection (b), an entity  
7 shall prepare and submit to the Secretary an appli-  
8 cation at such time, in such manner and containing  
9 such information as the Secretary may require, in-  
10 cluding—

11           “(A) an assessment of the need within the  
12 community to be served for the establishment  
13 or expansion of a program to facilitate the dis-  
14 charge of individuals in need of long-term care  
15 who are in hospitals or other acute care facili-  
16 ties into home and community-care programs  
17 that provide individually planned, flexible serv-  
18 ices that reflect individual choice or preference  
19 rather than nursing home or institutional set-  
20 tings;

21           “(B) a plan for establishing or expanding  
22 a program for identifying individuals in hospital  
23 or acute care facilities who are in need of indi-  
24 vidualized long-term care provided in home and  
25 community-based settings rather than nursing

1 homes or other institutional settings and under-  
2 taking the planning and management of indi-  
3 vidualized care plans to facilitate discharge into  
4 such settings;

5 “(C) assurances that nongovernmental  
6 case management agencies funded under grants  
7 awarded under this section are not direct pro-  
8 viders of home and community-based services;

9 “(D) satisfactory assurances that adequate  
10 home and community-based long term care  
11 services are available, or will be made available,  
12 within the community to be served so that indi-  
13 viduals being discharged from hospitals or acute  
14 care facilities under the proposed program can  
15 be served in such home and community-based  
16 settings, with flexible, individualized care which  
17 reflects individual choice and preference;

18 “(E) a description of the manner in which  
19 the program to be administered with amounts  
20 received under the grant will be continued after  
21 the termination of the grant for which such ap-  
22 plication is submitted; and

23 “(F) a description of any waivers or ap-  
24 provals necessary to expand the number of indi-  
25 viduals served in federally funded home and

1 community-based long term care programs in  
2 order to provide satisfactory assurances that  
3 adequate home and community-based long term  
4 care services are available in the community to  
5 be served.

6 “(3) AWARDING OF GRANTS.—

7 “(A) PREFERENCES.—In awarding grants  
8 under subsection (b), the Secretary shall give  
9 preference to entities submitting applications  
10 that—

11 “(i) demonstrate an ability to coordi-  
12 nate activities funded using amounts re-  
13 ceived under the grant with programs pro-  
14 viding individualized home and community-  
15 based case management and services to in-  
16 dividuals in need of long term care with  
17 hospital discharge planning programs; and

18 “(ii) demonstrate that adequate home  
19 and community-based long term care man-  
20 agement and services are available, or will  
21 be made available to individuals being  
22 served under the program funded with  
23 amounts received under subsection (b).

1           “(B) DISTRIBUTION.—In awarding grants  
2           under subsection (b), the Secretary shall ensure  
3           that such grants—

4                   “(i) are equitably distributed on a ge-  
5                   ographic basis;

6                   “(ii) include projects operating in  
7                   urban areas and projects operating in rural  
8                   areas; and

9                   “(iii) are awarded for the expansion of  
10                  existing hospital linkage programs as well  
11                  as the establishment of new programs.

12           “(C) EXPEDITED CONSIDERATION.—The  
13           Secretary shall provide for the expedited consid-  
14           eration of any waiver application that is nec-  
15           essary under title XIX of the Social Security  
16           Act to enable an applicant for a grant under  
17           subsection (b) to satisfy the assurance required  
18           under paragraph (1)(D).

19           “(4) USE OF GRANTS.—An entity that receives  
20           amounts under a grant under subsection (b) may  
21           use such amounts for planning, development and  
22           evaluation services and to provide reimbursements  
23           for the costs of one or more case managers to be lo-  
24           cated in or assigned to selected hospitals who  
25           would—

1           “(A) identify patients in need of individ-  
2           ualized care in home and community-based  
3           long-term care;

4           “(B) assess and develop care plans in co-  
5           operation with the hospital discharge planning  
6           staff; and

7           “(C) arrange for the provision of commu-  
8           nity care either immediately upon discharge  
9           from the hospital or after any short term nurs-  
10          ing-home stay that is needed for recuperation  
11          or rehabilitation;

12          “(5) DIRECT SERVICES SUBJECT TO REIM-  
13          BURSEMENTS.—None of the amounts provided  
14          under a grant under this section may be used to  
15          provide direct services, other than case management,  
16          for which reimbursements are otherwise available  
17          under title XVIII or XIX of the Social Security Act.

18          “(6) LIMITATIONS.—

19                 “(A) TERM.—Grants awarded under this  
20                 section shall be for terms of less than 3 years.

21                 “(B) AMOUNT.—Grants awarded to an en-  
22                 tity under this section shall not exceed  
23                 \$300,000 per year. The Secretary may waive  
24                 the limitation under this subparagraph where  
25                 an applicant demonstrates that the number of

1 hospitals or individuals to be served under the  
2 grant justifies such increased amounts.

3 “(C) SUPPLANTING OF FUNDS.—Amounts  
4 awarded under a grant under this section may  
5 not be used to supplant existing State funds  
6 that are provided to support hospital link pro-  
7 grams.

8 “(d) EVALUATION AND REPORTS.—

9 “(1) BY GRANTEES.—An entity that receives a  
10 grant under this section shall evaluate the effective-  
11 ness of the services provided under the grant in fa-  
12 cilitating the placement of individuals being dis-  
13 charged from hospitals or acute care facilities into  
14 home and community-based long term care settings  
15 rather than nursing homes. Such entity shall pre-  
16 pare and submit to the Secretary a report containing  
17 such information and data concerning the activities  
18 funded under the grant as the Secretary determines  
19 appropriate.

20 “(2) BY SECRETARY.—Not later than the end  
21 of the third fiscal year for which funds are appro-  
22 priated under subsection (e), the Secretary shall pre-  
23 pare and submit to the appropriate committees of  
24 Congress, a report concerning the results of the eval-

1 uations and reports conducted and prepared under  
2 paragraph (1).

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
4 are authorized to be appropriated to carry out this section,  
5 \$5,000,000 for each of the fiscal years 1994 through  
6 1996.”.

7 **Subtitle C—Long-Term Care Insur-**  
8 **ance Improvement and Account-**  
9 **ability**

10 **SEC. 2200. SHORT TITLE.**

11 This subtitle may be cited as the “Long-Term Care  
12 Insurance Improvement and Accountability Act”.

13 **PART 1—PROMULGATION OF STANDARDS AND**  
14 **MODEL BENEFITS**

15 **SEC. 2201. STANDARDS.**

16 (a) APPLICATION OF STANDARDS.—

17 (1) IN GENERAL.—Except as provided in para-  
18 graph (2), the Secretary, in consultation with the  
19 NAIC, shall develop and publish specific standards  
20 to implement the standards specified in this subtitle.

21 (2) STATE STANDARDS.—Nothing in this sub-  
22 title shall be construed as preventing a participating  
23 State from applying standards that provide greater  
24 protection to insured individuals under long-term  
25 care insurance policies than the standards promul-

1 gated under this subtitle, except that such State  
2 standards may not be inconsistent with any of the  
3 standards specified in this subtitle.

4 (b) DEADLINE FOR APPLICATION OF STANDARDS.—

5 (1) IN GENERAL.—Subject to paragraph (2),  
6 the date specified in this subsection for a State is—

7 (A) the date the State adopts the stand-  
8 ards established under subsection (a)(1); or

9 (B) the date that is 1 year after the first  
10 day of the first regular legislative session that  
11 begins after the date such standards are first  
12 established under subsection (a)(2);

13 whichever is earlier.

14 (2) STATE REQUIRING LEGISLATION.—In the  
15 case of a State which the Secretary identifies, in  
16 consultation with the NAIC, as—

17 (A) requiring State legislation (other than  
18 legislation appropriating funds) in order for the  
19 standards established under subsection (a) to be  
20 applied; but

21 (B) having a legislature which is not  
22 scheduled to meet within 1 year following the  
23 beginning of the next regular legislative session  
24 in which such legislation may be considered;

1 the date specified in this subsection is the first day  
2 of the first calendar quarter beginning after the  
3 close of the first legislative session of the State legis-  
4 lature that begins on or after January 1, 1995. For  
5 purposes of the previous sentence, in the case of a  
6 State that has a 2-year legislative session, each year  
7 of such session shall be deemed to be a separate reg-  
8 ular session of the State legislature.

9 (c) ITEMS INCLUDED IN STANDARDS.—The stand-  
10 ards promulgated under subsection (a) shall include—

11 (1) minimum Federal standards for long-term  
12 care insurance consistent with the provisions of this  
13 subtitle;

14 (2) standards for the enhanced protection of  
15 consumers with long-term care insurance; and

16 (3) procedures for the modification of the  
17 standards established under paragraph (1) in a  
18 manner consistent with future laws to expand exist-  
19 ing Federal or State long-term care benefits or es-  
20 tablish a comprehensive Federal or State long-term  
21 care benefit program.

22 (d) CONSULTATION.—In establishing standards and  
23 models of benefits under this section, the Secretary shall,  
24 after consultation with representatives of carriers, con-  
25 sumer groups, and providers of long-term care services—

1           (1) recommend the appropriate inflationary  
2 index to be used with respect to the inflation protec-  
3 tion benefit portion of the standards;

4           (2) recommend the uniform needs assessment  
5 mechanism to be used in determining the eligibility  
6 of individuals for benefits under a policy;

7           (3) recommend appropriate standards for the  
8 regulation of the insurance aspects of supported  
9 housing arrangements; and

10           (4) perform such other activities as determined  
11 appropriate by the Secretary.

12 **PART 2—ESTABLISHMENT AND IMPLEMENTA-**  
13 **TION OF LONG-TERM CARE INSURANCE POL-**  
14 **ICY STANDARDS**

15 **SEC. 2211. IMPLEMENTATION OF POLICY STANDARDS.**

16 (a) IN GENERAL.—

17           (1) REGULATORY PROGRAM.—No long-term  
18 care policy (as defined in section (2221)) may be  
19 issued, sold, or offered for sale as a long-term care  
20 insurance policy in a State on or after the date spec-  
21 ified in section 2201(b) unless—

22           (A) the Secretary determines that the  
23 State has established a regulatory program  
24 that—

1 (i) provides for the application and  
2 enforcement of the standards established  
3 under section 2201(a); and

4 (ii) complies with the requirements of  
5 subsection (b);

6 by the date specified in section 2201(b), and  
7 the policy has been approved by the State com-  
8 missioner or superintendent of insurance under  
9 such program; or

10 (B) if the State has not established such a  
11 program, or if the State's regulatory program  
12 has been decertified, the policy has been cer-  
13 tified by the Secretary (in accordance with such  
14 procedures as the Secretary may establish) as  
15 meeting the standards established under section  
16 2201(a) by the date specified in section  
17 2201(b).

18 For purposes of this subsection, the advertising or  
19 soliciting with respect to a policy, directly or indi-  
20 rectly, shall be deemed the offering for sale of the  
21 policy.

22 (2) REVIEW OF STATE REGULATORY PRO-  
23 GRAMS.—The Secretary shall review regulatory pro-  
24 grams described in paragraph (1)(A) at least bian-  
25 nually to determine if they continue to provide for

1 the application and enforcement of the standards  
2 and procedures established under section 2201(a)  
3 and (b). If the Secretary determines that a State  
4 regulatory program no longer meets such standards  
5 and requirements, before making a final determina-  
6 tion, the Secretary shall provide the State an oppor-  
7 tunity to adopt such a plan of correction as would  
8 permit the program to continue to meet such stand-  
9 ards and requirements. If the Secretary makes a  
10 final determination that the State regulatory pro-  
11 gram, after such an opportunity, fails to meet such  
12 standards and requirements, the Secretary shall as-  
13 sume responsibility under paragraph (1)(B) with re-  
14 spect to certifying policies in the State and shall ex-  
15 ercise full authority under section 2201 for carriers,  
16 agents, or associations or its subsidiary in the State  
17 plans in the State.

18 (b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF  
19 STATE REGULATORY PROGRAMS.—For purposes of sub-  
20 section (a)(1)(A)(ii), the requirements of this subsection  
21 for a State regulatory program are as follows:

22 (1) ENFORCEMENT.—The enforcement under  
23 the program—

24 (A) shall be designed in a manner so as to  
25 secure compliance with the standards within 30

1 days after the date of a finding of noncompli-  
2 ance with such standards; and

3 (B) shall provide for notice in the annual  
4 report required under paragraph (5) to the Sec-  
5 retary of cases where such compliance is not se-  
6 cured within such 30-day period.

7 (2) PROCESS.—The enforcement process under  
8 each State regulatory program shall provide for—

9 (A) procedures for individuals and entities  
10 to file written, signed complaints respecting al-  
11 leged violations of the standards;

12 (B) responding to such complaints within  
13 90 days;

14 (C) the investigation of—

15 (i) those complaints which have a rea-  
16 sonable probability of validity; and

17 (ii) such other alleged violations of the  
18 standards as the program finds appro-  
19 priate; and

20 (D) the imposition of appropriate sanctions  
21 (which include, in appropriate cases, the imposi-  
22 tion of a civil money penalty as provided for in  
23 section 2218) in the case of a carrier, agent, or  
24 association or its subsidiary determined to have  
25 violated the standards.

1           (3) PRIVATE ACTIONS.—An individual may  
2 commence a civil action in an appropriate State or  
3 United States district court to enforce the provisions  
4 of this title and may be awarded appropriate relief  
5 and reasonable attorney’s fees.

6           (4) CONSUMER ACCESS TO COMPLIANCE INFOR-  
7 MATION.—

8           (A) IN GENERAL.—A State regulatory pro-  
9 gram shall provide for consumer access to com-  
10 plaints filed with the State commissioner or su-  
11 perintendent of insurance with respect to long-  
12 term care insurance policies.

13           (B) CONFIDENTIALITY.—The access pro-  
14 vided under subparagraph (A) shall be limited  
15 to the extent required to protect the confiden-  
16 tiality of the identity of individual policyholders.

17           (5) PROCESS FOR APPROVAL OF PREMIUMS.—

18           (A) IN GENERAL.—Each State regulatory  
19 program shall—

20           (i) provide for a process for approving  
21 or disapproving proposed premium in-  
22 creases or decreases with respect to long-  
23 term care insurance policies; and

24           (ii) establish a policy for receipt and  
25 consideration of public comments before

1 approving such a premium increase or de-  
2 crease.

3 (B) CONDITIONS FOR APPROVAL.—No pre-  
4 mium increase shall be approved (or deemed ap-  
5 proved) under subparagraph (A) unless the pro-  
6 posed increase is accompanied by an actuarial  
7 memorandum which—

8 (i) includes a description of the as-  
9 sumptions that justify the increase, includ-  
10 ing a financial report on expenditures;

11 (ii) contains such information as may  
12 be required under the Standards; and

13 (iii) is made available to the public.

14 (C) APPLICATION.—Except as provided in  
15 subparagraph (D), this paragraph shall not  
16 apply to a group long-term care insurance pol-  
17 icy issued to a group described in section  
18 4(E)(1) of the NAIC Long Term Care Insur-  
19 ance Model Act (effective January 1991), ex-  
20 cept that such group policy shall, pursuant to  
21 guidelines developed by the NAIC, provide no-  
22 tice to policyholders and certificate holders of  
23 any premium change under such group policy.

24 (D) EXCEPTION.—Subparagraph (C) shall  
25 not apply to—

1 (i) group conversion policies;  
2 (ii) the group continuation feature of  
3 a group policy if the insurer separately  
4 rates employee and continuation coverages;  
5 and

6 (iii) group policies where the function  
7 of the employer is limited solely to col-  
8 lecting premiums (through payroll deduc-  
9 tions or dues checkoff) and remitting them  
10 to the insurer.

11 (E) CONSTRUCTION.—Nothing in this  
12 paragraph shall be construed as preventing the  
13 Secretary, in consultation with the NAIC, from  
14 promulgating standards, or a State from enact-  
15 ing and enforcing laws, with respect to pre-  
16 mium rates or loss ratios for all, including  
17 group, long-term care insurance policies.

18 (6) ANNUAL REPORTS.—Each State regulatory  
19 program shall provide for annual reports to be sub-  
20 mitted to the Secretary on the implementation and  
21 enforcement of the standards in the State, including  
22 information concerning violations in excess of 30  
23 days.

24 (7) ACCESS TO OTHER INFORMATION.—The  
25 State regulatory program shall provide for consumer

1 access to actuarial memoranda, including financial  
2 information, provided under paragraph (4).

3 (8) DEFAULT.—In the case of a State without  
4 a regulatory program approved under subsection (a),  
5 the Secretary shall provide for the enforcement ac-  
6 tivities described in subsection (c).

7 (c) SECRETARIAL ENFORCEMENT AUTHORITY.—

8 (1) IN GENERAL.—The Secretary shall exercise  
9 authority under this section in the case of a State  
10 that does not have a regulatory program approved  
11 under this section.

12 (2) COMPLAINTS AND INVESTIGATIONS.—The  
13 Secretary shall establish procedures—

14 (A) for individuals and entities to file writ-  
15 ten, signed complaints respecting alleged viola-  
16 tions of the requirements of this subtitle;

17 (B) for responding on a timely basis to  
18 such complaints; and

19 (C) for the investigation of—

20 (i) those complaints that have a rea-  
21 sonable probability of validity; and

22 (ii) such other alleged violations of the  
23 requirements of this subtitle as the Sec-  
24 retary determines to be appropriate.

1 In conducting investigations under this subsection,  
2 agents of the Secretary shall have reasonable access  
3 necessary to enable such agents to examine evidence  
4 of any carrier, agent, or association or its subsidiary  
5 being investigated.

6 (3) HEARINGS.—

7 (A) IN GENERAL.—Prior to imposing an  
8 order described in paragraph (4) against a car-  
9 rier, agent, or association or its subsidiary  
10 under this section for a violation of the require-  
11 ments of this subtitle, the Secretary shall pro-  
12 vide the carrier, agent, association or subsidiary  
13 with notice and, upon request made within a  
14 reasonable time (of not less than 30 days, as  
15 established by the Secretary by regulation) of  
16 the date of the notice, a hearing respecting the  
17 violation.

18 (B) CONDUCT OF HEARING.—Any hearing  
19 requested under subparagraph (A) shall be con-  
20 ducted before an administrative law judge. If no  
21 hearing is so requested, the Secretary's imposi-  
22 tion of the order shall constitute a final and  
23 unappealable order.

24 (C) AUTHORITY IN HEARINGS.—In con-  
25 ducting hearings under this paragraph—

1 (i) agents of the Secretary and admin-  
2 istrative law judges shall have reasonable  
3 access necessary to enable such agents and  
4 judges to examine evidence of any carrier,  
5 agent, or association or its subsidiary  
6 being investigated; and

7 (ii) administrative law judges, may, if  
8 necessary, compel by subpoena the attend-  
9 ance of witnesses and the production of  
10 evidence at any designated place or hear-  
11 ing.

12 In case of contumacy or refusal to obey a sub-  
13 poena lawfully issued under this subparagraph  
14 and upon application of the Secretary, an ap-  
15 propriate district court of the United States  
16 may issue an order requiring compliance with  
17 such subpoena and any failure to obey such  
18 order may be punished by such court as a con-  
19 tempt thereof.

20 (D) ISSUANCE OF ORDERS.—If an admin-  
21 istrative law judge determines in a hearing  
22 under this paragraph, upon the preponderance  
23 of the evidence received, that a carrier, agent,  
24 or association or its subsidiary named in the  
25 complaint has violated the requirements of this

1 subtitle, the administrative law judge shall state  
2 the findings of fact and issue and cause to be  
3 served on such carrier, agent, association, or  
4 subsidiary an order described in paragraph (4).

5 (4) CEASE AND DESIST ORDER WITH CIVIL  
6 MONEY PENALTY.—

7 (A) IN GENERAL.—Subject to the provi-  
8 sions of subparagraphs (B) through (F), an  
9 order under this paragraph—

10 (i) shall require the agent, association  
11 or its subsidiary, or a carrier—

12 (I) to cease and desist from such  
13 violations; and

14 (II) to pay a civil penalty in an  
15 amount not to exceed \$15,000 in the  
16 case of each agent, and not to exceed  
17 \$25,000 for each association or its  
18 subsidiary or a carrier for each such  
19 violation; and

20 (ii) may require the agent, association  
21 or its subsidiary, or a carrier to take such  
22 other remedial action as is appropriate.

23 (B) CORRECTIONS WITHIN 30 DAYS.—No  
24 order shall be imposed under this paragraph by  
25 reason of any violation if the carrier, agent, or

1 association or its subsidiary establishes to the  
2 satisfaction of the Secretary that—

3 (i) such violation was due to reason-  
4 able cause and was not intentional and was  
5 not due to willful neglect; and

6 (ii) such violation is corrected within  
7 the 30-day period beginning on the earliest  
8 date the carrier, agent, association, or sub-  
9 sidiary knew, or exercising reasonable dili-  
10 gence could have known, that such a viola-  
11 tion was occurring.

12 (C) WAIVER BY SECRETARY.—In the case  
13 of a violation under this subtitle that is due to  
14 reasonable cause and not to willful neglect, the  
15 Secretary may waive part or all of the civil  
16 money penalty imposed under subparagraph  
17 (A)(i)(II) to the extent that payment of such  
18 penalty would be grossly excessive relative to  
19 the violation involved and to the need for deter-  
20 rence of violations.

21 (D) ADMINISTRATIVE APPELLATE RE-  
22 VIEW.—The decision and order of an adminis-  
23 trative law judge under this paragraph shall be-  
24 come the final agency decision and order of the  
25 Secretary unless, within 30 days, the Secretary

1 modifies or vacates the decision and order, in  
2 which case the decision and order of the Sec-  
3 retary shall become a final order under this  
4 paragraph.

5 (E) JUDICIAL REVIEW.—A carrier, agent,  
6 or association or its subsidiary or any other in-  
7 dividual adversely affected by a final order  
8 issued under this paragraph may, within 45  
9 days after the date the final order is issued, file  
10 a petition in the Court of Appeals for the ap-  
11 propriate circuit for review of the order.

12 (F) ENFORCEMENT OF ORDERS.—If a car-  
13 rier, agent, or association or its subsidiary fails  
14 to comply with a final order issued under this  
15 paragraph against the carrier, agent, associa-  
16 tion or subsidiary after opportunity for judicial  
17 review under subparagraph (E), the Secretary  
18 shall file a suit to seek compliance with the  
19 order in any appropriate district court of the  
20 United States. In any such suit, the validity  
21 and appropriateness of the final order shall not  
22 be subject to review.

23 **SEC. 2212. REGULATION OF SALES PRACTICES.**

24 (a) DUTY OF GOOD FAITH AND FAIR DEALING.—

1           (1) IN GENERAL.—Each agent (as defined in  
2           section 2233) or association that is selling or offer-  
3           ing for sale a long-term care insurance policy has  
4           the duty of good faith and fair dealing to the pur-  
5           chaser or potential purchaser of such a policy.

6           (2) POLICY REPLACEMENT FORM.—With re-  
7           spect to any individual who elects to replace or effect  
8           a change in a long-term care insurance policy, the  
9           individual that is selling such policy shall ensure  
10          that such individual completes a policy replacement  
11          form developed by the Secretary, in consultation  
12          with the NAIC. A copy of such form shall be pro-  
13          vided to such individual and additional copies shall  
14          be delivered by the selling individual to the old policy  
15          issuer and the new issuer and kept on file for inspec-  
16          tion by the State regulatory agency.

17          (3) PROHIBITED PRACTICES.—An agent or as-  
18          sociation is considered to have violated paragraph  
19          (1) if the agent or association engages in any of the  
20          following practices:

21                (A) TWISTING.—Knowingly making any  
22                misleading representation (including the inac-  
23                curate completion of medical histories) or in-  
24                complete or fraudulent comparison of any long-  
25                term care insurance policy or insurers for the

1           purpose of inducing, or tending to induce, any  
2           individual to retain or effect a change with re-  
3           spect to a long-term care insurance policy.

4           (B) HIGH PRESSURE TACTICS.—Employ-  
5           ing any method of marketing having the effect  
6           of, or intending to, induce the purchase of long-  
7           term care insurance policy through force, fright,  
8           threat or undue pressure, whether explicit or  
9           implicit.

10          (C) COLD LEAD ADVERTISING.—Making  
11          use directly or indirectly of any method of mar-  
12          keting which fails to disclose in a conspicuous  
13          manner that a purpose of the method of mar-  
14          keting is solicitation of insurance and that con-  
15          tact will be made by an insurance agent or in-  
16          surance company.

17          (D) OTHERS.—Engaging in such other  
18          practices determined inappropriate under guide-  
19          lines issued by the Secretary, in consultation  
20          with the NAIC.

21          (b) FINANCIAL NEEDS STANDARDS.—The Secretary,  
22          in consultation with the NAIC, shall develop recommended  
23          minimum financial needs standards (including both in-  
24          come and asset criteria) for the purpose of advising indi-  
25          viduals as to the costs and amounts of insurance needed

1 when considering the purchase of a long-term care insur-  
2 ance policy.

3 (c) PROHIBITION OF SALE OR ISSUANCE TO MED-  
4 ICAID BENEFICIARIES.—An agent, an association, or a  
5 carrier may not knowingly sell or issue a long-term care  
6 insurance policy to an individual who is eligible for medical  
7 assistance under title XIX of the Social Security Act.

8 (d) PROHIBITION OF SALE OR ISSUANCE OF DUPLI-  
9 CATE SERVICE BENEFIT POLICIES.—An agent, associa-  
10 tion or its subsidiary, or a carrier may not sell or issue  
11 a service-benefit long-term care insurance policy to an in-  
12 dividual—

13 (1) knowing that the policy provides for cov-  
14 erage that duplicates coverage already provided in  
15 another service-benefit long-term care insurance pol-  
16 icy held by such individual (unless the policy is in-  
17 tended to replace such other policy); or

18 (2) for the benefit of an individual unless the  
19 individual (or a representative of the individual) pro-  
20 vides a written statement to the effect that the cov-  
21 erage—

22 (A) does not duplicate other coverage in ef-  
23 fect under a service-benefit long-term care in-  
24 surance policy; or

1 (B) will replace another service-benefit  
2 long-term care insurance policy.

3 In this subsection, the term “service-benefit long-term  
4 care insurance policy” means a long-term care insurance  
5 policy which provides for benefits based on the type and  
6 amount of services furnished.

7 (e) PROHIBITION BASED ON ELIGIBILITY FOR  
8 OTHER BENEFITS.—A carrier may not sell or issue a  
9 long-term care insurance policy that reduces, limits, or co-  
10 ordinates the benefits provided under the policy on the  
11 basis that the policyholder has or is eligible for other long-  
12 term care insurance coverage or benefits.

13 (f) PROVISION OF OUTLINE OF COVERAGE.—No  
14 agent, association or its subsidiary, or carrier may sell or  
15 offer for sale a long-term care insurance policy without  
16 providing to every individual purchaser or potential pur-  
17 chaser (or representative) an outline of coverage that com-  
18 plies with the standards established under section  
19 2201(a).

20 (g) PENALTIES.—Any agent who sells, offers for sale,  
21 or issues a long-term care insurance policy in violation of  
22 this section may be imprisoned not more than 5 years,  
23 or fined in accordance with title 18, United States Code,  
24 and, in addition, is subject to a civil money penalty of not  
25 to exceed \$15,000 for each such violation. Any association

1 or its subsidiary or carrier that sells, offers for sale, or  
2 issues a long-term care insurance policy in violation of this  
3 section may be fined in accordance with title 18, United  
4 States Code, and in addition, is subject to a civil money  
5 penalty of not to exceed \$25,000 for each violation. Noth-  
6 ing in this subsection shall be construed as preempting  
7 or otherwise limiting the penalties that may be imposed  
8 by a State for conduct that violates this section.

9 (h) AGENT TRAINING AND CERTIFICATION REQUIRE-  
10 MENTS.—The Secretary, in consultation with the NAIC,  
11 shall establish requirements for long-term care insurance  
12 agent training and certification that—

13 (1) specify requirements for training insurance  
14 agents who desire to sell or offer for sale long-term  
15 care insurance policies; and

16 (2) specify procedures for certifying and recerti-  
17 fying agents who have completed such training and  
18 who are qualified to sell or offer for sale long-term  
19 care insurance policies.

20 **SEC. 2213. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.**

21 (a) REFUND OF PREMIUMS.—If an application for a  
22 long-term care insurance policy (or for a certificate under  
23 a group long-term care insurance policy) is denied or an  
24 applicant returns a policy or certificate within 30 days of  
25 the date of its issuance pursuant to subsection 2217, the

1 carrier shall, not later than 30 days after the date of the  
2 denial or return, refund directly to the applicant, or in  
3 the case of an employer to whomever remits the premium,  
4 any premiums paid with respect to such a policy (or cer-  
5 tificate). Any such refund shall not be made by delivery  
6 by the carrier.

7 (b) MAILING OF POLICY.—If an application for a  
8 long-term care insurance policy (or for a certificate under  
9 a group long-term care insurance policy) is approved, the  
10 carrier shall provide each individual applicant the policy  
11 (or certificate) of insurance and outline of coverage not  
12 later than 30 days after the date of the approval.

13 (c) INFORMATION ON DENIALS OF CLAIMS.—If a  
14 claim under a long-term care insurance policy is denied,  
15 the carrier shall, within 15 days of the date of a written  
16 request by the policyholder or certificate holder (or rep-  
17 resentative)—

18 (1) provide a written explanation of the reasons  
19 for the denial;

20 (2) make available all medical and patient  
21 records directly relating to such denial; and

22 (3) provide a written explanation of the manner  
23 in which to appeal the denial.

24 Except as provided in subsection (e) of section 2215, no  
25 claim under such a policy may be denied on the basis of

1 a failure to disclose a condition at the time of issuance  
2 of the policy if the application for the policy failed to re-  
3 quest information respecting the condition.

4 (d) REPORTING OF INFORMATION.—A carrier that  
5 issues one or more long-term care insurance policies shall  
6 periodically (not less often than annually) report, in a  
7 form and in a manner determined by the Secretary, in  
8 consultation with the NAIC, to the Commissioner, super-  
9 intendent or director of insurance of each State in which  
10 the policy is delivered, and shall make available to the Sec-  
11 retary, upon request, information in a form and manner  
12 determined by the Secretary, in consultation with the  
13 NAIC, concerning—

14 (1) the long-term care insurance policies of the  
15 carrier that are in force;

16 (2) the most recent premiums for such policies  
17 and the premiums imposed for such policies since  
18 their initial issuance;

19 (3) the lapse rate, replacement rate, and rescis-  
20 sion rates by policy;

21 (4) the names of that 10 percent of its agents  
22 that—

23 (A) have the greatest lapse and replace-  
24 ment rate; and

1           (B) have produced at least \$50,000 of  
2           long-term care insurance sales in the previous  
3           year; and

4           (5) the claims denied (expressed as a number  
5           and as a percentage of claims submitted) by policy.

6 Information required under this subsection shall be re-  
7 ported in a format specified in the standards established  
8 under section 2201(a). For purposes of paragraph (3),  
9 there shall be included (but reported separately) data con-  
10 cerning lapses due to the death of the policyholder. For  
11 purposes of paragraph (4), there shall not be included as  
12 a claim any claim that is denied solely because of the fail-  
13 ure to meet a deductible, waiting period, or exclusionary  
14 period.

15       (e) STANDARDS ON COMPENSATION FOR SALE OF  
16 POLICIES.—

17           (1) IN GENERAL.—Until the Secretary, in con-  
18 sultation with the NAIC, promulgates mandatory  
19 standards concerning compensation for the sale of  
20 long-term care policies, a carrier that issues one or  
21 more long-term care insurance policies may provide  
22 a commission or other compensation to an agent or  
23 other representative for the sale of such a policy only  
24 if the first year commission or other first year com-  
25 pensation to be paid does not exceed—

1           (A) 200 percent of the commission or  
2           other compensation paid for selling or servicing  
3           the policy in the second year, or

4           (B) 50 percent of the premium paid on the  
5           first year policy.

6           (2) SUBSEQUENT YEARS.—The commission or  
7           other compensation provided for the sale of long-  
8           term care policies to an individual during each of the  
9           years during the 5-year period subsequent to the  
10          first year of the policy shall be the same as that pro-  
11          vided in the second subsequent year.

12          (3) LIMITATION.—No carrier shall provide com-  
13          pensation to its agents for the sale of a long-term  
14          care policy which replaces an existing policy, and no  
15          agent shall receive compensation for such sale great-  
16          er than the renewal compensation payable by the re-  
17          placing carrier on renewal policies.

18          (4) COMPENSATION DEFINED.—As used in this  
19          subsection, the term “compensation” includes pecu-  
20          niary or nonpecuniary remuneration of any kind re-  
21          lating to the sale or renewal of the policy, including,  
22          but not limited to, deferred compensation, bonuses,  
23          gifts, prizes, awards, and finders fees.

1 **SEC. 2214. RENEWABILITY STANDARDS FOR ISSUANCE, AND**  
2 **BASIS FOR CANCELLATION OF POLICIES.**

3 (a) IN GENERAL.—No long-term care insurance pol-  
4 icy may be canceled or nonrenewed for any reason other  
5 than nonpayment of premium, material misrepresentation,  
6 or fraud.

7 (b) CONTINUATION AND CONVERSION RIGHTS FOR  
8 GROUP POLICIES.—

9 (1) IN GENERAL.—Each group long-term care  
10 insurance policy shall provide covered individuals  
11 with a basis for continuation or conversion in ac-  
12 cordance with this subsection.

13 (2) BASIS FOR CONTINUATION.—For purposes  
14 of paragraph (1), a policy provides a basis for con-  
15 tinuation of coverage if the policy maintains cov-  
16 erage under the existing group policy when such cov-  
17 erage would otherwise terminate and which is sub-  
18 ject only to the continued timely payment of pre-  
19 miums when due. A group policy which restricts pro-  
20 vision of benefits and services to, or contains incen-  
21 tives to use certain providers or facility, may provide  
22 continuation benefits which are substantially equiva-  
23 lent to the benefits of the existing group policy.

24 (3) BASIS FOR CONVERSION.—For purposes of  
25 paragraph (1), a policy provides a basis for conver-

1 sion of coverage if the policy entitles each indi-  
2 vidual—

3 (A) whose coverage under the group policy  
4 would otherwise be terminated for any reason;  
5 and

6 (B) who has been continuously insured  
7 under the policy (or group policy which was re-  
8 placed) for at least 6 months before the date of  
9 the termination;

10 to issuance of a policy providing benefits not less  
11 than, substantially equivalent to, or in excess of,  
12 those of the policy being terminated, without evi-  
13 dence of insurability.

14 (4) TREATMENT OF SUBSTANTIAL EQUIVA-  
15 LENCE.—In determining under this subsection  
16 whether benefits are substantially equivalent, consid-  
17 eration should be given to the difference between  
18 managed care and non-managed care plans.

19 (5) GROUP REPLACEMENT OF POLICIES.—If a  
20 group long-term care insurance policy is replaced by  
21 another long-term care insurance policy purchased  
22 by the same policyholder, the succeeding issuer shall  
23 offer coverage to all individuals covered under the  
24 old group policy on its date of termination. Coverage  
25 under the new group policy shall not result in any

1 exclusion for preexisting conditions that would have  
2 been covered under the group policy being replaced.

3 (c) STANDARDS FOR ISSUANCE.—

4 (1) IN GENERAL.—

5 (A) GUARANTEE.—An agent, association  
6 or carrier that sells or issues long-term care in-  
7 surance policies shall guarantee that such poli-  
8 cies shall be sold or issued to an individual, or  
9 eligible individual in the case of a group plan,  
10 if such individual meets the minimum medical  
11 underwriting requirements of such policy.

12 (B) PREMIUM FOR CONVERTED POLICY.—

13 If a group policy from which conversion is made  
14 is a replacement for a previous group policy,  
15 the premium for the converted policy shall be  
16 calculated on the basis of the insured's age at  
17 the inception of coverage under the group policy  
18 from which conversion is made. Where the  
19 group policy from which conversion is made re-  
20 placed previous group coverage, the premium  
21 for the converted policy shall be calculated on  
22 the basis of the insured's age at inception of  
23 coverage under the group policy replaced.

24 (2) UPGRADE FOR CURRENT POLICIES.—The  
25 Secretary, in consultation with the NAIC, shall es-

1       tabish standards, including those providing guid-  
2       ance on medical underwriting and age rating, with  
3       respect to the access of individuals to policies offer-  
4       ing upgraded benefits.

5           (3) RATE STABILIZATION.—The Secretary, in  
6       consultation with the NAIC, shall establish stand-  
7       ards for premium rate stabilization.

8       (d) EFFECT OF INCAPACITATION.—

9           (1) IN GENERAL.—

10           (A) PROHIBITION.—Except as provided in  
11       paragraph (2), a long-term care insurance pol-  
12       icy in effect as of the effective date of the  
13       standards established under section 2201(a)  
14       may not be canceled for nonpayment if the pol-  
15       icy holder is determined by a long-term care  
16       provider, physician, or other health care pro-  
17       vider (independent of the issuer of the policy),  
18       to be cognitively or mentally incapacitated so as  
19       to not make payments in a timely manner.

20           (B) REINSTATEMENT.—A long-term care  
21       policy shall include a provision that provides for  
22       the reinstatement of such coverage, in the event  
23       of lapse, if the insurer is provided with proof of  
24       cognitive or mental incapacitation. Such rein-  
25       statement option shall remain available for a

1 period of not less than 5 months after termi-  
2 nation and shall allow for the collection of past  
3 due premium.

4 (2) PERMITTED CANCELLATION.—A long-term  
5 care insurance policy may be canceled under para-  
6 graph (1) for nonpayment if—

7 (A) the period of such nonpayment is in  
8 excess of 30 days; and

9 (B) notice of intent to cancel is provided to  
10 the policyholder or designated representative of  
11 the policy holder not less than 30 days prior to  
12 such cancellation, except that notice may not be  
13 provided until the expiration of 30 days after a  
14 premium is due and unpaid.

15 Notice under this paragraph shall be deemed to have  
16 been given as of 5 days after the mailing date.

17 **SEC. 2215. BENEFIT STANDARDS.**

18 (a) USE OF STANDARD DEFINITIONS AND TERMI-  
19 NOLOGY, UNIFORM FORMAT, AND STANDARD BENE-  
20 FITS.—Pursuant to standards established under section  
21 2201(a), each long-term care insurance policy shall, with  
22 respect to services, providers or facilities—

23 (1) use uniform language and definitions, ex-  
24 cept that such language and definitions may take  
25 into account the differences between States with re-

1       spect to definitions and terminology used for long-  
2       term care services and providers; and

3           (2) use a uniform format for presenting the  
4       outline of coverage under such a policy;  
5 as prescribed under guidelines issued by the Secretary, in  
6 consultation with the NAIC, and periodically updated.

7       (b) DISCLOSURE.—

8           (1) OUTLINE OF COVERAGE.—

9           (A) REQUIREMENT.—Each carrier that  
10       sells or offers for sale a long-term care insur-  
11       ance policy shall provide an outline of coverage  
12       to each individual policyholder under such pol-  
13       icy that meets the applicable standards estab-  
14       lished pursuant to section 2201(a), complies  
15       with the requirements of subparagraph (B), and  
16       is in a uniform format as prescribed in guide-  
17       lines issued by the Secretary, in consultation  
18       with the NAIC, and periodically updated.

19           (B) CONTENTS.—The outline of coverage  
20       for each long-term care policy shall substan-  
21       tially and accurately reflect the contents of the  
22       policy or the master policy and shall include at  
23       least the following:

24           (i) A description of the benefits and  
25       coverage under the policy.

1           (ii) A statement of the exclusions, re-  
2           ductions, and limitations contained in the  
3           policy.

4           (iii) A statement of the terms under  
5           which the policy (or certificate) may be  
6           continued in force or discontinued, the  
7           terms for continuation or conversion, and  
8           any reservation in the policy of a right to  
9           change premiums.

10          (iv) Consumer protection information,  
11          including the manner in which to file a  
12          claim and to register complaints.

13          (v) A statement, in bold face type on  
14          the face of the document in language that  
15          is understandable to an average individual,  
16          that the outline of coverage is a summary  
17          only and not a contract of insurance, and  
18          that the policy (or master policy) contains  
19          the contractual provisions that govern.

20          (vi) A description of the terms, speci-  
21          fied in section 2217, under which a policy  
22          or certificate may be returned and pre-  
23          mium refunded.

24          (vii) Information on—

1 (I) national average costs for  
2 nursing facility and home health care  
3 and information (in graph form) on  
4 the relationship of the value of the  
5 benefits provided under the policy to  
6 such national average costs and State  
7 average costs; and

8 (II) other public and private  
9 long-term care insurance products and  
10 long-term care programs where made  
11 available by the Federal Government  
12 or by a State government.

13 (viii) A statement of the percentage  
14 limit on annual premium increases that is  
15 provided under the policy pursuant to this  
16 section.

17 (2) CERTIFICATES.—A certificate issued pursu-  
18 ant to a group long-term care insurance policy shall  
19 include—

20 (A) a description of the principal benefits  
21 and coverage provided in the policy;

22 (B) a statement of the principal exclusions,  
23 reductions, and limitations contained in the pol-  
24 icy; and

1 (C) a statement that the group master pol-  
2 icy determines governing contractual provisions.

3 (3) LONG-TERM CARE AS PART OF LIFE INSUR-  
4 ANCE.—In the case of a long-term care insurance  
5 policy issued as a part of, or a rider on, a life insur-  
6 ance policy, at the time of policy delivery there shall  
7 be provided a policy summary that includes—

8 (A) an explanation of how the long-term  
9 care benefits interact with other components of  
10 the policy (including deductions from death  
11 benefits);

12 (B) an illustration of the amount of bene-  
13 fits, the length of benefits, and the guaranteed  
14 lifetime benefits (if any) for each covered indi-  
15 vidual; and

16 (C) any exclusions, reductions, and limita-  
17 tions on benefits of long-term care.

18 (4) ADDITIONAL INFORMATION.—The Sec-  
19 retary, in consultation with the NAIC shall develop  
20 recommendations with respect to informing con-  
21 sumers of the long-term economic viability of car-  
22 riers issuing long-term care insurance policies.

23 (c) LIMITING CONDITIONS ON BENEFITS; MINIMUM  
24 BENEFITS.—

1           (1) IN GENERAL.—A long-term care insurance  
2 policy may not condition or limit eligibility—

3           (A) for benefits for a type of services to  
4 the need for or receipt of any other services;

5           (B) for any benefit on the medical neces-  
6 sity for such benefit;

7           (C) for benefits furnished by licensed or  
8 certified providers in compliance with conditions  
9 which are in addition to those required for li-  
10 censure or certification under State law, or if  
11 no State licensure or certification laws exists,  
12 developed by the Secretary, in consultation with  
13 the NAIC; or

14           (D) for residential care (if covered under  
15 the policy) only—

16           (i) to care provided in facilities which  
17 provide a higher level of care; or

18           (ii) to care provided in facilities which  
19 provide for 24-hour or other nursing care  
20 not required in order to be licensed by the  
21 State.

22           (2) HOME HEALTH CARE OR COMMUNITY-  
23 BASED SERVICES.—If a long-term care insurance  
24 policy provides benefits for the payment of specified

1 home health care or community-based services, the  
2 policy—

3 (A) may not limit such benefits to services  
4 provided by registered nurses or licensed prac-  
5 tical nurses;

6 (B) may not require benefits for such serv-  
7 ices to be provided by a nurse or therapist that  
8 can be provided by a home health aide or a  
9 home care worker who is licensed or certified  
10 under State licensure or certification laws, or if  
11 no such laws exist, who is in compliance with  
12 qualifications developed by the Secretary, in  
13 consultation with the NAIC;

14 (C) may not limit such benefits to services  
15 provided by agencies or providers certified  
16 under title XVIII of the Social Security Act;  
17 and

18 (D) shall provide, at a minimum—

19 (i) benefits for personal care services  
20 (including home health aide and home care  
21 worker services as defined by the Sec-  
22 retary, in consultation with the NAIC),  
23 home health services, adult day care, and  
24 respite care in an individual's home or in  
25 another setting in the community; or

1 (ii) any of such benefits on a respite  
2 care basis.

3 (3) NURSING FACILITY SERVICES.—If a long-  
4 term care policy provides benefits for the payment of  
5 specified nursing facility services, the policy shall  
6 provide such benefits with respect to all nursing fa-  
7 cilities in the State. Except as provided by the Sec-  
8 retary, in consultation with the NAIC, under uni-  
9 form language and definitions established under sec-  
10 tion 2215(a)(1)), the term ‘nursing facilities’ has the  
11 meaning given such term by section 1919(a) of the  
12 Social Security Act.

13 (4) PER DIEM POLICIES.—

14 (A) DEFINITION.—For purposes of this  
15 subtitle, the term “per diem long-term care in-  
16 surance policy” means a long-term care insur-  
17 ance policy (or certificate under a group long-  
18 term care insurance policy) that provides for  
19 benefit payments on a periodic basis due to cog-  
20 nitive impairment or loss of functional capacity  
21 without regard to the expenses incurred or serv-  
22 ices rendered during the period to which the  
23 payments relate.

24 (B) LIMITATION.—No per diem long-term  
25 care insurance policy (or certificate) may condi-

1           tion, limit or otherwise exclude benefit pay-  
2           ments based on the receipt of any type services  
3           from any type providers of long-term care serv-  
4           ice providers.

5           (d) PROHIBITION OF DISCRIMINATION.—A long-term  
6 care insurance policy may not, with respect to benefits  
7 under the policy, treat an individual with Alzheimer’s dis-  
8 ease, with any related progressive degenerative dementia  
9 of an organic origin, with any organic or inorganic mental  
10 illness, or with mental retardation or any other cognitive  
11 or mental impairment, differently from an individual hav-  
12 ing a functional impairment for which such benefits may  
13 be made available.

14           (e) LIMITATION ON USE OF PREEXISTING CONDI-  
15 TION LIMITS.—

16           (1) INITIAL ISSUANCE.—

17           (A) IN GENERAL.—Subject to subpara-  
18 graph (B), a long-term care insurance policy  
19 may not exclude or condition benefits based on  
20 a medical condition for which the policyholder  
21 received treatment or was otherwise diagnosed  
22 before the issuance of the policy.

23           (B) 6-MONTH LIMIT.—A long-term care  
24 policy or certificate issued under this subtitle  
25 may impose a limitation or exclusion of benefits

1 relating to treatment of a condition based on  
2 the fact that the condition preexisted the effective  
3 date of the policy or certificate with respect  
4 to an individual if—

5 (i) a condition that was diagnosed or  
6 treated during the 6-month period ending  
7 on the day before the first date of coverage  
8 under the policy or certificate; and

9 (ii) the limitation or exclusion extends  
10 for a period not more than 6 months after  
11 the date of coverage under the policy or  
12 certificate.

13 (2) REPLACEMENT POLICIES.—If a long-term  
14 care insurance policy replaces another long-term  
15 care insurance policy, the issuer of the replacing policy  
16 shall waive any time periods applicable to pre-  
17 existing conditions, waiting periods, elimination periods,  
18 and probationary periods in the new policy for  
19 similar benefits to the extent such time was spent  
20 under the original policy.

21 (f) ELIGIBILITY FOR BENEFITS.—

22 (1) LONG-TERM CARE POLICIES.—Each long-  
23 term care insurance policy shall—

24 (A) describe the level of benefits available  
25 under the policy; and

1           (B) specify in clear, understandable terms,  
2           the level (or levels) of physical, cognitive, or  
3           mental impairment required in order to receive  
4           benefits under the policy.

5           (2) FUNCTIONAL ASSESSMENT.—In order to  
6           submit a claim under any long-term care insurance  
7           policy, each claimant shall have a professional func-  
8           tional assessment of his or her functional or cog-  
9           nitive abilities. Such initial assessment shall be con-  
10          ducted by an individual or entity, meeting the quali-  
11          fications established by the Secretary, in consulta-  
12          tion with the NAIC, to assure the professional com-  
13          petence and credibility of such individual or entity  
14          and that such individual meets any applicable State  
15          licensure and certification requirements. The indi-  
16          vidual or entity conducting such assessment may not  
17          control, or be controlled by, the issuer of the policy.

18          (3) CLAIMS REVIEW.—Except as provided in  
19          paragraph (4), each long-term care insurance policy  
20          shall be subject to final claims review by the carrier  
21          pursuant to the terms of the long-term care insur-  
22          ance policy.

23          (4) APPEALS PROCESS.—

24                 (A) IN GENERAL.—Each long-term care in-  
25                 surance policy shall provide for a timely and

1 independent appeals process, meeting standards  
2 established by the Secretary, in consultation  
3 with the NAIC, for individuals who dispute the  
4 results of the claims review conducted under  
5 paragraph (3) or the policyholder's functional  
6 assessment conducted under paragraph (2).

7 (B) INDEPENDENT ASSESSMENT.—An ap-  
8 peals process under this paragraph shall in-  
9 clude, at the request of the claimant, an inde-  
10 pendent assessment of the claimant's functional  
11 or cognitive abilities.

12 (C) CONDUCT.—An independent assess-  
13 ment under subparagraph (B) shall be con-  
14 ducted by an individual or entity meeting the  
15 qualifications established by the Secretary, in  
16 consultation with the NAIC, to assure the pro-  
17 fessional competence and credibility of such in-  
18 dividual or entity and any applicable State li-  
19 censure and certification requirements and may  
20 not be conducted—

21 (i) by an individual who has a direct  
22 or indirect significant or controlling inter-  
23 est in, or direct affiliation or relationship  
24 with, the issuer of the policy;

1                   (ii) by an entity that provides services  
2                   to the policyholder or certificate holder for  
3                   which benefits are available under the  
4                   long-term care insurance policy; or

5                   (iii) by an individual or entity in con-  
6                   trol of, or controlled by, the issuer of the  
7                   policy.

8                   (5) STANDARD ASSESSMENTS.—Not later than  
9                   2 years after the date of enactment of this subtitle,  
10                  the advisory committee established under section  
11                  2201(d) shall recommend uniform needs assessment  
12                  mechanisms for the determination of eligibility for  
13                  benefits under such assessments.

14                  (6) CONTROL DEFINED.—For purposes of para-  
15                  graphs (2) and (4), the term “control” means the  
16                  direct or indirect possession of the power to direct  
17                  the management and policies of a person. Control is  
18                  presumed to exist, if any person directly or indi-  
19                  rectly, owns, controls, holds with the power to vote,  
20                  or holds proxies representing at least 10 percent of  
21                  the voting securities of another person.

22                  (g) INFLATION PROTECTION.—

23                  (1) OPTION TO PURCHASE.—A carrier may not  
24                  offer a long-term care insurance policy unless the  
25                  carrier also offers to the proposed policyholder, in-

1 including each group policyholder, the option to pur-  
2 chase a long-term care insurance policy that pro-  
3 vides for increases in benefit levels, with benefit  
4 maximums or reasonable durations that are mean-  
5 ingful, to account for reasonably anticipated in-  
6 creases in the costs of long-term care services cov-  
7 ered by the policy. A carrier may not offer to a pol-  
8 icyholder an inflation protection feature that is less  
9 favorable to the policyholder than one of the fol-  
10 lowing:

11 (A) With respect to policies that provide  
12 for automatic periodic increases in benefits, the  
13 policy provides for an annual increase in bene-  
14 fits in a manner so that such increases are  
15 computed annually at a rate of not less than 5  
16 percent.

17 (B) With respect to policies that provide  
18 for periodic opportunities to elect an increase in  
19 benefits, the policy guarantees that the insured  
20 individual will have the right to periodically in-  
21 crease the benefit levels under the policy with-  
22 out providing evidence of insurability or health  
23 status so long as the option for the previous pe-  
24 riod was not declined. The amount of any such

1 additional benefit may not be less than the dif-  
2 ference between—

- 3 (i) the existing policy benefit; and  
4 (ii) such existing benefit compounded  
5 annually at a rate of at least 5 percent for  
6 the period beginning on the date on which  
7 the existing benefit is purchased and ex-  
8 tending until the year in which the offer of  
9 increase is made.

10 (C) With respect to service benefit policies,  
11 the policy covers a specified percentage of the  
12 actual or reasonable charges and does not in-  
13 clude a maximum specified indemnity amount  
14 or limit.

15 (2) EXCEPTION.—The requirements of para-  
16 graph (1) shall not apply to life insurance policies or  
17 riders containing accelerated long-term care benefits.

18 (3) REQUIRED INFORMATION.—Carriers shall  
19 include the following information in or together with  
20 the outline of coverage provided under this subtitle:

21 (A) A comparison (shown as a graph) of  
22 the benefit levels of a policy that increases ben-  
23 efits over the policy period with a policy that  
24 does not increase benefits. Such comparison

1 shall show benefit levels over not less than a  
2 20-year period.

3 (B) Any expected premium increases or  
4 additional premiums required to pay for any  
5 automatic or optional benefit increases, whether  
6 the individual who purchases the policy obtains  
7 the inflation protection initially or whether such  
8 individual delays purchasing such protection  
9 until a future time.

10 (4) CONTINUATION OF PROTECTION.—Benefit  
11 increases under a policy described in paragraph (1)  
12 shall continue without regard to an insured's age,  
13 claim status or claim history, or the length of time  
14 the individual has been insured under the policy.

15 (5) CONSTANT PREMIUM.—A policy described  
16 in paragraph (1) that provides for automatic benefit  
17 increases shall include an offer of a premium that  
18 the carrier expects to remain constant. Such offer  
19 shall disclose in a conspicuous manner that the pre-  
20 mium may change in the future unless the premium  
21 is guaranteed to remain constant.

22 (6) REJECTION.—Inflation protection under  
23 this subsection shall be included in a long-term care  
24 insurance policy unless a carrier obtains a written

1 rejection of such protection signed by the policy-  
2 holder.

3 **SEC. 2216. NONFORFEITURE.**

4 (a) IN GENERAL.—Each long-term care insurance  
5 policy (or certificate) shall provide that if the policy lapses  
6 after the policy has been in effect for a minimum period  
7 (specified under the standards under section 2201(a)), the  
8 policy will provide, without payment of any additional pre-  
9 miums, nonforfeiture benefits as determined appropriate  
10 by the Secretary, in consultation with the NAIC.

11 (b) ESTABLISHMENT OF STANDARDS.—The stand-  
12 ards under section 2201(a) shall provide that the percent-  
13 age or amount of benefits under subsection (a) shall in-  
14 crease based upon the policyholder's equity in the policy.

15 **SEC. 2217. LIMIT OF PERIOD OF CONTESTABILITY AND**  
16 **RIGHT TO RETURN.**

17 (a) CONTESTABILITY.—A carrier may not cancel or  
18 renew a long-term care insurance policy or deny a claim  
19 under the policy based on fraud or intentional misrepre-  
20 sentation relating to the issuance of the policy unless no-  
21 tice of such fraud or misrepresentation is provided within  
22 a time period to be determined by the Secretary, in con-  
23 sultation with the NAIC.

24 (b) RIGHT TO RETURN.—Each applicant for a long-  
25 term care insurance policy shall have the right to return

1 the policy (or certificates) within 30 days of the date of  
2 its delivery (and to have the premium refunded) if, after  
3 examination of the policy or certificate, the applicant is  
4 not satisfied for any reason.

5 **SEC. 2218. CIVIL MONEY PENALTY.**

6 (a) CARRIER.—Any carrier, association or its sub-  
7 sidiary that sells or offers for sale a long-term care insur-  
8 ance policy and that—

9 (1) fails to make a refund in accordance with  
10 section 2213(a);

11 (2) fails to transmit a policy in accordance with  
12 section 2213(b);

13 (3) fails to provide, make available, or report  
14 information in accordance with subsections (c) or (d)  
15 of section 2213;

16 (4) provides a commission or compensation in  
17 violation of section 2213(e);

18 (5) fails to provide an outline of coverage in  
19 violation of section 2215(b)(1); or

20 (6) issues a policy without obtaining certain in-  
21 formation in violation of section 2215(f);

22 is subject to a civil money penalty of not to exceed \$25,000  
23 for each such violation.

24 (b) AGENTS.—Any agent that sells or offers for sale  
25 a long-term care insurance policy and that—

1 (1) fails to make a refund in accordance with  
2 section 2213(a);

3 (2) fails to transmit a policy in accordance with  
4 section 2213(b);

5 (3) fails to provide, make available, or report  
6 information in accordance with subsections (c) or (d)  
7 of section 2213;

8 (4) fails to provide an outline of coverage in  
9 violation of section 2215(b)(1); or

10 (5) issues a policy without obtaining certain in-  
11 formation in violation of section 2215(f);

12 is subject to a civil money penalty of not to exceed \$15,000  
13 for each such violation.

14 (c) EFFECT ON STATE LAW.—Nothing in this section  
15 shall be construed as preempting or otherwise limiting the  
16 penalties that may be imposed by a State for the types  
17 of conduct described in this section.

### 18 **PART 3—LONG-TERM CARE INSURANCE**

#### 19 **POLICIES, DEFINITION AND ENDORSEMENTS**

##### 20 **SEC. 2221. LONG-TERM CARE INSURANCE POLICY DEFINED.**

21 (a) IN GENERAL.—As used in this section, the term  
22 “long-term care insurance policy” means any insurance  
23 policy, rider or certificate advertised, marketed, offered or  
24 designed to provide coverage for not less than 12 consecu-  
25 tive months for each covered individual on an expense in-

1 curred, indemnity prepaid or other basis, for one or more  
2 necessary diagnostic, preventive, therapeutic, rehabilita-  
3 tive, maintenance or personal care services, provided in a  
4 setting other than an acute care unit of a hospital. Such  
5 term includes—

6 (1) group and individual annuities and life in-  
7 surance policies, riders or certificates that provide  
8 directly, or that supplement long-term care insur-  
9 ance; and

10 (2) a policy, rider or certificates that provides  
11 for payment of benefits based on cognitive impair-  
12 ment or the loss of functional capacity.

13 (b) ISSUANCE.—Long-term care insurance policies  
14 may be issued by—

15 (1) carriers;

16 (2) fraternal benefit societies;

17 (3) nonprofit health, hospital, and medical serv-  
18 ice corporations;

19 (4) prepaid health plans;

20 (5) health maintenance organizations; or

21 (6) any similar organization to the extent they  
22 are otherwise authorized to issue life or health insur-  
23 ance.

24 (c) POLICIES EXCLUDED.—The term “long-term care  
25 insurance policy” shall not include any insurance policy,

1 rider or certificate that is offered primarily to provide  
2 basic Medicare supplement coverage, basic hospital ex-  
3 pense coverage, basic medical-surgical expense coverage,  
4 hospital confinement indemnity coverage, major medical  
5 expense coverage, disability income or related asset-protec-  
6 tion coverage, accident only coverage, specified disease or  
7 specified accident coverage, or limited benefit health cov-  
8 erage. With respect to life insurance, such term shall not  
9 include life insurance policies, riders or certificates—

10           (1) that accelerate the death benefit specifically  
11           for one or more of the qualifying events of terminal  
12           illness, medical conditions requiring extraordinary  
13           medical intervention, or permanent institutional con-  
14           finement,

15           (2) that provide the option of a lump-sum pay-  
16           ment for those benefits, or

17           (3) with respect to which neither the benefits  
18           nor the eligibility for the benefits is conditioned  
19           upon the receipt of long-term care.

20           (d) APPLICATIONS.—Notwithstanding any other pro-  
21 vision of this subtitle, this subtitle shall apply to any prod-  
22 uct advertised, marketed or offered as a long-term insur-  
23 ance policy, rider or certificate.

1 **SEC. 2222. CODE OF CONDUCT WITH RESPECT TO EN-**  
2 **DORSEMENTS.**

3 Not later than 1 year after the date of enactment  
4 of this subtitle, the Secretary, in consultation with the  
5 NAIC, shall issue guidelines that shall apply to organiza-  
6 tions and associations (other than employers and labor or-  
7 ganizations that do not accept compensation) that provide  
8 endorsements of long-term care insurance policies, or that  
9 permit such policies to be offered for sale through the or-  
10 ganization or association. Such guidelines shall include at  
11 minimum the following:

12 (1) In endorsing or selling long-term care insur-  
13 ance policies, the primary responsibility of an orga-  
14 nization or association shall be to educate their  
15 members concerning such policies and assist such  
16 members in making informed decisions. Such organi-  
17 zations and associations may not function primarily  
18 as sales agents for insurance companies.

19 (2) Organizations and associations shall provide  
20 objective information regarding long-term care insur-  
21 ance policies sold or endorsed by such organizations  
22 and associations to ensure that members of such or-  
23 ganizations and associations have a balanced and  
24 complete understanding of both the strengths and  
25 weaknesses of the policies that are being endorsed or  
26 sold.

1           (3) Organizations and associations selling or  
2           endorsing long-term care insurance policies shall dis-  
3           close in marketing literature provided to their mem-  
4           bers concerning such policies the manner in which  
5           such policies and the insurance company issuing  
6           such policies were selected. If the organization or as-  
7           sociation and the insurance company have inter-  
8           locking directorates, the organization or association  
9           shall disclose such fact to their members.

10           (4) Organizations and associations selling or  
11           endorsing long-term care insurance policies shall dis-  
12           close in marketing literature provided to their mem-  
13           bers concerning such policies the nature and amount  
14           of the compensation arrangements (including all  
15           fees, commissions, administrative fees and other  
16           forms of financial support that the organization or  
17           association receives) from the endorsement or sale of  
18           the policy to its members.

19           (5) The Boards of Directors of organizations  
20           and associations selling or endorsing long-term care  
21           insurance policies, if such organizations and associa-  
22           tions have a Board of Directors, shall review and ap-  
23           prove such insurance policies, the compensation ar-  
24           rangements and the marketing materials used to  
25           promote sales of such policies.

1                   **Subtitle D—Life Care**

2   **SEC. 2301. SHORT TITLE.**

3           This title may be cited as the “Life Care Act”.

4   **SEC. 2302. LIFE CARE: PUBLIC INSURANCE PROGRAM FOR**  
 5                   **NURSING HOME CARE.**

6           The Public Health Service Act is amended by adding  
 7 at the end thereof the following new title:

8   **“TITLE XXVII—LIFE CARE: PUB-**  
 9       **LIC INSURANCE PROGRAM**  
 10       **FOR NURSING HOME CARE**

11   **“SEC. 2701. ESTABLISHMENT OF VOLUNTARY LONG-TERM**  
 12                   **CARE INSURANCE PROGRAM.**

13           “The Secretary shall establish a voluntary insurance  
 14 program for individuals 35 years of age and over to cover  
 15 the nursing home stays of such individuals. The Secretary  
 16 shall establish a process for enrollment in the Life Care  
 17 program.

18   **“SEC. 2702. BENEFITS.**

19           “(a) IN GENERAL.—

20                   “(1) ELIGIBILITY FOR COVERAGE.—Subject to  
 21 subsection (c), an individual who meets the eligibility  
 22 criteria prescribed in section 2703 shall be eligible  
 23 under the program established under this title for  
 24 coverage for necessary services described in sub-  
 25 section (b) (in the amounts described in subsection

1 (c)) that are provided to the individual by a nursing  
2 facility while the individual is an inpatient of the fa-  
3 cility.

4 “(2) NONFORFEITURE.—The Secretary shall  
5 establish standards to ensure the nonforfeiture of  
6 benefits for which premiums have been paid.

7 “(b) TYPES.—Coverage may be provided under this  
8 title for—

9 “(1) nursing care provided by or under the su-  
10 pervision of a registered professional nurse;

11 “(2) physical, occupational, or speech therapy  
12 furnished by a facility or by others under arrange-  
13 ments with a facility;

14 “(3) medical social work services;

15 “(4) drug, biological, supply, appliance, and  
16 equipment for use in the facility, that is ordinarily  
17 furnished by the facility for the care and treatment  
18 of an inpatient;

19 “(5) such other services necessary to the func-  
20 tioning of a patient, including personal care and as-  
21 sistance with activities of daily living, as are gen-  
22 erally provided by a nursing home facility; and

23 “(6) with respect to the initial 6 months of cov-  
24 ered residence in a nursing facility, such room and

1 board costs as are not covered by beneficiary copay-  
2 ment.

3 “(c) COVERAGE AMOUNT.—

4 “(1) IN GENERAL.—The amount of coverage  
5 provided with respect to an eligible individual for the  
6 services described in subsection (b) shall, based on  
7 an election made by the individual, not exceed  
8 \$30,000, \$60,000, or \$90,000 over the lifetime of  
9 the eligible individual. Such amounts shall be ad-  
10 justed by the Secretary to reflect increases in the  
11 Consumer Price Index.

12 “(2) ASSET PROTECTION.—An eligible indi-  
13 vidual shall be entitled to the asset protection pro-  
14 vided under section 2708.

15 “(d) PAYMENT.—Amounts provided under this title  
16 with respect to an eligible individual for the services de-  
17 scribed in subsection (b) shall be paid from the general  
18 fund of the Treasury of the United States.

19 “(e) RESIDENTIAL CARE FACILITIES.—The Sec-  
20 retary shall consider the feasibility of making payments  
21 under this title for services delivered in residential care  
22 facilities. Not later than 2 years after the date of enact-  
23 ment of this Act, the Secretary shall report its findings  
24 to the Congress with respect to the feasibility of making  
25 such payments.

1 **“SEC. 2703. ELIGIBILITY.**

2 “(a) IN GENERAL.—An individual shall be eligible for  
3 benefits under this title if—

4 “(1) the individual—

5 “(A) is a legal resident of the United  
6 States and has elected coverage under sub-  
7 section (c); and

8 “(B) has been determined by a Screening  
9 Agency through a screening process (conducted  
10 in accordance with section 2707)—

11 “(i)(I) to require hands-on or standby  
12 assistance, supervision, or cueing (as de-  
13 fined in regulations) to perform three or  
14 more activities of daily living; or

15 “(II) to require hands-on or standby  
16 assistance, supervision, or cueing with at  
17 least such instrumental activity (or activi-  
18 ties) of daily living related to cognitive or  
19 mental impairment as the Secretary speci-  
20 fies; or

21 “(III) to display symptoms of one or  
22 more serious behavioral problems (that is  
23 on a list of such problems specified by the  
24 Secretary) which create a need for super-  
25 vision to prevent harm to self or others; or

1           “(IV) has achieved a score, on a  
2           standard mental status protocol (or proto-  
3           cols) appropriate for measuring the indi-  
4           vidual’s particular condition specified by  
5           the Secretary, that indicates either severe  
6           cognitive impairment or severe mental im-  
7           pairment, or both; and

8           “(ii) to require such assistance, super-  
9           vision, or cueing over a period of at least  
10          90 days; and

11          “(2)(A) the individual has filed an application  
12          for such benefits, and is in need of, benefits covered  
13          under this title; or

14          “(B) the legal guardian of the individual has  
15          filed an application on behalf of an individual who  
16          is in need of benefits covered under this title; or

17          “(C) the representative of an individual who is  
18          cognitively impaired and who is in need of benefits  
19          covered under this title has filed an application on  
20          behalf of the individual.

21          “(b) CURRENT INDIVIDUALS.—An individual who is  
22          in a hospital or nursing home on the date of the enroll-  
23          ment of the individual in the program established under  
24          this title shall be ineligible for coverage under this section

1 until the individual's first spell of illness beginning after  
2 such date.

3 “(c) ELECTION OF COVERAGE.—

4 “(1) IN GENERAL.—Subject to this subsection,  
5 an individual shall have the option to purchase cov-  
6 erage under this title when the individual is 35 years  
7 of age, 45 years of age, 55 years of age, or 65 years  
8 of age.

9 “(2) INITIAL YEAR.—During the 1-year period  
10 beginning on the date on which final regulations  
11 that implement this title are issued, an individual  
12 who is 35 years of age or older shall be eligible to  
13 purchase insurance under this title, except that such  
14 an individual shall not be eligible to purchase such  
15 insurance—

16 “(A) while confined to a hospital or nurs-  
17 ing home;

18 “(B) within the 6-month period after the  
19 individual's confinement in a nursing home; or

20 “(C) within the 90-day period after the in-  
21 dividual's confinement in a hospital.

22 Individuals described in the matter preceding sub-  
23 paragraph (A) shall become eligible to receive bene-  
24 fits under this title on the expiration of the 3-year

1 period beginning on the date such individuals pur-  
2 chase insurance under this title.

3 “(3) EXTENSION BEYOND INITIAL YEAR.—If an  
4 individual is confined to a nursing home or hospital  
5 during a period that extends beyond the first year  
6 after the effective date of this title, an individual  
7 shall be eligible to enroll in the program established  
8 by this title during the 60-day period beginning after  
9 the individual’s spell of illness.

10 “(4) SUBSEQUENT YEARS.—During years sub-  
11 sequent to the 1-year period referred to in para-  
12 graph (2), an individual shall be eligible to purchase  
13 insurance under this title within 6 months of the  
14 35th, 45th, 55th or 65th birthday of the individual.

15 “(5) ACTIVATION OF BENEFITS.—To receive  
16 coverage under the insurance program established by  
17 this title, an individual shall have purchased such  
18 coverage not later than 1 month prior to admission  
19 to a nursing facility, unless the reason for the need  
20 of services is a result of an accident or stroke subse-  
21 quent to the date that such individual enrolled for  
22 coverage under this title.

23 “(d) PUBLIC EDUCATION.—In the 12 months pre-  
24 ceding the initial enrollment period, the Secretary shall,  
25 either directly or through grants and contracts, conduct

1 a public service and education campaign designed to in-  
2 form potentially eligible individuals as to the nature of the  
3 benefits and the limited enrollment period. In conducting  
4 such campaigns the Secretary shall make information  
5 available to individuals through the open enrollment pro-  
6 cess for obtaining health care benefits under this Act.

7 **“SEC. 2704. PREMIUM RATES.**

8       “(a) IN GENERAL.—The Secretary shall determine  
9 one premium rate for individuals electing to purchase cov-  
10 erage under this title at age 35 (or between the ages of  
11 35 and 44 during the initial enrollment period), a separate  
12 rate for those individuals who elect coverage at age 45  
13 (or between the ages of 45 and 54 during the initial enroll-  
14 ment period), a separate rate for those individuals who  
15 elect such coverage at age 55 (or between that ages of  
16 55 and 64 during the initial enrollment period), and a sep-  
17 arate rate for those individuals who elect such coverage  
18 at age 65 (or at age 65 and over during the initial enroll-  
19 ment period). During the initial enrollment period, the  
20 Secretary shall establish actuarially fair, age-rated pre-  
21 miums for persons age 65 and over.

22       “(b) REVISION.—The Secretary shall revise premium  
23 rates annually to increase such rates to reflect the amount  
24 of the increase in the cost of living adjustment with re-  
25 spect to benefits under title II of the Social Security Act.

1       “(c) RATES.—In developing premium rates under the  
2 program established under this title, the Secretary shall  
3 establish rates that are expected to cover 100 percent of  
4 the reimbursement amount provided under this title for  
5 nursing home stays for those individuals enrolled in the  
6 program.

7       “(d) WAIVER.—An individual electing to purchase  
8 coverage under this title shall not be required to pay pre-  
9 miums during any period in which such individual is re-  
10 ceiving benefits under this title.

11       “(e) PAYMENT.—Premiums shall be paid under this  
12 section into the general fund of the Treasury of the United  
13 States.

14 **“SEC. 2705. QUALIFIED SERVICE PROVIDERS.**

15       “(a) IN GENERAL.—To be considered as a covered  
16 nursing home service under this title, such service must  
17 have been provided by a qualified service provider.

18       “(b) TYPES.—A provider shall be considered a quali-  
19 fied service provider under this title if the provider is a  
20 nursing facility that is certified by the State and meets  
21 the requirements of this title and any other standards es-  
22 tablished by the Secretary by regulation for the safe and  
23 efficient provision of services covered under this title.

1 **“SEC. 2706. REIMBURSEMENT.**

2       “(a) AMOUNT.—Monthly reimbursement for nursing  
3 facility services under this title shall equal 65 percent (or  
4 during the initial 6 months of coverage, 80 percent) of  
5 the amount the Secretary determines to be reasonable and  
6 appropriate to cover the cost of care provided under this  
7 title.

8       “(b) PROSPECTIVE PAYMENT.—To the extent fea-  
9 sible, the Secretary shall establish a prospective payment  
10 mechanism for payment for nursing home services under  
11 this title that takes into account the expected resource uti-  
12 lization of individual patients based on their degree of dis-  
13 ability, the methodology recommended for reimbursement  
14 of skilled nursing facilities under title XVIII of the Social  
15 Security Act, and other factors determining service re-  
16 quirements.

17       “(c) ROOM AND BOARD PAYMENT.—An individual  
18 receiving benefits under this program shall be responsible  
19 for the payment of an amount for room and board that  
20 is equal to—

21               “(1) with respect to the initial 6 months of resi-  
22 dence in a nursing facility, 20 percent of the average  
23 per diem rate paid by the Secretary to nursing facili-  
24 ties receiving reimbursement under this title; and

25               “(2) with respect to subsequent periods of resi-  
26 dence, 35 percent of the average per diem rate paid

1 by the Secretary to nursing facilities receiving reim-  
2 bursement under this title. Payments under sub-  
3 section (a) and (c) shall be considered payment in  
4 full for services received under this section.

5 “(d) PRIORITY PAYERS.—Notwithstanding any other  
6 provision of this title, reimbursement for nursing facility  
7 services provided under this title to an individual shall,  
8 to the extent available, be made under the Medicare pro-  
9 gram, under Department of Veterans Affairs’ programs,  
10 or under private insurance policies prior to reimbursement  
11 under this title.

12 **“SEC. 2707. LONG-TERM CARE SCREENING AGENCY.**

13 “(a) ESTABLISHMENT.—The Secretary shall contract  
14 with entities to act as Long-Term Care Screening Agen-  
15 cies (hereafter referred to in this title as the ‘Screening  
16 Agency’) for each designated area of a State. It shall be  
17 the responsibility of such agency to assess the eligibility  
18 of individuals residing in the geographic jurisdiction of the  
19 Agency, for services provided under this title according to  
20 the requirements of this title and regulations prescribed  
21 by the Secretary. In entering into such contracts, the Sec-  
22 retary shall give preference to State governmental entities  
23 and private nonprofit agencies.

24 “(b) ELIGIBILITY.—The Screening Agency shall de-  
25 termine the eligibility of an individual under this title

1 based on the results of a preliminary telephone interview  
2 or written questionnaire (completed by the applicant, by  
3 the caregiver of the applicant, or by the legal guardian  
4 or representative of the applicant) that shall be validated  
5 through the use of a screening tool administered in person  
6 to each applicant determined eligible through initial tele-  
7 phone or written questionnaire interviews not later than  
8 15 days from the date on which such individual initially  
9 applied for services under this title.

10 “(c) QUESTIONNAIRES AND SCREENING TOOLS.—

11 “(1) IN GENERAL.—The Secretary shall estab-  
12 lish a telephone or written questionnaire and a  
13 screening tool to be used by the Screening Agency  
14 to determine the eligibility of an individual for serv-  
15 ices under this title consistent with requirements of  
16 this title and the standards established by the Sec-  
17 retary by regulation.

18 “(2) QUESTIONNAIRES.—The questionnaire  
19 shall include questions about the functional impair-  
20 ment and mental status of an individual and other  
21 criteria that the Secretary shall prescribe by regula-  
22 tion.

23 “(3) SCREENING TOOLS.—The screening tool  
24 should measure functional impairment caused by  
25 physical or cognitive conditions as well as informa-

1       tion concerning cognition disability, behavioral prob-  
2       lems (such as wandering or abusive and aggressive  
3       behavior), and any other criteria that the Secretary  
4       shall prescribe by regulation. The screening tool  
5       shall be administered in person.

6       “(d) NOTIFICATION.—Not later than 15 days after  
7       the date on which an individual initially applied for serv-  
8       ices under this title (by telephone or written question-  
9       naire), the Screening Agency shall notify such individual  
10      that such individual is not eligible for benefits, or that  
11      such individuals must schedule an in-person screening to  
12      determine final eligibility for benefits under this title. The  
13      Screening Agency shall notify such individual of its final  
14      decision not later than 2 working days after the in-person  
15      screening.

16      “(e) IN-PERSON SCREENING.—An individual (or the  
17      legal guardian or representative of such individual) whose  
18      application for benefits under this title is denied on the  
19      basis of information provided through a telephone or writ-  
20      ten questionnaire, shall be notified of such individual’s  
21      right to an in-person screening by a nurse or appropriate  
22      health care professionals.

23      “(f) APPEALS.—The Secretary shall establish a  
24      mechanism for hearings and appeals in cases in which in-

1 individuals contest the eligibility findings of the Screening  
2 Agency.

3 “(g) PAYMENT.—

4 “(1) PAYMENT FOR SCREENING.—The Screen-  
5 ing Agency may require payment from individuals  
6 only in accordance with standards established by the  
7 Secretary.

8 “(2) NO PAYMENT FOR POOREST.—The Screen-  
9 ing Agency may not require payment for individuals  
10 with incomes of less than 150 percent of the official  
11 poverty line.

12 **“SEC. 2708. ASSET PROTECTION.**

13 “Notwithstanding any other provision of law, the as-  
14 sets an eligible individual may retain and be determined  
15 eligible for nursing facility benefits, including payments of  
16 room and board under this title, under State Medicaid  
17 programs (in accordance with section 1902(a)(10)) shall  
18 be increased by the amount of coverage (\$30,000,  
19 \$60,000, or \$90,000) elected under section 2702.

20 **“SEC. 2709. RELATION TO PRIVATE INSURANCE.**

21 “(a) IN GENERAL.—Except as provided in subsection  
22 (b), an insurer may not offer a long-term care insurance  
23 policy to an individual who has purchased coverage under  
24 this title if the coverage under such policy duplicates the  
25 coverage provided under this title.

1       “(b) DEVELOPMENT OF STANDARD PACKAGES.—The  
2 Secretary shall develop standard long-term care insurance  
3 benefits packages that insurers may offer to insured indi-  
4 viduals under this title. Such packages shall provide cov-  
5 erage for benefits that compliment, but do not duplicate,  
6 those covered under this title.

7       **“SEC. 2710. DEFINITIONS.**

8       “As used in this title:

9               “(1) NURSING FACILITY.—The term ‘nursing  
10 facility’ means—

11                       “(A) a skilled nursing facility (as defined  
12 in section 1819(a) of the Social Security Act);  
13 or

14                       “(B) a facility that is a nursing facility (as  
15 defined in section 1919(a) of such Act) which  
16 meets the requirements of section  
17 1819(b)(4)(C) of such Act (relating to nursing  
18 care).

19               “(2) SPELL OF ILLNESS.—The term ‘spell of  
20 illness’ means a period of consecutive days beginning  
21 with the first day on which an individual is fur-  
22 nished services as an inpatient in a hospital or nurs-  
23 ing facility and ending with the close of the first 6  
24 consecutive months thereafter during which the indi-  
25 vidual is no longer an inpatient of a nursing facility,

1 or 90 days after the individual is no longer an inpa-  
2 tient in a hospital.

3 **“SEC. 2711. REPORTS.**

4 “(a) IN GENERAL.—Prior to the promulgation of reg-  
5 ulations implementing this title, the Secretary shall report  
6 to Congress on—

7 “(1) the actuarially-sound premium rates to be  
8 used in the implementation of this Act, including  
9 whether the premiums will cover 100 percent of the  
10 benefits paid out, and whether Federal funds will be  
11 required to support the payment of benefits;

12 “(2) an assessment of the impact of such pre-  
13 mium rates on the affordability of coverage under  
14 this Act;

15 “(3) a projected enrollment of individuals by  
16 age category; and

17 “(4) an estimate of current and projected en-  
18 rollment of individuals, by age category in coverage  
19 under private long-term care insurance.

20 “(b) LIFE CARE REPORT.—Not later than 2 years  
21 after the promulgation of regulations implementing this  
22 title, the Secretary shall report to Congress on the fol-  
23 lowing aspects of the Life Care Act:

24 “(1) The current and projected premium rates.



1 end of life, including how to determine the appro-  
2 priateness of curative or life-prolonging or palliative  
3 services for gravely or terminally ill or injured per-  
4 sons of all ages.

5 (2) SPECIFIC ISSUES.—The study described in  
6 paragraph (1) shall specifically include an examina-  
7 tion of the following issues:

8 (A) The epidemiology of dying.

9 (B) The feasibility and utility of clinical  
10 practice guidelines for appropriate care.

11 (C) Conditions that promote or impede ap-  
12 propriate care (such as professional training  
13 and beliefs, financing and organization of serv-  
14 ices, patient and public knowledge and atti-  
15 tudes).

16 (D) Priorities for research on the issues  
17 described in the preceding subparagraphs.

18 (E) Concerns of health care practitioners  
19 and providers, medical educators, the general  
20 public, and those responsible for public and pri-  
21 vate decisions about the organization, financing,  
22 and quality of health care in the United States.

23 (b) REPORT.—The Institute of Medicine (or the orga-  
24 nization conducting the study under this section) shall  
25 submit to the Secretary and the Congress a report on the

1 study described in subsection (a) within 27 months after  
2 the date of the enactment of this Act.

3 (c) AUTHORIZATION OF APPROPRIATIONS.—There  
4 are authorized to be appropriated such sums as are nec-  
5 essary to carry out the purposes of this section.

6 **TITLE III—HEALTH**  
7 **PROFESSIONS WORKFORCE**  
8 **Subtitle A—Workforce Priorities**  
9 **Under Federal Payments**

10 **SEC. 3000. DEFINITIONS.**

11 For purposes of this subtitle:

12 (1) The term “academic year” has the meaning  
13 given such term in section 3011(b)(3)(A).

14 (2) The term “allocation period” has the mean-  
15 ing given such term in section 3015(d).

16 (3) The term “annual number of specialty posi-  
17 tions” has the meaning given such term in section  
18 3013(g)(1).

19 (4) The term “approved physician training pro-  
20 gram” has the meaning given such term in section  
21 3011(b)(1).

22 (5) The term “consumer price index” has the  
23 meaning given such term in section 3033(e)(1).

24 (6) The term “designation period” has the  
25 meaning given such term in section 3013(g)(2).

1           (7) The term “funding agreement” has the  
2 meaning given such term in section 3011(b)(3)(B).

3           (8) The term “general health care inflation fac-  
4 tor” has the meaning given such term in section  
5 3033(e)(4).

6           (9) The term “medical school” has the meaning  
7 given such term in section 3001(e)(2).

8           (10) The term “medical specialty” has the  
9 meaning given such term in section 3011(b)(3)(C).

10          (11) The term “National Council” has the  
11 meaning given such term in section 3001(e)(3).

12          (12) The term “primary health care” has the  
13 meaning given such term in section 3013(g)(3).

14          (13) The term “qualified applicant” has the  
15 meaning given such term in section 3011(b)(2), in  
16 the case of subpart B; and has the meaning given  
17 such term in section 3031(e), in the case of subpart  
18 C.

19          (14) The term “specialty position” has the  
20 meaning given such term in section 3013(g)(4).

21          (15) The term “training participant” has the  
22 meaning given such term in section 3013(g)(5).

1 **PART 1—INSTITUTIONAL COSTS OF GRADUATE**  
2 **MEDICAL EDUCATION; WORKFORCE PRIORITIES**  
3 **Subpart A—National Council Regarding Workforce**  
4 **Priorities**

5 **SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL**  
6 **EDUCATION.**

7 (a) IN GENERAL.—There is established within the  
8 Department of Health and Human Services a council to  
9 be known as the National Council on Graduate Medical  
10 Education.

11 (b) DUTIES.—The Secretary shall carry out subpart  
12 B acting through the National Council.

13 (c) COMPOSITION.—

14 (1) IN GENERAL.—The membership of the Na-  
15 tional Council shall include between 12 and 16 indi-  
16 viduals who are appointed to the Council from  
17 among individuals who are not officers or employees  
18 of the United States. Such individuals shall be ap-  
19 pointed by the Secretary, and shall include individ-  
20 uals from each of the following categories in the fol-  
21 lowing proportions:

22 (A) One-quarter composed of consumers of  
23 health care services, at least one of whom re-  
24 sides in a rural area.

25 (B) One-quarter composed of primary  
26 health care physicians who are faculty members

1 of medical schools (including officials of medical  
2 schools and executives of teaching hospitals)  
3 and primary health care physicians who are  
4 practicing and are not faculty members of med-  
5 ical schools, at least one of whom resides in a  
6 rural area.

7 (C) One-quarter composed of non-primary  
8 health care specialty physicians who are faculty  
9 members of medical schools, non-primary health  
10 care specialty physicians who are not faculty  
11 members of medical schools, officials of medical  
12 schools, and executive officers of teaching hos-  
13 pitals.

14 (D) One-quarter composed of officers and  
15 employees of health plans, and officers or mem-  
16 bers of purchasing cooperatives.

17 (2) EX OFFICIO MEMBERS; OTHER FEDERAL  
18 OFFICERS OR EMPLOYEES.—The membership of the  
19 National Council shall include individuals designated  
20 by the Secretary to serve as members of the Council  
21 from among Federal officers or employees who are  
22 appointed by the President, or by the Secretary or  
23 other Federal officers who are appointed by the  
24 President with the advice and consent of the Senate.

1 (d) CHAIR.—The Secretary shall, from among mem-  
 2 bers of the National Council appointed under subsection  
 3 (c)(1), designate an individual to serve as the Chair of  
 4 the Council.

5 (e) DEFINITIONS.—For purposes of this subtitle:

6 (1) The term “academic health center” means  
 7 an entity defined in section 3051(e)(1).

8 (2) The term “medical school” means a school  
 9 of medicine (as defined in section 799 of the Public  
 10 Health Service Act) or a school of osteopathic medi-  
 11 cine (as defined in such section).

12 (3) The term “National Council” means the  
 13 council established in subsection (a).

14 (f) CONFORMING AMENDMENT REPEALING THE  
 15 COUNCIL ON GRADUATE MEDICAL EDUCATION  
 16 (COGME).—Effective on the date of the first meeting of  
 17 the National Council, section 30 of the Health Professions  
 18 Education Extension Amendments of 1992 (Public Law  
 19 102-408) is repealed.

20 **Subpart B—Authorized Positions in Specialty**

21 **Training**

22 **SEC. 3011. COOPERATION REGARDING APPROVED PHYSI-**  
 23 **CIAN TRAINING PROGRAMS.**

24 (a) IN GENERAL.—With respect to an approved phy-  
 25 sician training program in a medical specialty, a funding

1 agreement with a qualified applicant for payments under  
2 section 3031 and section 3051 for a calendar year is that  
3 the qualified applicant will ensure that the number of indi-  
4 viduals enrolled in the program in the subsequent aca-  
5 demic year is in accordance with this subpart.

6 (b) DEFINITIONS.—

7 (1) APPROVED PROGRAM.—For purposes of this  
8 subtitle:

9 (A) The term “approved physician training  
10 program”, with respect to the medical specialty  
11 involved, means a residency or other post-  
12 graduate program that trains physicians and  
13 meets the following conditions:

14 (i) Participation in the program may  
15 be counted toward certification in the med-  
16 ical specialty as determined under the ap-  
17 plicable standards of the American Board  
18 of Medical Specialties or the Council on  
19 Postdoctoral Training of the American Os-  
20 teopathic Association.

21 (ii) The program is accredited by the  
22 Accreditation Council on Graduate Medical  
23 Education, or approved by the Council on  
24 Postdoctoral Training of the American Os-  
25 teopathic Association.

1 (B) The term “approved physician training  
2 program” includes any postgraduate program  
3 described in subparagraph (A) that provides  
4 health services in an ambulatory setting, with-  
5 out regard to whether the program provides in-  
6 patient hospital services.

7 (C) The term “approved physician training  
8 program” includes any postgraduate program  
9 described in subparagraph (A), whether oper-  
10 ated by academic health centers, teaching hos-  
11 pitals, group practices, ambulatory care pro-  
12 viders, prepaid health plans, or other entities.

13 (D) The term “approved physician training  
14 program” includes any postgraduate program  
15 described in subparagraph (A) that provides fel-  
16 lowship training in family medicine, general in-  
17 ternal medicine or general pediatrics, and pro-  
18 vides training for a faculty position in family  
19 medicine, general medicine or general pediat-  
20 rics.

21 (2) QUALIFIED APPLICANT; SUBPART DEFINI-  
22 TION.—For purposes of this subpart, the term  
23 “qualified applicant”, with respect to an academic  
24 year, means an entity that trains individuals in an  
25 approved physician program that receives payments

1 under subpart C for the calendar year in which the  
2 academic year begins.

3 (3) OTHER DEFINITIONS.—For purposes of this  
4 subtitle:

5 (A)(i) Except as provided in clause (iii),  
6 the term “academic year” means the 1-year pe-  
7 riod beginning on July 1. The academic year  
8 beginning July 1, 1993, is academic year 1993–  
9 1994.

10 (ii) With respect to the funding agreement  
11 described in subsection (a), the term “subse-  
12 quent academic year” means the academic year  
13 beginning July 1 of the calendar year for which  
14 payments are to be made under the agreement.

15 (iii) For purposes of determining the aca-  
16 demic year in which a training participant en-  
17 ters an approved physician training program,  
18 the academic year is the 1-year period begin-  
19 ning on or after June 1.

20 (B) The term “funding agreement”, with  
21 respect to payments under section 3031 and  
22 3051 to a qualified applicant, means that the  
23 Secretary may make the payments only if the  
24 qualified applicant signs the agreement in-  
25 volved.

1 (C) The term “medical specialty” includes  
2 all medical, surgical, and other physician spe-  
3 cialties and subspecialties.

4 **SEC. 3012. ANNUAL AUTHORIZATION OF TOTAL NUMBER OF**  
5 **GRADUATE MEDICAL EDUCATION POSITIONS.**

6 With respect to the numbers designated by the Coun-  
7 cil for individuals entering eligible programs for an aca-  
8 demic year pursuant to section 3011, the Council shall en-  
9 sure that the aggregate number of individuals first enter-  
10 ing any such program for the year does not exceed the  
11 following number (expressed as a percentage), as applica-  
12 ble to the academic year involved:

13 (1) For academic year 1998–1999, 134 percent  
14 of the number of individuals who graduated from  
15 medical schools in the United States in academic  
16 year 1997–1998.

17 (2) For academic year 1999–2000, 126 percent  
18 of such number.

19 (3) For academic year 2000–2001, 118 percent  
20 of such number.

21 (4) For academic year 2001–2002 and each  
22 subsequent academic year, 110 percent of such num-  
23 ber, except as provided in section 3014.

1 **SEC. 3013. ANNUAL AUTHORIZATION OF NUMBER OF SPE-**  
2 **CIALTY POSITIONS; REQUIREMENTS REGARD-**  
3 **ING PRIMARY HEALTH CARE.**

4 (a) ANNUAL AUTHORIZATION OF NUMBER OF POSI-  
5 TIONS.—In the case of each medical specialty, the Na-  
6 tional Council shall, pursuant to section 3011, designate  
7 for academic year 1998–1999 and each subsequent aca-  
8 demic year the number of individuals nationwide who are  
9 authorized to be enrolled in eligible programs in each med-  
10 ical specialty for the academic year involved.

11 (b) PRIMARY HEALTH CARE.—

12 (1) REQUIREMENT ACROSS SPECIALITIES.—In  
13 carrying out subsection (a) for an academic year, the  
14 National Council shall ensure that, of the class of  
15 training participants entering all eligible programs  
16 for their first year of graduate medical education for  
17 academic year 1998–1999 or any subsequent aca-  
18 demic year, the percentage of such class that com-  
19 pletes eligible programs in primary health care and  
20 does not subsequently enter a non-primary health  
21 care training program, is not less than the following,  
22 as applicable to the academic year involved:

23 (A) For academic year 1998–1999, 39 per-  
24 cent.

25 (B) For academic year 1999–2000, 44 per-  
26 cent.

1 (C) For academic year 2000–2001, 49 per-  
2 cent.

3 (D) For academic year 2001–2002 and  
4 each subsequent academic year, 55 percent, ex-  
5 cept as provided in section 3014.

6 (2) RULE OF CONSTRUCTION.—The require-  
7 ment of paragraph (1) regarding a percentage ap-  
8 plies in the aggregate to training participants enter-  
9 ing eligible programs for the academic year involved,  
10 and not individually to any eligible program.

11 (c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

12 (1) DESIGNATION PERIODS.—For each medical  
13 specialty, the National Council shall make the an-  
14 nual designations under subsection (a) for periods of  
15 3 academic years.

16 (2) INITIAL PERIOD.—The first designation pe-  
17 riod established by the National Council after the  
18 date of the enactment of this Act shall be the aca-  
19 demic years 1998–1999 through 2000–2001.

20 (d) CERTAIN CONSIDERATIONS IN DESIGNATING AN-  
21 NUAL NUMBERS.—

22 (1) IN GENERAL.—Factors considered by the  
23 National Council in designating the annual number  
24 of specialty positions for an academic year for a  
25 medical specialty shall include the extent to which

1       there is a need for additional practitioners in the  
2       speciality, as indicated by the following:

3               (A) The characteristics of diseases, dis-  
4               orders, or health conditions treated, including—

5                       (i) the incidence and prevalence (in  
6                       the general population and in various other  
7                       populations) of the diseases, disorders, or  
8                       other health conditions with which the spe-  
9                       cialty is concerned;

10                      (ii) the intensity of care required for  
11                      each of these diseases, disorders, or health  
12                      conditions;

13                      (iii) the relevant training received and  
14                      experience attained by primary health care  
15                      and specialist physicians in caring for each  
16                      of these diseases, disorders, or health con-  
17                      ditions; and

18                      (iv) should sufficient data become  
19                      available, the extent to which individuals  
20                      with certain diseases, disorders, or health  
21                      conditions have better health outcomes  
22                      when treated by non-primary health care  
23                      physicians than by primary health care  
24                      physicians.

1 (B) The number of physicians who will be  
2 practicing in the specialty in the academic year.

3 (C) The number of physicians who will be  
4 practicing in the specialty at the end of the 5-  
5 year period beginning on the first day of the  
6 academic year.

7 (D) Whether, after examining medical spe-  
8 cialty requirements, the National Council deter-  
9 mines that specialty is a medical shortage spe-  
10 cialty (as defined by the National Council).

11 (2) RECOMMENDATIONS OF PRIVATE ORGANIZA-  
12 TIONS.—In designating the annual number of spe-  
13 cialty positions for an academic year for a medical  
14 specialty, the National Council shall consider the  
15 recommendations of organizations representing phy-  
16 sicians in the specialty, organizations representing  
17 academic medicine, and the recommendations of or-  
18 ganizations representing consumers of the services of  
19 such physicians.

20 (e) VOLUNTARY COMPLIANCE.—

21 (1) ESTABLISHMENT OF THE POSITIONS FOR  
22 FIRST DESIGNATION PERIOD.—Not later than June  
23 1, 1996, the National Council shall establish the  
24 number of positions in each medical specialty that  
25 will be allocated under subsection (a) for the aca-

1       demic years 1998–1999, 1999–2000, and 2000–  
2       2001.

3               (2) VOLUNTARY COMPLIANCE.—A medical spe-  
4       cialty shall not be subject to the mandatory alloca-  
5       tion system described in section 3015 if—

6               (A) by June 1, 1997, each eligible ap-  
7       proved physician training program has sub-  
8       mitted to the National Council a proposal for  
9       first year positions in approved physician train-  
10      ing programs in that particular medical spe-  
11      cialty for the academic years 1998–99, 1999–  
12      2000, and 2000–2001 and the total proposed  
13      number of all such positions for the specialty  
14      does not exceed the number of positions estab-  
15      lished for such specialty under paragraph (1)  
16      for each such academic year; and

17              (B) in subsequent academic years, the  
18      total proposed number of first year positions in  
19      approved physician training programs in that  
20      particular medical specialty does not exceed the  
21      number of individuals nationwide who are au-  
22      thorized to be enrolled in approved medical  
23      training programs for such medical specialty for  
24      such year pursuant to subsection (a).

1           (3) LOSS OF COMPLIANCE.—The National  
2           Council may, at any time, determine that a specialty  
3           is not in compliance with the number of positions es-  
4           tablished by the Council under paragraph (1) or  
5           subsection (a) and initiate, with respect to that spe-  
6           cialty, the system of mandatory allocations described  
7           in section 3015.

8           (f) STUDY.—Not later than January 1, 2005, the  
9           Secretary shall arrange for the completion, by the Insti-  
10          tute of Medicine or other similar entity, of an independent  
11          study concerning the effect of medical workforce regula-  
12          tion and planning in general and in particular geographic  
13          areas. The results of such study together with rec-  
14          ommendations concerning the appropriateness of modi-  
15          fying or eliminating workforce regulations shall be com-  
16          piled in a report and transmitted by the Secretary to the  
17          President and the Congress.

18          (g) DEFINITIONS.—For purposes of this subtitle:

19                (1) The term “annual number of specialty posi-  
20                tions”, with respect to a medical specialty, means  
21                the number designated by the National Council  
22                under subsection (a) for eligible programs for the  
23                academic year involved.

24                (2) The term “designation period” means a 3-  
25                year period under subsection (c)(1) for which des-

1       ignations under subsection (a) are made by the Na-  
2       tional Council.

3               (3) The term “primary health care” means the  
4       following medical specialties: Family medicine, gen-  
5       eral internal medicine, general pediatrics, geriatric  
6       medicine, and obstetrics and gynecology. Only those  
7       participants in programs with a significant primary  
8       care training emphasis will be considered to have  
9       completed an eligible program in primary care for  
10      the purposes of subsection (b)(1). Determination of  
11      the meaning of a “significant primary care training  
12      emphasis” will be made by the National Council.

13              (4) The term “specialty position” means a posi-  
14      tion as a training participant.

15              (5) The term “training participant” means an  
16      individual who is enrolled in an approved physician  
17      training program.

18 **SEC. 3014. NATIONAL COUNCIL RECOMMENDATION OF**  
19                                   **NUMBER OF GRADUATE MEDICAL EDU-**  
20                                   **CATION POSITIONS.**

21      (a) IN GENERAL.—

22              (1) RECOMMENDATIONS.—Beginning with aca-  
23      demic year 2001-2002 and each subsequent aca-  
24      demic year, the National Council may after consid-

1 ering the factors described in paragraph (2) annu-  
2 ally recommend to the Secretary a change in—

3 (A) the aggregate number of all training  
4 participants entering the first year of graduate  
5 medical education training in approved physi-  
6 cian training programs nationwide determined  
7 under section 3012(4); and

8 (B) in accordance with subsection (b), the  
9 distribution of positions among medical special-  
10 ties determined under section 3013(a) and  
11 3013(b)(1)(D).

12 (2) FACTORS FOR CONSIDERATION.—In devel-  
13 oping a recommendation under paragraph (1), the  
14 Secretary shall consider the impact on rural, inner  
15 city, and public hospitals of reducing numbers of in-  
16 dividuals authorized to enter approved physician  
17 training programs and the appropriate supply of  
18 physicians in the aggregate and in particular med-  
19 ical specialties.

20 (b) LIMITATIONS ON RECOMMENDED PERCENT FOR  
21 PRIMARY CARE FOR ACADEMIC YEAR 2001–2002.—For  
22 the academic year 2001–2002, the number that the Na-  
23 tional Council may recommend under subsection (a)(1)(B)  
24 may not be more than 5 percentage points less or 5 per-

1 centage points more than the number described in section  
2 3013(b)(1)(D).

3 (c) CONSIDERATION AND IMPLEMENTATION BY THE  
4 SECRETARY.—The Secretary shall in the Secretary’s dis-  
5 cretion implement the recommendations by the National  
6 Council under subsection (a) in accordance with sections  
7 3012 and 3013(b)(1). The Secretary may not modify such  
8 recommendations.

9 **SEC. 3015. ALLOCATIONS AMONG SPECIALITIES AND PRO-**  
10 **GRAMS.**

11 (a) IN GENERAL.—Subject to the provisions of sec-  
12 tions 3012 and 3013, for each academic year, the National  
13 Council shall for each medical specialty make allocations  
14 among eligible programs of the annual number of specialty  
15 positions that the Council has designated for such year.  
16 The preceding sentence is subject to subsection (b)(3).

17 (b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

18 (1) IN GENERAL.—For each medical specialty,  
19 the National Council shall make the annual alloca-  
20 tions under subsection (a) for periods of 3 academic  
21 years.

22 (2) ADVANCE NOTICE TO PROGRAMS.—With re-  
23 spect to the first academic year of an allocation pe-  
24 riod established by the National Council, the Na-  
25 tional Council shall, not later than July 1 of the pre-

1 ceding academic year, notify each eligible program of  
2 the allocations made for the program for each of the  
3 academic years of the period.

4 (3) INITIAL PERIOD.—The first allocation pe-  
5 riod established by the National Council after the  
6 date of the enactment of this Act shall be the aca-  
7 demic years 1998–1999 through 2000–2001.

8 (c) CERTAIN CONSIDERATIONS.—

9 (1) GEOGRAPHIC AREAS.—In making alloca-  
10 tions under subsection (a) for eligible programs of  
11 the various geographic areas, the National Council  
12 shall include among the factors considered the—

13 (A) distribution of approved physician  
14 training programs with respect to population  
15 and community need; and

16 (B) historical distribution of approved phy-  
17 sician training programs among the geographic  
18 areas.

19 (2) QUALITY OF PROGRAMS.—In making alloca-  
20 tions under subsection (a) for eligible programs, the  
21 National Council shall consider the quality of such  
22 programs.

23 (3) UNDERREPRESENTATION OF MINORITY  
24 GROUPS AND WOMEN.—In making an allocation  
25 under subsection (a) for an eligible program, the

1 National Council shall include among the factors  
2 considered the following:

3 (A) The extent to which the population of  
4 training participants in the program includes  
5 training participants who are members of racial  
6 or ethnic minority groups and women.

7 (B) With respect to a racial or ethnic  
8 group or women represented among the train-  
9 ing participants, the extent to which the group  
10 is underrepresented in the field of medicine  
11 generally and in the various medical specialities.

12 (4) UNDERSERVED RURAL AND INNER-CITY  
13 COMMUNITIES.—In making allocations under sub-  
14 section (a) for eligible programs, the National Coun-  
15 cil shall consider the extent to which the population  
16 of training participants in the program includes  
17 training participants who have resided in rural or  
18 inner-city communities for a substantial period, as  
19 defined by the Council and the proportion of past  
20 participants in the program who are practicing in  
21 rural or inner-city communities.

22 (5) RECOMMENDATIONS OF PRIVATE ORGANIZA-  
23 TIONS.—In making allocations under subsection (a)  
24 for eligible programs, the National Council shall con-  
25 sider the recommendations of organizations rep-

1       resenting physicians in the medical specialties, the  
 2       recommendations of organizations representing aca-  
 3       demic medicine and the recommendations of organi-  
 4       zations representing consumers of the services of  
 5       such physicians.

6       (d) DEFINITIONS.—For purposes of this subtitle, the  
 7       term “allocation period” means a 3-year period under sub-  
 8       section (b)(1) for which allocations under subsection (a)  
 9       are made by the National Council.

10       **Subpart C—Costs of Graduate Medical Education**

11       **CHAPTER 1—OPERATION OF APPROVED**

12       **PHYSICIAN TRAINING PROGRAMS**

13       **SEC. 3031. FEDERAL FORMULA PAYMENTS TO QUALIFIED**  
 14               **ENTITIES FOR THE COSTS OF THE OPER-**  
 15               **ATION OF APPROVED PHYSICIAN TRAINING**  
 16               **PROGRAMS.**

17       (a) IN GENERAL.—In the case of a qualified entity  
 18       that in accordance with section 3032 submits to the Sec-  
 19       retary an application for calendar year 1997 or any subse-  
 20       quent calendar year, the Secretary shall make payments  
 21       for such year to the qualified entity for the purpose speci-  
 22       fied in subsection (b). The Secretary shall make the pay-  
 23       ments in an amount determined in accordance with section  
 24       3033 and 3034, and may administer the payments as a  
 25       contract, grant, or cooperative agreement.

1           (b) PAYMENTS FOR OPERATION OF APPROVED PHY-  
2   SICIAN TRAINING PROGRAMS.—The purpose of payments  
3   under subsection (a) is to assist a qualified applicant with  
4   the costs of operation of an approved physician training  
5   program. A funding agreement for such payments is that  
6   the qualified applicant involved will expend the payments  
7   only for such purpose or for such other related purposes  
8   as the Secretary may authorize.

9           (c) QUALIFIED APPLICANT; SUBPART DEFINITION.—

10           (1) IN GENERAL.—For purposes of this sub-  
11   part, the term “qualified applicant”, with respect to  
12   the calendar year involved, means an entity—

13           (A) that trains individuals in approved  
14   physician training programs; and

15           (B) that submits to the Secretary an appli-  
16   cation for such year in accordance with section  
17   3032.

18           (2) ENTITIES INCLUDED.—The term “qualified  
19   applicant” may include an approved physician train-  
20   ing program, teaching hospital, medical school,  
21   group practice, an entity representing two or more  
22   parties engaged in a formal association, a commu-  
23   nity health center or another entity operating an ap-  
24   proved physician training program.

1 (d) TREATMENT OF PODIATRIC AND DENTAL RESI-  
2 DENCY PROGRAMS.—Except as provided in section 3034,  
3 for the purposes of this subpart, an approved physician  
4 training program includes training programs approved by  
5 the Commission on Dental Accreditation or the Council  
6 of Podiatric Medical Education of the American Podiatric  
7 Medical Association. This subsection shall not apply for  
8 purposes of subpart B.

9 **SEC. 3032. APPLICATION FOR PAYMENTS.**

10 (a) IN GENERAL.—

11 (1) IN GENERAL.—For purposes of section  
12 3031(a), an application for payments under such  
13 section for a calendar year is in accordance with this  
14 section if—

15 (A) the eligible entity involved submits the  
16 application not later than the date specified by  
17 the Secretary;

18 (B) the application demonstrates that the  
19 condition described in subsection (b) is met  
20 with respect to the program;

21 (C) the application contains each funding  
22 agreement described in this part and the appli-  
23 cation provides such assurances of compliance  
24 with the agreements as the Secretary may re-  
25 quire; and

1 (D) the application is in such form, is  
2 made in such manner, and contains such agree-  
3 ments, assurances, and information as the Sec-  
4 retary determines to be necessary to carry out  
5 this part.

6 (2) CERTAIN ENTITIES.—If an applicant under  
7 paragraph (1) is an entity representing two or more  
8 parties—

9 (A) the application shall contain a written  
10 agreement, signed by all participants, in which  
11 all of the participants agree as to the manner  
12 in which the payments will be allocated; and

13 (B) the applicant shall agree to submit ad-  
14 ditional documentation, if requested by the Na-  
15 tional Council, that demonstrates that the  
16 funds are distributed in the manner agreed  
17 upon by all participants.

18 (b) CERTAIN CONDITIONS.—An eligible entity meets  
19 the condition described in this subsection for receiving  
20 payments under section 3031 for a calendar year if—

21 (1) the entity agrees to use such funds only to  
22 support an approved physician training program;

23 (2) with respect to—

24 (A) a specialty for which programs have  
25 received allocations under section 3015, the en-

1           tity agrees that funds will be used only to sup-  
2           port approved training programs for which the  
3           number of specialists in training is consistent  
4           with the allotment under section 3015; and

5                   (B) a specialty for which a voluntary pro-  
6           gram has received allocations under section  
7           3013(e), the entity agrees that funds will only  
8           be used to support approved training programs  
9           for which the number of specialists in training  
10          is consistent with the allocations under section  
11          3015(e); and

12                   (3) the entity notifies each residency training  
13          program director of each approved physician train-  
14          ing program operated by the entity of the amount of  
15          payments received by the entity under this section  
16          and sections 3051 and 3055 that is attributable to  
17          the number of training participants in the program.

18          (c) RESIDENCY TRAINING PROGRAM DIRECTOR.—  
19          For purposes of this section, the term “residency training  
20          program director” means an individual specified in the ap-  
21          plication of the entity as the official with primary adminis-  
22          trative responsibility for an approved physician training  
23          program.

1 **SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**  
2 **NUAL AMOUNT OF PAYMENTS.**

3 (a) GRADUATE MEDICAL EDUCATION ACCOUNT.—

4 (1) IN GENERAL.—Subject to paragraph (2)  
5 and except as provided in section 3034, the following  
6 amounts shall be available for a calendar year for  
7 making payments under sections 3031 and 3055  
8 from the Graduate Medical Education Account es-  
9 tablished under section 9551(a)(2)(A) of the Inter-  
10 nal Revenue Code of 1986:

11 (A) In the case of calendar year 1997,  
12 \$3,200,000,000.

13 (B) In the case of calendar year 1998,  
14 \$3,550,000,000.

15 (C) In the case of calendar year 1999,  
16 \$5,800,000,000.

17 (D) In the case of each of calendar years  
18 2000 and 2001, \$5,800,000,000.

19 (E) In the case of each subsequent cal-  
20 endar year, the amount specified in subpara-  
21 graph (C) increased by the product of such  
22 amount and the general health care inflation  
23 factor for such year (as defined in subsection  
24 (e)).

25 (2) TRANSITIONAL PROVISION.—

1           (A) IN GENERAL.—With respect to making  
2           payments under sections 3031 and 3055 for  
3           calendar year 1997 or 1998, the Secretary shall  
4           first make payments under section 3031 to eli-  
5           gible programs described in subparagraph (B)  
6           in the amount determined for the programs  
7           under subsection (b) for such year, and then,  
8           from such amounts as remain available under  
9           paragraph (1) for such year, shall make pay-  
10          ments under section 3031 to other eligible pro-  
11          grams and shall make payments under section  
12          3055.

13           (B) PARTICIPATING STATE.—An eligible  
14          program described in this subparagraph is such  
15          a program that is operated in a State that is  
16          a participating State under title I.

17          (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-  
18          BLE ENTITIES.—

19           (1) IN GENERAL.—Except as provided in sec-  
20          tion 3034, payment amounts with respect to any  
21          physician training program under this section shall  
22          be equal to the product of the number of full time  
23          equivalent training participants in the program, and  
24          the per resident amount for the training program.

25           (2) PER RESIDENT AMOUNT.—

1           (A) IN GENERAL.—Except as provided  
2 under subparagraph (B), the per resident  
3 amount for a training program shall be equal  
4 to—

5           (i) with respect to—

6           (I) the first calendar year during  
7 which the program receives payment  
8 under subsection (a), 90 percent;

9           (II) the second calendar year  
10 during which the program receives  
11 payment under subsection (a), 80 per-  
12 cent;

13           (III) the third calendar year dur-  
14 ing which the program receives pay-  
15 ment under subsection (a), 70 per-  
16 cent;

17           (IV) the fourth calendar year  
18 during which the program receives  
19 payment under subsection (a), 60 per-  
20 cent; and

21           (V) the fifth and subsequent cal-  
22 endar year during which the program  
23 receives payment under subsection  
24 (a), 50 percent;

1 of the approved FTE resident amount that  
2 would have been determined under section  
3 1886(h)(2)(D) of the Social Security Act  
4 (42 U.S.C. 1395ww(h)(2)(D)) for the hos-  
5 pital operating such approved physician  
6 training program for a cost reporting pe-  
7 riod beginning in such calendar year if the  
8 amendments made by section 4306 of the  
9 Health Security Act had not been made;  
10 and

11 (ii) with respect to—

12 (I) the first calendar year during  
13 which the program receives payment  
14 under subsection (a), 10 percent;

15 (II) the second calendar year  
16 during which the program receives  
17 payment under subsection (a), 20 per-  
18 cent;

19 (III) the third calendar year dur-  
20 ing which the program receives pay-  
21 ment under subsection (a), 30 per-  
22 cent;

23 (IV) the fourth calendar year  
24 during which the program receives

1 payment under subsection (a), 40 per-  
2 cent; and

3 (V) the fifth and subsequent cal-  
4 endar years during which the program  
5 receives payment under subsection  
6 (a), 50 percent;

7 of the geographically adjusted national av-  
8 erage per resident amount.

9 (B) MINIMUM PER RESIDENT AMOUNT.—

10 Notwithstanding the provisions of subparagraph  
11 (A), the per resident amount for a training pro-  
12 gram shall not be less than 75 percent of the  
13 geographically adjusted national average per  
14 resident amount determined in accordance with  
15 subparagraph (A)(ii).

16 (C) NO HISTORIC PAYMENT BASIS.—For  
17 purposes of subparagraph (A)(i), the Secretary  
18 shall determine the appropriate per resident  
19 amount applicable to an entity that—

20 (i) has an approved physician training  
21 program that sponsored or is affiliated  
22 with more than one hospital that had a per  
23 resident amount determined under section  
24 1886(h) of the Social Security Act which

1 reflects the average per resident amounts  
2 under such section for such hospitals; or

3 (ii) is an institution that did not have  
4 a per resident amount determined under  
5 such section for cost reporting periods be-  
6 ginning before 1996 which reflects the na-  
7 tional average per resident amount.

8 (3) ADJUSTMENT FACTOR.—Payments under  
9 this section shall be subject to an adjustment factor,  
10 as determined by the Secretary, so that total pay-  
11 ments in any year will not exceed the amounts speci-  
12 fied in subsection (a) and as provided in subsection  
13 (d).

14 (4) ADDITIONAL PROVISIONS REGARDING NA-  
15 TIONAL AVERAGE COST.—

16 (A) DETERMINATION OF NATIONAL AVER-  
17 AGE COST.—The Secretary shall in accordance  
18 with clause (ii) of subsection (b)(2)(A) deter-  
19 mine, for academic year 1992–1993, an amount  
20 equal to the geographically adjusted national  
21 average per resident amount described in such  
22 clause with respect to training a participant in  
23 an approved physician training program. The  
24 national average applicable under such clause  
25 for a calendar year for such programs is, sub-

1           ject to subparagraph (B), the amount deter-  
2           mined under the preceding sentence increased  
3           by the amount necessary to offset the effects of  
4           inflation occurring since academic year 1992–  
5           1993, as determined through use of the con-  
6           sumer price index.

7           (B) GEOGRAPHIC ADJUSTMENT.—The na-  
8           tional average determined under subparagraph  
9           (A) and applicable to a calendar year shall, in  
10          the case of the eligible entity involved, be ad-  
11          justed by a factor to reflect regional differences  
12          in the applicable wage and wage-related costs.

13          (5) FUNDING LEVEL AND ALLOCATION METH-  
14          OD.—Not later than January 1, 1998, the Secretary  
15          shall complete a study to determine the effect and  
16          appropriateness of the funding level and allocation  
17          method described in subsection (a) and paragraphs  
18          (1), (2), (3), and (4) of this subsection on the oper-  
19          ation of training programs and on national work-  
20          force goals and shall compile the findings and rec-  
21          ommendations derived from such study in a report  
22          to be submitted to the President and the Congress.

23          (c) DETERMINATION OF FULL-TIME-EQUIVALENT  
24          TRAINING PARTICIPANTS.—

1           (1) RULES.—The Secretary shall establish rules  
2 consistent with this subsection for the computation  
3 of the number of full-time-equivalent training par-  
4 ticipants in approved physician training programs  
5 under subsection (b)(1).

6           (2) ADJUSTMENT FOR PART-YEAR OR PART-  
7 TIME TRAINING PARTICIPANTS.—Such rules shall  
8 take into account individuals who serve as training  
9 participants for only a portion of a period in an ap-  
10 proved physician training program or simultaneously  
11 with more than one such program.

12           (3) WEIGHTING FACTORS FOR CERTAIN TRAIN-  
13 ING PARTICIPANTS.—

14           (A) IN GENERAL.—Subject to paragraph  
15 (4), such rules shall provide, in calculating the  
16 number of full-time-equivalent training partici-  
17 pants in an approved physician training pro-  
18 gram—

19                   (i) for a training participant who is in  
20 the participant's initial training period, the  
21 weighting factor is 1.00,

22                   (ii) except as provided in clause (iii),  
23 for a training participant who is not in the  
24 participant's initial training period, the  
25 weighting factor is 0.75, and

1 (iii) in an academic year in which the  
2 total number of training participant posi-  
3 tions in all approved physician training  
4 programs does not exceed—

5 (I) 134 percent of United States  
6 medical school graduates in academic  
7 year 1997–1998, the weighting factor  
8 for a training participant who is not  
9 in the training participant’s initial  
10 training period is 0.70;

11 (II) 126 percent of United States  
12 medical school graduates in academic  
13 year 1997–1998, the weighting factor  
14 for such a participant is 0.90;

15 (III) 118 percent of United  
16 States medical school graduates in  
17 1997–1998, the weighting factor for  
18 such a participant is 0.95 percent;  
19 and

20 (IV) 110 percent of United  
21 States medical school graduates in  
22 academic year 1997–1998, the  
23 weighting factor for such a partici-  
24 pant, the weighting factor is 1.0.

1           (B) STUDY.—Not later than January 1,  
2           1998, the Secretary shall complete a study to  
3           determine the effect that applying weighting  
4           factors in calculating the number of full-time-  
5           equivalent training participants would have on  
6           supporting national workforce goals.

7           (4) INTERNATIONAL MEDICAL GRADUATES RE-  
8           QUIRED TO PASS FMGEMS EXAMINATION.—Such  
9           rules shall provide that, in the case of an individual  
10          who is an international medical graduate, the indi-  
11          vidual shall not be counted as a training participant  
12          unless—

13                 (A) the individual has passed the  
14                 FMGEMS examination or the U.S. Medical Li-  
15                 censing Examination, or

16                 (B) the individual has previously received  
17                 certification from, or has previously passed the  
18                 examination of, the Educational Commission for  
19                 Foreign Medical Graduates.

20          (5) COUNTING TIME SPENT IN OUTPATIENT  
21          SETTINGS.—Such rules shall provide that only time  
22          spent in activities relating to patient care shall be  
23          counted and that all the time so spent by a training  
24          participant under an approved physician training  
25          program shall be counted towards the determination

1 of full-time equivalency, without regard to the set-  
2 ting in which the activities are performed.

3 (d) LIMITATION.—Subject to subsection (a), if the  
4 amount available from the Graduate Medical Education  
5 Account established under section 9551(a)(2)(A) of the  
6 Internal Revenue Code of 1986 for a calendar year is in-  
7 sufficient for providing each eligible entity with the  
8 amount of payments determined under subsection (b) for  
9 the entity for such year, the Secretary shall make such  
10 pro rata reductions in the amounts so determined as may  
11 be necessary to ensure that the total of payments made  
12 under section 3031 for such year equals the amount speci-  
13 fied under section 3033(a).

14 (e) DEFINITIONS.—For purposes of this subtitle:

15 (1) CONSUMER PRICE INDEX.—The term “con-  
16 sumer price index” means the Consumer Price Index  
17 for All Urban Consumers (U.S. city average).

18 (2) INTERNATIONAL MEDICAL GRADUATE.—The  
19 term “international medical graduate” means a  
20 training participant who is a graduate of a school of  
21 medicine, school of osteopathy, school of dentistry,  
22 or school of podiatry that is not—

23 (A) a school of medicine accredited by the  
24 Liaison Committee on Medical Education of the  
25 American Medical Association and the Associa-

1           tion of American Medical Colleges (or approved  
2           by such Committee as meeting the standards  
3           necessary for such accreditation),

4           (B) a school of osteopathic medicine ac-  
5           credited by the American Osteopathic Associa-  
6           tion, or approved by such Association as meet-  
7           ing the standards necessary for such accredita-  
8           tion,

9           (C) a school of dentistry which is accred-  
10          ited by the Commission on Dental Accredita-  
11          tion, or

12          (D) a school of podiatric medicine which is  
13          accredited by the Council of Podiatric Medical  
14          Education of the American Podiatric Medical  
15          Association.

16          (3) FMGEMS EXAMINATION.—The term  
17          “FMGEMS examination” means parts I and II of  
18          the Foreign Medical Graduate Examination in the  
19          Medical Sciences or any successor examination rec-  
20          ognized by the Secretary for this purpose.

21          (4) GENERAL HEALTH CARE INFLATION FAC-  
22          TOR.—(A) The term “general health care inflation  
23          factor”, with respect to a year, means the percent-  
24          age increase in the consumer price index for the year  
25          plus the following:

1 (i) For 1997, 1.0 percentage points.

2 (ii) For 1998, 0.5 percentage points.

3 (iii) For 1999 and for 2000, 0 percentage  
4 points.

5 (B) YEARS AFTER 2000.—

6 (i) RECOMMENDATION TO CONGRESS.—In  
7 1999, the Secretary shall submit to Congress  
8 recommendations, after consultation with the  
9 Federal Reserve Board, on what the general  
10 health care inflation factor should be for years  
11 beginning with 2001.

12 (ii) FAILURE OF CONGRESS TO ACT.—If  
13 the Congress fails to enact a law specifying the  
14 general health care inflation factor for a year  
15 after 2000, the Secretary, in January of the  
16 year before the year involved, shall compute  
17 such factor for the year involved. Such factor  
18 shall be the product of the factors described in  
19 subparagraph (C) for that fiscal year, minus 1.

20 (iii) STUDY BY FEDERAL RESERVE  
21 BOARD.—Not later than January 1, 1999, the  
22 Federal Reserve Board shall conduct a study,  
23 and report to the Secretary, concerning what  
24 the general health care inflation factor should  
25 be for years beginning with 2001. Such study

1 shall consider whether continued indexing with  
2 respect to such factor is advisable and whether  
3 the consumer price index should be used (in  
4 whole or in part, modified or unmodified) with  
5 respect to premium caps for future years. The  
6 recommendations of the Federal Reserve Board  
7 under such study shall be considered in the rec-  
8 ommendations submitted under clause (i).

9 (C) FACTORS.—The factors described in this  
10 subparagraph for a year are the following:

11 (i) CPI.—1 plus the percentage change in  
12 the CPI for the year, determined based upon  
13 the percentage change in the average of the  
14 CPI for the 12-month period ending with Au-  
15 gust 31 of the previous fiscal year over such av-  
16 erage for the preceding 12-month period.

17 (ii) REAL GDP PER CAPITA.—1 plus the  
18 average annual percentage change in the real,  
19 per capita gross domestic product of the United  
20 States during the 3-year period ending in the  
21 preceding calendar year, determined by the Sec-  
22 retary based on data supplied by the Depart-  
23 ment of Commerce.

1           (5) INITIAL TRAINING PERIOD.—The term “ini-  
2           tial training period” means the period of time re-  
3           quired for board eligibility, except that—

4                   (A) except as provided in subparagraph  
5                   (B), in no case shall the initial period of partici-  
6                   pation exceed an aggregate period of formal  
7                   training of more than 5 years for any indi-  
8                   vidual, and

9                   (B) a period, of not more than 2 years,  
10                  during which an individual is in a—

11                           (i) residency or fellowship program in  
12                           geriatric medicine, preventive medicine, or  
13                           adolescent medicine, or

14                           (ii) a fellowship program in family  
15                           medicine, general internal medicine or gen-  
16                           eral pediatrics, which provides training for  
17                           a faculty position in family medicine, gen-  
18                           eral internal medicine or general pediat-  
19                           rics,

20                  shall be treated as part of the initial training  
21                  participation period, but shall not be counted  
22                  against any limitation on the initial training pe-  
23                  riod.

24                  The initial training period shall be determined, with  
25                  respect to a training participant, as of the time the

1 training participant enters any approved physician  
2 training program.

3 (6) PERIOD OF TIME REQUIRED FOR BOARD  
4 ELIGIBILITY.—

5 (A) GENERAL RULE.—Subject to subpara-  
6 graphs (B) and (C), the term “period of time  
7 required for board eligibility” means, for a  
8 training participant, the minimum number of  
9 years of formal training necessary to satisfy the  
10 requirements for initial board eligibility in the  
11 particular specialty for which the training par-  
12 ticipant is training.

13 (B) APPLICATION OF 1985–1986 DIREC-  
14 TORY.—Except as provided in subparagraph  
15 (C), the period of time required for board eligi-  
16 bility shall be such period specified in the  
17 1985–1986 Directory of Residency Training  
18 Programs published by the Accreditation Coun-  
19 cil on Graduate Medical Education or a more  
20 current version of such Directory or the equiva-  
21 lent directory regarding postdoctoral training  
22 for osteopathic physician training programs.

23 (C) CHANGES IN PERIOD OF TIME RE-  
24 QUIRED FOR BOARD ELIGIBILITY.—If the Ac-  
25 creditation Council on Graduate Medical Edu-

1 cation, in its Directory of Residency Training  
2 Programs or the equivalent directory regarding  
3 postdoctoral training for osteopathic physician  
4 training programs—

5 (i) increases the minimum number of  
6 years of formal training necessary to sat-  
7 isfy the requirements for a specialty, above  
8 the period specified in its 1985–1986 Di-  
9 rectory, the Secretary may increase the pe-  
10 riod of time required for board eligibility  
11 for that specialty, but not to exceed the pe-  
12 riod of time required for board eligibility  
13 specified in that later Directory, or

14 (ii) decreases the minimum number of  
15 years of formal training necessary to sat-  
16 isfy the requirements for a specialty, below  
17 the period specified in its 1985–1986 Di-  
18 rectory, the Secretary may decrease the pe-  
19 riod of time required for board eligibility  
20 for that specialty, but not below the period  
21 of time required for board eligibility speci-  
22 fied in that later Directory.

1 **SEC. 3034. PAYMENTS FOR DENTAL AND PODIATRIC POSI-**  
2 **TIONS.**

3 (a) IN GENERAL.—Except as provided in subsections  
4 (b) and (c), the provisions of this chapter shall apply with  
5 respect to dental and podiatric medicine training pro-  
6 grams.

7 (b) LIMITATION.—Subject to the amount made avail-  
8 able under section 3033(a), the aggregate amount avail-  
9 able for making payments to all approved physician train-  
10 ing programs in dentistry and podiatric medicine may not  
11 exceed \$200,000,000 in any calendar year.

12 (c) PAYMENT METHODOLOGY.—The Secretary shall  
13 determine the amount to be paid to approved dental and  
14 podiatric training programs on the basis of a methodology  
15 to be developed by the Secretary that is equivalent to the  
16 methodology described in section 3033(b)(5).

17 **CHAPTER 2—ACADEMIC HEALTH CEN-**  
18 **TERS AND OTHER ELIGIBLE INSTITU-**  
19 **TIONS**

20 **SEC. 3051. FEDERAL FORMULA PAYMENTS TO ACADEMIC**  
21 **HEALTH CENTERS AND OTHER ELIGIBLE IN-**  
22 **STITUTIONS.**

23 (a) IN GENERAL.—In the case of an eligible institu-  
24 tion that in accordance with section 3052 submits to the  
25 Secretary a written request for calendar year 1997 or any  
26 subsequent calendar year, the Secretary shall make pay-

1 ments for such year to the eligible institution for the pur-  
2 pose specified in subsection (b). The Secretary shall make  
3 the payments in an amount determined in accordance with  
4 section 3053, and may administer the payments as a con-  
5 tract, grant, or cooperative agreement.

6 (b) PAYMENTS FOR COSTS INCURRED BY ELIGIBLE  
7 INSTITUTIONS.—

8 (1) COSTS ATTRIBUTABLE TO ACADEMIC NA-  
9 TURE OF INSTITUTIONS.—With respect to an eligible  
10 institution that is a qualified academic health center  
11 or a qualified teaching hospital, the purpose of pay-  
12 ments under subsection (a) is to assist such institu-  
13 tions with costs that are not routinely incurred by  
14 other entities in providing health services, but are  
15 incurred by such institutions in providing health  
16 services by virtue of the academic nature of such in-  
17 stitutions. Such costs include—

18 (A) with respect to productivity in the pro-  
19 vision of health services, costs resulting from  
20 the reduced rate of productivity of faculty due  
21 to teaching responsibilities;

22 (B) the uncompensated costs of clinical re-  
23 search; and

24 (C) exceptional costs associated with the  
25 treatment of health conditions with respect to

1           which an eligible institution has specialized ex-  
2           pertise (including treatment of rare diseases,  
3           treatment of unusually severe conditions, and  
4           providing other specialized health care).

5           (2) HIGH INTENSITY NONTEACHING RURAL  
6           HOSPITAL.—With respect to an eligible institution  
7           that is a high intensity nonteaching rural hospital,  
8           the purpose of payments under subsection (a) is to  
9           assist the institution with the costs of treating a  
10          substantial number of severely ill patients.

11          (c) DEFINITIONS.—

12           (1) ACADEMIC HEALTH CENTER.—For purposes  
13           of this subtitle, the term “academic health center”  
14           means an entity that operates a teaching hospital  
15           that sponsors or is affiliated with an approved physi-  
16           cian training program.

17           (2) ELIGIBLE INSTITUTION.—For purposes of  
18           this subtitle, the term “eligible institution”, with re-  
19           spect to a calendar year, means a qualified academic  
20           health center, qualified teaching hospital, or high in-  
21           tensity nonteaching rural hospital that submits to  
22           the Secretary a written request in accordance with  
23           section 3052.

24           (3) HIGH INTENSITY NONTEACHING RURAL  
25           HOSPITAL.—For purposes of this subtitle, the term

1 “high intensity nonteaching rural hospital” means a  
2 nonteaching hospital located in a rural area as de-  
3 fined in section 1886(d)(2)(D) of the Social Security  
4 Act (42 U.S.C. 1395ww(d)(2)(D)) that the Sec-  
5 retary determines has a case-mix index (defined as  
6 the average weight of all cases in the hospital for all  
7 diagnosis-related groups as determined in accord-  
8 ance with section 1886(d)(4) of such Act (42 U.S.C.  
9 1395ww(d)(4)) of greater than 120 percent of the  
10 national average case-mix index for all rural hos-  
11 pitals.

12 (4) QUALIFIED CENTER OR HOSPITAL.—For  
13 purposes of this subtitle:

14 (A) The term “qualified academic health  
15 center” means an academic health center that  
16 operates a teaching hospital.

17 (B) The term “qualified teaching hospital”  
18 means any teaching hospital other than a teach-  
19 ing hospital that is operated by an academic  
20 health center.

21 (5) TEACHING HOSPITAL.—For purposes of this  
22 subtitle, the term “teaching hospital” means a hos-  
23 pital that sponsors or is affiliated with an approved  
24 physician training program (as defined in section  
25 3011(b) or section 3031(d)).

1 **SEC. 3052. REQUEST FOR PAYMENTS.**

2 (a) IN GENERAL.—For purposes of section 3051, a  
3 written request for payments under such section is in ac-  
4 cordance with this section if—

5 (1) the eligible institution involved submits the  
6 request not later than the date specified by the Sec-  
7 retary;

8 (2) the request is accompanied by each funding  
9 agreement described in this part; and

10 (3) the request is in such form, is made in such  
11 manner, and contains such agreements, assurances,  
12 and information as the Secretary determines to be  
13 necessary to carry out this part.

14 (b) CONTINUED STATUS AS ELIGIBLE INSTITU-  
15 TION.—A funding agreement for payments under section  
16 3051 is that the eligible institution involved will maintain  
17 status as such an eligible institution. For purposes of this  
18 subtitle, the term “funding agreement”, with respect to  
19 payments under section 3051 to such an eligible institu-  
20 tion, means that the Secretary may make the payments  
21 only if the eligible institution makes the agreement in-  
22 volved.

23 (c) COMPLIANCE WITH SPECIALTY ALLOCATIONS.—  
24 A funding agreement for payments under section 3051 is  
25 that an eligible institution that operates or is affiliated  
26 with an approved physician training program shall receive

1 such payments only if the number of specialists in such  
2 a program is consistent with the allotment under section  
3 3015 or 3013(e).

4 **SEC. 3053. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**  
5 **NUAL AMOUNT OF PAYMENTS.**

6 (a) ANNUAL ACADEMIC HEALTH CENTER AC-  
7 COUNT.—

8 (1) AVAILABILITY OF FUNDS FROM ACCOUNT.—

9 Except as provided in paragraph (2), the following  
10 amounts shall be available for a calendar year for  
11 making payments under section 3051 from the Aca-  
12 demic Health Center Account established under sec-  
13 tion 9551(a)(2)(B) of the Internal Revenue Code of  
14 1986 is the following, as applicable to the calendar  
15 year:

16 (A) In the case of calendar year 1997,  
17 \$6,280,000,000.

18 (B) In the case of calendar year 1997,  
19 \$7,250,000,000.

20 (C) In the case of calendar year 1997,  
21 \$8,220,000,000.

22 (D) In the case of calendar year 2000,  
23 \$9,400,000,000.

24 (E) In the case of calendar year 2001,  
25 \$10,640,000,000.

1           (F) In the case of each subsequent cal-  
2           endar year, the amount specified in subpara-  
3           graph (E) increased by the product of such  
4           amount and the general health care inflation  
5           factor (as defined in subsection (d)).

6           (2) SPECIAL ALLOTMENTS.—Of the amounts  
7           available for a calendar year for making payments  
8           under subsection (a) pursuant to paragraph (1)—

9           (A) such amounts as are necessary shall be  
10          reserved to make payments to eligible institu-  
11          tions that are high intensity nonteaching rural  
12          hospitals; and

13          (B) the remainder of the amounts available  
14          for making payments under subsection (a),  
15          shall be expended for making payments under  
16          section 3051 to other eligible institutions.

17          (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-  
18          BLE INSTITUTIONS.—

19           (1) QUALIFIED ACADEMIC HEALTH CENTERS  
20          AND QUALIFIED TEACHING HOSPITALS.—The  
21          amount of payments required in section 3051 to be  
22          made to a qualified academic health center or a  
23          qualified teaching hospital for a calendar year is an  
24          amount equal to the product of—

1 (A) the amount available for making such  
2 payments for the calendar year from the Aca-  
3 demic Health Center Account established under  
4 section 9551(a)(2)(B) of the Internal Revenue  
5 Code of 1986; and

6 (B) the percentage constituted by the ratio  
7 of—

8 (i) the product of—

9 (I) the sum, for all discharges of  
10 individuals, of the amounts otherwise  
11 paid on behalf of such individuals;  
12 and

13 (II) an adjustment factor equal  
14 to  $(e \text{ raised to the power } (.405 \times r)$   
15  $-1)$ , where “r” is the ratio of the  
16 qualified academic health center’s or  
17 the qualified teaching hospital’s full-  
18 time equivalent training participants  
19 to beds and “e” is the natural log of  
20 one; and

21 (ii) the sum of the respective amounts  
22 determined under clause (i) for qualified  
23 academic health centers and qualified  
24 teaching hospitals.

1           (2) HIGH INTENSITY NONTEACHING RURAL  
2 HOSPITAL.—Subject to the annual amount reserved  
3 for high intensity nonteaching rural hospitals under  
4 subsection (a)(2)(A) for a calendar year, the amount  
5 required under section 3051 to be made to a high  
6 intensity nonteaching rural hospital is an amount  
7 equal to 5 percent of the inpatient costs of patient  
8 care for all patients of the hospital.

9           (3) ADJUSTMENT FACTOR.—Payments under  
10 this section shall be subject to an adjustment factor,  
11 as determined by the Secretary, so that total pay-  
12 ments in any year will not exceed the amounts speci-  
13 fied in 3053(a).

14       (c) REPORT REGARDING MODIFICATIONS IN FOR-  
15 MULA.—Not later than July 1, 2000, the Secretary shall  
16 submit to the Congress a report containing any rec-  
17 ommendations of the Secretary for the modification of the  
18 program of formula payments described in this chapter.  
19 In preparing such report the Secretary shall consider—

20           (1) the costs described in section 3051(b) in-  
21 curred by academic health centers;

22           (2) the adequacy of the formula payments es-  
23 tablished in this chapter to cover such costs, taking  
24 into account any additional revenues to cover such

1 costs paid by other payers, including private health  
2 plans;

3 (3) the impact of the current payment method-  
4 ology on training in the ambulatory setting of na-  
5 tional workforce goals, and its effect on the edu-  
6 cation and training of primary care physicians;

7 (4) the importance to the maintenance of a  
8 quality national health care system of academic  
9 health centers in providing for the training of health  
10 professionals, in conducting clinical research, and in  
11 providing innovative, technically advanced care; and

12 (5) the overall impact of the reformed health  
13 care system on the ability of academic health centers  
14 to perform such functions.

15 (d) GENERAL HEALTH CARE INFLATION FACTOR.—

16 For purposes of this subtitle, the term “general health  
17 care inflation factor”, with respect to a year, has the  
18 meaning given such term in section 3033(e)(4) for such  
19 year.

20 **Subpart D—Transitional Provisions**

21 **SEC. 3055. TRANSITIONAL PAYMENTS TO INSTITUTIONS.**

22 (a) PAYMENTS REGARDING EFFECTS OF SUBPART B  
23 ALLOCATIONS.—For each of the calendar years specified  
24 in subsection (b)(2), in the case of an eligible entity that  
25 submits to the Secretary an application for such year in

1 accordance with subsection (d), the Secretary shall make  
2 payments for the year to the entity for the purpose speci-  
3 fied in subsection (c). The Secretary shall make the pay-  
4 ments in an amount determined in accordance with sub-  
5 section (e), and may administer the payments as a con-  
6 tract, grant, or cooperative agreement.

7 (b) ELIGIBLE ENTITIES LOSING SPECIALTY POSI-  
8 TIONS; RELEVANT YEARS REGARDING PAYMENTS.—

9 (1) ELIGIBLE ENTITIES LOSING SPECIALTY PO-  
10 SITIONS.—The Secretary may make payments under  
11 subsection (a) to an eligible entity only if, with re-  
12 spect to the calendar year involved, the entity meets  
13 the following conditions:

14 (A) During the year preceding the initi-  
15 ation of transitional payments, the entity—

16 (i) received payments under section  
17 1886(h) of the Social Security Act (42  
18 U.S.C. 1395ww(h)) for residents in one or  
19 more approved programs, or

20 (ii) sponsored or was affiliated with  
21 one or more approved physician training  
22 programs that received payments under  
23 section 3031.

24 (B) The aggregate number of full-time-  
25 equivalent training participant positions in such

1 programs have been reduced below the aggregate  
2 number of full-time-equivalent training  
3 participant positions for the academic year  
4 1993–1994.

5 (C) The aggregate number of full-time-  
6 equivalent training participant positions in such  
7 programs spend in patient care activities at the  
8 hospital have been reduced below the aggregate  
9 number of full-time-equivalent training partici-  
10 pant positions for the academic year 1993–  
11 1994, as a result of allocations under subpart  
12 B, or as a result of voluntary changes under  
13 section 3013(e) prior to January 1, 2002.

14 (2) RELEVANT YEARS.—Except as provided in  
15 subsection (e)(3), the Secretary may make payments  
16 under subsection (a) to an eligible entity only for the  
17 first four calendar years after the initial calendar  
18 year for which the entity meets the conditions de-  
19 scribed in paragraph (1).

20 (3) ELIGIBLE ENTITY.—For purposes of this  
21 section, the term “eligible entity” means a qualified  
22 academic health center or teaching hospital entity  
23 that submits to the Secretary an application in ac-  
24 cordance with subsection (d).

1 (c) PURPOSE OF PAYMENTS.—The purpose of pay-  
2 ments under subsection (a) is to assist an eligible entity  
3 with the costs of operation. A funding agreement for such  
4 payments is that the entity involved will expend the pay-  
5 ments only for such purpose.

6 (d) APPLICATION FOR PAYMENTS.—For purposes of  
7 subsection (a), an application for payments under such  
8 subsection is in accordance with this subsection if—

9 (1) the eligible entity involved submits the ap-  
10 plication not later than the date specified by the  
11 Secretary;

12 (2) the application demonstrates that the entity  
13 meets the conditions described in subsection (b)(1)  
14 and that the entity has cooperated with the approved  
15 physician training programs of the entity in meeting  
16 the condition described in section 3032(b);

17 (3) the application contains each funding agree-  
18 ment described in this subpart and the application  
19 provides such assurances of compliance with the  
20 agreements as the Secretary may require; and

21 (4) the application is in such form, is made in  
22 such manner, and contains such agreements, assur-  
23 ances, and information as the Secretary determines  
24 to be necessary to carry out this subpart.

25 (e) AMOUNT OF PAYMENTS.—

1           (1) IN GENERAL.—Subject to the amounts  
2 available from the Graduate Medical Education Ac-  
3 count established under section 9551(a)(2)(A) of the  
4 Internal Revenue Code of 1986 in the calendar year  
5 involved, the amount of payments required in sub-  
6 section (a) to be made to an eligible entity for such  
7 year is the product of the amount determined under  
8 paragraph (2) and the applicable percentage speci-  
9 fied in paragraph (3).

10           (2) NUMBER OF SPECIALTY POSITIONS LOST.—  
11 For purposes of paragraph (1), the amount deter-  
12 mined under this paragraph for an eligible entity for  
13 the calendar year involved is the product of—

14           (A) an amount equal to the aggregate  
15 number of full-time equivalent specialty posi-  
16 tions lost; and

17           (B) the amount that would be received  
18 under section 3033 for each speciality position  
19 lost.

20           (3) APPLICABLE PERCENTAGE.—

21           (A) IN GENERAL.—Except as provided  
22 under subparagraph (B), for purposes of para-  
23 graph (1), the applicable percentage for a cal-  
24 endar year is the following, as applicable to  
25 such year:

1 (i) For the first calendar year after  
2 calendar year 1996 for which the eligible  
3 entity involved meets the conditions de-  
4 scribed in subsection (b)(1), 100 percent.

5 (ii) For the second such year, 75 per-  
6 cent.

7 (iii) For the third such year, 50 per-  
8 cent.

9 (iv) For the fourth such year, 25 per-  
10 cent.

11 (B) EXCEPTIONS.—

12 (i) URBAN OR RURAL UNDERSERVED  
13 COMMUNITIES.—If the Secretary deter-  
14 mines that access to health care in a rural  
15 or urban underserved community would be  
16 impaired by the annual reductions of the  
17 applicable percentage described in subpara-  
18 graph (A), the Secretary may eliminate  
19 such annual reduction or adjust such per-  
20 centage (at the discretion of the Secretary)  
21 to eligible institutions in such a commu-  
22 nity.

23 (ii) VOLUNTARY COMPLIANCE POSI-  
24 TIONS.—For the number of positions de-  
25 termined in paragraph (4)(A) that result

1 from voluntary reductions in the number of  
2 specialty positions under section 3013(e),  
3 the applicable percentage for a calendar  
4 year is the following as applicable to such  
5 year:

6 (I) For the first 2 calendar years  
7 after calendar year 1997 for which  
8 the eligible entity involved meets the  
9 conditions described in subsection  
10 (b)(1), 100 percent.

11 (II) For the third such year, 75  
12 percent.

13 (III) For the fourth such year,  
14 50 percent.

15 (IV) For the fifth such year, 25  
16 percent.

17 (4) DETERMINATION OF SPECIALTY POSITIONS

18 LOST.—

19 (A) For purposes of this paragraph, the  
20 aggregate number of specialty positions lost,  
21 with respect to a calendar year, is the difference  
22 between—

23 (i) the aggregate number of specialty  
24 positions described in subparagraph (B)  
25 that are estimated for the eligible entity in-

1           involved for the academic year beginning in  
2           such calendar year; and

3                   (ii) the aggregate number of such spe-  
4           cialty positions at the entity for academic  
5           year 1993–1994.

6           (B) For purposes of subparagraph (A), the  
7           specialty positions described in this subpara-  
8           graph are specialty positions in the medical spe-  
9           cialties with respect to which payments under  
10          section 3031 are made to the approved physi-  
11          cian training programs of the eligible entities  
12          involved.

13          (C) The total number of physicians lost for  
14          all eligible entities may not exceed the number  
15          by which the aggregate number of specialty po-  
16          sitions with respect to which payments are  
17          made under section 3031 for the academic year  
18          beginning in such calendar year is below the  
19          number of full-time-equivalent positions for the  
20          academic year 1993–1994.

21 **SEC. 3056. WAIVER OF FOREIGN COUNTRY RESIDENCE RE-**  
22 **QUIREMENT WITH RESPECT TO INTER-**  
23 **NATIONAL MEDICAL GRADUATES.**

24          (a) WAIVER.—Section 212(e) of the Immigration and  
25          Nationality Act (8 U.S.C. 1182(e)) is amended—

1           (1) in the first proviso by inserting “(or, in the  
2 case of an alien described in clause (iii), pursuant to  
3 the request of an interested State agency)” after  
4 “interested United States Government agency”; and

5           (2) by inserting after “public interest” the fol-  
6 lowing: “except that in the case of a waiver re-  
7 quested by an interested State agency the waiver  
8 shall be subject to the requirements of section  
9 214(k)”.

10       (b) RESTRICTIONS ON WAIVER.—Section 214 of that  
11 Act (8 U.S.C. 1184) is amended by adding at the end the  
12 following:

13       “(k)(1) In the case of a request by an interested  
14 State agency for a waiver of the two-year foreign residence  
15 requirement under section 212(e) with respect to an alien  
16 described in clause (iii) of that section, the Attorney Gen-  
17 eral shall not grant such waiver unless—

18           “(A) in the case of an alien who is otherwise  
19 contractually obligated to return to a foreign country  
20 the Director of such country furnishes a statement  
21 in writing that it has no objection to such waiver;

22           “(B) the alien demonstrates a bona fide offer of  
23 full-time employment at a health facility and begins  
24 employment at such facility within 90 days of arrival  
25 and agrees to continue to work in accordance with

1 paragraph (2) at the health care facility in which the  
2 alien is employed for a total of not less than 3 years  
3 (unless the Attorney General determines that ex-  
4 tenuating circumstances such as the closure of the  
5 facility or hardship to the alien would justify a lesser  
6 period of time);

7 “(C) the alien agrees to practice medicine in ac-  
8 cordance with paragraph (2) for a total of not less  
9 than 3 years only in the geographic area or areas  
10 which are designated by the Secretary of Health and  
11 Human Services as having a shortage of health care  
12 professionals; and

13 “(D) the grant of such waiver would not cause  
14 the number of waivers allotted for that State for  
15 that fiscal year to exceed twenty.

16 “(2) Whenever an interested State agency requests  
17 the waiver of the two-year residence requirement under  
18 section 212(e) with respect to an alien described in clause  
19 (iii) of that section, the Attorney General shall adjust the  
20 status of the alien to that of an alien described in section  
21 101(a)(15)(H)(b).

22 “(3) If an alien whose status was adjusted under  
23 paragraph (2) demonstrates that the alien has worked for  
24 a period of 10 years in a health professional shortage area,  
25 then the Attorney General may approve a petition filed

1 on the alien's behalf by the health care facility in which  
2 the alien is employed seeking adjustment of the alien's sta-  
3 tus to that of a special immigrant described in section  
4 101(a)(27)(L).

5       “(4) Notwithstanding any other provision of this sub-  
6 section, the two-year foreign residence requirement under  
7 section 212(e) shall apply with respect to an alien de-  
8 scribed in clause (iii) of that section, who has not other-  
9 wise been accorded status under section 101(a)(27)(L), if  
10 at any time the alien practices medicine in an area other  
11 than an area described in paragraph (1)(C).”.

12       (c) SPECIAL IMMIGRANT STATUS.—Section  
13 101(a)(27) of the Immigration and Nationality Act is  
14 amended by adding at the end the following new subpara-  
15 graph:

16               “(L) immigrants whose status have been  
17 adjusted from that of an alien described in  
18 paragraph (15)(H)(b) pursuant to section  
19 214(k)(2), except that not more than 500 immi-  
20 grants may be admitted in any fiscal year  
21 under this subparagraph.”.

22       (d) GROUNDS FOR DEPORTATION.—Section 241(a)  
23 of the Immigration and Nationality Act (8 U.S.C.  
24 1251(a)) is amended by adding at the end the following  
25 new subparagraph:

1           “(I) FAILURE TO MAINTAIN EMPLOYMENT  
2 AS A HEALTH CARE PROFESSIONAL.—Any alien  
3 described in section 212(e)(iii) who fails to  
4 maintain employment in accordance with sub-  
5 paragraphs (B) and (C) of section 212(k)(1).”.

6           (e) EFFECTIVE DATE.—The amendments made by  
7 this section shall apply to aliens admitted to the United  
8 States under section 101(a)(15)(J) of the Immigration  
9 and Nationality Act, or acquiring such status after admis-  
10 sion to the United States, before, on, or after the date  
11 of enactment of this Act and before June 1, 2005.

## 12           **PART 2—HEALTH PROFESSIONS SCHOOLS**

### 13                           **PAYMENTS**

#### 14                   **Subpart A—Payments to Medical Schools**

#### 15           **SEC. 3061. FEDERAL PAYMENTS TO MEDICAL SCHOOLS.**

16           (a) ENTITLEMENT.—Each eligible medical school  
17 that in accordance with section 3062 submits to the Sec-  
18 retary an application for academic year 1997, or any sub-  
19 sequent academic year, shall be entitled to payments for  
20 such year for the purpose specified in subsection (b). The  
21 Secretary shall make such payments in an amount deter-  
22 mined in accordance with section 3063, and shall admin-  
23 ister the payments as a grant. The preceding sentence  
24 constitutes budget authority in advance of appropriations  
25 Acts and represents the obligation of the Federal Govern-

1 ment to provide funding for such payments in the  
2 amounts, and for the years specified in this subpart.

3 (b) PAYMENTS TO MEDICAL SCHOOLS.—The purpose  
4 specified in this subsection is to assist an eligible medical  
5 school with the direct costs of academic programs includ-  
6 ing the education of medical students (especially in pri-  
7 mary health care and ambulatory training), graduate stu-  
8 dents in biomedical sciences, and otherwise unfunded fac-  
9 ulty research. Payments under this section shall supple-  
10 ment and not supplant existing resources for this purpose.  
11 A funding agreement for such payments is that the med-  
12 ical school involved will expend the payments received pur-  
13 suant to section 3063(b) as follows:

14 (1) 50 percent shall be expended for primary  
15 health care education (including prevention), and  
16 peer reviewed primary care research in departments  
17 and divisions of primary care, including family medi-  
18 cine departments, and divisions of general internal  
19 medicine, geriatric medicine, and general pediatrics,  
20 or in medical schools in which primary care activities  
21 are primarily performed by other organizational  
22 units of the medical school, such other units. The  
23 medical school will distribute such amounts among  
24 the departments, divisions, or other units of primary  
25 care so that the distribution of such amounts bears

1 a reasonable relationship to the amount of ambula-  
2 tory primary care education of medical students in  
3 such departments and divisions and the national  
4 workforce goals and shall specify such information  
5 and the distribution of funds in the application  
6 under section 3062.

7 (2) 25 percent shall be expended for other am-  
8 bulatory training.

9 (3) 25 percent shall be expended for the sup-  
10 port of peer-reviewed faculty research in biomedicine  
11 and health services.

12 (c) PER CAPITA PAYMENTS BY MEDICAL SCHOOLS  
13 FOR OFF-SCHOOL EDUCATION.—A funding agreement for  
14 payments under subsection (a) for an eligible medical  
15 school for an academic year is that if, for the academic  
16 year, one or more students is enrolled (or accepted for en-  
17 rollment) in the medical school on the contingency of suc-  
18 cessfully completing for the academic year a substantial  
19 number of hours in medical education through an edu-  
20 cational institution that does not operate a medical school,  
21 and if the medical school provides credit toward a doc-  
22 torate in medicine for the hours successfully completed at  
23 such other institution, then the medical school will pay to  
24 the other institution for such academic year an amount  
25 equal to the product of—

1 (1) the product of—

2 (A) the number of such students attending  
3 the other institution for such academic year;  
4 and

5 (B) the percentage of the academic year  
6 spent at the other institution; and

7 (2) the quotient of—

8 (A) the amount of payments made to the  
9 medical school under subsection (a) for the aca-  
10 demic year; over

11 (B) the number of students in the eligible  
12 medical school in the academic year (including  
13 students described in this subsection).

14 (d) **ELIGIBLE MEDICAL SCHOOL; SUBPART DEFINI-**  
15 **TION.**—For purposes of this subpart, the term “eligible  
16 medical school” with respect to the academic year in-  
17 volved, means an approved medical school that submits to  
18 the Secretary an application for such year in accordance  
19 with section 3062.

20 **SEC. 3062. APPLICATION FOR PAYMENTS.**

21 For purposes of section 3061(a), an application for  
22 payments under such section for an academic year is in  
23 accordance with this section if—

1           (1) the dean (or appropriate presiding official)  
2 of the eligible medical school submits the application  
3 not later than the date specified by the Secretary;

4           (2) the application contains each funding agree-  
5 ment described in this subpart and provides such as-  
6 surances of compliance with the agreements as the  
7 Secretary may require; and

8           (3) the application is in such form, is made in  
9 such manner, and contains such agreements, assur-  
10 ances, and information as the Secretary determines  
11 to be necessary to carry out this part.

12 **SEC. 3063. AUTHORIZATION OF APPROPRIATIONS; ANNUAL**  
13 **AMOUNT OF PAYMENTS.**

14 (a) AUTHORIZATION OF APPROPRIATIONS.—

15           (1) IN GENERAL.—The appropriation author-  
16 ized for each each of the following academic years  
17 for making payments pursuant to section 3061(a)  
18 shall not be less than or in excess of the following:

19           (A) In the case of academic year 1997,  
20           \$200,000,000.

21           (B) In the case of academic year 1998,  
22           \$300,000,000.

23           (C) In the case of academic year 1998,  
24           \$400,000,000.

1           (D) In the case of academic year 2000,  
2           \$500,000,000.

3           (E) In the case of academic year 2001,  
4           \$600,000,000.

5           (F) In the case of each subsequent aca-  
6           demic year, the amount specified in subpara-  
7           graph (F) increased by the product of such  
8           amount and the general health care inflation  
9           factor (as defined in subsection (d)).

10       (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-  
11       BLE PROGRAMS.—Subject to the annual amount available  
12       for making payments pursuant to subsection (a) for an  
13       academic year, the amount of the payment required under  
14       section 3041 to be made to an eligible medical school for  
15       the academic year is an amount equal to the sum of—

16           (1) the product of  $\frac{1}{2}$  of the amount available  
17           for the academic year pursuant to subsection (a)  
18           and the proportion of students (as determined by the  
19           Secretary) at the eligible medical school in academic  
20           year 1993–1994 compared to all students enrolled in  
21           eligible medical schools nationwide in academic year  
22           1993–1994;

23           (2) the product of  $\frac{1}{4}$  of the amount available  
24           for the academic year pursuant to subsection (a)  
25           and the proportion of peer-reviewed research con-

1 ducted by the faculty at the eligible medical school  
2 (including health services research) compared to all  
3 such research conducted by the faculty at all eligible  
4 medical schools nationwide; and

5 (3) the product of  $\frac{1}{4}$  of the amount available  
6 for the academic year pursuant to subsection (a)  
7 and the proportion of the eligible medical school's  
8 number of graduates in primary care specialties  
9 from the class graduating 6 years prior to such aca-  
10 demic year who complete eligible programs in pri-  
11 mary health care and do not subsequently enter a  
12 nonprimary health care training program compared  
13 to such number of graduates of all eligible medical  
14 schools nationwide in such year.

15 The Secretary shall establish a method for measuring fac-  
16 ulty research contributions.

17 (c) STUDIES.—

18 (1) FUNDING LEVEL AND ALLOCATION METH-  
19 OD.—Not later than January 1, 1998, the Secretary  
20 shall arrange for an independent study and report to  
21 be completed, by the Institute of Medicine or other  
22 similar entity, concerning the amount of and alloca-  
23 tion method for medical school funding, and the im-  
24 pact of the payments under this part on national  
25 workforce goals, including the education and train-

1 ing of primary care physicians. Such report shall be  
 2 submitted to the President and the Congress and  
 3 shall include findings and recommendations as to the  
 4 appropriateness of modifying funding levels or allo-  
 5 cations.

6 (2) **IMPACT OF HEALTH CARE REFORM ON**  
 7 **MEDICAL EDUCATION.**—Not later than January 1,  
 8 2000, the Secretary shall arrange for an inde-  
 9 pendent study and report to be completed, by the In-  
 10 stitute of Medicine or other similar entity, con-  
 11 cerning the impact of health reform on under-  
 12 graduate medical education. Such report shall be  
 13 submitted to the President and the Congress and  
 14 shall include appropriate findings and recommenda-  
 15 tions.

16 (d) **GENERAL HEALTH CARE INFLATION FACTOR.**—  
 17 As used in this subtitle, the term “general health care in-  
 18 flation factor” with respect to a year, has the meaning  
 19 given such term in section 3033(e)(4) for such year.

20 **Subpart B—Payments to Nursing Programs**

21 **SEC. 3071. FEDERAL PAYMENTS TO GRADUATE NURSE**  
 22 **TRAINING PROGRAMS.**

23 (a) **FEDERAL PAYMENTS TO GRADUATE NURSE**  
 24 **TRAINING PROGRAMS.**—

1           (1) ENTITLEMENT.—Each eligible graduate  
2 nurse training program that in accordance with  
3 paragraph (2) submits to the Secretary an applica-  
4 tion for calendar year 1997 or any subsequent cal-  
5 endar year shall be entitled to payments for such  
6 year to the program for the purpose specified in  
7 paragraph (3). The Secretary shall make such pay-  
8 ments in an amount determined in accordance with  
9 subsection (b), and shall administer the payments as  
10 a grant. The preceding sentence constitutes budget  
11 authority in advance of appropriations Acts and rep-  
12 resents the obligation of the Federal Government to  
13 provide funding for such payments in the amounts,  
14 and for the years specified in this subpart.

15           (2) APPLICATION FOR PAYMENTS.—For pur-  
16 poses of paragraph (1), an application for payments  
17 for a calendar year is in accordance with this para-  
18 graph if—

19                   (A) the eligible graduate nurse training  
20 program involved submits the application not  
21 later than the date specified by the Secretary;

22                   (B) the application provides such assur-  
23 ances as the Secretary may require that the  
24 program will expend payments only for the pur-  
25 pose described in paragraph (3);

1           (C) the application contains each funding  
2           agreement described in this subpart and the ap-  
3           plication provides such assurances of compli-  
4           ance with the agreements as the Secretary may  
5           require;

6           (D) the application contains an assurance  
7           that the graduate nurse training program shall  
8           annually submit a report on the costs of clinical  
9           training of nurses in such manner as the Sec-  
10          retary may require; and

11          (E) the application is in such form, is  
12          made in such manner, and contains such agree-  
13          ments, assurances, and information as the Sec-  
14          retary determines to be necessary to carry out  
15          this part.

16          (3) PAYMENTS FOR OPERATION OF GRADUATE  
17          NURSE TRAINING PROGRAMS.—The purpose of pay-  
18          ments under paragraph (1) is to assist an eligible  
19          graduate nurse training program with the costs of  
20          the clinical portions of training programs and sup-  
21          porting full-time enrollees in such training pro-  
22          grams.

23          (b) AUTHORIZATION OF APPROPRIATIONS; ANNUAL  
24          AMOUNT OF PAYMENTS.—

1           (1) IN GENERAL.—The appropriation author-  
2 ized for each of the following calendar years for  
3 making payments pursuant to subsection (a)(1) shall  
4 not be less than or in excess of the following:

5           (A) In the case of calendar year 1997,  
6           \$200,000,000.

7           (B) In the case of each subsequent cal-  
8 endar year, the amount specified in subpara-  
9 graph (A) increased by the product of such  
10 amount and the general health care inflation  
11 factor as defined in subsection (c).

12           (2) AMOUNT OF PAYMENTS FOR INDIVIDUAL  
13 ELIGIBLE PROGRAMS.—Subject to the annual  
14 amount available under paragraph (1) for a calendar  
15 year, the amount of payments required under sub-  
16 section (a) to be made to an eligible graduate nurse  
17 training program that submits to the Secretary an  
18 application for such year in accordance with sub-  
19 section (a)(2) is an amount equal to the product  
20 of—

21           (A) the number of full-time enrollees in the  
22 program; and

23           (B) the estimated national average per  
24 full-time enrollee cost of each graduate nurse  
25 training program described in subsection (c)(1)

1           for the calendar year (as determined by the  
2           Secretary), adjusted by a factor to reflect re-  
3           gional differences in the applicable wage and  
4           wage related costs.

5           (3) LIMITATION.—If the annual amount avail-  
6           able under paragraph (1) for a calendar year is in-  
7           sufficient for providing each eligible graduate nurse  
8           training program that submits to the Secretary an  
9           application for such year in accordance with sub-  
10          section (a)(2) with the amount of payments deter-  
11          mined under paragraph (2) for the program for such  
12          year, the Secretary shall make such pro rata reduc-  
13          tions in the amounts so determined as may be nec-  
14          essary to ensure that the total of payments made  
15          under subsection (a) for such year equals the total  
16          of such amount.

17          (c) DEFINITIONS.—For purposes of this part:

18           (1) ELIGIBLE GRADUATE NURSE TRAINING  
19          PROGRAM.—The term “eligible graduate nurse train-  
20          ing program” means programs in advanced practice  
21          nurse education that are programs for education as  
22          nurse practitioners, programs for education as nurse  
23          midwives, programs for education as nurse anes-  
24          thetists, and programs for training clinical nurse  
25          specialists that are—

1 (A) designated by the Secretary as eligible  
2 graduate nurse training programs;

3 (B) accredited programs that award a  
4 master degree or a post-nurse master certificate  
5 and provide training preparing an individual for  
6 practice as an advanced practice nurse; and

7 (C) existing programs funded in 1994  
8 under section 822 or 831 of the Public Health  
9 Service Act that do not award a master degree  
10 may also be designated eligible programs.

11 (2) PROGRAMS FOR EDUCATION AS NURSE  
12 PRACTITIONERS.—The term “programs for edu-  
13 cation as nurse practitioners” means programs  
14 meeting the conditions to be programs for which  
15 awards of grants and contracts may be made under  
16 section 822 of the Public Health Service Act for  
17 education as a nurse practitioners.

18 (3) PROGRAMS FOR EDUCATION AS NURSE MID-  
19 WIVES.—The term “programs for education as nurse  
20 midwives” means programs meeting the conditions  
21 to be programs for which awards of grants and con-  
22 tracts may be made under section 822 of the Public  
23 Health Service Act for education as nurse midwives.

24 (4) PROGRAMS FOR TRAINING CLINICAL NURSE  
25 SPECIALISTS.—The term “programs for training

1 clinical nurse specialists” means programs in ad-  
2 vanced practice nurse education meeting the condi-  
3 tions to be programs for which awards of grants and  
4 contracts may be made under section 821 of the  
5 Public Health Service Act.

6 (5) FULL-TIME ENROLLEE.—The term “full-  
7 time enrollee” means an individual who is enrolled  
8 in an advanced nurse training program and qualifies  
9 as a full-time student at the institution operating  
10 such program.

11 (6) GENERAL HEALTH CARE INFLATION FAC-  
12 TOR.—The term “general health care inflation fac-  
13 tor”, with respect to a year, has the meaning given  
14 such term in section 3033(e)(4) for such year.

15 **SEC. 3072. NATIONAL COUNCIL ON GRADUATE NURSE**  
16 **TRAINING.**

17 (a) IN GENERAL.—There is established within the  
18 Department of Health and Human Services a council to  
19 be known as the National Council on Graduate Nurse  
20 Training.

21 (b) DUTIES.—The National Council on Graduate  
22 Nurse Training shall—

23 (1) collect and analyze data on trends of supply  
24 and demand for advanced practice nurses;

1           (2) analyze and consider the supply of advanced  
2 practice nurses in the context of changes in the over-  
3 all supply of health professionals;

4           (3) recommend priorities for support of grad-  
5 uate nurse training by type of programs described in  
6 section 3071(c);

7           (4) report to Congress annually and include in  
8 its report the number of students who graduated the  
9 previous year from funded programs; and

10          (5) consider and recommend appropriate stand-  
11 ards for assessing the quality of advanced practice  
12 nursing clinical training programs.

13 (c) COMPOSITION.—

14          (1) IN GENERAL.—The membership of the Na-  
15 tional Council on Graduate Nurse Training shall in-  
16 clude individuals who are appointed to the Council  
17 from among individuals who are not officers or em-  
18 ployees of the United States. Such individuals shall  
19 be appointed by the Secretary, and shall include—

20           (A) a nurse practitioner, a nurse-midwife,  
21 a nurse anesthetist, and a clinical nurse spe-  
22 cialist; and

23           (B) an official of a school of nursing, an  
24 official of a teaching hospital or other health

1 services entity, and other experts in health care  
2 financing, delivery, and professions training.

3 (2) EX OFFICIO MEMBERS; OTHER FEDERAL  
4 OFFICERS OR EMPLOYEES.—The membership of the  
5 National Council on Graduate Nurse Training shall  
6 include individuals designated by the Secretary, the  
7 Secretary of Veterans Affairs, and the Secretary of  
8 the Department of Defense to serve as members of  
9 the Council from among Federal officers or employ-  
10 ees who are appointed by the President, by the Sec-  
11 retary, the Secretary of Veterans Affairs, the Sec-  
12 retary of Defense, or other Federal officers who are  
13 appointed by the President with the advice and con-  
14 sent of the Senate.

15 (d) CHAIR.—The Secretary shall, from among mem-  
16 bers of the National Council on Graduate Nurse Training  
17 appointed under subsection (c)(1), designate an individual  
18 to serve as the Chair of the Council.

19 **Subpart C—Payments to Dental Schools**

20 **SEC. 3073. DENTAL SCHOOLS.**

21 (a) FEDERAL PAYMENTS TO DENTAL SCHOOLS.—

22 (1) ENTITLEMENT.—Each eligible school of  
23 dentistry that in accordance with paragraph (2) sub-  
24 mits to the Secretary an application for calendar  
25 year 1997 or any subsequent calendar year shall be

1 entitled to payments for such year to the program  
2 for the purpose specified in paragraph (3). The Sec-  
3 retary shall make such payments in an amount de-  
4 termined in accordance with subsection (b), and  
5 shall administer the payments as a grant. The pre-  
6 ceding sentence constitutes budget authority in ad-  
7 vance of appropriations Acts and represents the obli-  
8 gation of the Federal Government to provide funding  
9 for such payments in the amounts, and for the years  
10 specified in this subpart.

11 (2) APPLICATION FOR PAYMENTS.—For pur-  
12 poses of paragraph (1), an application for payments  
13 for a calendar year is in accordance with this para-  
14 graph if—

15 (A) the dean (or appropriate presiding offi-  
16 cial of the eligible school of dentistry involved)  
17 submits the application not later than the date  
18 specified by the Secretary;

19 (B) the application provides such assur-  
20 ances as the Secretary may require that the  
21 program will expend payments only for the pur-  
22 pose described in paragraph (3);

23 (C) the application contains each funding  
24 agreement described in this subpart and the ap-  
25 plication provides such assurances of compli-

1           ance with the agreements as the Secretary may  
2           require; and

3           (D) the application is in such form, is  
4           made in such manner, and contains such agree-  
5           ments, assurances, and information as the Sec-  
6           retary determines to be necessary to carry out  
7           this subpart.

8           (3) PURPOSE.—With respect to an eligible  
9           school of dentistry, the purpose of payments under  
10          paragraph (1) is to assist such school with the costs  
11          of training dentists, including unreimbursed oral  
12          health care costs. A funding agreement for such pay-  
13          ments is that the school of dentistry involved will ex-  
14          pend the payments only for direct expenses deter-  
15          mined as allowable by the Secretary.

16          (4) SCHOOL OF DENTISTRY.—For purposes of  
17          this subtitle, the term “eligible school of dentistry”  
18          means an accredited public or nonprofit private  
19          school in a State that provides training leading to a  
20          degree of doctor of dentistry or an equivalent degree,  
21          and any advanced training relating to such training.

22          (b) AUTHORIZATION OF APPROPRIATIONS; ANNUAL  
23          AMOUNT OF PAYMENTS.—

24          (1) IN GENERAL.—The appropriation author-  
25          ized for each of the following calendar years for

1 making payments pursuant to subsection (a)(1) shall  
2 not be less than or in excess of the following:

3 (A) In the case of each of calendar years  
4 1997, 1998, 1999 and 2000, \$50,000,000.

5 (B) In the case of each subsequent cal-  
6 endar year, the amount specified in subpara-  
7 graph (A) increased by the product of such  
8 amount and the general health care inflation  
9 factor as defined in subsection (c).

10 (2) AMOUNT OF PAYMENTS FOR INDIVIDUAL  
11 ELIGIBLE PROGRAMS.—Subject to the annual  
12 amount available under paragraph (1) for a calendar  
13 year, the amount of payments required under sub-  
14 section (a) to be made to an eligible school of den-  
15 tistry that submits to the Secretary an application  
16 for such year in accordance with subsection (a)(2) is  
17 an amount equal to the sum of—

18 (A) 75 percent of the amount available  
19 pursuant to paragraph (1) multiplied by the  
20 ratio of the number of full-time equivalent  
21 training participants in the school of dentistry  
22 (determined in accordance with a method to be  
23 developed by the Secretary) to the national  
24 number of full-time equivalent training partici-  
25 pants in all schools of dentistry (as determined

1 by the Secretary) in the academic year 1993–  
2 1994; and

3 (B) 25 percent of the amount available  
4 pursuant to paragraph (1) multiplied by the  
5 ratio of the unreimbursed oral health care costs  
6 of the school of dentistry to the national unre-  
7 imbursement oral health care costs of all schools of  
8 dentistry (as determined by the Secretary).

9 (c) ELIGIBLE SCHOOL OF DENTISTRY.—For pur-  
10 poses of this subpart, the term “eligible school of den-  
11 tistry” with respect to a calendar year involved, means a  
12 school of dentistry that submits to the Secretary an appli-  
13 cation for such year in accordance with subsection (a)(2).

14 **Subpart D—Payments to Schools of Public Health**

15 **SEC. 3074. SCHOOLS OF PUBLIC HEALTH.**

16 (a) FEDERAL PAYMENTS TO SCHOOLS OF PUBLIC  
17 HEALTH.—

18 (1) ENTITLEMENT.—Each eligible school of  
19 public health that in accordance with paragraph (2)  
20 submits to the Secretary an application for calendar  
21 year 1997 or any subsequent calendar year shall be  
22 entitled to payments for such year to the program  
23 for the purpose specified in paragraph (3). The Sec-  
24 retary shall make such payments in an amount de-  
25 termined in accordance with subsection (b), and

1 shall administer the payments as a grant. The pre-  
2 ceding sentence constitutes budget authority in ad-  
3 vance of appropriations Acts and represents the obli-  
4 gation of the Federal Government to provide funding  
5 for such payments in the amounts, and for the years  
6 specified in this subpart.

7 (2) APPLICATION FOR PAYMENTS.—For pur-  
8 poses of paragraph (1), an application for payments  
9 for a calendar year is in accordance with this para-  
10 graph if—

11 (A) the dean (or appropriate presiding offi-  
12 cial of the eligible school of public health in-  
13 volved submits the application not later than  
14 the date specified by the Secretary;

15 (B) the application provides such assur-  
16 ances as the Secretary may require that the  
17 program will expend payments only for the pur-  
18 pose described in paragraph (3);

19 (C) the application contains each funding  
20 agreement described in this subpart and the ap-  
21 plication provides such assurances of compli-  
22 ance with the agreements as the Secretary may  
23 require; and

24 (D) the application is in such form, is  
25 made in such manner, and contains such agree-

1           ments, assurances, and information as the Sec-  
2           retary determines to be necessary to carry out  
3           this subpart.

4           (3) PURPOSE.—With respect to an eligible  
5           school of public health, the purpose of payments  
6           under this paragraph is to assist such school with  
7           the costs of training public health professionals in  
8           disease prevention and health promotion, the man-  
9           agement of health services, health care policy and  
10          health care organization, public health practice, out-  
11          comes and quality of care, and epidemiologic and  
12          biostatistical research. A funding agreement for such  
13          payments is that the school of public health involved  
14          will expend the payments only for direct expenses  
15          determined as allowable by the Secretary.

16          (4) SCHOOL OF PUBLIC HEALTH.—For pur-  
17          poses of this subpart, the term “school of public  
18          health” means an accredited public or non-profit pri-  
19          vate school in a State that—

20                  (A) is located within a university accred-  
21                  ited by one of the recognized regional accred-  
22                  iting bodies;

23                  (B) has as its central concept the preven-  
24                  tion of disease and the promotion of health

1 through research, education and professional  
2 practice;

3 (C) offers the Master of Public Health de-  
4 gree;

5 (D) provides, with sufficient faculty and  
6 other resources, education at the master degree  
7 level with an emphasis in at least each of the  
8 following areas:

9 (i) Behavioral sciences.

10 (ii) Biostatistics.

11 (iii) Environmental and health  
12 sciences.

13 (iv) Epidemiology.

14 (v) Health services administration;

15 and

16 (E) offers graduate education at the doc-  
17 toral degree level in at least 1 of the 5 areas  
18 described in subparagraph (D).

19 (b) AUTHORIZATION OF APPROPRIATIONS; ANNUAL  
20 AMOUNT OF PAYMENTS.—

21 (1) IN GENERAL.—The appropriation author-  
22 ized for each of the following calendar years for  
23 making payments pursuant to subsection (a)(1) shall  
24 not be less than or in excess of the following:

1 (A) In the case of each of calendar years  
2 1997, 1998, 1999 and 2000, \$25,000,000.

3 (B) In the case of each subsequent cal-  
4 endar year, the amount specified in subpara-  
5 graph (A) increased by the product of such  
6 amount and the general health care inflation  
7 factor.

8 (2) PAYMENTS TO SCHOOLS OF PUBLIC  
9 HEALTH.—

10 (A) IN GENERAL.—The amount required  
11 under subsection (a) to be made to an eligible  
12 school of public health is an amount equal to  
13 the product of—

14 (i) the amount available for making  
15 such payments for the calendar year pur-  
16 suant to paragraph (1); and

17 (ii) the percentage constituted by the  
18 ratio of the number of full-time students  
19 enrolled in degree programs in such  
20 schools and the number of full-time equiva-  
21 lents of part-time students enrolled in de-  
22 gree programs in such school (determined  
23 in accordance with subparagraph (B)) to  
24 the national number of all such students in

1 all schools of public health in the academic  
2 year beginning in the previous fiscal year.

3 (B) FULL-TIME EQUIVALENCE.—For the  
4 purposes of this paragraph, the number of full-  
5 time equivalents of part-time students for a  
6 school of public health for any school year is a  
7 number equal to—

8 (i) the total number of credit hours of  
9 instructions in such year for which study  
10 leading to a graduate degree in public  
11 health or an equivalent degree, divided by

12 (ii) the number of credit hours of in-  
13 structions which a student pursuing a full-  
14 time course of study leading to a graduate  
15 degree in public health or equivalent de-  
16 gree.

17 (C) NEW SCHOOL.—In the case of a new  
18 school of public health which applies for a grant  
19 under this section in the fiscal year preceding  
20 the fiscal year in which it will admit its first  
21 class, the enrollment for purposes of subpara-  
22 graph (A)(ii) shall be the number of full-time  
23 students which the Secretary determines, on the  
24 basis of assurances provided by the school, will

1           be enrolled in the school, in the fiscal year after  
2           the fiscal year in which the grant is made.

3           (c) **ELIGIBLE SCHOOL OF PUBLIC HEALTH.**—The  
4 term “eligible school of public health” with respect to the  
5 calendar year involved, means a school of public health  
6 that submits to the Secretary for such year in accordance  
7 with subsection (a)(2).

### 8                           **PART 3—RELATED PROGRAMS**

#### 9                           **Subpart A—Workforce Development**

#### 10 **SEC. 3081. PROGRAMS OF THE SECRETARY OF HEALTH AND** 11 **HUMAN SERVICES.**

12           (a) **IN GENERAL.**—

13                   (1) **FUNDING.**—For purposes of carrying out  
14 the programs described in this section, there is au-  
15 thorized to be appropriated \$100,000,000 for each  
16 of the fiscal years 1995 and 1996, and  
17 \$150,000,000 for each of the fiscal years 1997  
18 through 2000 (in addition to amounts that may oth-  
19 erwise be authorized to be appropriated for carrying  
20 out the programs).

21                   (2) **ADMINISTRATION.**—The programs described  
22 in this section and carried out with amounts made  
23 available under subsection (a) shall be carried out by  
24 the Secretary of Health and Human Services.

1           (b) PRIMARY CARE PHYSICIAN AND PHYSICIAN AS-  
2   SISTANT TRAINING.—For purposes of subsection (a), the  
3   programs described in this section include programs to  
4   support projects to train additional numbers of primary  
5   care physicians and physician assistants, including  
6   projects to enhance community-based generalist training  
7   for medical students, residents, and practicing physicians;  
8   to retrain mid-career physicians previously certified in a  
9   nonprimary care medical specialty; to expand the supply  
10  of physicians with special training to serve in rural and  
11  inner-city medically underserved areas; to support expan-  
12  sion of service-linked educational networks that train a  
13  range of primary care providers in community settings;  
14  to provide for training in managed care, cost-effective  
15  practice management, and continuous quality improve-  
16  ment; to provide interdisciplinary training for medical stu-  
17  dents, residents or practicing physicians, and dental stu-  
18  dents, residents, and dental hygienists, to deliver primary  
19  care to individuals with mental, physical, and develop-  
20  mental disabilities, including mental retardation, particu-  
21  larly those who are more than 18 years of age; and to  
22  develop additional information on primary care workforce  
23  issues as required to meet future needs in health care.

24           (c) TRAINING OF UNDERREPRESENTED RACIAL AND  
25  ETHNIC MINORITIES AND DISADVANTAGED PERSONS.—

1 For purposes of subsection (a), the programs described  
2 in this section include a program to support projects to  
3 increase the number of racial and ethnic underrepresented  
4 minority and disadvantaged persons in medicine, osteop-  
5 athy, dentistry, advanced practice nursing, public health,  
6 psychology, and other health professions, including  
7 projects to provide continuing financial assistance for such  
8 persons entering health professions training programs; for  
9 financial assistance for facility renovation or construction;  
10 to increase support for recruitment and retention of such  
11 persons in the health professions; to maintain efforts to  
12 foster interest in health careers among such persons at  
13 the preprofessional level; and to increase the number of  
14 racial and ethnic minority health professions faculty at  
15 programs that have a significant number of underrep-  
16 resented racial and ethnic minorities.

17 (d) EXPANDING RURAL HEALTH CAREER OPPORTU-  
18 NITIES AND RETENTION EFFORTS.—

19 (1) IN GENERAL.—For purposes of subsection  
20 (a), the programs described in this section include  
21 programs to support projects to increase the number  
22 of individuals living in rural, underserved commu-  
23 nities who enter the fields of medicine, osteopathy,  
24 dentistry, advanced practice nursing, public health,  
25 psychology, and other health professions, and to en-

1       courage the retention of such health care profes-  
2       sionals in rural, underserved communities.

3           (2) RURAL HEALTH CAREER TRAINING.—

4       Projects to increase the number of individuals re-  
5       cruited from rural, underserved areas include  
6       projects—

7           (A) to provide continuing financial assist-  
8           ance for such persons entering health profes-  
9           sions education and training programs;

10          (B) to increase efforts to foster interest in  
11          health careers among such persons at the  
12          preprofessional level;

13          (C) to foster the development of training  
14          curricula appropriate to rural health care set-  
15          tings; and

16          (D) to increase support for recruitment of  
17          such persons in the health professions.

18           (3) RETENTION OF RURAL HEALTH CARE PRO-

19       VIDERS.—Projects to encourage the retention of in-  
20       dividuals providing health care in rural, underserved  
21       areas include projects—

22           (A) to establish State and regional locum  
23           tenans programs in rural health care settings so  
24           that substitute health care providers are avail-

1           able when permanent staff is absent from the  
2           health care setting;

3                   (B) to implement programs to foster inter-  
4           disciplinary team approaches to rural health  
5           training and practice; and

6                   (C) to develop state-of-the-art network  
7           telecommunications and telemedicine systems to  
8           link rural health professionals to other health  
9           care providers and academic health care cen-  
10          ters.

11          (e) NURSE TRAINING.—For purposes of subsection  
12 (a), the programs described in this section include a pro-  
13 gram to support projects to support midlevel provider  
14 training and address priority nursing workforce needs, in-  
15 cluding projects to train additional nurse practitioners and  
16 nurse midwives; to support baccalaureate-level nurse  
17 training programs providing preparation for careers in  
18 teaching, community health service, and specialized clin-  
19 ical care; to train additional nurse clinicians and nurse  
20 anesthetists; to support interdisciplinary school-based  
21 community nursing programs; and to promote research on  
22 nursing workforce issues.

23          (f) INAPPROPRIATE PRACTICE BARRIERS; FULL UTI-  
24 LIZATION OF SKILLS.—For purposes of subsection (a), the  
25 programs described in this section include a program—

1           (1) to develop and encourage the adoption of  
2 model professional practice statutes for advanced  
3 practice nurses and physician assistants, and to oth-  
4 erwise support efforts to remove inappropriate bar-  
5 riers to practice by such nurses and such physician  
6 assistants; and

7           (2) to promote the full utilization of the profes-  
8 sional education and clinical skills of advanced prac-  
9 tice nurses and physician assistants.

10       (g) ADVISORY BOARD ON HEALTH CARE WORK-  
11 FORCE DEVELOPMENT.—

12           (1) IN GENERAL.—The Secretary shall establish  
13 an Advisory Board known as the National Advisory  
14 Board on Health Care Workforce Development to  
15 advise, consult with, and make recommendations to  
16 the Secretary and to the Secretary of Labor on mat-  
17 ters relating to—

18           (A) health care worker supply and its ade-  
19 quacy to assure proper health care delivery sys-  
20 tem staffing in both rural and urban areas; and

21           (B) the impact of this Act, and of related  
22 changes in law regarding health care, on health  
23 care workers and the needs of such workers, in-  
24 cluding needs regarding education, training,  
25 and other career development matters and the

1 relationship of health care workers to health  
2 care professionals.

3 (2) COMPOSITION.—The Board established  
4 under paragraph (1) shall be composed of the fol-  
5 lowing members with expertise in health care work-  
6 force issues appointed by the Secretary in consulta-  
7 tion with the Secretary of Labor:

8 (A) Five representatives of labor organiza-  
9 tions representing health care workers.

10 (B) Five representatives of health care de-  
11 livery institutions.

12 (C) Two representatives from health care  
13 education organizations.

14 (D) Two representatives from consumer  
15 organizations.

16 (3) ASSISTANCE.—The Secretary shall provide  
17 the Board with such administrative assistance as  
18 may be necessary for the Board to carry out this  
19 subsection.

20 (h) OTHER PROGRAMS.—For purposes of subsection  
21 (a), the programs described in this section include a pro-  
22 gram to train health professionals and administrators in  
23 managed care, cost-effective practice management, contin-  
24 uous quality improvement practices, and provision of cul-  
25 turally sensitive care.

1 (i) RELATIONSHIP TO EXISTING PROGRAMS.—This  
2 section may be carried out through programs established  
3 in title VII or VIII of the Public Health Service Act, as  
4 appropriate and as consistent with the purposes of such  
5 programs.

6 (j) MENTAL RETARDATION AND OTHER DEVELOP-  
7 MENTAL DISABILITIES.—Title VII of the Public Health  
8 Service Act is amended by inserting after section 778, the  
9 following new section:

10 **“SEC. 779. MENTAL RETARDATION AND OTHER DEVELOP-**  
11 **MENTAL DISABILITIES.**

12 “(a) IN GENERAL.—The Secretary may make grants  
13 and enter into contracts with university affiliated pro-  
14 grams, schools of medicine, and schools of dentistry to as-  
15 sist in meeting the costs of such programs or schools to—

16 “(1) improve the interdisciplinary training of  
17 primary care physicians and dentists in the health  
18 care services needs of individuals with mental, phys-  
19 ical, and developmental disabilities, including mental  
20 retardation, particularly those who are more than 18  
21 years of age;

22 “(2) develop, evaluate, and disseminate cur-  
23 ricula relating to the health care service needs of in-  
24 dividuals with mental, physical, and developmental  
25 disabilities, including mental retardation, particu-

1 larly those individuals who are more than 18 years  
2 of age;

3 “(3) support the training and retraining of fac-  
4 ulty to provide such instruction; and

5 “(4) support continuing education of health  
6 professionals who provide health care services and  
7 support to individuals with mental, physical, and de-  
8 velopmental disabilities, including mental retarda-  
9 tion, particularly those who are more than 18 years  
10 of age.

11 “(b) AUTHORIZATION OF APPROPRIATIONS.—For  
12 purposes of carrying out this section, there are authorized  
13 to be appropriated, \$10,000,000 for each of the fiscal  
14 years 1995 through 2000.”.

15 **SEC. 3082. PROGRAMS OF THE SECRETARY OF LABOR.**

16 (a) IN GENERAL.—

17 (1) FUNDING.—For purposes of carrying out  
18 the programs described in this section, and for car-  
19 rying out section 3083, there is authorized to be ap-  
20 propriated \$200,000,000 for fiscal year 1995 and  
21 each subsequent fiscal year (in addition to amounts  
22 that may otherwise be authorized to be appropriated  
23 for carrying out the programs).

24 (2) ADMINISTRATION.—The programs described  
25 in this section and carried out with amounts made

1 available under subsection (a) shall be carried out by  
2 the Secretary of Labor (in this section referred to as  
3 the “Secretary”).

4 (b) RETRAINING PROGRAMS; ADVANCED CAREER  
5 POSITIONS; WORKFORCE ADJUSTMENT PROGRAMS.—

6 (1) IN GENERAL.—For purposes of subsection  
7 (a), the programs described in this section are the  
8 following:

9 (A) A program for skills upgrading and oc-  
10 cupational retraining (including retraining  
11 health care workers for more advanced positions  
12 as technicians, nurses, and physician assist-  
13 ants), and for quality and workforce improve-  
14 ment.

15 (B) A demonstration program to assist  
16 workers in health care institutions in obtaining  
17 advanced career positions.

18 (C) A program to develop and operate  
19 health care industry worker job banks in local  
20 employment services agencies or one-stop career  
21 centers, subject to the following:

22 (i) Such job banks shall be available  
23 to all health care providers in the commu-  
24 nity involved.

1           (ii) Such job banks shall begin oper-  
2           ation not later than 90 days after the date  
3           of the enactment of this Act.

4           (iii)(I) With respect to each affected  
5           community, the local employment service  
6           agency or one-stop career center serving  
7           such community shall be allocated not less  
8           than one counselor whose responsibility it  
9           shall be to develop and operate health and  
10          insurance industry worker job banks.  
11          Where the impact of health care industry  
12          restructuring in the affected community is  
13          such that the functions required under this  
14          clause cannot be adequately provided by  
15          one counselor, additional counselors shall  
16          be allocated to carry out such functions.

17          (II) Such counselor shall solicit job  
18          openings from local health care industry  
19          employers, maintain frequent contacts with  
20          these and other employers, and monitor  
21          and update all job listings appropriate for  
22          displaced health care workers seeking em-  
23          ployment.

24          (III) The local employment service  
25          agency or one-stop career center shall pro-

1           vide directly, or facilitate the provision of,  
2           labor exchange services to displaced health  
3           care industry workers, including assess-  
4           ment, counseling, testing, job-search assist-  
5           ance, job referral and placement, and re-  
6           ferral to training and educational pro-  
7           grams, where appropriate.

8           (IV) The Secretary of Labor shall de-  
9           velop performance goals for the effective  
10          performance of such job banks with respect  
11          to the number and quality of jobs listed,  
12          the degree of participation by employers in  
13          the affected community, and success in  
14          placement of job bank users in jobs listed,  
15          taking into account specific geographic,  
16          economic and labor market characteristics  
17          of the community served.

18          (D) A program to provide for joint labor-  
19          management decision-making in the health care  
20          sector on workplace matters related to the re-  
21          structuring of the health care delivery system  
22          provided for in this Act.

23          (E) A program to collect data regarding  
24          the adequacy of the supply of health care work-  
25          ers by occupation and sector of the health in-

1 industry in light of existing and projected demand  
2 for such workers.

3 (F)(i) A program to encourage the adop-  
4 tion and utilization of high performance, high  
5 quality health care delivery systems, including  
6 employee participation committees and em-  
7 ployee team systems that will contribute to  
8 more effective health care by increasing the role  
9 and the area of independent decisionmaking of  
10 health care workers.

11 (ii) For purposes of this subparagraph, the  
12 term “employee participation committees”  
13 means committees of workers independently se-  
14 lected by and from a facility’s nonmanagerial  
15 workforce, or selected by unions where collective  
16 bargaining agreements are in effect, and which  
17 operate independently without employer inter-  
18 ference and consult with management on issues  
19 of efficiency, productivity, and quality of care,  
20 except that an employee participation com-  
21 mittee established under and operating in con-  
22 formity with this subparagraph shall not be  
23 considered a labor organization within the  
24 meaning of section 2(5) of the National Labor  
25 Relations Act or a representative within the

1 meaning of section 1, sixth, of the Railway  
2 Labor Act.

3 (2) USE OF FUNDS.—Amounts made available  
4 under subsection (a) for carrying out this section  
5 may be expended for program support, faculty devel-  
6 opment, trainee support, workforce analysis, and dis-  
7 semination of information, as necessary to produce  
8 required performance outcomes.

9 (c) CERTAIN REQUIREMENTS FOR PROGRAMS.—In  
10 carrying out the programs described in subsection (b), the  
11 Secretary shall, with respect to the organizations and em-  
12 ployment positions involved, provide for the following:

13 (1) Explicit, clearly defined skill requirements  
14 developed for all the positions and projections of the  
15 number of openings for each position.

16 (2) Opportunities for internal career movement.

17 (3) Opportunities to work while training or  
18 completing an educational program.

19 (4) Evaluation and dissemination.

20 (5) Training opportunities in several forms, as  
21 appropriate.

22 (d) ADMINISTRATIVE REQUIREMENTS.—In carrying  
23 out the programs described in subsection (b), the Sec-  
24 retary shall, with respect to the organizations and employ-  
25 ment positions involved, provide for the following:

1           (1) Joint labor-management implementation  
2           and administration.

3           (2) Discussion with employees as to training  
4           needs for career advancement.

5           (3) Commitment to a policy of internal hirings  
6           and promotion.

7           (4) Provision of support services.

8           (5) Consultations with employers and with or-  
9           ganized labor.

10 **SEC. 3083. REQUIREMENT FOR CERTAIN PROGRAMS RE-**  
11 **GARDING REDEPLOYMENT OF HEALTH CARE**  
12 **WORKERS.**

13           (a) STATE PROGRAMS FOR HOME AND COMMUNITY-  
14 BASED SERVICES FOR INDIVIDUALS WITH DISABIL-  
15 ITIES.—With respect to the plan required in section  
16 2102(a) (for State programs for home and community-  
17 based services for individuals with disabilities under part  
18 1 of subtitle B of title II), the plan shall, in addition to  
19 requirements under such part, provide for the following:

20           (1) Before initiating the process of imple-  
21 menting the State program under such plan, nego-  
22 tiations will be commenced with labor unions rep-  
23 resenting the employees of the affected hospitals or  
24 other facilities.

1           (2) Negotiations under paragraph (1) will ad-  
2           dress the following:

3                   (A) The impact of the implementation of  
4                   the program upon the workforce.

5                   (B) Methods to redeploy workers to posi-  
6                   tions in the proposed system, in the case of  
7                   workers affected by the program.

8           (3) The plan will provide evidence that there  
9           has been compliance with paragraphs (1) and (2),  
10          including a description of the results of the negotia-  
11          tions.

12          (b) PLAN FOR INTEGRATION OF MENTAL HEALTH  
13          SYSTEMS.—With respect to the plan required in section  
14          3511(a) (relating to the integration of the mental health  
15          and substance abuse services of a State and its political  
16          subdivisions with the mental health and substance abuse  
17          services included in the comprehensive benefit package  
18          under title I), the plan shall, in addition to requirements  
19          under such section, provide for the following:

20                   (1) Before initiating the process of imple-  
21                   menting the integration of such services, negotia-  
22                   tions will be commenced with labor unions rep-  
23                   resenting the employees of the affected hospitals or  
24                   other facilities.

1           (2) Negotiations under paragraph (1) will ad-  
2       dress the following:

3           (A) The impact of the proposed changes  
4       upon the workforce.

5           (B) Methods to redeploy workers to posi-  
6       tions in the proposed system, in the case of  
7       workers affected by the proposed changes.

8           (3) The plan will provide evidence that there  
9       has been compliance with paragraphs (1) and (2),  
10      including a description of the results of the negotia-  
11      tions.

12      **Subpart B—Transitional Provisions for Workforce**

13                                      **Stability**

14      **SEC. 3091. APPLICATION.**

15      (a) **LIMITATION TO TRANSITION PERIOD.**—The pro-  
16      visions of this subpart are intended to minimize, to the  
17      extent possible, disruptions in established employment re-  
18      lationships during the period of transition to a restruc-  
19      tured health care delivery system, and shall terminate De-  
20      cember 31, 2000.

21      (b) **HEALTH CARE ENTITIES COVERED BY SUB-**  
22      **PART.**—The provisions of this subpart, including ref-  
23      erences to displacing employers, hiring employers, succes-  
24      sors and contractors, apply only to health care entities  
25      that employ more than 25 individuals.

1 **SEC. 3092. DEFINITIONS.**

2 (a) **HEALTH CARE ENTITY.**—As used in this sub-  
3 part, the term “health care entity” includes individuals,  
4 sole proprietorships, partnerships, associations, business  
5 trusts, corporations, governmental institutions, and public  
6 agencies (including state governments and political sub-  
7 divisions thereof) that—

8 (1) provide health care services under title I  
9 (including nonmandatory health care services under  
10 title I) or under the amendments made or programs  
11 referred to in titles IV and VIII; or

12 (2) provide necessary related services, including  
13 administrative, food service, janitorial or mainte-  
14 nance services, to an entity that provides health care  
15 services (as described in subparagraph (1));

16 except that an entity that solely manufactures or provides  
17 goods or equipment to a health care entity shall not be  
18 considered a health care entity.

19 (b) **AFFILIATED ENTERPRISE.**—As used in this sub-  
20 part, the term “affiliated enterprise” means a health care  
21 entity that, together with the displacing employer, is con-  
22 sidered a single employer as defined under 414 of the In-  
23 ternal Revenue Code of 1986.

24 (c) **PREFERENCE ELIGIBLE EMPLOYEE.**—As used in  
25 this subpart, the term “preference eligible employee”  
26 means an employee who—

1           (1) has been employed for in excess of 1 year  
2           by a health care entity; and

3           (2) has been displaced by or has received notice  
4           of an impending displacement by such entity.

5           (d) **DISPLACEMENT.**—As used in this subpart, the  
6 term “displacement” includes a lay off, termination, sig-  
7 nificant cutback in paid work hours, or other loss of em-  
8 ployment, except that a discharge for just cause shall not  
9 constitute a displacement within the meaning of this para-  
10 graph.

11 **SEC. 3093. OBLIGATIONS OF DISPLACING EMPLOYER AND**  
12 **AFFILIATED ENTERPRISES IN EVENT OF DIS-**  
13 **PLACEMENT.**

14           (a) **NOTICE.**—A health care entity which displaces a  
15 preference eligible employee shall provide such employee  
16 with—

17           (1) written notice, no later than the date of dis-  
18 placement, of employment rights under this subpart,  
19 including employment rights with respect to affili-  
20 ated enterprises of the displacing employer; and

21           (2) notice of any existing or subsequent vacan-  
22 cies with the displacing employer or an affiliated en-  
23 terprise, which notice may be given by posting of  
24 such vacancies wherever notices to applicants for  
25 employment are customarily posted, by listing such

1 vacancies with the local employment services agency,  
2 or in such other manner as the Secretary of Labor,  
3 by regulation, may hereafter specify.

4 Any such vacancy shall remain open for applications by  
5 preference eligible employees for not less than 14 calendar  
6 days from the date on which the initial notice is provided.

7 (b) HIRING PREFERENCE.—

8 (1) IN GENERAL.—A qualified preference eligi-  
9 ble employee who applies during the notice period  
10 described in subsection (a)(2) for a vacant position  
11 with the displacing employer or an affiliated enter-  
12 prise, which position is in the employee's occupa-  
13 tional specialty and is located in the same State or  
14 Standard Metropolitan Statistical Area in which the  
15 employee was employed prior to the displacement,  
16 shall be given the right to accept or decline the posi-  
17 tion before the employer may offer the position to a  
18 nonpreference eligible employee.

19 (2) MULTIPLE APPLICATIONS.—When consid-  
20 ering applications from more than one qualified pref-  
21 erence eligible employee, the hiring health care enti-  
22 ty shall have discretion as to which of such employ-  
23 ees will be offered the position.

24 (3) EMPLOYMENT QUALIFICATIONS.—Nothing  
25 in this subsection shall be construed to prohibit the

1 hiring health care entity from establishing reason-  
2 able employment qualifications for a vacancy to  
3 which this subpart applies, except that employees  
4 who performed essentially the same work prior to  
5 their displacement shall be deemed presumptively  
6 qualified for comparable positions.

7 (c) TERMINATION OF PREFERENCE ELIGIBILITY.—  
8 A displaced employee's preference eligibility shall termi-  
9 nate—

10 (1) at such time as the displaced employee ob-  
11 tains substantially equivalent employment with the  
12 displacing employer; or

13 (2) if the employee does not obtain such em-  
14 ployment—

15 (A) with respect to health care entities  
16 other than the displacing employer, 2 years  
17 after the date of the displacement; or

18 (B) with respect to the displacing em-  
19 ployer, upon the termination of this subpart  
20 pursuant to section 3081(a).

21 **SEC. 3094. EMPLOYMENT WITH SUCCESSORS.**

22 A health care entity that succeeds another health care  
23 entity through merger, consolidation, acquisition, contract,  
24 or other similar manner shall provide employees of the  
25 previous health care entity who would otherwise be dis-

1 placed the right to continued employment in the job posi-  
2 tions held by such employees prior thereto, unless the em-  
3 ployer can establish that such positions no longer exist.

4 **SEC. 3095. COLLECTIVE BARGAINING OBLIGATIONS DUR-**  
5 **ING TRANSITION PERIOD.**

6 (a) CONTINUATION OF PREVIOUSLY RECOGNIZED  
7 BARGAINING REPRESENTATIVES AND AGREEMENTS.—If  
8 a majority of the employees in an appropriate bargaining  
9 unit consists of employees who were previously covered by  
10 a bargaining agreement or represented by an exclusive  
11 representative with respect to terms and conditions of em-  
12 ployment, and there has not been a substantial change in  
13 the operations performed by the employees in that unit,  
14 the employer shall recognize such representative as the ex-  
15 clusive representative for the unit and shall assume the  
16 bargaining agreement, except that where application of  
17 this subsection would result in the recognition of more  
18 than one bargaining representative for a single unit, the  
19 question concerning which representative shall be recog-  
20 nized as the exclusive representative for the unit shall be  
21 resolved in accordance with applicable Federal or State  
22 law.

23 (b) JOINT EMPLOYER STATUS.—If employees of a  
24 contractor are assigned on a regular basis to perform work  
25 on the premises of a contracting entity and the tasks per-

1 formed by these employees are functionally integrated with  
2 the operations of the contracting entity on whose premises  
3 such employees work, both the contractor and the con-  
4 tracting entity shall be considered joint employers of the  
5 employees with respect to work performed on those prem-  
6 ises for purposes of determining compliance with labor re-  
7 lations laws. Employees of such joint employers may not  
8 be excluded from a bargaining unit within either entity  
9 on the basis of such joint employer status.

10 **SEC. 3096. GENERAL PROVISIONS.**

11 (a) REGULATIONS.—Not later than 120 days after  
12 the date of enactment of this Act, the Secretary shall pro-  
13 mulgate regulations to implement the requirements of sec-  
14 tion 3093.

15 (b) OTHER LAWS.—The standards and requirements  
16 of this subpart shall not preempt or excuse noncompliance  
17 with any other applicable Federal or State law, regulation  
18 or municipal ordinance that establishes additional notice  
19 and preference standards or requirements concerning em-  
20 ployee dislocation, employee representation, or collective  
21 bargaining.

22 (c) RULES OF CONSTRUCTION.—Nothing in this sub-  
23 part shall be construed—

24 (1) to excuse or otherwise limit the obligation  
25 of an employer to comply with any collective bar-

1       gaining agreement or any employment benefit plan  
2       that provides rights to employees in addition to  
3       those provided under this subpart; or

4               (2) to require an employer to recognize or bar-  
5       gain with a labor organization in violation of State  
6       law.

7       (d) ENFORCEMENT.—Unless otherwise specifically  
8       provided in this subpart, the enforcement provisions of  
9       section 107 of the Family and Medical Leave Act of 1993  
10      (29 U.S.C. 2617) shall apply with respect to the enforce-  
11      ment of the individual rights, including notice require-  
12      ments, provided under section 3093. The collective bar-  
13      gaining and contractual rights provided under sections  
14      3094 and 3095 shall be enforced through administrative  
15      and judicial procedures otherwise provided under Federal  
16      or State law with respect to such rights.

17                   **Subtitle B—Academic Health**  
18                                   **Centers**

19      **SEC. 3131. DISCRETIONARY GRANTS REGARDING ACCESS**  
20                                   **TO CENTERS.**

21               (a) RURAL INFORMATION AND REFERRAL SYS-  
22      TEMS.—The Secretary may make grants to eligible centers  
23      for the establishment and operation of information and re-  
24      ferral systems to provide the services of such centers to  
25      rural health plans.

1 (b) OTHER PURPOSES REGARDING URBAN AND  
2 RURAL AREAS.—The Secretary may make grants to  
3 community- and provider-based health plans under section  
4 1651(d) to carry out activities (other than activities car-  
5 ried out under subsection (a)) for the purpose of providing  
6 the services of eligible centers to residents of rural or  
7 urban communities who otherwise would not have ade-  
8 quate access to such services.

9 (c) AUTHORIZATION OF APPROPRIATIONS.—For the  
10 purpose of carrying out this section, there are authorized  
11 to be appropriate, \$3,000,000 for fiscal year 1995,  
12 \$4,000,000 for fiscal year 1996, and \$5,000,000 for each  
13 of the fiscal years 1997 through 2000.

## 14 **Subtitle C—Health Research** 15 **Initiatives**

### 16 **PART 1—PROGRAMS FOR CERTAIN AGENCIES**

#### 17 **SEC. 3201. BIOMEDICAL, BEHAVIORAL AND HEALTH SERV-** 18 **ICES RESEARCH.**

19 (a) FINDINGS.—Congress finds the following:

20 (1) Nearly 4 of 5 peer reviewed research  
21 projects deemed worthy of funding by the National  
22 Institutes of Health are not funded, and 9 of 10  
23 peer reviewed research projects deemed worthy of  
24 funding by the Agency for Health Care Policy and  
25 Research are not funded.

1           (2) Less than 2 percent of the nearly one tril-  
2           lion dollars our Nation spends on health care is de-  
3           voted to health research, while the defense industry  
4           spends 15 percent of its budget on research.

5           (3) Public opinion surveys have shown that  
6           Americans want more Federal resources put into  
7           health research and support by having a portion of  
8           their health insurance premiums set aside for this  
9           purpose.

10          (4) Ample evidence exists to demonstrate that  
11          health research has improved the quality of health  
12          care in the United States. Advances such as the de-  
13          velopment of vaccines, the cure of many childhood  
14          cancers, drugs that effectively treat a host of dis-  
15          eases and disorders, a process to protect our Na-  
16          tion's blood supply from the HIV virus, progress  
17          against cardiovascular disease including heart attack  
18          and stroke, and new strategies for the early detec-  
19          tion and treatment of diseases such as colon, breast,  
20          and prostate cancer clearly demonstrates the bene-  
21          fits of health research.

22          (5) Among the most effective methods to con-  
23          trol health care costs are the prevention of inten-  
24          tional and unintentional injury and the prevention  
25          and cure of disease and disability, thus, health re-

1 search which holds the promise of prevention of in-  
2 tentional and unintentional injury and cure and pre-  
3 vention of disease and disability is a critical compo-  
4 nent of any comprehensive health care reform plan.

5 (6) The state of our Nation's research facilities  
6 at the National Institutes of Health and at univer-  
7 sities is deteriorating significantly. Renovation and  
8 repair of these facilities are badly needed to main-  
9 tain and improve the quality of research.

10 (7) Because the Omnibus Budget Reconciliation  
11 Act of 1993 freezes discretionary spending for the  
12 next 5 years, the Nation's investment in health re-  
13 search through the National Institutes of Health  
14 and the Agency for Health Care Policy and Re-  
15 search is likely to decline in real terms unless correc-  
16 tive legislative action is taken.

17 (8) A health research fund is needed to main-  
18 tain our Nation's commitment to health research  
19 and to increase the percentage of approved projects  
20 which receive funding at the National Institutes of  
21 Health and the Agency for Health Care Policy and  
22 Research to at least 33 percent.

23 (9) Private sector investment in research and  
24 development has been responsible for the vast major-  
25 ity of new developments in pharmaceuticals, medical

1 devices, biotechnology and other health care innova-  
2 tions. Over 90 percent of the most prescribed drugs  
3 in the United States were discovered by the re-  
4 search-based pharmaceutical industry.

5 (10) United States industry is the preeminent  
6 world leader in the research, development and deliv-  
7 ery of innovative therapies that improve the quality  
8 of care for people throughout the world.

9 (11) Global health care budgets may constrict  
10 private sector investment in research and develop-  
11 ment. Further, they may be inconsistent with the  
12 goal of developing promising new cost effective treat-  
13 ment therapies.

14 (b) AVAILABILITY OF FUNDS.—

15 (1) IN GENERAL.—With respect to each cal-  
16 endar year, the Secretary shall pay, from funds in  
17 the Treasury not otherwise appropriated, for activi-  
18 ties under this section, an amount equal to 0.25 per-  
19 cent in 1996 and subsequent years, of all private  
20 premiums required to be paid in accordance with the  
21 Act.

22 (2) DEFINITION.—For purposes of this sub-  
23 section, the term “private health premiums” means  
24 all premium related payments made by employers,  
25 individuals, and families for coverage under this Act.

1           (3) MAINTENANCE OF EFFORT.—No amounts  
2           made available under this subsection shall replace or  
3           reduce the amount of appropriations for the Na-  
4           tional Institutes of Health or the Agency for Health  
5           Care Policy and Research.

6           (c) PURPOSES FOR EXPENDITURES.—Part A of title  
7           IV of the Public Health Service Act (42 U.S.C. 281 et  
8           seq.) is amended by adding at the end thereof the fol-  
9           lowing new section:

10       **“SEC. 404F. EXPENDITURES FOR BIOMEDICAL AND BEHAV-**  
11                               **IORAL RESEARCH.**

12           “(a) IN GENERAL.—With respect to 80 percent of the  
13           amounts made available under section 3201 of the Health  
14           Security Act in a fiscal year, the Secretary shall dis-  
15           tribute—

16                       “(1) 2 percent of such amounts during any fis-  
17           cal year to the Office of the Director of the National  
18           Institutes of Health to be allocated at the Director’s  
19           discretion for the following activities:

20                               “(A) for carrying out the responsibilities of  
21           the Office of the Director, in including the Of-  
22           fice of Research on Women’s Health and the  
23           Office of Research on Minority Health, the Of-  
24           fice of Alternative Medicine and the Office of  
25           Rare Diseases Research; and

1           “(B) for construction and acquisition of  
2           equipment for or facilities of or used by the Na-  
3           tional Institutes of Health;

4           “(2) 2 percent of such amounts for transfer to  
5           the National Center for Research Resources to carry  
6           out section 1502 of the National Institutes of  
7           Health Revitalization Act of 1993 concerning Bio-  
8           medical and Behavioral Research Facilities;

9           “(3) 1 percent of such amounts during any fis-  
10          cal year for carrying out section 301 and part D of  
11          title IV with respect to health information commu-  
12          nications; and

13          “(4) the remainder of such amounts during any  
14          fiscal year to member institutes of the National In-  
15          stitutes of Health and Centers in the same propor-  
16          tion to the total amount received under this section,  
17          as the amount of annual appropriations under ap-  
18          propriations Acts for each member institute and  
19          Centers for the fiscal year bears to the total amount  
20          of appropriations under appropriations Acts for all  
21          member institutes and Centers of the National Insti-  
22          tutes of Health for the fiscal year.

23          “(b) PLANS OF ALLOCATION.—The amounts trans-  
24          ferred under subsection (a) shall be allocated by the Direc-  
25          tor of NIH or the various directors of the institutes and

1 centers, as the case may be, pursuant to allocation plans  
2 developed by the various advisory councils to such direc-  
3 tors, after consultation with such directors.”.

4 **SEC. 3202. HEALTH SERVICES RESEARCH.**

5 (a) IN GENERAL.—The Secretary shall distribute the  
6 remainder of the amounts made available under section  
7 3201 in a fiscal year (not to exceed 20 percent of the total  
8 of amounts available in a fiscal year under such section),  
9 to the Agency for Health Care Policy and Research for  
10 policy-initiated and investigator-initiated research.

11 (b) RESEARCH ON HEALTH CARE REFORM.—Section  
12 902 of the Public Health Service Act (42 U.S.C. 299a),  
13 as amended by section 2(b) of Public Law 102–410 (106  
14 Stat. 2094), is amended by adding at the end the following  
15 subsection:

16 “(f) RESEARCH ON HEALTH CARE REFORM.—

17 “(1) IN GENERAL.—In carrying out section  
18 901(b), the Administrator shall conduct and support  
19 research on the reform of the health care system of  
20 the United States, as directed by the Secretary.

21 “(2) PRIORITIES.—In carrying out paragraph  
22 (1), the Administrator shall give priority to the fol-  
23 lowing:

24 “(A) Conducting and supporting research  
25 on the appropriateness and effectiveness of al-

1           ternative clinical strategies (including commu-  
2           nity-based programs and preventive services),  
3           the quality and outcomes of care, and adminis-  
4           trative simplification.

5           “(B) Conducting and supporting research  
6           on the appropriateness and effectiveness of al-  
7           ternative community-based and clinical strate-  
8           gies including integrating preventive services  
9           into primary care, the effectiveness of preven-  
10          tive counseling and health education, and the  
11          efficacy and cost-effectiveness of clinical preven-  
12          tive services.

13          “(C) Conducting and supporting research  
14          on consumer choice and information resources;  
15          on the role of shared decision making in en-  
16          hancing patient and provider therapeutic op-  
17          tions; the effects of health care reform on  
18          health delivery systems; methods for risk ad-  
19          justment; factors influencing access to health  
20          care for vulnerable populations, including chil-  
21          dren, persons with low-income, persons with  
22          disabilities, or individuals with chronic or com-  
23          plex health conditions, and primary care.

24          “(D) The development of clinical practice  
25          guidelines consistent with section 913, the dis-

1           semination of such guidelines consistent with  
2           section 903, and the assessment of the effec-  
3           tiveness of such guidelines.”.

4 **SEC. 3203. AHCPR GUIDELINES AND STANDARDS.**

5           (a) **TRAINEESHIP PROGRAM.**—Section 902(c) of the  
6 Public Health Service Act (42 U.S.C. 299a(c)) is amend-  
7 ed—

8           (1) by redesignating the matter following the  
9 subsection heading as paragraph (1) and realigning  
10 the margin of such so as to align with the margin  
11 of section 903(a)(1);

12           (2) by inserting before “The Administrator” the  
13 following: “IN GENERAL.—”; and

14           (3) by adding at the end thereof the following  
15 new paragraph:

16           “(2) **TRAINEESHIP PROGRAM.**—The Adminis-  
17 trator shall establish a traineeship program for not  
18 to exceed 25 investigators, to enable such investiga-  
19 tors to carry out research at the Agency that would  
20 benefit the mission of the Agency and further the  
21 educational needs of such investigators. Such investi-  
22 gator positions shall not be counted against any  
23 Federal employment ceilings affecting the Agency.”.

1 (b) PRINTING SERVICES.—Section 902 of such Act  
2 (42 U.S.C. 299a) is amended by adding at the end thereof  
3 the following new subsection:

4 “(f) AUTHORITY TO CONTRACT FOR PRINTING SERV-  
5 ICES.—The Administrator may publish or arrange for the  
6 publication of research findings and practice guidelines,  
7 without regard to section 501 of title 44, United States  
8 Code.”.

9 (c) PANELS.—Section 913(a) of the Public Health  
10 Service Act (42 U.S.C. 299b–2(a)) is amended by adding  
11 at the end thereof the following new flush sentence:

12 “Panels convened for the purpose of carrying out para-  
13 graphs (1) and (2) shall not be considered advisory com-  
14 mittees within the meaning of section 3(2) of the Federal  
15 Advisory Committee Act (5 U.S.C. App. 3(2)), and prior  
16 to publication by the Administrator, clinical practice  
17 guidelines, performance measures, and review criteria as  
18 described in section 912(a) are not subject to the require-  
19 ments of section 552 of title 5, United States Code.”.

20 (d) ARRANGEMENTS.—Section 913 of such Act (42  
21 U.S.C. 299b–2) is amended by adding at the end thereof  
22 the following new subsection:

23 “(d) ARRANGEMENTS.—

24 “(1) IN GENERAL.—Upon the request of a pub-  
25 lic or private entity, the Administrator may collect,

1 tabulate, and analyze statistics, perform technology  
2 assessments, carry out health services and outcomes  
3 and effectiveness research, and facilitate the develop-  
4 ment of clinical practice guidelines under arrange-  
5 ments with such entities under which such entities  
6 compensate the Administrator for the costs of the  
7 services provided.

8 “(2) AMOUNTS AND PERSONNEL.—Amounts  
9 collected from payments under this subsection shall  
10 be available to the Administrator for obligation until  
11 expended, and personnel used to provide such serv-  
12 ices shall not be counted against any Federal em-  
13 ployment ceilings affecting the Agency.”.

14 (e) TECHNICAL AMENDMENT.—Section 913(c) of  
15 such Act (42 U.S.C. 299b–2(c)) is amended by moving  
16 the first sentence so as appear after the subsection head-  
17 ing.

## 18 **PART 2—FUNDING FOR PROGRAM**

### 19 **SEC. 3211. AUTHORIZATIONS OF APPROPRIATIONS.**

20 (a) RELATION TO OTHER FUNDS.—Amounts made  
21 available under this subtitle are in addition to any other  
22 authorizations of appropriations that are available to carry  
23 out section 3202 and the amendments made by such sec-  
24 tion.

1 (b) TRIGGER AND RELEASE OF MONIES.—No ex-  
2 penditure shall be made pursuant to section 3201(b) dur-  
3 ing any fiscal year in which the annual amount appro-  
4 priated for the National Institutes of Health and the  
5 Agency for Health Care Policy and Research is less than  
6 the amount so appropriated for the prior fiscal year. With  
7 respect to amounts available for expenditure pursuant to  
8 section 3201(b) which, as a result of the application of  
9 this subsection remain unexpended, such amounts shall be  
10 obligated by the Secretary of Health and Human Services  
11 under the public health initiative under subtitle H.

12 **PART 3—MEDICAL TECHNOLOGY IMPACT STUDY**

13 **SEC. 3221. MEDICAL TECHNOLOGY IMPACT STUDY.**

14 (a) ASSESSMENT OF THE STANDARD IMPACT OF  
15 MEDICAL TECHNOLOGIES.—

16 (1) IN GENERAL.—The Secretary, acting  
17 through the Administrator of the Agency for Health  
18 Care Policy and Research (hereafter referred to in  
19 this section as the “Administrator”), shall undertake  
20 an interdisciplinary study (to be known as the “Med-  
21 ical Technology Impact Study”) to assess the overall  
22 economic costs, economic benefits, and effect on pa-  
23 tient outcomes of medical technologies used in treat-  
24 ing each of a list of target diseases and conditions.  
25 The Secretary shall submit the report of the Admin-

1       istrator to Congress (in accordance with subsection  
2       (c)) concerning the results of the study and may  
3       provide any recommendations determined to be nec-  
4       essary to ensure the availability, access, and appro-  
5       priate use of medical technologies to improve the  
6       quality of health care in the United States.

7           (2) PURPOSE.—The purpose of the study under  
8       paragraph (1) is to assess the impact of old, new,  
9       and emerging medical technologies on health care  
10      costs, social costs, and patient outcomes, and to  
11      identify the factors, including government and pri-  
12      vate payor reimbursement policies, that impede or  
13      encourage innovation that improves patient out-  
14      comes. Congress intends that the study complement  
15      the technology assessment, outcomes research, and  
16      guideline development activities authorized under  
17      title IX of the Public Health Service Act by pro-  
18      viding a comprehensive context for understanding  
19      the economic and social factors related to the devel-  
20      opment and use of medical technologies.

21           (3) DEFINITIONS.—As used in this section:

22           (A) ECONOMIC BENEFITS.—The term  
23      “economic benefits” may include, based on  
24      available data—

1 (i) reductions in the economic costs of  
2 disease;

3 (ii) increases in employment attrib-  
4 utable to the medical technology industry;

5 (iii) increases in Federal and State  
6 tax revenues attributable to the medical  
7 technology industry and its employees;

8 (iv) improvements in the balance of  
9 trade deficit attributable to the medical  
10 technology industry; and

11 (v) other benefits that are determined  
12 by the Advisory Committee established  
13 under subsection (b) to be relevant to as-  
14 sessing the impact of medical technology.

15 (B) ECONOMIC COSTS.—The term ‘eco-  
16 nomic costs’ may include, based on available  
17 data—

18 (i) the financial costs to the health  
19 care system of diagnosing and treating dis-  
20 ease, including the costs of nontreatment  
21 and palliative care;

22 (ii) the financial costs to employers  
23 resulting from worker illness, including the  
24 costs of productivity losses and worker ab-  
25 senteeism;

1 (iii) the financial costs to families re-  
2 sulting from illness of a family member, in-  
3 cluding costs associated with loss of in-  
4 come, hiring of caretakers, and long term  
5 and hospice care;

6 (iv) the financial costs to government  
7 of illness, including reductions in income  
8 tax revenues attributable to worker illness  
9 and worker related injuries and increases  
10 in transfer payments, including unemploy-  
11 ment, disability, welfare, and survivor ben-  
12 efit payments, made to individuals and  
13 families on account of illness; and

14 (v) other costs that are determined by  
15 the Advisory Committee established under  
16 subsection (b) to be relevant to assessing  
17 the impact of medical technology.

18 (C) MEDICAL TECHNOLOGIES.—The term  
19 ‘medical technologies’ includes drugs, biologics  
20 (including vaccines), medical devices, drug de-  
21 livery systems, and surgical services and other  
22 procedures for preventing, diagnosing, and  
23 treating diseases or health conditions.

24 (D) MEDICAL TECHNOLOGY INDUSTRY.—  
25 The term ‘medical technology industry’ includes

1 the biotechnology, pharmaceutical, and medical  
2 device industries, and such other industries that  
3 invent, develop, or market medical technologies.

4 (E) PATIENT OUTCOMES.—The term ‘pa-  
5 tient outcomes’ may include—

6 (i) changes in clinical outcomes, in-  
7 cluding stabilization of patients with pro-  
8 gressive disease or health conditions, re-  
9 sulting from the use of safe and effective  
10 medical technology in prevention, diag-  
11 nosis, or treatment;

12 (ii) changes in mortality, morbidity,  
13 and health service use, including stabiliza-  
14 tion of patients with progressive diseases;

15 (iii) changes in quality of life, includ-  
16 ing ability to perform activities of daily liv-  
17 ing, ability to return to work, relief from  
18 discomfort or pain, alleviation of fatigue,  
19 and improved mental functioning and well-  
20 being; and

21 (iv) other outcomes that are deter-  
22 mined by the Advisory Committee to be  
23 relevant to assessing the impact of medical  
24 technology.

25 (b) ADVISORY COMMITTEE.—

1           (1) IN GENERAL.—The Administrator shall es-  
2           tablish an Advisory Committee to assist the Agency  
3           for Health Care Policy and Research in preparing  
4           the reports required under subsection (c). Except as  
5           provided in paragraph (3), no member of the Advi-  
6           sory Committee shall be an employee of the Federal  
7           Government.

8           (2) MEMBERSHIP.—The Advisory Committee  
9           shall be balanced in its representation of interested  
10          parties and shall be composed of at least two indi-  
11          viduals appointed by the President of the Institute  
12          of Medicine and two individuals from each of the fol-  
13          lowing categories to be appointed by the Adminis-  
14          trator:

15                (A) Experts in medical technology assess-  
16                ment.

17                (B) Experts in objective measures of im-  
18                proved patient outcomes, such as clinical out-  
19                comes, mortality, morbidity, and health service  
20                use.

21                (C) Experts in subjective measures of im-  
22                proved patient outcomes, such as quality of life.

23                (D) Experts in quantifying the economic  
24                costs of disease to the health care system, in-  
25                cluding public and private payers.

1           (E) Experts in quantifying the economic  
2 impact of the medical technology industry.

3           (F) Experts in health statistics and epide-  
4 miology.

5           (G) Physicians and other health care pro-  
6 viders.

7           (H) Officers or employees of health plans  
8 and other health care payers.

9           (I) Experts in the ethical implications of  
10 health care.

11           (J) Experts in private sector financial mar-  
12 ket investment in the medical technology indus-  
13 try.

14           (K) Consumers and members of patient  
15 advocacy groups.

16           (L) Health professional organizations.

17           (M) Officers or employees of biotechnology  
18 companies.

19           (N) Officers or employees of medical device  
20 companies.

21           (O) Officers or employees of pharma-  
22 ceutical companies.

23           (3) EX OFFICIO.—The following individuals or  
24 their designees shall serve as ex officio members of  
25 the Advisory Committee:

1 (A) The Director of the National Institutes  
2 of Health.

3 (B) The Commissioner of Food and Drugs.

4 (C) The Director of the Centers for Dis-  
5 ease Control and Prevention.

6 (D) The Administrator of the Health Care  
7 Financing Administration.

8 (E) The Under Secretary of Commerce for  
9 Technology.

10 (F) The Director of the Congressional Of-  
11 fice of Technology Assessment.

12 (c) INTERDISCIPLINARY STUDY AND REPORT.—

13 (1) IN GENERAL.—The Administrator, in con-  
14 sultation with the Advisory Committee established  
15 under subsection (b), shall determine which diseases  
16 or conditions should be studied in the Medical Tech-  
17 nology Impact Study under subsection (a). In car-  
18 rying out the medical technology assessment re-  
19 quired under this subsection, the Administrator shall  
20 consider various factors, including those outlined in  
21 section 904(b)(2) of the Public Health Service Act  
22 and government and private payor reimbursement  
23 policies that impede or encourage innovation that  
24 improves patient outcomes. The diseases or condi-  
25 tions studied in such Study shall be those considered

1 to be high priority according to the following cri-  
2 teria:

3 (A) Aggregate economic costs to the  
4 United States.

5 (B) Overall importance to public health.

6 (C) Potential for improvements in patient  
7 outcomes.

8 (D) Significant changes expected in man-  
9 agement of the condition.

10 (E) Other criteria identified by the Advi-  
11 sory Committee.

12 (2) DESIGN.—The Administrator, in consulta-  
13 tion with the Advisory Committee established under  
14 subsection (b), and the Institute of Medicine pursu-  
15 ant to paragraph (3), shall develop a design, based  
16 on the list of target diseases and conditions, for un-  
17 dertaking the Medical Technology Impact Study  
18 under subsection (a).

19 (3) CONTRACT.—The Secretary shall request  
20 the Institute of Medicine of the National Academy  
21 of Sciences to enter into a contract to review the de-  
22 sign of the Medical Technology Impact Study under  
23 subsection (a) and report to the Administrator con-  
24 cerning any recommendations for revising such de-

1 sign, in the interest of assuring that it reflects the  
2 best available scientific methodologies.

3 (4) PUBLICATION.—The Administrator shall  
4 publish the study design under this section and list  
5 of target diseases and conditions, the recommenda-  
6 tions of the Institute of Medicine, and the response  
7 of the Administrator to such recommendations in  
8 the Federal Register for a 60-day period for public  
9 comment. Any such comments shall be considered by  
10 the Administrator in completing the proposed study  
11 design for submission to the Secretary.

12 (5) DESIGN REPORT.—The Secretary shall re-  
13 port to Congress concerning the proposed design of  
14 the Medical Technology Impact Study, together with  
15 recommendations for appropriations necessary to  
16 carry out the Study.

17 (6) GRANTS AND CONTRACTS.—Beginning in  
18 the first fiscal year for which Congress appropriates  
19 funds under subsection (d), and ending on Sep-  
20 tember 30 of that year, the Administrator shall  
21 enter into grants and contracts with appropriate en-  
22 tities to conduct any investigations and analyses that  
23 may be required to carry out the design of the Med-  
24 ical Technology Impact Study under subsection (a).

1           (7) REPORT ON FINDINGS.—The Administrator,  
2           in consultation with the Advisory Committee estab-  
3           lished under subsection (b), shall develop a draft  
4           comprehensive report concerning the findings of the  
5           Medical Technology Impact Study under subsection  
6           (a), shall make copies of the draft report available  
7           to the public, and shall publish a notice in the Fed-  
8           eral Register providing for a 60-day period of public  
9           comment. Any such comments shall be considered by  
10          the Administrator in completing and submitting the  
11          final report to the Secretary.

12          (8) FINAL REPORT.—Not later than 3 years  
13          after the date of enactment of this section, the Sec-  
14          retary shall submit the report of the Administrator  
15          under this section to Congress, and may include any  
16          recommendations determined necessary to assure the  
17          availability, access and appropriate use of medical  
18          technologies to improve the quality of health care in  
19          the United States.

20          (d) AUTHORIZATION OF APPROPRIATIONS.—There  
21          are authorized to be appropriated such sums as may be  
22          necessary to carry out this section.

1 **Subtitle D—Core Functions of Pub-**  
2 **lic Health Programs; National**  
3 **Initiatives Regarding Preven-**  
4 **tive Health**

5 **PART 1—FUNDING**

6 **SEC. 3301. AUTHORIZATIONS OF APPROPRIATIONS.**

7 (a) CORE FUNCTIONS OF PUBLIC HEALTH PRO-  
8 GRAMS.—For the purpose of carrying out part 2, there  
9 are authorized to be appropriated \$123,000,000 for fiscal  
10 year 1995, \$184,500,000 for fiscal year 1996,  
11 \$266,500,000 for fiscal year 1997, \$348,500,000 for fis-  
12 cal year 1998, \$410,000,000 for fiscal year 1999,  
13 \$512,500,000 for fiscal year 2000, and \$2,000,000 for  
14 each of the fiscal years 2001 through 2004.

15 (b) NATIONAL INITIATIVES REGARDING HEALTH  
16 PROMOTION AND DISEASE PREVENTION.—For the pur-  
17 pose of carrying out part 3, there are authorized to be  
18 appropriated \$102,500,000 for each of the fiscal years  
19 1996 through 1998, \$123,000,000 for each of the fiscal  
20 years 1999 and 2000, and \$2,000,000 for each of the fis-  
21 cal years 2001 through 2004.

22 (c) RELATION TO OTHER FUNDS.—The authoriza-  
23 tions of appropriations established in subsections (a) and  
24 (b) are in addition to any other authorizations of appro-

1 priations that are available for the purposes described in  
2 such subsections.

3 **PART 2—CORE FUNCTIONS OF PUBLIC HEALTH**  
4 **PROGRAMS**

5 **SEC. 3311. PURPOSES.**

6 Subject to the subsequent provisions of this subtitle,  
7 the purposes of this part are to strengthen the capacity  
8 of State and local public health agencies to carry out the  
9 following functions:

10 (1) To monitor and protect the health of com-  
11 munities against communicable diseases and expo-  
12 sure to toxic environmental pollutants, occupational  
13 hazards, harmful products, and poor quality health  
14 care.

15 (2) To identify and control outbreaks of infec-  
16 tious disease and patterns of chronic disease and in-  
17 jury.

18 (3) To inform and educate health care con-  
19 sumers and providers about their roles in preventing  
20 injury, preventing and controlling disease and the  
21 appropriate use of medical services.

22 (4) To develop and test new prevention and  
23 public health control interventions.

24 (5) To integrate and coordinate the prevention  
25 programs and services of standard health plans,

1 community-based providers, local health depart-  
2 ments, State health departments, purchasing co-  
3 operatives, and other sectors of State and local gov-  
4 ernment that affect health, including education,  
5 labor, transportation, welfare, criminal justice, envi-  
6 ronment, agriculture, and housing.

7 (6) To conduct research on the effectiveness  
8 and cost-effectiveness of public health programs.

9 **SEC. 3312. GRANTS TO STATES FOR CORE FUNCTIONS OF**  
10 **PUBLIC HEALTH.**

11 (a) IN GENERAL.—The Secretary shall make grants  
12 to States that submit applications as prescribed in section  
13 3313 in an amount which bears the same ratio to the  
14 available amounts for that fiscal year as the amounts pro-  
15 vided by the Secretary under the provisions of law listed  
16 in section 1902(2) of the Public Health Service Act to the  
17 State for fiscal year 1981 bear to the total amount appro-  
18 priated for such provisions of law for fiscal year 1981.

19 (b) CORE FUNCTIONS OF PUBLIC HEALTH PRO-  
20 GRAMS.—For purposes of subsection (a), the functions de-  
21 scribed in this subsection are, subject to subsection (c),  
22 as follows:

23 (1)(A) Data collection, activities related to pop-  
24 ulation health (including the population of individ-  
25 uals ineligible for the comprehensive benefit pack-

1 age) measurement and outcomes monitoring, includ-  
2 ing the acquisition and installation of hardware and  
3 software, personnel training and technical assistance  
4 to operate and support automated and integrated in-  
5 formation systems, the regular collection and anal-  
6 ysis of public health data, vital statistics, and per-  
7 sonal health services data and analysis for planning  
8 and needs assessment purposes of data collected  
9 from health plans through the information system  
10 under title V of this Act.

11 (B) Data measures under this paragraph must  
12 include an ethnic identifier on all forms. To the ex-  
13 tent feasible, ethnic identifiers should be classified  
14 by ethnic sub-group populations. Access to data  
15 must be ensured for research organizations and data  
16 clearinghouses. Population health measurement and  
17 outcome monitoring should focus on health status  
18 differentials between racial, and ethnic groups, by  
19 subpopulation, and gender differences.

20 (2) Activities to protect the environment and to  
21 assure the safety of housing, workplaces, food and  
22 water, including the following activities:

23 (A) Monitoring and improving the overall  
24 public health quality and safety of communities.

1           (B) Assessing exposure to high lead levels  
2           and water contamination.

3           (C) Providing support for poison control  
4           centers.

5           (D) Monitoring sewage and solid waste dis-  
6           posal, radiation exposure, radon exposure, and  
7           noise levels.

8           (E) Abatement of lead-related hazards.

9           (F) Assuring recreation, home and worker  
10          safety.

11          (G) Public information and education pro-  
12          grams that help to reduce intentional and unin-  
13          tentional injuries, including training parents  
14          and children on use of safety devices.

15          (H) Enforcing public health safety and  
16          sanitary codes.

17          (I) Other activities relating to promoting  
18          the public health of communities.

19          (3) Investigation and control of adverse health  
20          conditions, including improvements in emergency  
21          treatment preparedness, injury prevention, coopera-  
22          tive activities to reduce violence levels in homes and  
23          communities, activities to control the outbreak of  
24          disease, exposure related conditions and other  
25          threats to the health status of individuals.

1           (4) Public information and education programs  
2           to reduce risks to health such as use of tobacco, al-  
3           cohol and other drugs, sexual activities that increase  
4           the risk to HIV transmission and sexually trans-  
5           mitted diseases, domestic violence, poor diet, phys-  
6           ical inactivity, and low childhood immunization lev-  
7           els.

8           (5) Accountability and quality assurance activi-  
9           ties, including monitoring the quality of personal  
10          health services furnished by health plans and pro-  
11          viders of medical and health services in a manner  
12          consistent with the overall quality of care monitoring  
13          activities undertaken under title V, and monitoring  
14          communities' overall access to health services.

15          (6) Provision of public health laboratory serv-  
16          ices to complement private clinical laboratory serv-  
17          ices and that screen for diseases and conditions such  
18          as metabolic diseases in newborns, provide toxicology  
19          assessments of blood lead levels and other environ-  
20          mental toxins, diagnose sexually transmitted dis-  
21          eases, tuberculosis and other diseases requiring part-  
22          ner notification, test for infectious and food-borne  
23          diseases, and monitor the safety of water and food  
24          supplies.

1           (7) Training and education to assure provision  
2 of care by all health professionals, with special em-  
3 phasis placed on the training of public health profes-  
4 sions including epidemiologists, biostatisticians,  
5 health educators, public health administrators,  
6 sanitarians and laboratory technicians.

7           (8) Leadership, policy development and admin-  
8 istration activities, including needs assessment, the  
9 setting of public health standards, the development  
10 of community public health policies, and the develop-  
11 ment of community public health coalitions.

12           (9) Establishment of programs that encourage  
13 partnerships among local law enforcement and com-  
14 munity groups for the purpose of developing commu-  
15 nity response teams to assist victims of domestic vio-  
16 lence.

17 (c) RESTRICTIONS ON USE OF GRANT.—

18           (1) IN GENERAL.—A funding agreement for a  
19 grant under subsection (a) for a State is that the  
20 grant will not be expended—

21                   (A) to provide inpatient services;

22                   (B) to make cash payments to intended re-  
23 cipients of health services;

24                   (C) to purchase or improve land, purchase,  
25 construct, or permanently improve (other than

1 minor remodeling) any building or other facil-  
2 ity, or purchase major medical equipment;

3 (D) to satisfy any requirement for the ex-  
4 penditure of non-Federal funds as a condition  
5 for the receipt of Federal funds; or

6 (E) to provide financial assistance to any  
7 entity other than a public or nonprofit private  
8 entity.

9 (2) LIMITATION ON ADMINISTRATIVE EX-  
10 PENSES.—A funding agreement for a grant under  
11 subsection (a) is that the State involved will not ex-  
12 pend more than 10 percent of the grant for adminis-  
13 trative expenses with respect to the grant.

14 (d) MAINTENANCE OF EFFORT.—A funding agree-  
15 ment for a grant under subsection (a) is that the State  
16 involved will maintain expenditures of non-Federal  
17 amounts for core health functions at a level that is not  
18 less than the level of such expenditures maintained by the  
19 State for the fiscal year preceding the first fiscal year for  
20 which the State receives such a grant.

21 **SEC. 3313. SUBMISSION OF INFORMATION.**

22 The Secretary may make a grant under section 3312  
23 only if the State involved submits to the Secretary the fol-  
24 lowing information:

1           (1) A description of existing deficiencies in the  
2 State's public health system (at the State level and  
3 the local level), using standards of sufficiency devel-  
4 oped by the Secretary.

5           (2) A description of health status measures to  
6 be improved within the State (at the State level and  
7 the local level) through expanded public health func-  
8 tions.

9           (3) Measurable outcomes and process objectives  
10 for improving health status and core health func-  
11 tions for which the grant is to be expended.

12           (4) Information regarding each such function,  
13 which—

14                 (A) identifies the amount of State and  
15 local funding expended on each such function  
16 for the fiscal year preceding the fiscal year for  
17 which the grant is sought; and

18                 (B) provides a detailed description of how  
19 additional Federal funding will improve each  
20 such function by both the State and local public  
21 health agencies.

22           (5) A description of the core health functions to  
23 be carried out at the local level, and a specification  
24 for each such function of—

1 (A) the communities in which the function  
2 will be carried out; and

3 (B) the amount of the grant to be ex-  
4 pended for the function in each community so  
5 specified.

6 **SEC. 3314. REPORTS.**

7 A funding agreement for a grant under section 3312  
8 is that the States involved will, not later than the date  
9 specified by the Secretary, submit to the Secretary a re-  
10 port describing—

11 (1) the purposes for which the grant was ex-  
12 pended; and

13 (2) describing the extent of progress made by  
14 the State in achieving measurable outcomes and  
15 process objectives described in section 3313(3).

16 **SEC. 3315. APPLICATION FOR GRANT.**

17 The Secretary may make a grant under section 3312  
18 only if an application for the grant is submitted to the  
19 Secretary, the application contains each agreement de-  
20 scribed in this part, the application contains the informa-  
21 tion required in section 3314, and the application is in  
22 such form, is made in such manner, and contains such  
23 agreements, assurances, and information as the Secretary  
24 determines to be necessary to carry out this part.

1 **SEC. 3316. ALLOCATIONS FOR CERTAIN ACTIVITIES.**

2 Of the amounts made available under section 3301  
3 for a fiscal year for carrying out this part, the Secretary  
4 may reserve not more than 5 percent for carrying out the  
5 following activities:

6 (1) Technical assistance with respect to plan-  
7 ning, development, and operation of core health  
8 functions carried out under section 3312, including  
9 provision of biostatistical and epidemiological exper-  
10 tise and provision of laboratory expertise.

11 (2) Development and operation of a national in-  
12 formation network among State and local health  
13 agencies.

14 (3) Program monitoring and evaluation of core  
15 health functions carried out under section 3312.

16 (4) Development of a unified electronic report-  
17 ing mechanism to improve the efficiency of adminis-  
18 trative management requirements regarding the pro-  
19 vision of Federal grants to State public health agen-  
20 cies.

21 **SEC. 3317. DEFINITIONS.**

22 For purposes of this part:

23 (1) The term “funding agreement”, with re-  
24 spect to a grant under section 3312 to a State,  
25 means that the Secretary may make the grant only  
26 if the State makes the agreement involved.

1           (2) The term “core health functions”, with re-  
2           spect to a State, means the functions described in  
3           section 3312(b).

4 **SEC. 3318. SINGLE APPLICATION AND UNIFORM REPORT-**  
5 **ING SYSTEMS FOR CORE FUNCTIONS OF PUB-**  
6 **LIC HEALTH AND PUBLIC HEALTH CATEGOR-**  
7 **ICAL GRANT PROGRAMS ADMINISTERED BY**  
8 **THE CENTERS FOR DISEASE CONTROL AND**  
9 **PREVENTION.**

10 (a) SINGLE APPLICATION.—

11           (1) IN GENERAL.—The Secretary, acting  
12           through the Director of the Centers for Disease  
13           Control and Prevention, shall establish a single con-  
14           solidated application to enable States to apply for  
15           the Core Functions of Public Health Grants Pro-  
16           gram and any or all of the Public Health Service  
17           Act categorical programs described in subsection (b).

18           (2) REQUIREMENTS.—The application devel-  
19           oped under paragraph (1) shall—

20                   (A) be designed so that information col-  
21                   lected will be consistent with the requirements  
22                   of this part including subsection (b);

23                   (B) be designed and implemented not later  
24                   than 1 year after the date of enactment of this  
25                   Act; and

1           (C) be developed with resources made  
2           available under section 3316 (not resources  
3           made available for the programs described in  
4           subsection (b)).

5           (3) STATE PUBLIC HEALTH OFFICERS.—In de-  
6           veloping the single consolidated application form to  
7           be used under this subsection the Secretary shall  
8           consult with Federal, State and local public health  
9           agencies.”.

10          (4) ELIGIBILITY.—States and local govern-  
11          ments that have grants, contracts or cooperative  
12          agreements in effect with the Centers for Disease  
13          Control and Prevention on the date of enactment of  
14          this Act shall be eligible to use a single application  
15          under this section to apply for any or all of the Pub-  
16          lic Health Service Act categorical programs de-  
17          scribed in subsection (b).

18          (b) ELIGIBLE PUBLIC HEALTH SERVICE ACT PRO-  
19          GRAMS.—Eligible Public Health Service Act categorical  
20          programs described in this subsection are the following:

21               (1) The Preventive Health and Health Services  
22               Block Grant under section 1903 of the Public  
23               Health Service Act.

1           (2) The Childhood Lead Poisoning Prevention  
2 Program under section 317A of the Public Health  
3 Service Act.

4           (3) The Sexually Transmitted Diseases Pro-  
5 gram under section 318 of the Public Health Service  
6 Act.

7           (4) The Prevention of Sexually Transmitted  
8 Diseases-Related Infertility Program under section  
9 318A of the Public Health Service Act.

10          (5) The Breast and Cervical Cancer Early De-  
11 tection Program under sections 1501 through 1509  
12 of the Public Health Service Act.

13          (6) The National Program of Cancer Registries  
14 under section 399H of the Public Health Service  
15 Act.

16          (7) The Injury Control and Prevention Pro-  
17 gram under sections 391 through 394 of the Public  
18 Health Service Act.

19          (8) The preventive health for prostate cancer  
20 program under section 317D of the Public Health  
21 Service Act.

22          (9) The birth defects data program under sec-  
23 tion 317C of the Public Health Service Act.

24          (10) Programs under subtitle D of this title.

1           (11) Other relevant programs as determined ap-  
2           propriate by the Secretary.

3           (c) ALLOCATION OF FUNDS.—In awarding grants to  
4 States and local governments under a single application  
5 under this section, the Secretary shall delineate to each  
6 grantee the amounts to be dedicated to each of the pro-  
7 grams described in subsection (b) and ensure that funding  
8 allotments for each of such programs are consistent with  
9 the requirements of Federal law.

10          (d) UNIFORM CORE FUNCTIONS OF PUBLIC HEALTH  
11 REPORTING SYSTEM.—

12           (1) DEVELOPMENT.—The Secretary, acting  
13 through the Director of the Office of Disease Pre-  
14 vention and Health Promotion and the Director of  
15 the Centers for Disease Control and Prevention, in  
16 consultation with other relevant Federal and State  
17 health agencies with data collection responsibilities,  
18 shall develop and implement a Uniform Core Public  
19 Health Functions Reporting System to collect pro-  
20 gram and fiscal data concerning the programs de-  
21 scribed in subsection (b).

22           (2) REQUIREMENTS.—The system developed  
23 under paragraph (1) shall—

24                   (A) use outcomes consistent with the goals  
25                   of Healthy People 2000;

1 (B) be designed so that information col-  
2 lected will be consistent with the requirements  
3 of this part including subsection (b);

4 (C) be designed and implemented not later  
5 than 2 years after the date of enactment of this  
6 Act; and

7 (D) be developed with resources made  
8 available under section 3316 of this Act (not re-  
9 sources made available for the programs de-  
10 scribed in subsection (b)).

11 (3) STATE PUBLIC HEALTH OFFICERS.—In de-  
12 veloping the data set to be used under Uniform Core  
13 Public Health Functions Reporting System the Sec-  
14 retary shall consult with Federal, State and local  
15 public health agencies.

16 (e) STUDY.—

17 (1) IN GENERAL.—Within a reasonable period  
18 of time after the date of enactment of this Act, the  
19 Secretary shall request that the Institute of Medi-  
20 cine conduct a study concerning—

21 (A) the effects of consolidating any or all  
22 of the grant programs administered by the Cen-  
23 ters for Disease Control and Prevention and de-  
24 scribed in subsection (b) into a Core Functions  
25 of Public Health Block Grant Program;

1 (B) the development of alternative methods  
2 for implementing a block grant program or cat-  
3 egorical grant program; and

4 (C) alternative formulas for allocating  
5 State grants that incorporate measures of  
6 health status, population and degree of poverty.

7 In particular, the impact of program consolidation  
8 on the targeted recipients, including women and vul-  
9 nerable populations, shall be addressed in the study.  
10 If the Institute of Medicine declines to do the study,  
11 the Secretary shall make grants to or enter into con-  
12 tracts with a public or nonprofit private entity with  
13 relevant expertise for the conduct of such a study.

14 (2) REPORT.—Not later than 1 year after the  
15 date of the receipt of the contract under paragraph  
16 (1), the contract recipient shall prepare and submit  
17 to the Secretary, the Energy and Commerce Com-  
18 mittee of the House of Representatives, and the  
19 Committee on Labor and Human Resources of the  
20 Senate a report that contains the results of the  
21 study conducted under paragraph (1).

22 (3) ISSUANCE OF PLAN.—Not later than 1 year  
23 after the date on which the report under paragraph  
24 (2) is received by the Secretary and the committees  
25 referred to in such paragraph, the Secretary shall

1 issue a plan in response to the report. Such a plan  
2 shall include the identification of relevant changes in  
3 authorizing language.

4 **PART 3—NATIONAL INITIATIVES REGARDING**  
5 **HEALTH PROMOTION AND DISEASE PREVENTION**

6 **Subpart A—General Grants**

7 **SEC. 3331. GRANTS FOR NATIONAL PREVENTION INITIA-**  
8 **TIVES.**

9 (a) IN GENERAL.—The Secretary may make grants  
10 to entities described in subsection (b) for the purpose of  
11 carrying out projects to develop and implement innovative  
12 community-based strategies to provide for health pro-  
13 motion and disease prevention activities for which there  
14 is a significant need, as identified under section 1701 of  
15 the Public Health Service Act.

16 (b) ELIGIBLE ENTITIES.—The entities referred to in  
17 subsection (a) are agencies of State or local government,  
18 private nonprofit organizations (including research institu-  
19 tions), and coalitions that link two or more of these  
20 groups.

21 (c) CERTAIN ACTIVITIES.—The Secretary shall en-  
22 sure that projects carried out under subsection (a)—

23 (1) reflect approaches that take into account  
24 the special needs and concerns of the affected popu-  
25 lations;

1           (2) are targeted to the most needy and vulner-  
2           able population groups and geographic areas of the  
3           Nation;

4           (3) examine links between various high priority  
5           preventable health problems and the potential com-  
6           munity-based remedial actions; and

7           (4) establish or strengthen the links between  
8           the activities of agencies engaged in public health  
9           activities with those of purchasing cooperatives,  
10          health care providers, and other entities involved in  
11          the personal health care delivery system described in  
12          title I.

13 **SEC. 3332. PRIORITIES.**

14          (a) ESTABLISHMENT.—

15           (1) ANNUAL STATEMENT.—The Secretary shall  
16           for each fiscal year develop a statement of proposed  
17           priorities for grants under section 3331 for the fiscal  
18           year.

19           (2) ALLOCATIONS AMONG PRIORITIES.—With  
20           respect to the amounts available under section  
21           3301(b) for the fiscal year for carrying out this part,  
22           each statement under paragraph (1) for a fiscal year  
23           shall include a specification of the percentage of the  
24           amount to be devoted to projects addressing each of  
25           the proposed priorities established in the statement.

1 (3) PROCESS FOR ESTABLISHING PRIORITIES.—

2 (A) PREFERENCE.—In establishing prior-  
3 ities for grants under this part, preference shall  
4 be given to projects that—

5 (i) reduce the prevalence of chronic  
6 diseases including cardiovascular disease,  
7 stroke, diabetes, and cancer;

8 (ii) prevent violence against women by  
9 training providers and other health care  
10 professionals to identify victims of domes-  
11 tic violence, to provide appropriate exam-  
12 ination and treatment, and to refer the vic-  
13 tims for appropriate social and legal serv-  
14 ices; and

15 (iii) establish community health advi-  
16 sor programs described in subparagraph  
17 (B).

18 (B) COMMUNITY HEALTH ADVISOR PRO-  
19 GRAMS.—For purposes of subparagraph  
20 (A)(iii), the term “community health advisor  
21 program” means a program that performs the  
22 following functions:

23 (i) Provides outreach services to in-  
24 form the community of the availability of  
25 program services.

1 (ii) Collaborate efforts with health  
2 care providers and related entities to facili-  
3 tate the provision of health services and  
4 health related social services.

5 (iii) Provide public education on  
6 health promotion and disease prevention  
7 and efforts to facilitate the use of available  
8 health services and health-related social  
9 services.

10 (iv) Provide health-related counseling.

11 (v) Make referrals for available health  
12 services and health-related social services.

13 (vi) Improve the ability of individuals  
14 to use health services and health-related  
15 social services under Federal, State, and  
16 local programs, through assisting individ-  
17 uals in establishing eligibility under the  
18 programs.

19 (vii) Establish a community health ad-  
20 visor training program.

21 (viii) Provide services in the language  
22 and cultural context most appropriate for  
23 the individuals served by the program.

24 (ix) Provide compensation for the  
25 services of, and opportunities for training

1 and employment of, community health ad-  
2 visors.

3 (x) Such other services as the Sec-  
4 retary determines to be appropriate, which  
5 may include transportation and translation  
6 services.

7 (C) PUBLICATION OF STATEMENT.—Not  
8 later than January 1 of each fiscal year, the  
9 Secretary shall publish a statement under para-  
10 graph (1) in the Federal Register. A period of  
11 60 days shall be allowed for the submission of  
12 public comments and suggestions concerning  
13 the proposed priorities. After analyzing and  
14 considering comments on the proposed prior-  
15 ities, the Secretary shall publish in the Federal  
16 Register final priorities (and associated reserva-  
17 tions of funds) for approval of projects for the  
18 following fiscal year.

19 (D) DEFINITION OF COMMUNITY HEALTH  
20 ADVISOR.—For purposes of subparagraph (B),  
21 the term “community health advisor” means an  
22 individual—

23 (i) who has demonstrated the capacity  
24 to carry out one or more of the authorized  
25 program services;

- 1 (ii) who, for not less than 1 year, has  
2 been a resident of the community in which  
3 the community health advisor program in-  
4 volved is to be operated; and  
5 (iii) is a member of a socioeconomic  
6 group to be served by the program.

7 (b) APPLICABILITY TO MAKING OF GRANTS.—

8 (1) IN GENERAL.—The Secretary may make  
9 grants under section 3331 for projects that the Sec-  
10 retary determines—

11 (A) are consistent with the applicable final  
12 statement of priorities and otherwise meets the  
13 objectives described in subsection (a); and

14 (B) will assist in meeting a health need or  
15 concern of a population within a defined health  
16 care coverage area or other service area.

17 (2) SPECIAL CONSIDERATION FOR CERTAIN  
18 PROJECTS.—In making grants under section 3331,  
19 the Secretary shall give special consideration to ap-  
20 plicants that will carry out projects that, in addition  
21 to being consistent with the applicable published pri-  
22 orities under subsection (a) and otherwise meeting  
23 the requirements of this part, have the potential for  
24 replication in other communities.

1 **SEC. 3333. SUBMISSION OF INFORMATION.**

2 The Secretary may make a grant under section 3331  
3 only if the applicant involved submits to the Secretary the  
4 following information:

5 (1) A description of the activities to be con-  
6 ducted, and the manner in which the activities are  
7 expected to contribute to meeting one or more of the  
8 priority health needs specified under section 3332  
9 for the fiscal year for which the grant is initially  
10 sought.

11 (2) A description of the total amount of Federal  
12 funding requested, the geographic area and popu-  
13 lations to be served, and the evaluation procedures  
14 to be followed.

15 (3) Such other information as the Secretary de-  
16 termines to be appropriate.

17 **SEC. 3334. APPLICATION FOR GRANT.**

18 The Secretary may make a grant under section 3331  
19 only if an application for the grant is submitted to the  
20 Secretary, the application contains each agreement de-  
21 scribed in this part, the application contains the informa-  
22 tion required in section 3333, and the application is in  
23 such form, is made in such manner, and contains such  
24 agreements, assurances, and information as the Secretary  
25 determines to be necessary to carry out this part.

1     **Subpart B—Development of Telemedicine in Rural**  
2                                     **Underserved Areas**

3     **SEC. 3341. GRANTS FOR DEVELOPMENT OF RURAL TELE-**  
4                                     **MEDICINE.**

5             (a) IN GENERAL.—

6                     (1) GRANTS AWARDED.—The Secretary, acting  
7             through the Office of Rural Health Policy, shall  
8             award grants to eligible entities that have applica-  
9             tions approved under subsection (b) for the purpose  
10            of expanding access to health care services for indi-  
11            viduals in rural areas through the use of telemedi-  
12            cine. Grants shall be awarded under this section to  
13            encourage the initial development of rural telemedi-  
14            cine networks, expand existing networks, link exist-  
15            ing networks together, or link such networks to ex-  
16            isting fiber optic telecommunications systems.

17                    (2) ELIGIBLE ENTITY.—For purposes of this  
18            section, the term “eligible entity” means a public or  
19            nonprofit entity operating in a nonmetropolitan area  
20            (as defined by the Secretary of Commerce) as part  
21            of a network of community-based providers that in-  
22            cludes at least three of the following:

23                            (A) Community or migrant health centers.

24                            (B) Local health departments.

25                            (C) Community mental health centers.

26                            (D) Nonprofit hospitals.

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

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

5           (b) APPLICATION.—To be eligible to receive a grant  
6 under this section an entity shall prepare and submit to  
7 the Secretary an application at such time, in such manner  
8 and containing such information as the Secretary may re-  
9 quire, including a description of the use to which the entity  
10 will apply any amounts received under the grant.

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

14           (1) are health care providers in rural health  
15           care networks or providers that propose to form  
16           such networks, and the majority of the providers in  
17           such a network are located in a medically under-  
18           served or health professional shortage areas;

19           (2) can demonstrate broad geographic coverage  
20           in the rural areas of the State, or States in which  
21           the applicant is located;

22           (3) propose to use Federal funds to develop  
23           plans for, or to establish, telemedicine systems that  
24           will link rural hospitals and rural health care pro-  
25           viders to other hospitals and health care providers;

1           (4) will use the amounts provided under the  
2           grant for a range of health care applications such as  
3           teleradiology, telepathology, interactive video con-  
4           sultation and remote educational services, and to  
5           promote greater efficiency in the use of health care  
6           resources; and

7           (5) propose to use local matching funds to fi-  
8           nance projects.

9           (d) USE OF AMOUNTS.—Amounts received under a  
10          grant awarded under this section shall be utilized for the  
11          development of telemedicine networks involving two or  
12          more providers. Such amounts may be used to cover the  
13          costs associated with the development of telemedicine net-  
14          works and the acquisition or construction of telecommuni-  
15          cations facilities and equipment including—

16                (1) the development and acquisition through  
17                lease or purchase of computer hardware and soft-  
18                ware, audio and visual equipment, computer network  
19                equipment, telecommunications transmission facili-  
20                ties, telecommunications terminal equipments, inter-  
21                active video equipment, data terminal equipment,  
22                and other facilities and equipment that would fur-  
23                ther the purposes of this section;

1           (2) the provision of technical assistance and in-  
2           struction for the development and use of such pro-  
3           gramming equipment or facilities;

4           (3) the development and acquisition of instruc-  
5           tional programming;

6           (4) demonstration projects for teaching or  
7           training medical students, residents, and other  
8           health professions students in rural training sites  
9           about the application of telemedicine;

10          (5) transmission costs, maintenance of equip-  
11          ment, and compensation of specialists and referring  
12          practitioners;

13          (6) demonstration projects to use telemedicine  
14          to facilitate collaboration between physicians and  
15          nonphysician primary care practitioners such as phy-  
16          sician assistants, nurse practitioners, and certified  
17          nurse-midwives; or

18          (7) such other uses that are consistent with  
19          achieving the purposes of this section as approved by  
20          the Secretary.

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

1           (1) Expenditures to purchase or lease equip-  
2           ment to the extent the expenditures would exceed  
3           more than 60 percent of the total grant funds.

4           (2) Expenditures for indirect costs (as deter-  
5           mined by the Secretary) to the extent the expendi-  
6           tures would exceed more than 10 percent of the total  
7           grant funds.

8 **SEC. 3342. REPORT AND EVALUATION OF TELEMEDICINE.**

9           Not later than the date that is 3 years after the date  
10          on which the first grant is awarded under section 3341,  
11          the Secretary, in consultation with the Administrator of  
12          the Rural Electrification Administration, the Secretary of  
13          Veterans Affairs, and other agencies and departments that  
14          have responsibilities for overseeing telemedicine projects,  
15          shall prepare and submit to the appropriate committees  
16          of Congress a report that evaluates telemedicine in the  
17          United States. Such report shall contain an evaluation  
18          of—

19               (1) whether telemedicine expands access to  
20               health care services;

21               (2) the cost effectiveness of telemedicine serv-  
22               ices; and

23               (3) the quality of telemedicine services deliv-  
24               ered.

1 **SEC. 3343. REGULATIONS ON REIMBURSEMENT OF TELE-**  
2 **MEDICINE.**

3 Not later than July 1, 1996, the Secretary, in con-  
4 sultation with the Director of the Office of Rural Health  
5 and the Administrator of the Health Care Financing Ad-  
6 ministration, shall issue regulations concerning reimburse-  
7 ment for telemedicine services provided under title XVIII  
8 of the Social Security Act.

9 **SEC. 3344. AUTHORIZATION OF APPROPRIATIONS.**

10 There are authorized to be appropriated such sums  
11 as may be necessary to carry out this subpart.

12 **SEC. 3345. DEFINITIONS.**

13 As used in this part:

14 (1) **COMPUTER NETWORKS.**—The term “com-  
15 puter networks” means computer hardware and soft-  
16 ware, terminals, signal conversion equipment includ-  
17 ing both modulators and demodulators, or related  
18 devices, used to communicate with other computers  
19 to process and exchange data through a tele-  
20 communication network in which signals are gen-  
21 erated, modified, or prepared for transmission, or re-  
22 ceived, via telecommunications terminal equipment  
23 and telecommunications transmission facilities.

24 (2) **DATA TERMINAL EQUIPMENT.**—The term  
25 “data terminal equipment” means equipment that  
26 converts user information into data signals for

1 transmission, or reconverts the received data signals  
2 into user information, and is normally found on the  
3 terminal of a circuit and on the premises of the end  
4 user.

5 (3) FIBER OPTIC CABLE.—The term “fiber  
6 optic cable” means a bundle of optical transmission  
7 elements or waveguides usually consisting of a fiber  
8 core and fiber cladding that can guide a lightwave  
9 and that are incorporated into an assembly of mate-  
10 rials that provide tensile strength and external pro-  
11 tection.

12 (4) INTERACTIVE VIDEO EQUIPMENT.—The  
13 term “interactive video equipment” means equip-  
14 ment used to produce and prepare for transmission  
15 audio and visual signals from at least two distant lo-  
16 cations in order that individuals at such locations  
17 can verbally and visually communicate with each  
18 other, and such equipment includes monitors, other  
19 display devices, cameras or other recording devices,  
20 audio pick-up devices, and other related equipment.

21 (5) RURAL HEALTH CARE NETWORK.—The  
22 term “rural health care network” means a group of  
23 rural hospitals or other rural care health care pro-  
24 viders (including clinics, physicians and non-physi-  
25 cians primary care providers) that have entered into

1 a formal relationship with each other or with  
2 nonrural hospitals and health care providers for the  
3 purpose of strengthening the delivery of health care  
4 services in rural areas or specifically to improve  
5 their patients' access to telemedicine services. At  
6 least 75 percent of hospitals and other health care  
7 providers participating in the network shall be lo-  
8 cated in rural areas.

9 (6) TELECOMMUNICATION TRANSMISSION FA-  
10 CILITIES.—The term “telecommunications trans-  
11 mission facilities” means those facilities that trans-  
12 mit, receive, or carry data between the telecommuni-  
13 cations terminal equipment at each end of a tele-  
14 communications circuit or path. Such facilities in-  
15 clude microwave antennae, relay stations and towers,  
16 other telecommunications antennae, fiber-optic ca-  
17 bles and repeaters, coaxial cables, communication  
18 satellite ground station complexes, copper cable elec-  
19 tronic equipment associated with telecommunications  
20 transmissions, and similar items as defined by the  
21 Secretary.

22 (7) TELECOMMUNICATION TERMINAL EQUIP-  
23 MENT.—The term “telecommunications terminal  
24 equipment” means the assembly of telecommuni-  
25 cations equipment at the end of a circuit, normally

1 located on the premises of the end user, that inter-  
 2 faces with telecommunications transmission facili-  
 3 ties, and that is used to modify, convert, encode, or  
 4 otherwise prepare signals to be transmitted via such  
 5 telecommunications facilities, or that is used to mod-  
 6 ify, reconvert or carry signals received from such fa-  
 7 cilities, the purpose of which is to accomplish the  
 8 goal for which the circuit was established.

9 **Subtitle E—Health Services for**  
 10 **Medically Underserved Popu-**  
 11 **lations**

12 **PART 1—INITIATIVES FOR ACCESS TO HEALTH**  
 13 **CARE**

14 **Subpart A—Authorization of Appropriations**

15 **SEC. 3411. AUTHORIZATIONS OF APPROPRIATIONS.**

16 (a) IMPROVING ACCESS TO HEALTH SERVICES.—

17 (1) SUBPART B.—

18 (A) Except as provided in subparagraph  
 19 (B), for the purpose of carrying out subpart B,  
 20 there are authorized to be appropriated  
 21 \$105,000,000 for fiscal year 1995,  
 22 \$245,000,000 for fiscal year 1996,  
 23 \$385,000,000 for fiscal year 1997,  
 24 \$315,000,000 for fiscal year 1998,

1           \$245,000,000 for fiscal year 1999, and  
2           \$105,000,000 for fiscal year 2000.

3           (B) With respect to awards to federally  
4           qualified health centers (as defined in section  
5           1861(aa)(4) of the Social Security Act) and  
6           rural health clinics under subpart B, there are  
7           authorized to be appropriated \$45,000,000 for  
8           fiscal year 1995, \$105,000,000 for fiscal year  
9           1996, \$165,000,000 for fiscal year 1997,  
10          \$135,000,000 for fiscal year 1998,  
11          \$105,000,000 for fiscal year 1999, and  
12          \$45,000,000 for fiscal year 2000.

13          (2) SUBPART C.—

14           (A) For the purpose of providing loans  
15           under subpart C, there are authorized to be ap-  
16           propriated such sums as may be necessary to  
17           support a loan level of \$200,000,000 for each  
18           of the fiscal years 1995 through 2000.

19           (B) For the purpose of making grants  
20           under subpart C, there are authorized to be ap-  
21           propriated \$35,000,000 for each of the fiscal  
22           year 1995 through 2000.

23          (b) RELATION TO OTHER FUNDS.—The authoriza-  
24          tions of appropriations established in subsection (a) are  
25          in addition to any other authorizations of appropriations

1 that are available for the purpose described in such sub-  
2 section.

3 (c) ELIGIBLE ENTITIES.—For purposes of this part,  
4 the term “eligible entities” means—

5 (1) covered entities as defined in section  
6 340B(a)(4) of the Public Health Service Act (42  
7 U.S.C. 256b(a)(4)), except that subsection  
8 (a)(4)(L)(iii) and (a)(7) of such section shall not  
9 apply;

10 (2) school health service sites under title III of  
11 this Act;

12 (3) nonprofit hospitals meeting the criteria for  
13 public hospitals which are eligible entities under sec-  
14 tion 340B of the Public Health Service Act, except  
15 that subsection (a)(4)(L)(iii) of such section shall  
16 not apply, and children’s hospitals meeting com-  
17 parable criteria as determined appropriate by the  
18 Secretary;

19 (4) public and private, nonprofit community  
20 mental health centers and substance abuse treat-  
21 ment providers receiving funds from the Substance  
22 Abuse and Mental Health Services Administration;

23 (5) runaway homeless youth centers or transi-  
24 tional living programs for homeless youth for the  
25 provision of health services under the Runaway

1 Homeless Youth Act of 1974 (42 U.S.C. 5701 et  
2 seq.);

3 (6) rural referral centers under section  
4 1886(d)(5)(C) of the Social Security Act, except  
5 that such eligibility is restricted to the receipt of  
6 grants under section 3441; and

7 (7) public or nonprofit entities in nonmetropoli-  
8 tan areas (as defined by the Department of Com-  
9 merce) in a consortium of community-based pro-  
10 viders that includes at least three of the following:

11 (A) community or migrant health centers;

12 (B) local health departments;

13 (C) community mental health centers;

14 (D) nonprofit hospitals;

15 (E) private practice health professionals,

16 including rural health clinics; or

17 (F) other publicly funded health or social  
18 services agencies;

19 except that such eligibility is restricted to the receipt  
20 of grants or contracts under section 3421(a).

21 (d) PRIORITY.—In making awards from amounts ap-  
22 propriated under subsection (a)(1)(B) and section 3462,  
23 the Secretary shall give the highest priority to providing  
24 adequate assistance to federally qualified health centers  
25 in order to ensure the provision of comprehensive primary

1 health care services, other covered services and benefits,  
 2 and enabling services to medically underserved populations  
 3 that were served by such centers prior to the date of enact-  
 4 ment of this Act, except that such federally qualified  
 5 health centers must continue to meet the requirements for  
 6 designation under section 1861(aa)(4) of the Social Secu-  
 7 rity Act.

8 (e) **EQUITABLE DISTRIBUTION.**—The Secretary  
 9 shall, in awarding grants, entering into contracts, and  
 10 making loans under this part, assure an equitable distribu-  
 11 tion of funds between rural and urban areas.

12 **Subpart B—Development of Community Health**

13 **Groups and Health Care Sites and Services**

14 **SEC. 3421. GRANTS AND CONTRACTS FOR DEVELOPMENT**  
 15 **OF PLANS AND NETWORKS AND THE EXPAN-**  
 16 **SION AND DEVELOPMENT OF HEALTH CARE**  
 17 **SITES AND SERVICES.**

18 (a) **AUTHORITY.**—

19 (1) **IN GENERAL.**—The Secretary may make  
 20 grants to and enter into contracts with eligible enti-  
 21 ties described in section 3411(c) for—

22 (A) the development of community health  
 23 groups whose principal purpose is to provide  
 24 the comprehensive benefit package under title I  
 25 in one or more health professional shortage

1 areas or to provide such items and services to  
2 a significant number of individuals who are  
3 members of a medically underserved population;  
4 and

5 (B) the expansion of existing health deliv-  
6 ery sites and services and the development of  
7 new health delivery sites and services.

8 (2) CONSIDERATION BY SECRETARY.—In  
9 awarding grants or contracts under paragraph (1),  
10 the Secretary shall give consideration to—

11 (A) the geographic proximity of the grant  
12 applicants and recipients;

13 (B) cultural and language differences ex-  
14 isting within the communities to be served  
15 under the grants or contracts; and

16 (C) the capacity needs of the communities  
17 to be served.

18 (b) SERVICE AREA.—In making an award under sub-  
19 section (a), the Secretary shall designate the geographic  
20 area with respect to which the community health group  
21 involved is to provide health services.

22 (c) PRIORITY.—In making awards under subsection  
23 (a)(1), the Secretary shall give priority to proposals in  
24 which a greater number of eligible entities and other  
25 health care providers, especially providers in community-

1 and provider-based health plans under section 1651(d),  
2 are participants in the community health group, except in  
3 areas such as rural areas, where providers are severely  
4 limited in number.

5 (d) LIMITATION ON AWARDS.—The Secretary may  
6 not make awards under subsection (a)(1) for more than  
7 5 years to the same community health group.

8 (e) DEFINITIONS.—For purposes of this subpart:

9 (1) The term “community health group”  
10 means—

11 (A) a community health network that—

12 (i) is a public or nonprofit private  
13 consortium of health care providers that  
14 principally provides some of the items and  
15 services of the standard benefit package to  
16 medically underserved populations, and  
17 residents of health professional shortage  
18 areas;

19 (ii) has an agreement with one or  
20 more health plans; and

21 (iii) has a written agreement gov-  
22 erning the participation of health care pro-  
23 viders in the consortium to which each par-  
24 ticipating provider is a party; or

25 (B) a community health plan that—

1 (i) is a public or nonprofit private en-  
2 tity that principally provides all of the  
3 items and services of the standard benefit  
4 package to medically underserved popu-  
5 lations, and residents of health professional  
6 shortage areas;

7 (ii) is a participant in one or more  
8 health alliances; and

9 (iii) has a written agreement gov-  
10 erning the participation of health care pro-  
11 viders in the consortium to which each par-  
12 ticipating provider is a party.

13 (2) The term “health professional shortage  
14 areas” means health professional shortage areas des-  
15 igned under section 332 of the Public Health Serv-  
16 ice Act.

17 (3) The term “medically underserved popu-  
18 lation” means a medically underserved population  
19 designated under section 330(b)(3) of the Public  
20 Health Service Act, populations residing in health  
21 professional shortage areas under section 332 of the  
22 Public Health Service Act, and populations eligible  
23 for premium subsidies and cost sharing reductions  
24 based on income under title I.

1 **SEC. 3422. CERTAIN USES OF AWARDS.**

2 (a) IN GENERAL.—Amounts awarded under section  
3 3421 may be expended for—

4 (1) the development of a community health  
5 group, including entering into contracts between the  
6 recipient of the award and health care providers who  
7 are to participate in the group;

8 (2) the expansion, development and on-going  
9 operation of health delivery sites and services; and

10 (3) activities under paragraphs (1) and (2)  
11 which include—

12 (A) the recruitment, compensation, and  
13 training of health professionals and administra-  
14 tive staff;

15 (B) the purchase and upgrading of equip-  
16 ment, supplies, and information systems includ-  
17 ing telemedicine systems; and

18 (C) the establishment of reserves required  
19 for furnishing services on a prepaid or capitated  
20 basis, except that eligible entities may use non-  
21 cash mechanisms (including bonds, letters of  
22 credit and federally guaranteed reinsurance  
23 pools) for establishing and maintaining finan-  
24 cial reserves.

25 (b) LOANS AND GRANTS.—The Secretary may ex-  
26 pend, in any fiscal year, not to exceed 10 percent of the

1 amounts appropriated to carry out this subpart to make  
2 loans and grants to eligible entities to support the types  
3 of activities described in section 3441, subject to the re-  
4 quirements of subpart C, except that, with respect to  
5 amounts available for non-federally qualified health center  
6 activities, such funds may be used to convert facilities  
7 from providers of acute care service to providers of pri-  
8 mary, emergency or long-term care.

9 **SEC. 3423. APPLICATION.**

10 The Secretary may not make an award to an entity  
11 under section 3421 until such entity submits and applica-  
12 tion to the Secretary, in such form and containing such  
13 assurances and information as the Secretary determines  
14 appropriate, including—

15 (1) an assessment of the need that the medi-  
16 cally underserved population or populations proposed  
17 to be served by the applicant have for health services  
18 and for enabling services (as defined in section  
19 3461);

20 (2) a description of how the applicant will de-  
21 sign the proposed community health plan or practice  
22 network (including the service sites involved) for  
23 such populations based on the assessment of need;

1           (3) a description of efforts to secure financial  
2           and professional assistance and support for the  
3           project; and

4           (4) evidence of significant community involve-  
5           ment in the initiation, development and ongoing op-  
6           eration of the project.

7 **SEC. 3424. PURPOSES AND CONDITIONS.**

8           Grants shall be made under this subpart for the pur-  
9           poses and subject to all of the conditions under which eli-  
10          gible entities otherwise receive funding to provide health  
11          services to medically underserved populations under the  
12          Public Health Service Act. The Secretary shall prescribe  
13          comparable purposes and conditions for eligible entities  
14          not receiving funding under the Public Health Service Act.

15                 **Subpart C—Capital Cost of Development of**  
16                 **Community Health Groups and Other Purposes**

17 **SEC. 3441. DIRECT LOANS AND GRANTS.**

18           (a) IN GENERAL.—The Secretary shall make grants  
19          and loans to—

20                 (1) eligible entities (as defined in section  
21                 3412(c));

22                 (2) hospitals designated by the Secretary as es-  
23                 sential access community hospitals under section  
24                 1820(i)(1) of the Social Security Act; or

1           (3) rural primary care hospitals under section  
2           1820(i)(2) of such Act;  
3 for the capital costs of developing community health  
4 groups (as defined in section 3421(e)) and expanding ex-  
5 isting health delivery sites or developing new health deliv-  
6 ery sites.

7           (b) USE OF ASSISTANCE.—

8           (1) IN GENERAL.—The capital costs for which  
9           grants and loans made pursuant to subsection (a)  
10          may be expended are, subject to paragraphs (2) and  
11          (3), the following:

12                   (A) The acquisition, modernization, expan-  
13                   sion or construction of facilities, or the conver-  
14                   sion of unneeded hospital facilities to facilities  
15                   that will assure or enhance the provision and  
16                   accessibility of health care and enabling services  
17                   to medically underserved populations.

18                   (B) The purchase of major equipment, in-  
19                   cluding equipment necessary for the support of  
20                   external and internal information systems.

21                   (C) The establishment of reserves required  
22                   for furnishing services on a prepaid or capitated  
23                   basis.

1           (D) Such other capital costs as the Sec-  
2           retary may determine are necessary to achieve  
3           the objectives of this section.

4           (2) PRIORITIES REGARDING USE OF FUNDS.—

5           In providing grants and loans under subsection (a)  
6           for an entity, the Secretary shall give priority to au-  
7           thorizing the use of amounts for projects for the  
8           renovation and modernization of medical facilities  
9           necessary to prevent or eliminate safety hazards in-  
10          cluding asbestos removal, avoid noncompliance with  
11          licensure or accreditation standards, or projects to  
12          replace obsolete facilities.

13          (3) LIMITATION.—The Secretary may authorize  
14          the use of grants and loans under subsection (a) for  
15          the construction of new buildings only if the Sec-  
16          retary determines that appropriate facilities are not  
17          available through acquiring, modernizing, expanding  
18          or converting existing buildings, or that construction  
19          new buildings will cost less.

20          (c) AMOUNT OF ASSISTANCE.—

21           (1) IN GENERAL.—The principal amount of  
22           loans under subsection (a) may cover up to 90 per-  
23           cent of the costs involved.

24           (2) GRANTS.—Grants under this subsection  
25           may not exceed 75 percent of the costs involved.

1 (d) INTEREST SUBSIDIES.—Amounts provided under  
2 this section may be used to provide interest subsidies for  
3 loans provided under this section where such subsidies are  
4 necessary to make a project financial feasible.

5 **SEC. 3442. CERTAIN REQUIREMENTS.**

6 (a) IN GENERAL.—The Secretary may approve a loan  
7 under section 3441 only if—

8 (1) the Secretary is reasonably satisfied that  
9 the applicant for the project for which the loan  
10 would be made will be able to make payments of  
11 principal and interest thereon when due; and

12 (2) the applicant provides the Secretary with  
13 reasonable assurances that there will be available to  
14 it such additional funds as may be necessary to com-  
15 plete the project or undertaking with respect to  
16 which such loan is requested.

17 (b) TERMS AND CONDITIONS.—Any loan made under  
18 section 3441 shall, subject to the Federal Credit Reform  
19 Act of 1990, meet such terms and conditions (including  
20 provisions for recovery in case of default) as the Secretary,  
21 in consultation with the Secretary of the Treasury, deter-  
22 mines to be necessary to carry out the purposes of such  
23 section while adequately protecting the financial interests  
24 of the United States. Terms and conditions for such loans  
25 shall include provisions regarding the following:

1 (1) Security.

2 (2) Maturity date.

3 (3) Amount and frequency of installments.

4 (4) Rate of interest, which shall be at a rate  
5 comparable to the rate of interest prevailing on the  
6 date the loan is made.

7 **SEC. 3443. DEFAULTS; RIGHT OF RECOVERY.**

8 (a) DEFAULTS.—

9 (1) IN GENERAL.—The Secretary may take  
10 such action as may be necessary to prevent a default  
11 on loans under section 3441, including the waiver of  
12 regulatory conditions, deferral of loan payments, re-  
13 negotiation of loans, and the expenditure of funds  
14 for technical and consultative assistance, for the  
15 temporary payment of the interest and principal on  
16 such a loan, and for other purposes.

17 (2) FORECLOSURE.—The Secretary may take  
18 such action, consistent with State law respecting  
19 foreclosure procedures, as the Secretary deems ap-  
20 propriate to protect the interest of the United States  
21 in the event of a default on a loan made pursuant  
22 to section 3441, including selling real property  
23 pledged as security for such a loan and for a reason-  
24 able period of time taking possession of, holding,

1 and using real property pledged as security for such  
2 a loan.

3 (3) WAIVERS.—The Secretary may, for good  
4 cause, but with due regard to the financial interests  
5 of the United States, waive any right of recovery  
6 which the Secretary has by reasons of the failure of  
7 a borrower to make payments of principal of and in-  
8 terest on a loan made pursuant to section 3441, ex-  
9 cept that if such loan is sold and guaranteed, any  
10 such waiver shall have no effect upon the Secretary's  
11 guarantee of timely payment of principal and inter-  
12 est.

13 (b) TWENTY-YEAR OBLIGATION; RIGHT OF RECOV-  
14 ERY; SUBORDINATION; WAIVERS.—

15 (1) IN GENERAL.—With respect to an eligible  
16 entity for which a grant or loan was made under  
17 section 3441, the Secretary may award the grant or  
18 loan only if the applicant involved agrees that the  
19 applicant will be liable to the United States for the  
20 amount of the grant or loan, together with an  
21 amount representing interest, if at any time during  
22 the 20-year period beginning on the date of comple-  
23 tion of the activities involved, the entity—

24 (A) ceases to be an eligible entity utilized  
25 by a community health group, or by another

1 public or nonprofit private entity that provides  
2 health services in one or more health profes-  
3 sional shortage areas or that provides such  
4 services to a significant number of individuals  
5 who are members of a medically underserved  
6 population; or

7 (B) is sold or transferred to any entity  
8 other than an entity that is—

9 (i) a community health group or other  
10 entity described in subparagraph (A); and

11 (ii) approved by the Secretary as a  
12 purchaser or transferee regarding the facil-  
13 ity.

14 (2) SUBORDINATION; WAIVERS.—With respect  
15 to essential community providers, the Secretary may  
16 subordinate or waive the right of recovery under  
17 paragraph (1), and any other Federal interest that  
18 may be derived by virtue of a grant or loan under  
19 section 3441, if the Secretary determines that subor-  
20 dination or waiver will further the objectives of this  
21 part.

22 **SEC. 3444. PROVISIONS REGARDING CONSTRUCTION OR EX-**  
23 **PANSION OF FACILITIES.**

24 (a) SUBMISSION OF INFORMATION.—In the case of  
25 a project for construction, conversion, expansion or mod-

1 ernization of a facility, the Secretary may provide loans  
2 under section 3441 only if the applicant submits to the  
3 Secretary the following:

4 (1) A description of the site.

5 (2) Plans and specifications which meet require-  
6 ments prescribed by the Secretary.

7 (3) Information reasonably demonstrating that  
8 title to such site is vested in one or more of the enti-  
9 ties filing the application (unless the agreement de-  
10 scribed in subsection (b)(1) is made).

11 (4) A specification of the type of assistance  
12 being requested under section 3441.

13 (b) AGREEMENTS.—In the case of a project for con-  
14 struction, conversion, expansion or modernization of a fa-  
15 cility, the Secretary may provide loans under section 3441  
16 only if the applicant makes the following agreements:

17 (1) Title to such site will be vested in one or  
18 more of the entities filing the application (unless the  
19 assurance described in subsection (a)(3) has been  
20 submitted under such subsection).

21 (2) Adequate financial support will be available  
22 for completion of the project and for its maintenance  
23 and operation when completed.

24 (3) All laborers and mechanics employed by  
25 contractors or subcontractors in the performance of

1 work on a project will be paid wages at rates not  
2 less than those prevailing on similar construction in  
3 the locality as determined by the Secretary of Labor  
4 in accordance with the Act of March 3, 1931 (40  
5 U.S.C. 276a et seq.; commonly known as the Davis-  
6 Bacon Act), and the Secretary of Labor shall have  
7 with respect to such labor standards the authority  
8 and functions set forth in Reorganization Plan  
9 Numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Ap-  
10 pendix) and section 276c of title 40.

11 (4) The facility will be made available to all  
12 persons seeking service regardless of their ability to  
13 pay.

14 **SEC. 3445. APPLICATION FOR ASSISTANCE.**

15 The Secretary may provide loans under section 3441  
16 only if an application for such assistance is submitted to  
17 the Secretary, the application contains each agreement de-  
18 scribed in this subpart, the application contains the infor-  
19 mation required in section 3444(a), and the application  
20 is in such form, is made in such manner, and contains  
21 such agreements, assurances, and information as the Sec-  
22 retary determines to be necessary to carry out this sub-  
23 part.

1 **SEC. 3446. ADMINISTRATION OF PROGRAMS.**

2 This subpart, and any other program of the Secretary  
3 that provides loans, shall be carried out by a centralized  
4 loan unit established within the Department of Health and  
5 Human Services.

6 **Subpart D—Enabling and Supplemental Services**

7 **SEC. 3461. GRANTS AND CONTRACTS FOR ENABLING AND**  
8 **SUPPLEMENTAL SERVICES.**

9 (a) **AUTHORITY.—**

10 (1) **IN GENERAL.—**The Secretary may make  
11 grants to and enter into contracts with eligible enti-  
12 ties to assist such entities in providing the services  
13 described in subsections (b) and (c) for the purpose  
14 of increasing the capacity of individuals to utilize the  
15 items and services included in the comprehensive  
16 benefits package under title I, and to provide access  
17 to essential supplemental services that are not fully  
18 reimbursable under title I prior to January 2001.

19 (2) **CONSIDERATION BY SECRETARY.—**In  
20 awarding grants or contracts under paragraph (1),  
21 the Secretary shall give consideration to—

22 (A) the geographic proximity of the grant  
23 applicants and recipients;

24 (B) cultural and language differences ex-  
25 isting within the communities to be served  
26 under the grants or contracts; and

1 (C) the capacity needs of the communities  
2 to be served.

3 (b) ENABLING SERVICES.—Enabling services shall  
4 include transportation, community and patient outreach,  
5 patient and family education, translation services, case  
6 management, home visiting, and such other services as the  
7 Secretary determines to be appropriate in carrying out the  
8 purpose described in such subsection.

9 (c) SUPPLEMENTAL SERVICES.—Supplemental serv-  
10 ices shall include items or services described in section  
11 1106 or section 1118 of this Act that would otherwise be  
12 excluded from coverage prior to January 1, 2001.

13 (d) CERTAIN REQUIREMENTS REGARDING PROJECT  
14 AREA.—The Secretary may make an award of a grant or  
15 contract under subsection (a) only if the applicant in-  
16 volved—

17 (1) submits to the Secretary—

18 (A) information demonstrating that the  
19 medically underserved populations in the com-  
20 munity to be served under the award have a  
21 need for enabling services; and

22 (B) a proposed budget for providing such  
23 services;

24 (2) the applicant for the award agrees that the  
25 medically underserved residents of the community

1 will be consulted with respect to the design and im-  
2 plementation of the project carried out with the  
3 award;

4 (3) agrees that the services will not be denied  
5 because the individual is unable to pay for such serv-  
6 ices; and

7 (4) agrees that the applicant will utilize existing  
8 resources to the maximum extent practicable.

9 (e) APPLICATION FOR AWARDS OF ASSISTANCE.—

10 The Secretary may make an award of a grant or contract  
11 under subsection (a) only if an application for the award  
12 is submitted to the Secretary, the application contains  
13 each agreement described in this subpart, and the applica-  
14 tion is in such form, is made in such manner, and contains  
15 such agreements, assurances, and information as the Sec-  
16 retary determines to be necessary to carry out this sub-  
17 part.

18 **SEC. 3462. AUTHORIZATIONS OF APPROPRIATIONS.**

19 (a) ENABLING SERVICES.—For the purpose of car-  
20 rying out section 3461(b), there are authorized to be ap-  
21 propriated \$17,200,000 for fiscal year 1996, \$68,900,000  
22 for each of the fiscal years 1997 through 1999,  
23 \$68,900,000 for fiscal year 2000, and \$2,000,000 for each  
24 of the fiscal years 2001 through 2004.

1 (b) SUPPLEMENTAL SERVICES.—For the purpose of  
2 carrying out section 3461(c), there are authorized to be  
3 appropriated \$82,000,000 for fiscal year 1996,  
4 \$123,000,000 for each of the fiscal years 1997 through  
5 1999, \$205,000,000 for fiscal year 2000, and \$2,000,000  
6 for each of the fiscal years 2001 through 2004.

7 (c) FEDERALLY QUALIFIED HEALTH CENTERS AND  
8 RURAL HEALTH CLINICS.—With respect to federally  
9 qualified health centers (as defined in section 1861(aa)(4)  
10 of the Social Security Act) and rural health clinics—

11 (1) for the purpose of carrying out section  
12 3461(b), there are authorized to be appropriated  
13 \$40,000,000 for fiscal year 1996, \$161,000,000 for  
14 each of the fiscal years 1997 through 1999,  
15 \$201,000,000 for fiscal year 2000, and \$2,000,000  
16 for each of the fiscal years 2001 through 2004; and

17 (2) for the purpose of carrying out section  
18 3461(c), there are authorized to be appropriated  
19 \$24,600,000 for fiscal year 1996, \$36,900,000 for  
20 each of the fiscal years 1997 through 1999,  
21 \$61,500,000 for fiscal year 2000, and \$2,000,000  
22 for each of the fiscal years 2001 through 2004; and

23 (d) RELATION TO OTHER FUNDS.—The authoriza-  
24 tions of appropriations established in subsection (a) are  
25 in addition to any other authorizations of appropriations

1 that are available for the purpose described in such sub-  
2 section.

3 **PART 2—NATIONAL HEALTH SERVICE CORPS**

4 **SEC. 3471. AUTHORIZATIONS OF APPROPRIATIONS.**

5 (a) **ADDITIONAL FUNDING; GENERAL CORPS PRO-**  
6 **GRAM; ALLOCATIONS REGARDING NURSES.**—For the pur-  
7 pose of carrying out subpart II of part D of title III of  
8 the Public Health Service Act, and for the purpose of car-  
9 rying out section 3472, there are authorized to be appro-  
10 priated \$123,000,000 for each of the fiscal years 1996  
11 and 1997, and \$201,000,000 for each of the fiscal years  
12 1998 through 2000, and \$2,000,000 for each of the fiscal  
13 years 2001 through 2004.

14 (b) **RELATION TO OTHER FUNDS.**—The authoriza-  
15 tions of appropriations established in subsection (a) are  
16 in addition to any other authorizations of appropriations  
17 that are available for the purpose described in such sub-  
18 section.

19 **SEC. 3472. ALLOCATION FOR PARTICIPATION OF NURSES**  
20 **IN SCHOLARSHIP AND LOAN REPAYMENT**  
21 **PROGRAMS.**

22 Of the amounts appropriated under section 3471, the  
23 Secretary shall reserve such amounts as may be necessary  
24 to ensure that, of the aggregate number of individuals who  
25 are participants in the Scholarship Program under section

1 338A of the Public Health Service Act, or in the Loan  
 2 Repayment Program under section 338B of such Act, the  
 3 total number who are being educated as nurse practi-  
 4 tioners, nurse midwives, or nurse anesthetists or are serv-  
 5 ing as nurse practitioners, nurse midwives, or nurse anes-  
 6 thetists, respectively, is increased to 20 percent.

7 **SEC. 3473. ALLOCATION FOR PARTICIPATION OF PSYCHIA-**  
 8 **TRISTS, PSYCHOLOGISTS, AND CLINICAL SO-**  
 9 **CIAL WORKERS IN SCHOLARSHIP AND LOAN**  
 10 **REPAYMENT PROGRAMS.**

11 Of the amounts appropriate under section 3471, the  
 12 Secretary shall reserve such amounts as may be necessary  
 13 to ensure that of the aggregate number of individuals who  
 14 are participants in the scholarship program under section  
 15 338A of the Public Health Service Act, the number who  
 16 are being educated as psychiatrists, psychologists, and  
 17 clinical social workers or are serving as psychiatrists, psy-  
 18 chologists, and clinical social workers, respectively, is in-  
 19 creased to 15 percent.

20 **PART 3—PAYMENTS TO HOSPITALS SERVING**  
 21 **VULNERABLE POPULATIONS**

22 **SEC. 3481. PAYMENTS TO HOSPITALS.**

23 (a) ENTITLEMENT STATUS.—The Secretary shall  
 24 make payments in accordance with this part to eligible

1 hospitals described in section 3482. The preceding sen-  
2 tence—

3 (1) is an entitlement in the Secretary on behalf  
4 of such eligible hospitals (but is not an entitlement  
5 in the State in which any such hospital is located or  
6 in any individual receiving services from any such  
7 hospital); and

8 (2) constitutes budget authority in advance of  
9 appropriations Acts and represents the obligation of  
10 the Federal Government to provide funding for such  
11 payments in the amounts, and for the fiscal years,  
12 specified in subsection (b).

13 (b) APPROPRIATIONS.—

14 (1) IN GENERAL.—For purposes of subsection  
15 (a)(2), the amounts and fiscal years specified in this  
16 subsection are (in the aggregate for all eligible hos-  
17 pitals) \$1,300,000,000 for the fiscal year in which  
18 the general effective date occurs and for each subse-  
19 quent fiscal year.

20 (2) SPECIAL RULE FOR YEARS BEFORE GEN-  
21 ERAL EFFECTIVE DATE.—

22 (A) IN GENERAL.—For each of the fiscal  
23 years 1996 and 1997, the amount specified in  
24 this subsection for purposes of subsection (a)(2)  
25 shall be equal to the aggregate DSH percentage

1 of the amount otherwise determined under  
2 paragraph (1).

3 (B) AGGREGATE DSH PERCENTAGE DE-  
4 FINED.—In subparagraph (A), the “aggregate  
5 DSH percentage” for a year is the amount (ex-  
6 pressed as a percentage) equal to—

7 (i) the total amount of payment made  
8 by the Secretary under section 1903(a) of  
9 the Social Security Act during the base  
10 year with respect to payment adjustments  
11 made under section 1923(c) of such Act  
12 for hospitals in the States in which eligible  
13 hospitals for the year are located; divided  
14 by

15 (ii) the total amount of payment made  
16 by the Secretary under section 1903(a) of  
17 such Act during the base year with respect  
18 to payment adjustments made under sec-  
19 tion 1923(c) of such Act for hospitals in  
20 all States.

21 (c) PAYMENTS MADE ON QUARTERLY BASIS.—Pay-  
22 ments to an eligible hospital under this section for a year  
23 shall be made on a quarterly basis during the year.

1 **SEC. 3482. IDENTIFICATION OF ELIGIBLE HOSPITALS.**

2 (a) STATE IDENTIFICATION.—In accordance with the  
3 criteria described in subsection (b) and such procedures  
4 as the Secretary may require, each State shall identify the  
5 hospitals in the State that meet such criteria and provide  
6 the Secretary with a list of such hospitals.

7 (b) CRITERIA FOR ELIGIBILITY.—A hospital meets  
8 the criteria described in this subsection if the hospital's  
9 low-income utilization rate for the base year under section  
10 1923(b)(3) of the Social Security Act (as such section is  
11 in effect on the day before the date of the enactment of  
12 this Act) is not less than 25 percent.

13 **SEC. 3483. AMOUNT OF PAYMENTS.**

14 (a) DISTRIBUTION OF ALLOCATION FOR LOW-IN-  
15 COME ASSISTANCE.—

16 (1) ALLOCATION FROM TOTAL AMOUNT.—Of  
17 the total amount available for payments under this  
18 section in a year, 66.66 percent shall be allocated to  
19 hospitals for low-income assistance in accordance  
20 with this subsection.

21 (2) DETERMINATION OF HOSPITAL PAYMENT  
22 AMOUNT.—The amount of payment to an eligible  
23 hospital from the allocation made under paragraph  
24 (1) during a year shall be the equal to the hospital's  
25 low-income percentage of the allocation for the year.

1 (b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE  
2 FOR UNCOVERED SERVICES.—

3 (1) ALLOCATION FROM TOTAL AMOUNT; DETER-  
4 MINATION OF STATE-SPECIFIC PORTION OF ALLOCA-  
5 TION.—Of the total amount available for payments  
6 under this section in a year, 33.33 percent shall be  
7 allocated to hospitals for assistance in furnishing  
8 hospital services that are not covered services under  
9 title I (in accordance with regulations of the Sec-  
10 retary) or in furnishing hospital services to individ-  
11 uals, including those residing in Southwestern bor-  
12 der States, who are not eligible individuals under  
13 title I, in accordance with this subsection. The  
14 amount available for payments to eligible hospitals  
15 in a State shall be equal to an amount determined  
16 in accordance with a methodology specified by the  
17 Secretary that shall take into consideration the vol-  
18 ume of such services provided by hospital in the  
19 State as compared to the volume of such services  
20 provided by all eligible hospitals.

21 (2) DETERMINATION OF HOSPITAL PAYMENT  
22 AMOUNT.—The amount of payment to an eligible  
23 hospital in a State from the amount available for  
24 payments to eligible hospitals in the State under  
25 paragraph (1) during a year shall be the equal to

1 the hospital's low-income percentage of such amount  
2 for the year.

3 (c) LOW-INCOME PERCENTAGE DEFINED.—

4 (1) IN GENERAL.—In this subsection, an eligi-  
5 ble hospital's "low-income percentage" for a year is  
6 equal to the amount (expressed as a percentage) of  
7 the total low-income days for all eligible hospitals for  
8 the year that are attributable to the hospital.

9 (2) LOW-INCOME DAYS DESCRIBED.—For pur-  
10 poses of paragraph (1), an eligible hospital's low-in-  
11 come days for a year shall be equal to the product  
12 of—

13 (A) the total number of inpatient days for  
14 the hospital for the year (as reported to the  
15 Secretary by the State in which the hospital is  
16 located, in accordance with a reporting schedule  
17 and procedures established by the Secretary);  
18 and

19 (B) the hospital's low-income utilization  
20 rate for the base year under section 1923(b)(3)  
21 of the Social Security Act (as such section is in  
22 effect on the day before the date of the enact-  
23 ment of this Act).

1 **SEC. 3484. BASE YEAR.**

2 In this part, the “base year” is, with respect to a  
3 State and hospitals in a State, the year immediately prior  
4 to the year in which the general effective date occurs.

5 **Subtitle F—Mental Health;**  
6 **Substance Abuse**

7 **PART 1—AUTHORITIES REGARDING**  
8 **PARTICIPATING STATES**

9 **SEC. 3510. INTEGRATION OF MENTAL HEALTH AND SUB-**  
10 **STANCE ABUSE SYSTEMS.**

11 (a) IN GENERAL.—As a condition of being a partici-  
12 pating State under title I, each State shall, not later than  
13 January 1, 2001, achieve the integration of the mental  
14 illness and substance abuse services of the State and its  
15 political subdivisions with the mental illness and substance  
16 abuse services offered by health plans pursuant to title I  
17 of this Act. A State may petition the Secretary for a waiv-  
18 er of the requirement of this subsection under the cir-  
19 cumstances described in section 3511(b)(7).

20 (b) CERTIFICATION OF READINESS.—

21 (1) PETITION.—A State may petition the Sec-  
22 retary to integrate the mental illness and substance  
23 abuse services of the State and its political subdivi-  
24 sions with the mental illness and substance abuse  
25 services offered by health plans pursuant to title I  
26 of this Act prior to January 1, 2001.

1           (2) STATE READINESS TO INTEGRATE.—Upon  
2 receiving such a petition, the Secretary shall, based  
3 on the reports submitted pursuant to subsections (b)  
4 and (c) of section 3511 and the criteria promulgated  
5 pursuant to paragraph (3), ascertain the State’s  
6 readiness to integrate its mental illness and sub-  
7 stance abuse services with the mental illness and  
8 substance abuse services offered by health plans pur-  
9 suant to title I of this Act and certify whether the  
10 State is prepared to conduct such an integration.

11           (3) CRITERIA.—The certification by the Sec-  
12 retary of a State’s readiness to integrate under  
13 paragraph (2) shall be based on objective criteria  
14 promulgated by the Secretary after consultation with  
15 the States.

16           (c) APPLICATION OF PROVISIONS.—Upon the  
17 issuance of a certification of readiness by the Secretary  
18 for a State, the limits set forth in subsections (d)(2)(B)  
19 and (e)(2)(A) of section 1106 shall not apply to the provi-  
20 sion of mental illness and substance abuse services in the  
21 State.

22 **SEC. 3511. REPORT ON INTEGRATION OF MENTAL HEALTH**  
23 **SYSTEMS.**

24           (a) IN GENERAL.—As a condition of being a partici-  
25 pating State under title I, each State shall, not later than

1 October 1, 1998, submit to the Secretary a report con-  
2 taining the information described in subsection (b) on (in-  
3 cluding a plan for) the measures to be implemented by  
4 the State to achieve the integration of the mental illness  
5 and substance abuse services of the State and its political  
6 subdivisions with the mental illness and substance abuse  
7 services that are included in the comprehensive benefit  
8 package under title I. The plan required in the preceding  
9 sentence shall meet the conditions described in section  
10 3083(b). In addition, each State shall submit to the Sec-  
11 retary a report containing the information described in  
12 subsection (c) for each year in which the State participates  
13 under title I up to and including the year 2001 or the  
14 date on which an unlimited benefit for mental illness and  
15 substance abuse services is provided, whichever occurs  
16 later.

17 (b) REQUIRED CONTENTS OF INTEGRATION RE-  
18 PORT.—With respect to the provision of items and services  
19 relating to mental illness and substance abuse, the report  
20 of a State under subsection (a) shall, at a minimum, con-  
21 tain the following information:

22 (1) Information on the number of individuals  
23 served by or through mental illness and substance  
24 abuse programs administered by State and local

1 agencies and the proportion who are eligible persons  
2 under title I.

3 (2) Information on the extent to which each  
4 health provider furnishing mental illness and sub-  
5 stance abuse services under a State program partici-  
6 pates or will participate in one or more regional or  
7 corporate alliance health plans, and, in the case of  
8 providers that do not so participate, the reasons for  
9 the lack of participation.

10 (3) With respect to the two years preceding the  
11 year in which the State becomes a participating  
12 State under title I—

13 (A) the amount of funds expended by the  
14 State and its political subdivisions for each of  
15 such years for items and services that are in-  
16 cluded in the comprehensive benefit package  
17 under such title;

18 (B) the amount of funds expended for  
19 medically necessary and appropriate items and  
20 services not included in such benefit package,  
21 including medical care, other health care, and  
22 supportive services related to the provision of  
23 health care.

24 (4) An estimate of the amount that the State  
25 will expend to furnish items and services not in-

1       cluded in such package once the expansion of cov-  
2       erage for mental illness and substance abuse services  
3       is implemented in the year 2001.

4           (5) A description of how the State will assure  
5       that all individuals served by mental illness and sub-  
6       stance abuse programs funded by the State will be  
7       enrolled in a health plan and how mental illness and  
8       substance abuse services not covered under the ben-  
9       efit package will continue to be furnished to such en-  
10      rollees.

11          (6) A description of the conditions under which  
12      the integration of mental illness and substance abuse  
13      providers into regional and corporate alliances can  
14      be achieved, and an identification of changes in par-  
15      ticipation and certification requirements that are  
16      needed to achieve the integration of such programs  
17      and providers into health plans.

18          (7) If the integration of mental illness and sub-  
19      stance abuse programs operated by the State into  
20      one or more health plans is not medically appro-  
21      priate or feasible for one or more groups of individ-  
22      uals treated under State programs, a description of  
23      the reasons that integration is not feasible or appro-  
24      priate and a plan for assuring the coordination for  
25      such individuals of the care and services covered

1 under the comprehensive benefit package with the  
2 additional items and services furnished by such pro-  
3 grams.

4 (8) A description of the manner in which the  
5 resources that the State and its political subdivisions  
6 currently spend on mental health and substance  
7 abuse services will be used to facilitate integration.

8 (c) REQUIRED CONTENTS OF TRANSITION RE-  
9 PORT.—With respect to the a report required under this  
10 subsection, the report shall, at a minimum, contain the  
11 following information:

12 (1) The amount of funds expended for sub-  
13 stance abuse and mental health services by the  
14 source of revenue, including, Federal block grant  
15 funds, under title XIX of the Public Health Service  
16 Act, Federal categorical grant funds, State and local  
17 revenues and health plan payments.

18 (2) The amount of funds expended for sup-  
19 portive services to individuals enrolled in substance  
20 abuse and mental health treatment programs, in-  
21 cluding transportation, child care, educational and  
22 vocational training and coordination with other pub-  
23 lic systems such as the social service, child welfare  
24 and juvenile and criminal justice systems, by source  
25 of revenue.

1           (3) The amount of funds expended on medically  
2           necessary and appropriate items and services not  
3           covered or reimbursed in the comprehensive benefit  
4           package by source of revenue.

5           (4) The amount of funds expended by the State  
6           on substance abuse and mental illness services for  
7           individuals who are not eligible to receive the com-  
8           prehensive benefit package pursuant to this Act, and  
9           the source of revenue for such services.

10          (d) GENERAL PROVISIONS.—Reports under sub-  
11          sections (b) and (c) shall be provided at the time and in  
12          the manner prescribed by the Secretary. The Secretary  
13          shall also determine what, if any, reports shall be sub-  
14          mitted in years following the implementation of an unlim-  
15          ited benefit for mental illness and substance abuse serv-  
16          ices.

17          (e) REPORTING REQUIREMENT.—Each State shall  
18          report annually to the Secretary on the incidence and  
19          prevalence of mental illness and substance abuse disorders  
20          in the prison population, changes in such incidence and  
21          prevalence in the prison population, and potential causa-  
22          tive factors with respect to such changes, including an es-  
23          timate of the extent to which the denial of treatment, or  
24          the provision of inadequate treatment, to individuals with

1 mental illness and substance abuse disorders is contrib-  
2 uting to the criminal activity of such individuals.

3 **PART 2—ASSISTANCE FOR STATE MANAGED MEN-**  
4 **TAL HEALTH AND SUBSTANCE ABUSE PRO-**  
5 **GRAMS**

6 **SEC. 3531. AVAILABILITY OF ASSISTANCE.**

7 (a) IN GENERAL.—The Secretary shall make grants  
8 to States for the development and operation of comprehen-  
9 sive managed mental health and substance abuse pro-  
10 grams that are integrated with the health delivery system  
11 established under this Act. Such programs shall—

12 (1) promote the development of integrated de-  
13 livery systems for the management of the mental  
14 health and substance abuse services provided under  
15 the comprehensive benefits package;

16 (2) give priority to providing services to low-in-  
17 come adults with serious mental illness or substance  
18 abuse disorders and children with serious emotional  
19 disturbance or substance abuse disorders and pro-  
20 vide for the phase-in of such services for all eligible  
21 persons within 5 years;

22 (3) ensure that individuals participating in the  
23 program have access to all medically necessary men-  
24 tal health and substance abuse services;

1           (4) promote the linkage of mental health and  
2           substance abuse services with primary and preven-  
3           tive health care services; and

4           (5) meet such other requirements as the Sec-  
5           retary may impose.

6           (b) EXCEPTION.—Nothing in this part shall be con-  
7           strued as preventing States that have separate administra-  
8           tive entities for mental health and for substance abuse  
9           services from establishing separate comprehensive man-  
10          aged care programs for such services and receiving assist-  
11          ance under this part for either or both programs.

12       **SEC. 3532. PLAN REQUIREMENTS.**

13          In order to receive a grant under this part, a State  
14          must have a plan for a comprehensive managed mental  
15          health and substance abuse program which is approved  
16          by the Secretary. Such plan shall—

17               (1) describe the management, access, and refer-  
18               ral structure that the State will use to promote and  
19               achieve integration of mental health and substance  
20               abuse services with the health delivery system estab-  
21               lished under this Act for eligible individuals in the  
22               State;

23               (2) describe how the State will ensure that pro-  
24               viders of specialized services will meet appropriate  
25               standards and provide assurances that the State has

1 complied with section 1504 as it affects mental  
2 health and substance abuse services;

3 (3) describe payment, utilization review, and  
4 other mechanisms that the State will use to encour-  
5 age appropriate service delivery and management of  
6 costs;

7 (4) describe uniform patient placement criteria  
8 that the State will use to ensure placement in appro-  
9 priate substance abuse treatment programs;

10 (5) describe the processes the State will use to  
11 ensure that individuals will continue to have access  
12 to treatment through referrals from nonhealth public  
13 entities, such the juvenile or criminal justice sys-  
14 tems, or social service systems;

15 (6) specify the methods the State will use to en-  
16 sure that individuals receiving services under the  
17 program have access to all medically necessary and  
18 appropriate mental health and substance abuse serv-  
19 ices;

20 (7) define terms that will be used by the State  
21 in determining the eligibility of individuals for serv-  
22 ices under the program;

23 (8) describe how health plans will use services  
24 under the comprehensive managed mental health

1 and substance abuse programs established under  
2 this part;

3 (9) describe the role of local government in fi-  
4 nancing and managing the integrated mental illness  
5 and substance abuse treatment system;

6 (10) describe the sources of funding, including  
7 Medicaid and the block grants authorized by title  
8 XIX of the Public Health Service Act, that will be  
9 used by the State, other than the grant received  
10 under this part, to operate the program, and provide  
11 the status of any request for a Medicaid waiver  
12 made by the State to the Secretary;

13 (11) describe how the State provided for broad-  
14 based public input in the development of the plan,  
15 and the mechanism that will be used for ongoing  
16 public comment on and review of amendments to the  
17 plan; and

18 (12) describe grievance procedures that will be  
19 available for individuals dissatisfied with their health  
20 plan's participation in the comprehensive managed  
21 mental health and substance abuse program, and  
22 mechanisms that will be available to review the per-  
23 formance of health plans and fee-for-service arrange-  
24 ments to ensure against under treatment.

1 **SEC. 3533. ADDITIONAL FEDERAL RESPONSIBILITIES.**

2       The Secretary shall, upon the submission of a State's  
3 plan under section 3532, ensure the timely consideration  
4 of any Medicaid waiver requests submitted by the State,  
5 affirm that section 1504 has been implemented, and en-  
6 sure the timely implementation of section 1641(b)(5).

7 **SEC. 3534. AUTHORIZATION OF APPROPRIATIONS.**

8       There are authorized to be appropriated for grants  
9 under this part, \$82,000,000 for each of the fiscal years  
10 1995 through 2000, and \$2,000,000 for each of the fiscal  
11 years 2001 through 2004.

12 **Subtitle G—Comprehensive School**  
13 **Health Education; School-Re-**  
14 **lated Health Services**

15 **PART       1—HEALTHY       STUDENTS-HEALTHY**  
16 **SCHOOLS GRANTS FOR SCHOOL HEALTH**  
17 **EDUCATION**

18 **SEC. 3601. PURPOSES.**

19       It is the purpose of this part—

20           (1) to support the development and implemen-  
21 tation of comprehensive age appropriate health edu-  
22 cation programs in public schools for children and  
23 youth kindergarten through grade 12; and

24           (2) to increase access to preventive and primary  
25 health care services for children and youth through

1 school-based or school-linked health service sites in  
2 accordance with locally determined needs.

3 **SEC. 3602. HEALTHY STUDENTS-HEALTHY SCHOOLS**  
4 **GRANTS.**

5 (a) IN GENERAL.—The Secretary, in consultation  
6 with the Secretary of Education, shall award grants to  
7 State educational agencies in eligible States to integrate  
8 comprehensive school health education in schools within  
9 the State, with priority given within States to those com-  
10 munities in greatest need as defined by section 3683(a).

11 (b) ELIGIBLE USES OF FUNDS.—Funds made avail-  
12 able under this section shall be used—

13 (1) to implement comprehensive school health  
14 education programs, as defined in subsection (f)(1)  
15 through grants to local educational agencies;

16 (2) to provide staff development and technical  
17 assistance to local educational agencies, schools,  
18 local health agencies, and other community organiza-  
19 tions involved in providing comprehensive school  
20 health education programs;

21 (3) to evaluate and report to the Secretary on  
22 the progress made towards attaining the goals and  
23 objectives described under subsection (c)(1)(A); and

1           (4) to conduct such other activities to achieve  
2           the objectives of this subpart as the Secretary may  
3           require.

4           (c) APPLICATION.—An application for a grant under  
5           subsection (a), shall be jointly developed by the State edu-  
6           cational agency and the State health agencies of the State  
7           involved, and shall contain—

8           (1) a State plan for comprehensive school  
9           health education programs, that outlines—

10                   (A) the goals and objectives of the State  
11                   for school health education programs, and the  
12                   manner in which the State will allocate funds to  
13                   local educational agencies in order to achieve  
14                   these goals and objectives;

15                   (B) the manner in which the State will co-  
16                   ordinate programs under this part with other  
17                   Federal, State and local health education pro-  
18                   grams and resources, and school health serv-  
19                   ices;

20                   (C) the manner in which comprehensive  
21                   school health education programs will be coordi-  
22                   nated with other Federal, State and local edu-  
23                   cation programs (such as programs under titles  
24                   I, II, and IV of the Elementary and Secondary  
25                   Education Act of 1965), with the school im-

1           provement plan of the State, if any, under title  
2           III of the Goals 2000: Educate America Act,  
3           and with any similar programs;

4           (D) the manner in which the State shall  
5           work with State and local educational agencies  
6           and with State and local health agencies to re-  
7           duce barriers to implementing school health  
8           education programs;

9           (E) the manner in which the State will  
10          monitor the implementation of such programs  
11          by local educational agencies and establish out-  
12          come criteria by which to evaluate their effec-  
13          tiveness in achieving progress towards the goals  
14          and objectives described in subparagraph (A);

15          (F) the manner in which the State will  
16          provide staff development and technical assist-  
17          ance to local educational agencies, and build ca-  
18          pacity for professional development of health  
19          educators; and

20          (G) the manner in which such school  
21          health education programs will be, to the extent  
22          practicable, culturally competent and linguis-  
23          tically appropriate and responsive to the diverse  
24          needs of the students served;

1           (2) a description of the respective roles of the  
2 State educational agency, local educational agencies,  
3 the State health agency and local health agencies in  
4 developing and implementing the State's school  
5 health education plan and resulting programs;

6           (3) a description of the input of the local com-  
7 munity (including students and parents) in the de-  
8 velopment and operation of comprehensive school  
9 health education programs;

10           (4) an assurance that communities identified in  
11 section 3683(a) receive priority as locations for com-  
12 prehensive school health education programs for all  
13 grades to the extent that a State does not implement  
14 a statewide program; and

15           (5) an assurance that grants to local edu-  
16 cational agencies under subsection (b)(1) are contin-  
17 gent upon submission by such agencies of a plan  
18 consistent with the requirements for the State plan  
19 as required under this subsection.

20           (d) WAIVERS OF STATUTORY AND REGULATORY RE-  
21 QUIREMENTS.—

22           (1) WAIVERS.— Except as provided in para-  
23 graph (4), upon the request of an entity and under  
24 a relevant program described in paragraph (2), the  
25 Secretary of Health and Human Services and the

1 Secretary of Education may grant to the entity a  
2 waiver of any requirement of such program regard-  
3 ing the use of funds, or of the regulations issued for  
4 the program by the Secretary involved, if the fol-  
5 lowing conditions are met with respect to such pro-  
6 gram:

7 (A) The Secretary involved determines that  
8 the requirements of such program impede the  
9 ability of the State educational agency to  
10 achieve more effectively the purposes described  
11 in section 3601.

12 (B) The Secretary involved determines  
13 that, with respect to the use of funds under  
14 such program, the requested use of the funds  
15 by the entity would be consistent with the pur-  
16 poses described in section 3601.

17 (C) The State educational agency provides  
18 all interested local educational agencies in the  
19 State with notice and an opportunity to com-  
20 ment on the proposal and makes these com-  
21 ments available to the Secretary.

22 (2) RELEVANT PROGRAMS.—For purposes of  
23 paragraph (1), the programs described in this sub-  
24 paragraph are the following:

1 (A) In the case of programs administered  
2 by the Secretary of Health and Human Serv-  
3 ices, the following:

4 (i) The program known as the Preven-  
5 tion, Treatment, and Rehabilitation Model  
6 Projects for High Risk Youth, carried out  
7 under section 517 of the Public Health  
8 Service Act.

9 (ii) The program known as the State  
10 and Local Comprehensive School Health  
11 Programs to Prevent Important Health  
12 Problems and Improve Educational Out-  
13 comes, carried out under such Act.

14 (B) In the case of programs administered  
15 by the Secretary of Education, any program  
16 carried out under part B of the Drug-Free  
17 Schools and Communities Act of 1986, except  
18 that a component of such comprehensive school  
19 health education must be consistent with the  
20 statutory intent and purposes of such Act.

21 (3) WAIVER PERIOD.—A waiver under this  
22 paragraph shall be for a period not to exceed 3  
23 years, unless the Secretary involved determines  
24 that—

1 (A) the waiver has been effective in ena-  
2 bling the State to carry out the activities for  
3 which it was requested and has contributed to  
4 improved performance of comprehensive health  
5 education programs; and

6 (B) such extension is in the public interest;

7 (4) WAIVERS NOT AUTHORIZED.—The Sec-  
8 retary involved under paragraph (1), may not waive,  
9 under this section, any statutory or regulatory re-  
10 quirements relating to—

11 (A) comparability of services;

12 (B) maintenance of effort;

13 (C) parental participation and involvement;

14 (D) the distribution of funds to States or  
15 to local educational agencies or other recipients  
16 of funds under the programs described in para-  
17 graph (2);

18 (E) maintenance of records;

19 (F) applicable civil rights requirements; or

20 (G) the requirements of sections 438 and  
21 439 of the General Education Provisions Act.

22 (5) TERMINATION OF WAIVER.—The Secretary  
23 involved under paragraph (1) shall terminate a waiv-  
24 er under this subsection if the Secretary determines  
25 that the performance of the State affected by the

1 waiver has been inadequate to justify a continuation  
2 of the waiver or if it is no longer necessary to  
3 achieve its original purpose.

4 (e) DEFINITIONS.—As used in this section:

5 (1) COMPREHENSIVE SCHOOL HEALTH EDU-  
6 CATION.—The term “comprehensive school health  
7 education” means a planned, sequential program of  
8 health education that addresses the physical, emo-  
9 tional and social dimensions of student health in  
10 kindergarten through grade 12. Such program  
11 shall—

12 (A) be designed to assist students in devel-  
13 oping the knowledge and behavioral skills need-  
14 ed to make positive health choices and maintain  
15 and improve their health, prevent disease and  
16 injuries, and reduce risk behaviors which ad-  
17 versely impact health;

18 (B) be comprehensive and include a variety  
19 of components addressing personal health, com-  
20 munity and environmental health, injury pre-  
21 vention and safety, nutritional health, the ef-  
22 fects of substance use and abuse, consumer  
23 health regarding the benefits and appropriate  
24 use of medical services including immunizations  
25 and other clinical preventive services, and other

1 components deemed appropriate by the local  
2 educational agencies;

3 (C) be designed to be linguistically and cul-  
4 turally competent and responsive to the needs  
5 of the students served; and

6 (D) address locally relevant priorities as  
7 determined by parents, students, teachers, and  
8 school administrators and health officials.

9 (2) ELIGIBLE STATE.—The term “eligible  
10 State” means a State with a memorandum of under-  
11 standing or a written cooperative agreement entered  
12 into by the agencies responsible for health and edu-  
13 cation concerning the planning and implementation  
14 of comprehensive school health education programs.  
15 Among these States a priority shall be given to  
16 qualified States as defined in section 3682(c).

17 (3) STATE EDUCATIONAL AGENCY.—The term  
18 “State educational agency” means the officer or  
19 agency primarily responsible for the State super-  
20 vision of public elementary and secondary schools.

21 (4) LOCAL EDUCATIONAL AGENCY.—The term  
22 “local educational agency” means a public board of  
23 education or other public authority legally con-  
24 stituted within a State for either administrative con-  
25 trol or direction of, or to perform a service function

1 for, public elementary or secondary schools in a city,  
2 county, township, school district, or other political  
3 subdivision of a State, or such combination of school  
4 districts or counties as are recognized in a State as  
5 an administrative agency for its public elementary or  
6 secondary schools. Such term includes any other  
7 public institution or agency having administrative  
8 control and direction of a public elementary or sec-  
9 ondary school.

10 (f) AUTHORIZED FUNDING.—For the purpose of car-  
11 rying out this section, out of the funds available under  
12 section 3695(b)(2), there are made available, not to exceed  
13 \$15,000,000 for fiscal year 1995, \$20,000,000 for fiscal  
14 year 1996, \$25,000,000 for fiscal year 1997, \$30,000,000  
15 for fiscal year 1998, \$40,000,000 for fiscal year 1999, and  
16 \$50,000,000 for fiscal year 2000.

17 **SEC. 3603. HEALTHY STUDENTS-HEALTHY SCHOOLS INTER-**  
18 **AGENCY TASK FORCE.**

19 (a) ESTABLISHMENT.—Not later than 120 days after  
20 the date of enactment of this Act, the Secretary shall es-  
21 tablish a Healthy Students-Healthy Schools Interagency  
22 Task Force to be composed of representatives of the Office  
23 of Disease Prevention and Health Promotion, the National  
24 Institutes of Health, the Centers for Disease Control and  
25 Prevention, the Health Resources and Services Adminis-

1 tration, the Office of School Health Education within the  
2 Department of Education, and other Federal agencies and  
3 departments which have responsibility for components of  
4 school health and education.

5 (b) CO-CHAIRPERSONS.—The Assistant Secretary for  
6 Health and the Assistant Secretary for Elementary and  
7 Secondary Education shall serve as co-chairpersons of the  
8 task force established under subsection (a).

9 (c) FUNCTIONS AND ACTIVITIES.—The task force es-  
10 tablished under subsection (a) shall—

11 (1) review and coordinate all Federal efforts in  
12 school health education and health services;

13 (2) provide scientific and technical advice con-  
14 cerning the development and implementation of  
15 model comprehensive school health education pro-  
16 grams and curricula;

17 (3) develop model student learning objectives  
18 and assessment instruments that shall be made  
19 available to all States;

20 (4) develop a uniform grant application form (a  
21 form that serves as the principal document con-  
22 taining the core information concerning a particular  
23 entity) and procedures that may be used with re-  
24 spect to all school health education-related programs  
25 (including supplementary information procedures to

1 be implemented when an entity that has already sub-  
2 mitted an application form is applying for additional  
3 assistance) that require the submission of an appli-  
4 cation; and

5 (5) recommend to the Secretary, for inclusion  
6 in the biennial report required by section 3604(2),  
7 methods for effectively linking school health edu-  
8 cation and health services research findings at the  
9 Federal level with implementation at the State and  
10 local levels.

11 (d) CONSOLIDATION OF INITIATIVES.—Not later  
12 than 12 months after the date of enactment of this Act,  
13 the task force established under subsection (a) shall pre-  
14 pare and submit to the Congress a report containing the  
15 recommendations of the task force for the consolidation  
16 of Federal school health education initiatives.

17 **SEC. 3604. DUTIES OF THE SECRETARY.**

18 The Secretary shall—

19 (1) establish and maintain a national clearing-  
20 house, using advanced technologies to the maximum  
21 extent practicable, and mechanisms for the diverse  
22 dissemination of school health education material,  
23 including written, audio-visual, and electronically  
24 conveyed information to educators, schools, health

1 care providers, and other individuals, organizations,  
2 and governmental entities;

3 (2) submit a biennial report to the Committee  
4 on Labor and Human Resources of the Senate and  
5 the appropriate committees of the House of Rep-  
6 resentatives on the implementation and contribution  
7 of comprehensive school health education programs  
8 funded under this part toward achieving relevant  
9 National Healthy People 2000 objectives established  
10 by the Secretary; and

11 (3) encourage coordination among Federal  
12 agencies, State and local governments, educators,  
13 school health providers, community-based organiza-  
14 tions, and private sector entities to support develop-  
15 ment of comprehensive school health education pro-  
16 grams and school health services.

17 **PART 5—SCHOOL-RELATED HEALTH SERVICES**

18 **Subpart A—Development and Operation**

19 **SEC. 3681. AUTHORIZATION OF APPROPRIATIONS.**

20 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-  
21 ICES.—For the purpose of carrying out this subpart, there  
22 are authorized to be appropriated \$82,000,000 for fiscal  
23 year 1995, \$164,000,000 for fiscal year 1996,  
24 \$266,500,000 for fiscal year 1997, and \$369,000,000 for  
25 fiscal year 1998, \$471,500,000 for fiscal year 1999,

1 \$574,000,000 for fiscal year 2000, and \$2,000,000 for  
2 each of the fiscal years 2001 through 2004.

3 (b) FUNDING FOR PLANNING AND DEVELOPMENT  
4 GRANTS.—Of amounts made available under this section,  
5 not to exceed \$10,000,000 for each of fiscal years 1995  
6 and 1996 may be utilized to carry out section 3684.

7 **SEC. 3682. ELIGIBILITY FOR GRANTS.**

8 (a) IN GENERAL.—

9 (1) PLANNING AND DEVELOPMENT GRANTS.—  
10 Entities eligible to apply for and receive grants  
11 under section 3684 are—

12 (A) State health agencies that apply on be-  
13 half of local community partnerships; or

14 (B) local community partnerships in States  
15 in which health agencies have not successfully  
16 applied.

17 (2) OPERATIONAL GRANTS.—Entities eligible to  
18 apply for and receive grants under section 3685  
19 are—

20 (A) a qualified State as designated under  
21 subsection (c) that apply on behalf of local com-  
22 munity partnerships; or

23 (B) local community partnerships in States  
24 that are not designated under subparagraph  
25 (A).

1 (b) LOCAL COMMUNITY PARTNERSHIPS.—

2 (1) IN GENERAL.—A local community partner-  
3 ship under subsection (a)(1)(B) and (a)(2)(B) is an  
4 entity that, at a minimum includes—

5 (A) a local health care provider, which may  
6 be a local public health department, with expe-  
7 rience in delivering services to children and  
8 youth or medically underserved populations;

9 (B) local educational agency on behalf of  
10 one or more public schools; and

11 (C) one community based organization lo-  
12 cated in the community to be served that has  
13 a history of providing services to at-risk chil-  
14 dren and youth.

15 (2) RURAL COMMUNITIES.—In rural commu-  
16 nities, local partnerships should seek to include, to  
17 the fullest extent practicable, providers and commu-  
18 nity based organizations with experience in serving  
19 the target population.

20 (3) PARENT AND COMMUNITY PARTICIPA-  
21 TION.—An applicant described in subsection (a)  
22 shall, to the maximum extent feasible, involve broad-  
23 based community participation (including parents of  
24 the youth to be served).

1 (c) QUALIFIED STATE.—A qualified State under sub-  
2 section (a)(2)(A) is a State that, at a minimum—

3 (1) demonstrates an organizational commitment  
4 (including a strategic plan) to providing a broad  
5 range of health, health education and support serv-  
6 ices to at-risk youth; and

7 (2) has a memorandum of understanding or co-  
8 operative agreement jointly entered into by the State  
9 agencies responsible for health and education re-  
10 garding the planned delivery of health and support  
11 services in school-based or school-linked centers.

12 **SEC. 3683. PREFERENCES.**

13 In making grants under sections 3684 and 3685, the  
14 Secretary shall give priority to applicants whose-commu-  
15 nities to be served show the most substantial level of need  
16 for health services among children and youth.

17 **SEC. 3684. PLANNING AND DEVELOPMENT GRANTS.**

18 (a) IN GENERAL.—The Secretary may make grants  
19 during fiscal years 1995 and 1996 to entities eligible  
20 under section 3862 to develop school-based or school-  
21 linked health service sites.

22 (b) USE OF FUNDS.—Amounts provided under a  
23 grant under this section may be used for the following:

24 (1) Planning for the provision of school health  
25 services, including—

1 (A) an assessment of the need for health  
2 services among youth in the communities to be  
3 served;

4 (B) the health services to be provided and  
5 how new services will be integrated with exist-  
6 ing services;

7 (C) assessing and planning for the mod-  
8 ernization and expansion of existing facilities  
9 and equipment to accommodate such services;  
10 and

11 (D) an affiliation with relevant health  
12 plans.

13 (2) recruitment and training of staff for the ad-  
14 ministration and delivery of school health services;

15 (3) the establishment of local community part-  
16 nerships as described in section 3682 (b);

17 (4) in the case of States, the development of  
18 memorandums of understanding or cooperative  
19 agreements for the coordinated delivery of health  
20 and support services through school health service  
21 sites; and

22 (5) other activities necessary to assume oper-  
23 ational status.

24 (c) APPLICATION FOR GRANTS.—To be eligible to re-  
25 ceive a grant under this section an entity described in sec-

1 tion 3682 (a) shall submit an application in a form and  
2 manner prescribed by the Secretary.

3 (d) NUMBER OF GRANTS.—Not more than one plan-  
4 ning grant may be made to a single applicant. A planning  
5 grant may not exceed 2 years in duration.

6 (e) AMOUNT AVAILABLE FOR DEVELOPMENT  
7 GRANT.—The Secretary may award not to exceed—

8 (1) \$150,000 to entities under section  
9 3682(a)(1)(A) and to localities planning for a city-  
10 wide or countywide school health services delivery  
11 system; and

12 (2) \$50,000 to entities under section  
13 3682(a)(1)(B).

14 **SEC. 3685. GRANTS FOR OPERATION OF SCHOOL HEALTH**  
15 **SERVICES.**

16 (a) IN GENERAL.—The Secretary may make grants  
17 to eligible entities described in section 3682(a)(2) that  
18 submit applications consistent with the requirements of  
19 this section, to pay the cost of operating school-based or  
20 school-linked health service sites.

21 (b) USE OF GRANT.—Amounts provided under a  
22 grant under this section may be used for the following—

23 (1) health services, including diagnosis and  
24 treatment of simple illnesses and minor injuries;

1           (2) preventive health services, including health  
2           screenings follow-up health care, mental health, and  
3           preventive health education;

4           (3) enabling services, as defined in section  
5           3461(b), and other necessary support services;

6           (4) training, recruitment, and compensation of  
7           health professionals and other staff necessary for the  
8           administration and delivery of school health services;  
9           and

10          (5) referral services, including the linkage of in-  
11          dividuals to health plans, and community-based  
12          health and social service providers.

13          (c) APPLICATION FOR GRANT.—To be eligible to re-  
14          ceive a grant under this section an entity described in sec-  
15          tion 3682(a)(2) shall submit an application in a form and  
16          manner prescribed by the Secretary. In order to receive  
17          a grant under this section, an applicant must include in  
18          the application the following information—

19               (1) a description of the services to be furnished  
20               by the applicant;

21               (2) the amounts and sources of funding that  
22               the applicant will expend, including estimates of the  
23               amount of payments the applicant will receive from  
24               health plans and other sources;

1           (3) a description of local community partner-  
2           ships, including parent and community participation;

3           (4) a description of the linkages with other  
4           health and social service providers; and

5           (5) such other information as the Secretary de-  
6           termines to be appropriate.

7           (d) ASSURANCES.—In order to receive a grant under  
8           this section, an applicant must meet the following condi-  
9           tions—

10           (1) school health service sites will, directly or  
11           indirectly, provide a broad range of health services,  
12           in accordance with the determinations of the local  
13           community partnership, that may include—

14                   (A) diagnosis and treatment of simple ill-  
15                   nesses and minor injuries;

16                   (B) preventive health services, including  
17                   health screenings and follow-up health care,  
18                   mental health and preventive health education;

19                   (C) enabling services, as defined in section  
20                   3461(b);

21                   (D) referrals (including referrals regarding  
22                   mental health and substance abuse) with follow-  
23                   up to ensure that needed services are received;

24           (2) the applicant provides services rec-  
25           ommended by the health provider, in consultation

1 with the local community partnership, and with the  
2 approval of the local education agency;

3 (3) the applicant provides the services under  
4 this subsection to adolescents, and other school age  
5 children and their families as deemed appropriate by  
6 the local partnership;

7 (4) the applicant maintains agreements with  
8 community-based health care providers with a his-  
9 tory of providing services to such populations for the  
10 provision of health care services not otherwise pro-  
11 vided directly or during the hours when school  
12 health services are unavailable;

13 (5) the applicant establishes an affiliation with  
14 relevant health plans and will establish reimburse-  
15 ment procedures and will make every reasonable ef-  
16 fort to collect appropriate reimbursement for serv-  
17 ices provided; and

18 (6) the applicant agrees to supplement and not  
19 supplant the level of State or local funds under the  
20 direct control of the applying State or participating  
21 local education or health authority expended for  
22 school health services as defined by this Act;

23 (7) services funded under this Act will be co-  
24 ordinated with existing school health services pro-  
25 vided at a participating school; and

1           (8) for applicants in rural areas, the assurances  
2           required under paragraph (4) shall be fulfilled to the  
3           maximum extent possible.

4           (e) STATE LAWS.—Notwithstanding any other provi-  
5           sion in this part, no school based health clinic may provide  
6           services, to any minor, when to do so is a violation of State  
7           laws or regulations pertaining to informed consent for  
8           medical services to minors.

9           (f) LIMITATION ON ADMINISTRATIVE FUNDS.—In  
10          the case of a State applying on behalf of local educational  
11          partnerships, the applicant may retain not more than 5  
12          percent of grants awarded under this subpart for adminis-  
13          trative costs.

14          (g) DURATION OF GRANT.—A grant under this sec-  
15          tion shall be for a period determined appropriate by the  
16          Secretary.

17          (h) AMOUNT OF GRANT.—The annual amount of a  
18          grant awarded under this section shall not be more than  
19          \$200,000 per school-based or school-linked health service  
20          site.

21          (i) FEDERAL SHARE.—

22                 (1) IN GENERAL.—Subject to paragraph (3), a  
23                 grant for services awarded under this section may  
24                 not exceed—

1 (A) 90 percent of the non-reimbursed cost  
2 of the activities to be funded under the program  
3 for the first 2 fiscal years for which the pro-  
4 gram receives assistance under this section; and

5 (B) 75 percent of the non-reimbursed cost  
6 of such activities for subsequent years for which  
7 the program receives assistance under this sec-  
8 tion.

9 The remainder of such costs shall be made available  
10 as provided in paragraph (2).

11 (2) FORM OF NON-FEDERAL SHARE.—The non-  
12 Federal share required by paragraph (1) may be in  
13 cash or in-kind, fairly evaluated, including facilities,  
14 equipment, personnel, or services, but may not in-  
15 clude amounts provided by the Federal Government.  
16 In-kind contributions may include space within a  
17 school facilities, school personnel, program use of  
18 school transportation systems, outposted health per-  
19 sonnel, and extension of health provider medical li-  
20 ability insurance.

21 (3) WAIVER.—The Secretary may waive the re-  
22 quirements of paragraph (1) for any year in accord-  
23 ance with criteria established by regulation. Such  
24 criteria shall include a documented need for the  
25 services provided under this section and an inability

1 of the grantee to meet the requirements of para-  
2 graph (1) despite a good faith effort.

3 (j) TRAINING AND TECHNICAL ASSISTANCE.—Enti-  
4 ties that receive assistance under this section may use not  
5 to exceed 10 percent of the amount of such assistance to  
6 provide staff training and to secure necessary technical as-  
7 sistance. To the maximum extent feasible, technical assist-  
8 ance should be sought through local community-based en-  
9 tities. The limitation contained in this subsection shall  
10 apply to individuals employed to assist in obtaining funds  
11 under this part. Staff training should include the training  
12 of teachers and other school personnel necessary to ensure  
13 appropriate referral and utilization of services, and appro-  
14 priate linkages between class-room activities and services  
15 offered.

16 (k) REPORT AND MONITORING.—The Secretary will  
17 submit to the Committee on Labor and Human Resources  
18 in the Senate and the Committee on Energy and Com-  
19 merce in the House of Representatives a biennial report  
20 on the activities funded under this Act, consistent with  
21 the ongoing monitoring activities of the Department. Such  
22 reports are intended to advise the relevant Committees of  
23 the availability and utilization of services, and other rel-  
24 evant information about program activities.

1     **Subpart B—Capital Costs of Developing Projects**

2     **SEC. 3691. FUNDING.**

3         Amounts available to the Secretary under section  
4 3412 for the purpose of carrying out subparts B and C  
5 of part 2 of subtitle E are, in addition to such purpose,  
6 available to the Secretary for the purpose of carrying out  
7 this subpart.

8     **Subtitle H—Public Health Service**  
9                   **Initiative**

10    **SEC. 3695. PUBLIC HEALTH SERVICE INITIATIVE.**

11         (a) IN GENERAL.—Subject to subsection (c), the Sec-  
12 retary of Health and Human Services shall pay, from  
13 funds in the Treasury not otherwise appropriated, individ-  
14 uals and entities that are eligible to receive assistance pur-  
15 suant to the provisions referred to in paragraphs (1)  
16 through (13) of subsection (b), to the extent of the  
17 amounts specified under subsection (b).

18         (b) AMOUNTS SPECIFIED.—The amounts specified in  
19 subsection (a) with respect to a fiscal year shall be—

20                 (1) with respect to the core functions of public  
21 health programs authorized under part 2 of subtitle  
22 D of title III, \$123,000,000 for fiscal year 1995,  
23 \$184,500,000 for fiscal year 1996, \$266,500,000 for  
24 fiscal year 1997, \$348,500,000 for fiscal year 1998,  
25 \$410,000,000 for fiscal year 1999, \$512,500,000 for

1 fiscal year 2000, and \$2,000,000 for each of the fis-  
2 cal years 2001 through 2004;

3 (2) with respect to the national initiatives re-  
4 garding health promotion and disease prevention  
5 under part 3 of subtitle D of title III, \$102,500,000  
6 for each of the fiscal years 1996 through 1998,  
7 \$123,000,000 for each of the fiscal years 1999 and  
8 2000, and \$2,000,000 for each of the fiscal years  
9 2001 through 2004;

10 (3) with respect to occupational injury and ill-  
11 ness prevention under section 3903, \$92,250,000 for  
12 each of the fiscal years 1995 through 2000, and  
13 \$2,000,000 for each of the fiscal years 2001 through  
14 2004;

15 (4) with respect to activities for the develop-  
16 ment of plans and networks under subpart B of part  
17 2 of subtitle E of title III—

18 (A) \$43,050,000 for fiscal year 1995,  
19 \$100,450,000 for fiscal year 1996,  
20 \$157,850,000 for fiscal year 1997,  
21 \$129,150,000 for fiscal year 1998,  
22 \$100,450,000 for fiscal year 1999, \$43,050,000  
23 for fiscal year 2000, and \$2,000,000 for each  
24 of the fiscal years 2001 through 2004; and

1 (B) with respect to awards to federally  
2 qualified health centers (as defined in section  
3 1861(aa)(4) of the Social Security Act) and  
4 rural health clinics under such subpart,  
5 \$79,950,000 for fiscal year 1995, \$186,550,000  
6 for fiscal year 1996, \$293,150,000 for fiscal  
7 year 1997, \$239,850,000 for fiscal year 1998,  
8 \$186,550,000 for fiscal year 1999, \$79,950,000  
9 for fiscal year 2000, and \$2,000,000 for each  
10 of the fiscal years 2001 through 2004;

11 (5) with respect to capital costs under subpart  
12 C of part 2 of subtitle E of title III, \$41,000,000  
13 for each of the fiscal years 1995 through 2000, and  
14 \$2,000,000 for each of the fiscal years 2001 through  
15 2004;

16 (6) with respect to enabling services under sub-  
17 part D of part 2 of subtitle E of title III—

18 (A) \$17,200,000 for fiscal year 1996,  
19 \$68,900,000 for each of the fiscal years 1997  
20 through 1999, \$68,900,000 for fiscal year  
21 2000, and \$2,000,000 for each of the fiscal  
22 years 2001 through 2004; and

23 (B) with respect to awards to federally  
24 qualified health centers (as defined in section  
25 1861(aa)(4) of the Social Security Act) and

1 rural health clinics under such subpart,  
2 \$40,000,000 for fiscal year 1996, \$161,000,000  
3 for each of the fiscal years 1997 through 1999,  
4 \$201,000,000 for fiscal year 2000, and  
5 \$2,000,000 for each of the fiscal years 2001  
6 through 2004;

7 (7) with respect to supplemental services under  
8 subpart D of part 1 of subtitle E of title III—

9 (A) \$24,600,000 for fiscal year 1996,  
10 \$36,900,000 for each of the fiscal years 1997  
11 through 1999, \$61,500,000 for fiscal year  
12 2000, and \$2,000,000 for each of the fiscal  
13 years 2001 through 2004; and

14 (B) with respect to awards to federally  
15 qualified health centers (as defined in section  
16 1861(aa)(4) of the Social Security Act) and  
17 rural health clinics under such subpart,  
18 \$57,400,000 for fiscal year 1996, \$86,100,000  
19 for each of the fiscal years 1997 through 1999,  
20 and \$143,500,000 for fiscal year 2000 and  
21 \$2,000,000 for each of the fiscal years 2001  
22 through 2004;

23 (8) with respect to the National Health Service  
24 Corps program referred to under section 3471,  
25 \$123,000,000 for each of the fiscal years 1996 and

1 1997, and \$201,000,000 for each of the fiscal years  
2 1998 through 2000, and \$2,000,000 for each of the  
3 fiscal years 2001 through 2004;

4 (9) with respect to school-related health service  
5 programs under subpart A of part 5 of subtitle G  
6 of title III, \$82,000,000 for fiscal year 1995,  
7 \$164,000,000 for fiscal year 1996, \$266,500,000 for  
8 fiscal year 1997, and \$369,000,000 for fiscal year  
9 1998, \$471,500,000 for fiscal year 1999,  
10 \$574,000,000 for fiscal year 2000, and \$2,000,000  
11 for each of the fiscal years 2001 through 2004;

12 (10) with respect to the development and oper-  
13 ation of comprehensive managed mental health and  
14 substance abuse programs under section 3534,  
15 \$82,000,000 for each of the fiscal years 1995  
16 through 2000, and \$2,000,000 for each of the fiscal  
17 years 2001 through 2004;

18 (11) with respect to programs of the Secretary  
19 of Health and Human Services under section 3081,  
20 \$82,000,000 for each of the fiscal years 1995 and  
21 1996, \$123,000,000 for each of the fiscal years  
22 1997 through 2000 and \$2,000,000 for each of the  
23 fiscal years 2001 through 2004;

24 (12) with respect to programs of the Secretary  
25 of Labor under section 3082, \$164,000,000 for each

1 of the fiscal years 1995 through 2000 and  
2 \$2,000,000 for each of the fiscal years 2001 through  
3 2004; and

4 (13) with respect to programs of the Indian  
5 Health Service under subtitle D of title VIII,  
6 \$164,000,000 for each of the fiscal years 1995  
7 through 2000 and \$2,000,000 for each of the fiscal  
8 years 2001 through 2004.

9 (c) AUTHORITY TO TRANSFER FUNDS.—The Com-  
10 mittee on Appropriations of the House of Representatives  
11 and the Committee on Appropriations of the Senate, act-  
12 ing through appropriations Acts, may transfer the  
13 amounts specified under subsection (b) in each fiscal year  
14 among the programs referred to in such subsection.

15 (d) REPORT.—The Secretary shall review the effec-  
16 tiveness of the programs included in the Public Health Ini-  
17 tiative. Not later than October 1, 1998, the Secretary shall  
18 prepare and submit to Congress a report concerning such  
19 review. Such report shall include recommendations con-  
20 cerning whether Congress should increase the program  
21 funding levels described in subsection (b) in fiscal years  
22 2001 through 2004 to a level equal to that of prior fiscal  
23 years.

1     **Subtitle I—Additional Provisions**  
2             **Regarding Public Health**

3     **SEC. 3901. CURRICULUM DEVELOPMENT AND IMPLEMEN-**  
4                     **TATION REGARDING DOMESTIC VIOLENCE**  
5                     **AND WOMEN'S HEALTH.**

6             (a) IN GENERAL.—The Secretary shall make grants  
7 to eligible entities for the purpose of implementing and  
8 developing for trainees a curriculum that includes training  
9 in identification, treatment and referral of victims of do-  
10 mestic violence and women's health needs.

11            (b) ELIGIBLE ENTITIES.—For purposes of sub-  
12 section (a), eligible entities are any school of medicine,  
13 school of osteopathic medicine, school of public health,  
14 graduate program in mental health practice, school of  
15 nursing as defined in section 853 of the Public Health  
16 Service Act, a program to train physician assistants, a  
17 program for training allied health professionals, and a  
18 program for training of family medicine physicians, gen-  
19 eral internists, general pediatricians, geriatricians, and ob-  
20 stetrician/gynecologists.

21            (c) CURRICULUM.—A curriculum developed under  
22 this section shall include—

23                    (1) identification of victims of domestic violence  
24                    and maintaining complete medical records that in-  
25                    clude documentation of the examination, treatment

1 provided, and referral made and recording the loca-  
2 tion and nature of the victim's injuries;

3 (2) examining and treating such victims within  
4 the scope of the health professional's discipline,  
5 training, and practice, including at a minimum pro-  
6 viding medical advice regarding the dynamics and  
7 nature of domestic violence;

8 (3) referring the victims to public and nonprofit  
9 entities that provide support services for such vic-  
10 tims;

11 (4) training in the identification and diagnosis  
12 of diseases afflicting women and other medical dis-  
13 orders as they affect women;

14 (5) training in the treatment of such diseases  
15 and disorders with emphasis on the unique needs of  
16 women; and

17 (6) research into the causes of such diseases  
18 and disorders, including determination of appro-  
19 priate means of prevention.

20 (d) ALLOCATION OF APPROPRIATIONS.—Of the  
21 amounts made available under section 3301(b) for a fiscal  
22 year, the Secretary shall reserve not to exceed  
23 \$20,000,000 for a fiscal year for carrying out this section.

1 **SEC. 3902. COMMUNITY SCHOLARSHIP PROGRAMS.**

2 Section 338L of the Public Health Service Act (42  
3 U.S.C. 254t) is amended—

4 (1) in the section heading, by striking “DEM-  
5 ONSTRATION”;

6 (2) in subsection (a)—

7 (A) by striking “for the purpose of car-  
8 rying out demonstration programs”; and

9 (B) by striking “health manpower shortage  
10 areas” and inserting “Federally-designated  
11 health professional shortage areas”;

12 (3) in subsection (c)—

13 (A) by striking “health manpower shortage  
14 areas” and inserting “Federally-designated  
15 health professional shortage areas” in the mat-  
16 ter preceding paragraph (1); and

17 (B) by striking “in the health manpower  
18 shortage areas in which the community organi-  
19 zations are located,” and inserting “in a Feder-  
20 ally-designated health professional shortage  
21 area that is served by the community organiza-  
22 tion awarding the scholarship,” in paragraph  
23 (2);

24 (4) in subsection (e)(1)—

1 (A) by striking “health manpower shortage  
2 area” and inserting “a Federally-designated  
3 health professional shortage area”; and

4 (B) by striking “in which the community”  
5 and all that follows through “located”;

6 (5) in subsection (k)(2), by striking “internal  
7 medicine” and all that follows through the end  
8 thereof and inserting “general internal medicine,  
9 general pediatrics, obstetrics and gynecology, den-  
10 tistry, or mental health, that are provided by physi-  
11 cians or other health professionals.”; and

12 (6) in subsection (l)(1), by striking  
13 “\$5,000,000” and all that follows through “1993”  
14 and inserting “\$1,000,000 for fiscal year 1994, and  
15 such sums as may be necessary for each fiscal year  
16 thereafter”.

17 **Subtitle J—Occupational Safety**  
18 **and Health**

19 **SEC. 3903. OCCUPATIONAL INJURY AND ILLNESS PREVEN-**  
20 **TION.**

21 (a) IN GENERAL.—The Secretary of Health and  
22 Human Services and the Secretary of Labor shall work  
23 together to develop and implement a comprehensive pro-  
24 gram to expand and coordinate initiatives to prevent occu-  
25 pational injuries and illnesses.

1 (b) SECRETARY OF LABOR.—The Secretary of Labor  
2 after consultation with the Secretary of Health and  
3 Human Services shall directly or by grants or contracts—

4 (1) provide for training and education programs  
5 for employees and employers in the recognition and  
6 control of workplace hazards and methods and meas-  
7 ures to prevent occupational injuries and illnesses;

8 (2) develop model educational materials for  
9 training and educating employees and employers on  
10 the recognition and control of workplace hazards, in-  
11 cluding a core curriculum for general safety and  
12 health training and materials related to specific safe-  
13 ty and health hazards; and

14 (3) provide programs and services for technical  
15 assistance to employers and employees on the rec-  
16 ognition and control of workplace safety and health  
17 hazards including programs for onsite consultation.

18 Technical assistance and consultative services under para-  
19 graph (3) shall be provided in a manner that is separate  
20 from the enforcement programs conducted by the Sec-  
21 retary of Labor.

22 (c) SECRETARY OF HEALTH AND HUMAN SERV-  
23 ICES.—The Secretary of Health and Human Services after  
24 consultation with the Secretary of Labor shall directly or  
25 by grants or contracts—

1           (1) provide education programs for training oc-  
2           cupational safety and health professionals including  
3           professionals in the fields of occupational medicine,  
4           occupational health nursing, industrial hygiene, safe-  
5           ty engineering, toxicology and epidemiology;

6           (2) provide education programs for other health  
7           professionals and health care providers and the pub-  
8           lic to improve the recognition, treatment and preven-  
9           tion of occupationally related injuries and illnesses;

10          (3) conduct surveillance programs to identify  
11          patterns and to determine the prevalence of occupa-  
12          tional illnesses, injuries and deaths related to expo-  
13          sure to particular safety and health hazards;

14          (4) conduct investigations and evaluations to  
15          determine if workplace exposures to toxic chemicals,  
16          harmful physical agents or potentially hazardous  
17          conditions pose a risk to exposed employees; and

18          (5) conduct research, demonstrations and ex-  
19          periments relating to occupational safety and health  
20          to identify the causes of and major factors contrib-  
21          uting to occupational illnesses and injuries.

22          (d) NATIONAL ADVISORY BOARD.—

23                 (1) ESTABLISHMENT.—There is established a  
24                 National Advisory Board for Occupational Injury  
25                 and Illness Prevention to provide oversight, advice

1 and direction on the occupational injury and illness  
2 prevention programs and initiatives conducted by the  
3 Secretary of Labor and Secretary of Health and  
4 Human Services.

5 (2) COMPOSITION.—The Board shall be com-  
6 posed of 10 members appointed by the Secretary of  
7 Labor, 5 of whom are to be designated by the Sec-  
8 retary of Health and Human Services. Such mem-  
9 bers shall be composed of representatives of employ-  
10 ers, employees, and occupational safety and health  
11 professionals.

12 (e) DIRECTOR OF NIOSH.—The responsibilities of  
13 the Secretary of Health and Human Services established  
14 under this section shall be carried out by the Director of  
15 the National Institute for Occupational Safety and Health.

16 (f) AUTHORIZATION OF APPROPRIATIONS.—For the  
17 purposes of carrying out this section there are authorized  
18 to be appropriated \$92,250,000 for each of the fiscal years  
19 1995 through 2000, and \$2,000,000 for each of the fiscal  
20 years 2001 through 2004.

## 21 **Subtitle K—Full Funding for WIC**

### 22 **SEC. 3905. FULL FUNDING FOR WIC.**

23 Section 17 of the Child Nutrition Act of 1966 (42  
24 U.S.C. 1786) is amended—

25 (1) in the second sentence of subsection (a)—

1 (A) by striking “authorized” and inserting  
2 “established”; and

3 (B) by striking “, up to the authorization  
4 levels set forth in subsection (g) of this sec-  
5 tion,” and inserting “, up to the levels made  
6 available under this section,”;

7 (2) in subsection (c)—

8 (A) in the first sentence of paragraph (1),  
9 by striking “may” and inserting “shall”;

10 (B) in paragraph (2), by striking “appro-  
11 priated” and inserting “made available”;

12 (3) in subsection (g)—

13 (A) by striking paragraph (1) and insert-  
14 ing the following new paragraph:

15 “(1)(A) There are authorized to be —

16 “(i) appropriated to carry out this section such  
17 amounts as are necessary for each of fiscal years  
18 1995 through 2000; and

19 “(ii) made available such amounts as are nec-  
20 essary for the Secretary of the Treasury to fulfill the  
21 requirements of subparagraph (B).

22 “(B)(i) Out of any money in the Treasury not other-  
23 wise appropriated, the Secretary of the Treasury shall pro-  
24 vide to the Secretary of Agriculture, on January 1 of each  
25 fiscal year, to carry out this subsection—

1 “(I) \$444,000,000 for fiscal year 1996;

2 “(II) \$696,000,000 for fiscal year 1997;

3 “(III) \$775,000,000 for fiscal year 1998;

4 “(IV) \$924,000,000 for fiscal year 1999; and

5 “(V) \$1,077,000,000 for fiscal year 2000.

6 “(ii) The Secretary of Agriculture shall be entitled  
7 to receive the funds and shall accept the funds.

8 “(C) In lieu of obligating the funds made available  
9 under subparagraph (B) to carry out this subsection, if  
10 the amount appropriated (in addition to the amount ap-  
11 propriated under subparagraph (B)(i)) to carry out this  
12 subsection for—

13 “(i) fiscal year 1996 is less than  
14 \$3,470,000,000, the amount referred to in subpara-  
15 graph (B)(i)(I) shall be obligated by the Secretary,  
16 during the period beginning December 31, 1995,  
17 and ending June 30, 1996, to increase the special  
18 assistance factor prescribed under section 11(a) of  
19 the National School Lunch Act (42 U.S.C.  
20 1759a(a)) for free lunches served under the school  
21 lunch program (as established under section 4 of  
22 such Act (42 U.S.C. 1753));

23 “(ii) fiscal year 1997 is less than  
24 \$3,470,000,000, the amount referred to in subpara-  
25 graph (B)(i)(II) shall be obligated by the Secretary,

1 during the period beginning December 31, 1996,  
2 and ending June 30, 1997, to increase the special  
3 assistance factor prescribed under section 11(a) of  
4 such Act for free lunches served under the school  
5 lunch program (as established under section 4 of  
6 such Act);

7 “(iii) fiscal year 1998 is less than  
8 \$3,470,000,000, the amount referred to in subpara-  
9 graph (B)(i)(III) shall be obligated by the Secretary,  
10 during the period beginning December 31, 1997,  
11 and ending June 30, 1998, to increase the special  
12 assistance factor prescribed under section 11(a) of  
13 such Act for free lunches served under the school  
14 lunch program (as established under section 4 of  
15 such Act);

16 “(iv) fiscal year 1999 is less than  
17 \$3,470,000,000, the amount referred to in subpara-  
18 graph (B)(i)(IV) shall be obligated by the Secretary,  
19 during the period beginning December 31, 1998,  
20 and ending June 30, 1999, to increase the special  
21 assistance factor prescribed under section 11(a) of  
22 such Act for free lunches served under the school  
23 lunch program (as established under section 4 of  
24 such Act); and

1           “(v) fiscal year 2000 is less than  
2           \$3,470,000,000, the amount referred to in subpara-  
3           graph (B)(i)(V) shall be obligated by the Secretary,  
4           during the period beginning December 31, 1999,  
5           and ending June 30, 2000, to increase the special  
6           assistance factor prescribed under section 11(a) of  
7           such Act for free lunches served under the school  
8           lunch program (as established under section 4 of  
9           such Act).

10          “(D) Any increase in the special assistance factor  
11         prescribed under section 11(a) of such Act as a result of  
12         subparagraph (C) shall not affect any annual adjustment  
13         in the factor under section 11(a)(3) of such Act.

14          “(E) Notwithstanding any other provision of law, no  
15         additional amounts shall be made available under this  
16         paragraph for any fiscal year after fiscal year 2000.”;

17                 (B) in the first sentence of paragraph (4),  
18                 by striking “appropriated” and inserting “made  
19                 available”; and

20                 (C) in paragraph (5), by striking “appro-  
21                 priated” and inserting “made available”;

22                 (4) in subsection (h)—

23                 (A) in paragraph (1)—

1 (i) in subparagraph (A), by striking  
2 “appropriated” both places it appears and  
3 inserting “made available”; and

4 (ii) in subparagraph (C), by striking  
5 “appropriated” both places it appears and  
6 inserting “made available”; and

7 (B) in the first sentence of paragraph  
8 (2)(A), by striking “1990, 1991, 1992, 1993  
9 and 1994” and inserting “1990 through 2000”;  
10 and

11 (5) in subsection (l), by striking “funds appro-  
12 priated” and inserting “funds made available”.

13 **Subtitle L—Border Health**  
14 **Improvement**

15 **SEC. 3908. BORDER HEALTH COMMISSION.**

16 (a) ESTABLISHMENT.—The President is authorized  
17 and encouraged to conclude an agreement with Mexico to  
18 establish a binational commission to be known as the  
19 United States-Mexico Border Health Commission.

20 (b) DUTIES.—It should be the duty of the Commis-  
21 sion—

22 (1) to conduct a comprehensive needs assess-  
23 ment in the United States-Mexico Border Area for  
24 the purposes of identifying, evaluating, preventing,  
25 and resolving health problems and potential health

1 problems that affect the general population of the  
2 area;

3 (2) to develop and implement a comprehensive  
4 plan for carrying out the actions recommended by  
5 the needs assessment through—

6 (A) assisting in the coordination of public  
7 and private efforts to prevent potential health  
8 problems and resolve existing health problems,

9 (B) assisting in the coordination of public  
10 and private efforts to educate the population, in  
11 a culturally competent manner, concerning such  
12 potential and existing health problems; and

13 (C) developing and implementing culturally  
14 competent programs to prevent and resolve  
15 such health problems and to educate the popu-  
16 lation, in a culturally competent manner, con-  
17 cerning such health problems where a new pro-  
18 gram is necessary to meet a need that is not  
19 being met through other public or private ef-  
20 forts; and

21 (3) to formulate recommendations to the Gov-  
22 ernments of the United States and Mexico con-  
23 cerning a fair and reasonable method by which the  
24 government of one country could reimburse a public  
25 or private person in the other country for the cost

1 of a health care service that such person furnishes  
2 to a citizen or resident alien of the first country who  
3 is unable, through insurance or otherwise, to pay for  
4 the service.

5 (c) OTHER AUTHORIZED FUNCTIONS.—In addition  
6 to the duties described in subsection (b), the Commission  
7 should be authorized to perform the following functions  
8 as the Commission determines to be appropriate—

9 (1) to conduct or support investigations, re-  
10 search, or studies designed to identify, study, and  
11 monitor, on an on-going basis, health problems that  
12 affect the general population in the United States-  
13 Mexico Border Area;

14 (2) to conduct or support a binational, public-  
15 private effort to establish a comprehensive and co-  
16 ordinated system, which uses advanced technologies  
17 to the maximum extent possible, for gathering  
18 health-related data and monitoring health problems  
19 in the United States-Mexico Border Area; and

20 (3) to provide financial, technical, or adminis-  
21 trative assistance to public or private persons who  
22 act to prevent or resolve such problems or who edu-  
23 cate the population concerning such health problems.

24 (d) MEMBERSHIP.—

1           (1) NUMBER AND APPOINTMENT OF UNITED  
2 STATES SECTION.—The United States section of the  
3 Commission should be composed of 13 members.  
4 The section should consist of the following members:

5           (A) The Secretary of Health and Human  
6 Services or the Secretary's delegate.

7           (B) The commissioners of health or chief  
8 health officer from the States of Texas, New  
9 Mexico, Arizona, and California or such com-  
10 missioners' delegates.

11           (C) Two individuals residing in United  
12 States-Mexico Border Area in each of the  
13 States of Texas, New Mexico, Arizona, and  
14 California who are nominated by the chief execu-  
15 tive officer of the respective States and ap-  
16 pointed by the President from among individ-  
17 uals—

18           (i) who have a demonstrated interest  
19 or expertise in health issues of the United  
20 States-Mexico Border Area; and

21           (ii) whose name appears on a list of  
22 6 nominees submitted to the President by  
23 the chief executive officer of the State  
24 where the nominees resides.

1           (2) COMMISSIONER.—The Commissioner of the  
2 United States section of the Commission should be  
3 the Secretary of Health and Human Services or  
4 such individual's delegate to the Commission. The  
5 Commissioner should be the leader of the section.

6           (3) COMPENSATION.—Members of the United  
7 States section of the Commission who are not em-  
8 ployees of the United States—

9           (A) shall each receive compensation at a  
10 rate of not to exceed the daily equivalent of the  
11 annual rate of basic pay payable for positions  
12 at GS-15 of the General Schedule under sec-  
13 tion 5332 of title 5, United States Code, for  
14 each day such member is engaged in the actual  
15 performance of the duties of the Commission;  
16 and

17           (B) shall be allowed travel expenses, in-  
18 cluding per diem in lieu of subsistence at rates  
19 authorized for employees of agencies under sub-  
20 chapter I of chapter 57 of title 5, United States  
21 Code, while away from their homes or regular  
22 places of business in the performance of serv-  
23 ices of the Commission.

24           (e) REGIONAL OFFICES.—The Commission should  
25 designate or establish one border health office in each of

1 the States of Texas, New Mexico, Arizona, and California.  
2 Such office should be located within the United States-  
3 Mexico Border Area, and should be coordinated with—

4 (1) State border health offices; and

5 (2) local nonprofit organizations designated by  
6 the State’s governor and directly involved in border  
7 health issues.

8 If feasible to avoid duplicative efforts, the Commission of-  
9 fices should be located in existing State or local nonprofit  
10 offices. The Commission should provide adequate com-  
11 pensation for cooperative efforts and resources.

12 (f) REPORTS.—Not later than February 1 of each  
13 year that occurs more than 1 year after the date of the  
14 establishment of the Commission, the Commission should  
15 submit an annual report to both the United States Gov-  
16 ernment and the Government of Mexico regarding all ac-  
17 tivities of the Commission during the preceding calendar  
18 year.

19 (g) DEFINITIONS.—As used in this section:

20 (1) COMMISSION.—The term “Commission”  
21 means the United States-Mexico Border Health  
22 Commission.

23 (2) HEALTH PROBLEM.—The term “health  
24 problem” means a disease or medical ailment or an  
25 environmental condition that poses the risk of dis-

1 ease or medical ailment. Such term includes dis-  
 2 eases, ailments, or risks of disease or ailment caused  
 3 by or related to environmental factors, control of  
 4 animals and rabies, control of insect and rodent vec-  
 5 tors, disposal of solid and hazardous waste, and con-  
 6 trol and monitoring of air quality.

7 (3) RESIDENT ALIEN.—The term “resident  
 8 alien”, when used in reference to a country, means  
 9 an alien lawfully admitted for permanent residence  
 10 to the United States or otherwise permanently resid-  
 11 ing in the United States under color of law (includ-  
 12 ing residence as an asylee, refugee, or parolee).

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

15 (5) UNITED STATES-MEXICO BORDER AREA.—  
 16 The term “United States-Mexico Border Area”  
 17 means the area located in the United States and  
 18 Mexico within 100 kilometers of the border between  
 19 the United States and Mexico.

## 20 **TITLE IV—MEDICARE AND** 21 **MEDICAID**

### 22 **SEC. 4000. REFERENCES IN TITLE.**

23 (a) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
 24 cept as otherwise specifically provided, whenever in this  
 25 title an amendment is expressed in terms of an amend-

1 ment to or repeal of a section or other provision, the ref-  
 2 erence shall be considered to be made to that section or  
 3 other provision of the Social Security Act.

4 (b) REFERENCES TO OBRA.—In this title, the terms  
 5 “OBRA–1986”, “OBRA–1987”, “OBRA–1989”,  
 6 “OBRA–1990”, and “OBRA–1993” refer to the Omnibus  
 7 Budget Reconciliation Act of 1986 (Public Law 99–509),  
 8 the Omnibus Budget Reconciliation Act of 1987 (Public  
 9 Law 100–203), the Omnibus Budget Reconciliation Act  
 10 of 1989 (Public Law 101–239), the Omnibus Budget Rec-  
 11 onciliation Act of 1990 (Public Law 101–508), and the  
 12 Omnibus Budget Reconciliation Act of 1993 (Public Law  
 13 103–66), respectively.

## 14 **Subtitle A—Medicare**

### 15 **PART 1—INTEGRATION OF MEDICARE**

#### 16 **BENEFICIARIES**

#### 17 **SEC. 4001. INDIVIDUAL ELECTION TO REMAIN IN CERTAIN** 18 **HEALTH PLANS.**

19 (a) IN GENERAL.—Section 1876 (42 U.S.C.  
 20 1395mm) is amended by adding at the end the following  
 21 new subsection:

22 “(k)(1) Notwithstanding any other provision of this  
 23 section, each eligible organization with a risk-sharing con-  
 24 tract (or which is eligible to enter into such a contract,  
 25 as determined by the Secretary) that is the sponsor of a

1 standard health plan under subtitle B of title I of the  
2 Health Security Act shall provide each individual who  
3 meets the requirements of paragraph (2) with the oppor-  
4 tunity to elect (by submitting an application at such time  
5 and in such manner as specified by the Secretary) to con-  
6 tinue enrollment in such plan (for the same benefits as  
7 other individuals enrolled in the plan) and to have pay-  
8 ments made by the Secretary to the plan on the individ-  
9 ual's behalf in accordance with paragraph (3). The pre-  
10 mium imposed with respect to such an individual by the  
11 plan shall be in an amount (determined in accordance with  
12 rules of the Secretary and notwithstanding other provi-  
13 sions of such Act) which reflects the difference between  
14 the premium otherwise established (adjusted by a factor  
15 to reflect the actuarial difference between medicare bene-  
16 ficiaries and other plan enrollees) and the amount payable  
17 under paragraph (3).

18       “(2) An individual meets the requirements of this  
19 paragraph if the individual is—

20               “(A) enrolled in the health plan of an eligible  
21 organization in a month in which the individual is  
22 either not entitled to benefits under part A, or is an  
23 employee (as defined in the Health Security Act) or  
24 the spouse or dependent of an employee,

1           “(B) entitled to benefits under part A and en-  
2           rolled under part B in the succeeding month,

3           “(C) a community-rated individual under the  
4           Health Security Act in that succeeding month, and

5           “(D) not an experience-rated employee (as de-  
6           fined in the Health Security Act) or the spouse or  
7           dependent of an experience-rated employee in that  
8           succeeding month.

9           “(3) The Secretary shall make a payment to an eligi-  
10          ble organization on behalf of each individual enrolled with  
11          the organization for whom an election is in effect under  
12          this subsection in an amount determined by the rate speci-  
13          fied by subsection (a)(1)(C) (notwithstanding the second  
14          sentence of paragraph (1)). Such payment shall be made  
15          from the Federal Hospital Insurance Trust Fund and the  
16          Federal Supplementary Medical Insurance Trust Fund as  
17          provided under subsection (a)(5) (other than as provided  
18          under subparagraph (B) of that paragraph).

19          “(4) The period for which payment may be made  
20          under paragraph (3)—

21                 “(A) begins with the first month for which the  
22                 individual meets the requirements of paragraph (2)  
23                 (or a later month, in the case of a late application,  
24                 as may be specified by the Secretary); and

25                 “(B) ends with the earliest of—

1 “(i) the month following the month—

2 “(I) in which the individual notifies  
3 the Secretary that the individual no longer  
4 wishes to be enrolled in the health plan of  
5 the eligible organization and to have pay-  
6 ment made on the individual’s behalf under  
7 this subsection; and

8 “(II) which is a month specified by  
9 the Secretary as a uniform open enroll-  
10 ment period under subsection (c)(3)(A)(i),  
11 or

12 “(ii) the month in which the individual  
13 ceases to meet the requirements of paragraph  
14 (2).

15 “(5) Notwithstanding any other provision of this title,  
16 payments to an eligible organization under this subsection  
17 on behalf of an individual shall be the sole payments made  
18 with respect to items and services furnished to the indi-  
19 vidual during the period for which the individual’s election  
20 under this subsection is in effect.”.

21 (b) CONFORMING AMENDMENT.—Section 1838(b)  
22 (42 U.S.C. 1395q(b)) is amended by inserting after “sec-  
23 tion 1843(e)” the following: “, 1876(c)(3)(B) or  
24 1876(k)(4)(B)”.

1 **SEC. 4002. ENROLLMENT AND TERMINATION OF ENROLL-**  
2 **MENT.**

3 (a) UNIFORM OPEN ENROLLMENT PERIODS.—

4 (1) FOR CAPITATED PLANS.—The first sentence  
5 of section 1876(c)(3)(A)(i) (42 U.S.C.  
6 1395mm(c)(3)(A)(i)) is amended by inserting  
7 “(which may be specified by the Secretary)” after  
8 “open enrollment period”.

9 (2) FOR MEDIGAP PLANS.—Section 1882(s) (42  
10 U.S.C. 1395ss(s)) is amended—

11 (A) in paragraph (3), by striking “para-  
12 graphs (1) and (2)” and inserting “paragraph  
13 (1), (2), or (3)”,

14 (B) by redesignating paragraph (3) as  
15 paragraph (4), and

16 (C) by inserting after paragraph (2) the  
17 following new paragraph:

18 “(3) Each issuer of a medicare supplemental policy  
19 shall have an open enrollment period (which shall be the  
20 period specified by the Secretary under section  
21 1876(c)(3)(A)(i)), of at least 30 days duration every year,  
22 during which the issuer may not deny or condition the  
23 issuance or effectiveness of a medicare supplemental pol-  
24 icy, or discriminate in the pricing of the policy, because  
25 of age, health status, claims experience, receipt of health  
26 care, or medical condition. The policy may not provide any

1 time period applicable to pre-existing conditions, waiting  
2 periods, elimination periods, and probationary periods (ex-  
3 cept as provided by paragraph (2)(B)). The Secretary may  
4 require enrollment through a third party designated under  
5 section 1876(c)(3)(B).”.

6 (b) ENROLLMENTS FOR NEW MEDICARE BENE-  
7 FICIARIES AND THOSE WHO MOVE.—Section  
8 1876(c)(3)(A) (42 U.S.C. 1395mm(c)(3)(A)) is amend-  
9 ed—

10 (1) in clause (i), by striking “clause (ii)” and  
11 inserting “clauses (ii) through (iv)”, and

12 (2) by adding at the end the following:

13 “(iii) Each eligible organization shall have an open  
14 enrollment period for each individual eligible to enroll  
15 under subsection (d) during any enrollment period speci-  
16 fied by section 1837 that applies to that individual. Enroll-  
17 ment under this clause shall be effective as specified by  
18 section 1838.

19 “(iv) Each eligible organization shall have an open  
20 enrollment period for each individual eligible to enroll  
21 under subsection (d) who has previously resided outside  
22 the geographic area which the organization serves. The en-  
23 rollment period shall begin with the beginning of the  
24 month that precedes the month in which the individual  
25 becomes a resident of that geographic area and shall end

1 at the end of the following month. Enrollment under this  
2 clause shall be effective as of the first of the month fol-  
3 lowing the month in which the individual enrolls.”.

4 (c) ENROLLMENT THROUGH THIRD PARTY; UNI-  
5 FORM TERMINATION OF ENROLLMENT.—The first sen-  
6 tence of section 1876(c)(3)(B) (42 U.S.C.  
7 1395mm(c)(3)(B)) is amended—

8 (1) by inserting “(including enrollment through  
9 a third party)” after “regulations”, and

10 (2) by striking everything after “with the eligi-  
11 ble organization” and inserting “during an annual  
12 period as prescribed by the Secretary, and as speci-  
13 fied by the Secretary in the case of financial insol-  
14 vency of the organization, if the individual moves  
15 from the geographic area served by the organization,  
16 or in other special circumstances that the Secretary  
17 may prescribe.”.

18 (d) EFFECTIVE DATE.—The amendments made by  
19 the previous subsections apply to enrollments and termi-  
20 nations of enrollments occurring after 1995 (but only after  
21 the Secretary of Health and Human Services has pre-  
22 scribed the relevant annual period), except that the  
23 amendments made by subsection (a)(2) apply to enroll-  
24 ments for a medicare supplemental policy made after  
25 1995.

1       **PART 2—PROVISIONS RELATING TO PART A**

2       **SEC. 4101. INPATIENT HOSPITAL SERVICES UPDATE FOR**  
3                       **PPS HOSPITALS.**

4       Section       1886(b)(3)(B)(i)       (42       U.S.C.  
5       1395ww(b)(3)(B)(i)) is amended—

6               (1) by amending subclause (XII) to read as fol-  
7       lows:

8               “(XII) for fiscal years 1997 through 2000, the  
9       market basket percentage minus 2.0 percentage  
10       points for hospitals in all areas, and”; and

11              (2) in subclause (XIII), by striking “1998” and  
12       inserting “2001”.

13       **SEC. 4102. REDUCTION IN PAYMENTS FOR CAPITAL-RE-**  
14                       **LATED COSTS FOR INPATIENT HOSPITAL**  
15                       **SERVICES.**

16       (a) PPS HOSPITALS.—

17              (1) REDUCTION IN BASE PAYMENT RATES FOR  
18       PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C.  
19       1395ww(g)(1)(A)) is amended by adding at the end  
20       the following new sentence: “In addition to the re-  
21       duction described in the preceding sentence, for dis-  
22       charges occurring after September 30, 1995, the  
23       Secretary shall reduce by 7.31 percent the  
24       unadjusted standard Federal capital payment rate  
25       (as described in 42 CFR 412.308(e), as in effect on  
26       the date of the enactment of the Health Security

1 Act) and shall reduce by 10.41 percent the  
2 unadjusted hospital-specific rate (as described in 42  
3 CFR 412.328(e)(1), as in effect on the date of the  
4 enactment of the Health Security Act).”.

5 (2) REDUCTION IN UPDATE.—Section  
6 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

7 (A) in subparagraph (B)(i)—

8 (i) by striking “and (II)” and insert-  
9 ing “(II)”, and

10 (ii) by striking the semicolon at the  
11 end and inserting the following: “, and  
12 (III) an annual update factor established  
13 for the prospective payment rates applica-  
14 ble to discharges in a fiscal year which  
15 (subject to reduction under subparagraph  
16 (C)) will be based upon such factor as the  
17 Secretary determines appropriate to take  
18 into account amounts necessary for the ef-  
19 ficient and effective delivery of medically  
20 appropriate and necessary care of high  
21 quality;”;

22 (B) by redesignating subparagraph (C) as  
23 subparagraph (D); and

24 (C) by inserting after subparagraph (B)  
25 the following new subparagraph:

1           “(C)(i) With respect to payments attributable  
2 to portions of cost reporting periods or discharges  
3 occurring during each of the fiscal years 1996  
4 through 2003, the Secretary shall include a reduc-  
5 tion in the annual update factor established under  
6 subparagraph (B)(i)(III) for discharges in the year  
7 equal to the applicable update reduction described in  
8 clause (ii) to adjust for excessive increases in capital  
9 costs per discharge for fiscal years prior to fiscal  
10 year 1992 (but in no event may such reduction re-  
11 sult in an annual update factor less than zero).

12           “(ii) In clause (i), the term ‘applicable update  
13 reduction’ means, with respect to the update factor  
14 for a fiscal year—

15                   “(I) 4.9 percentage points; or

16                   “(II) if the annual update factor for the  
17 previous fiscal year was less than the applicable  
18 update reduction for the previous year, the sum  
19 of 4.9 percentage points and the difference be-  
20 tween the annual update factor for the previous  
21 year and the applicable update reduction for the  
22 previous year.”.

23           (b) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1)  
24 (42 U.S.C. 1395x(v)(1)) is further amended by adding at  
25 the end the following new subparagraph:

1       “(T) Such regulations shall provide that, in deter-  
 2 mining the amount of the payments that may be made  
 3 under this title with respect to the capital-related costs  
 4 of inpatient hospital services furnished by a hospital that  
 5 is not a subsection (d) hospital (as defined in section  
 6 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital  
 7 (as defined in section 1886(d)(9)(A)), the Secretary shall  
 8 reduce the amounts of such payments otherwise estab-  
 9 lished under this title by 15 percent for payments attrib-  
 10 utable to portions of cost reporting periods occurring dur-  
 11 ing each of the fiscal years 1996 through 2003.”.

12 **SEC. 4103. REDUCTIONS IN DISPROPORTIONATE SHARE**  
 13 **PAYMENTS.**

14       (a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C.  
 15 1395ww(d)(5)(F)) is amended—

16           (1) in clause (ii), by striking “The amount”  
 17 and inserting “Subject to clause (ix), the amount”;

18           (2) in clause (vi), by striking “In” and insert-  
 19 ing “Subject to clause (x), in”; and

20           (3) by adding at the end the following new  
 21 clauses:

22       “(ix) Notwithstanding any other provision of this  
 23 subparagraph, the Secretary shall reduce the amount of  
 24 any additional payment made to a hospital under this sub-  
 25 paragraph by an amount equal to the sum of—

1           “(I) for discharges occurring on or after the  
2           date on which the State in which such hospital is lo-  
3           cated becomes a participating State (as such term is  
4           defined in title I of the Health Security Act), 33  
5           percent of such additional payment.”.

6 **SEC. 4104. EXTENSION OF FREEZE ON UPDATES TO ROU-**  
7                           **TINE SERVICE COST LIMITS FOR SKILLED**  
8                           **NURSING FACILITIES.**

9           (a) PAYMENTS BASED ON COST LIMITS.—Section  
10 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking  
11 “112 percent” each place it appears and inserting “100  
12 percent (adjusted by such amount as the Secretary deter-  
13 mines to be necessary to preserve the savings resulting  
14 from the enactment of section 13503(a)(1) of the Omni-  
15 bus Budget Reconciliation Act of 1993)”.

16           (b) ADJUSTMENTS TO LIMITS.—Section 1888(c) (42  
17 U.S.C. 1395yy(c)) is amended by inserting the following  
18 sentence at the end: “The effect of the amendment made  
19 by section 4104(a) of the Health Security Act shall not  
20 be considered by the Secretary in making adjustments  
21 pursuant to this subsection.”

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

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

4 (d) EFFECTIVE DATE.—The amendments made by  
 5 subsections (a), (b), and (c) shall apply to cost reporting  
 6 periods beginning on or after October 1, 1995.

7 **SEC. 4105. MEDICARE-DEPENDENT, SMALL RURAL HOS-**  
 8 **PITALS.**

9 (a) CLARIFICATION OF ADDITIONAL PAYMENT.—  
 10 Section 1886(d)(5)(G)(ii)(I) (42 U.S.C.  
 11 1395ww(d)(5)(G)(ii)(I)) is amended by striking “the first  
 12 3 12-month cost reporting periods that begin” and insert-  
 13 ing “the 36-month period beginning with the first day of  
 14 the cost reporting period that begins”.

15 (b) SPECIAL TREATMENT EXTENDED.—Section  
 16 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amend-  
 17 ed—

18 (1) in clause (i), by striking “October 1, 1994”  
 19 and inserting “October 1, 1999”; and

20 (2) in clause (ii)(II), by striking “October 1,  
 21 1994” and inserting “October 1, 1999”.

22 (c) EXTENSION OF TARGET AMOUNT.—Section  
 23 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amend-  
 24 ed—

1 (1) in the matter preceding clause (i), by strik-  
 2 ing “March 31, 1993” and inserting “September 30,  
 3 1999”; and

4 (2) by amending clause (iii) to read as follows:

5 “(iii) with respect to discharges occurring in fis-  
 6 cal years 1994 through 1999, the target amount for  
 7 the cost reporting period beginning in the previous  
 8 fiscal year increased by the applicable percentage in-  
 9 crease under subparagraph (B)(iv).”.

10 **SEC. 4106. PROVISIONS RELATING TO RURAL HEALTH**  
 11 **TRANSITION GRANT PROGRAM.**

12 (a) **ELIGIBILITY OF RURAL PRIMARY CARE HOS-**  
 13 **PITALS FOR GRANTS.—**

14 (1) **IN GENERAL.—**Section 4005(e)(2) of the  
 15 Omnibus Budget Reconciliation Act of 1987 is  
 16 amended in the matter preceding subparagraph (A)  
 17 by inserting “any rural primary care hospital as de-  
 18 fined in section 1861(mm)(1), or” after “means”.

19 (2) **EFFECTIVE DATE.—**The amendment made  
 20 by paragraph (1) shall apply to grants made on or  
 21 after October 1, 1993.

22 (b) **EXTENSION OF AUTHORIZATION OF APPROPRIA-**  
 23 **TIONS.—**Section 4005(e)(9) of Omnibus Budget Reconcili-  
 24 ation Act of 1987 is amended—

1           (1) by striking “1989 and” and inserting  
2           “1989,”; and

3           (2) by striking “1992” and inserting “1992  
4           and \$30,000,000 for each of the fiscal years 1993  
5           through 1999”.

6           (c) FREQUENCY OF REQUIRED REPORTS.—Section  
7           4008(e)(8)(B) of the Omnibus Budget Reconciliation Act  
8           of 1987 is amended by striking “every 6 months” and in-  
9           serting “every 12 months”.

10   **SEC. 4107. PAYMENTS FOR SOLE COMMUNITY HOSPITALS**

11                           **WITH TEACHING PROGRAMS AND MULTIHOS-**

12                           **PITAL CAMPUSES.**

13           (a) IN GENERAL.—Section 1886(d)(5)(D) (42 U.S.C.  
14           1395ww(d)(5)(D)) is amended by adding at the end the  
15           following new clause:

16           “(vi) The Secretary shall determine payment under  
17           clause (i) for a sole-community hospital that is a part of  
18           a multi-campus hospital by making the determination  
19           under such clause for each facility of the multi-campus  
20           hospital if any facility of the hospital would have a value  
21           of ‘r’ greater than 0, as ‘r’ is defined in subparagraph  
22           (B)(ii). In making a determination for each such facility,  
23           the Secretary shall determine the DRG-specific rate appli-  
24           cable to the facility based on its location in accordance  
25           with paragraph (3)(D).”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) shall apply to discharges occurring on or  
3 after October 1, 1993, from multi-campus hospitals that  
4 merged facilities on or after October 1, 1987.

5 **SEC. 4108. MORATORIUM ON DESIGNATION OF NEW LONG-**  
6 **TERM HOSPITALS.**

7 Notwithstanding clause (iv) of section 1886(d)(1)(B)  
8 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)),  
9 a hospital which has an average inpatient length of stay  
10 (as determined by the Secretary of Health and Human  
11 Services) of greater than 25 days shall not be treated as  
12 a hospital described in such clause for purposes of such  
13 title unless such hospital was treated as a hospital de-  
14 scribed in such clause for purposes of such title as of the  
15 date of the enactment of this Act.

16 **SEC. 4109. REVISED PAYMENT METHODOLOGY FOR REHA-**  
17 **BILITATION AND LONG-TERM CARE HOS-**  
18 **PITALS.**

19 (a) REHABILITATION HOSPITALS AND DISTINCT  
20 PART UNITS.—

21 (1) DEFINITION.—Section 1886(d)(1)(B) (42  
22 U.S.C. 1395ww(d)(1)(B)) is amended by adding at  
23 the end the following new sentence: “In defining a  
24 rehabilitation hospital and a rehabilitation unit of a  
25 hospital which is a distinct part of a hospital, the

1 Secretary shall take into account the impact of new  
2 technologies, survival rates, and changes in the prac-  
3 tice of rehabilitation medicine.”.

4 (2) TARGET AMOUNT CALCULATION FOR REHA-  
5 BILITATION HOSPITALS AND DISTINCT PART  
6 UNITS.—

7 (A) IN GENERAL.—Section 1886(b)(3) (42  
8 U.S.C. 1395ww(b)(3)) is amended—

9 (i) in subparagraph (A), by striking  
10 “(D), and (E)” and inserting “(D), (E),  
11 and (F)”;

12 (ii) in subparagraph (B)(ii), by strik-  
13 ing “and (E)” and inserting “(E), and  
14 (F)”;

15 (iii) by adding at the end the fol-  
16 lowing new subparagraph:

17 “(F)(i) Subject to clause (ii), for cost re-  
18 porting periods beginning on or after October 1,  
19 1994, in the case of a hospital described in sub-  
20 section (d)(1)(B)(ii) or a rehabilitation unit de-  
21 scribed in such subparagraph, the term ‘target  
22 amount’ means—

23 “(I) with respect to the first 12-  
24 month cost reporting period in which this

1           subparagraph is applied to the hospital or  
2           unit—

3                   “(aa) the allowable operating  
4                   costs of inpatient hospital services (as  
5                   defined in subsection (a)(4)) recog-  
6                   nized under this title for the hospital  
7                   or unit for the 12-month cost report-  
8                   ing period (in this subparagraph re-  
9                   ferred to as the ‘base cost reporting  
10                  period’) preceding the first cost re-  
11                  porting period for which this subpara-  
12                  graph was in effect with respect to  
13                  such hospital, increased (in a com-  
14                  pounded manner), by

15                   “(bb) the applicable percentage  
16                   increases applied to such hospital or  
17                   unit under this paragraph for cost re-  
18                   porting periods after the base cost re-  
19                   porting period and up to and includ-  
20                   ing such first 12-month cost reporting  
21                   period, or

22                   “(II) with respect to a later cost re-  
23                  porting period, the target amount for the  
24                  preceding 12-month cost reporting period,

1           increased by the applicable percentage in-  
2           crease under subparagraph (B).

3           There shall be substituted for the allowable av-  
4           erage costs of inpatient hospital services deter-  
5           mined under subclause (I)(aa), the average of  
6           the allowable average costs of inpatient hospital  
7           services (as so defined) recognized under this  
8           title for the hospital or unit for cost reporting  
9           periods beginning during fiscal years 1990 and  
10          1991 (if any).

11          “(ii)(I) Notwithstanding the provisions of  
12          clause (i), in the case of a hospital or unit to  
13          which the last sentence of clause (i) applies, the  
14          hospital or unit’s target amount under such  
15          clause for a cost reporting period shall be—

16                 “(aa) not less than 70 percent of the  
17                 national weighted average of all target  
18                 amounts calculated under such clause for  
19                 all hospitals and units described in such  
20                 clause (as determined by the Secretary),  
21                 and

22                 “(bb) not less than the allowable oper-  
23                 ating costs of inpatient hospital services  
24                 (as defined in subsection (a)(4) for such  
25                 hospital or unit in the base cost reporting

1 period (including any payments made to  
2 such hospital or unit pursuant to para-  
3 graph (1)(A)), multiplied by the applicable  
4 percentage increase for such cost reporting  
5 period under subparagraph (B).

6 “(II) Notwithstanding the provisions of  
7 clause (i), in the case of a hospital or unit that  
8 is not described in subclause (I), the hospital or  
9 unit’s target amount under such clause for a  
10 cost reporting period shall be—

11 “(aa) not less than the amount de-  
12 scribed in subclause (I)(aa), and

13 “(bb) not greater than 110 percent of  
14 the national weighted average of all target  
15 amounts calculated under clause (i) for all  
16 hospitals and units described in such  
17 clause (as determined by the Secretary).”.

18 (B) EFFECTIVE DATE.—The amendments  
19 made by subparagraph (A) shall apply with re-  
20 spect to cost reporting periods beginning on or  
21 after October 1, 1994.

22 (3) DEVELOPMENT OF NATIONAL PROSPECTIVE  
23 RATES FOR REHABILITATION HOSPITALS AND DIS-  
24 TINCT PART UNITS.—

1           (A) DEVELOPMENT OF PROPOSAL.—The  
2           Secretary of Health and Human Services (here-  
3           after in this section referred to as the “Sec-  
4           retary”) shall develop a proposal to replace the  
5           current system under which rehabilitation hos-  
6           pitals and rehabilitation units of a hospital  
7           which are a distinct part of a hospital (as de-  
8           scribed in section 1886(d)(1)(B) of the Social  
9           Security Act (42 U.S.C. 1395ww(d)(1)(B))) re-  
10          ceive payment for the operating and capital-re-  
11          lated costs of inpatient hospital services under  
12          part A of title XVIII of such Act with a pro-  
13          spective payment system. In developing any  
14          proposal under this paragraph to replace the  
15          current system with a prospective payment sys-  
16          tem, the Secretary shall develop a system that  
17          provides for—

18                   (i) a payment on a per-discharge  
19                   basis, and

20                   (ii) an appropriate weighting of such  
21                   payment amount as it relates to the classi-  
22                   fication of the discharge.

23          (B) REPORTS.—Not later than October 1,  
24          1996, the Secretary shall submit the proposal

1 developed under subparagraph (A) to the Con-  
2 gress.

3 (b) ASSIGNMENT OF NEW BASE YEAR FOR CER-  
4 TIFIED LONG-STAY HOSPITALS THAT ALSO SERVE A SIG-  
5 NIFICANT PROPORTION OF LOW-INCOME PATIENTS.—

6 (1) REBASING FOR LONG-TERM HOSPITALS.—

7 (A) IN GENERAL.—Section 1886(b)(3) (42  
8 U.S.C. 1395ww(b)(3)), as amended by sub-  
9 section (a), is further amended—

10 (i) in subparagraph (A), by striking  
11 “(E), and (F)” and inserting “(E), (F),  
12 and (G)”;

13 (ii) in subparagraph (B)(ii), by strik-  
14 ing “(E), and (F)” and inserting “(E),  
15 (F), and (G)”;

16 (iii) by inserting after subparagraph  
17 (F) the following new subparagraph:

18 “(G)(i) For cost reporting periods begin-  
19 ning on or after October 1, 1994, in the case  
20 of a hospital described in subsection  
21 (d)(1)(B)(iv) that—

22 “(I) has not received the additional  
23 payment amount described in paragraph  
24 (1)(A) for at least the preceding 2 consecu-  
25 tive 12-month cost reporting periods; and

1           “(II) for which the sum of the  
2           amounts described in subclauses (I) and  
3           (II) of subsection (d)(5)(F)(vi) during the  
4           period described in clause (I) exceeds 25  
5           percent,

6           the term ‘target amount’ has the meaning given  
7           such term by clause (ii).

8           “(ii) In the case of a hospital described in  
9           clause (i), the term ‘target amount’ means—

10           “(I) with respect to the first 12-  
11           month cost reporting period in which this  
12           subparagraph is applied to the hospital—

13           “(aa) the average allowable oper-  
14           ating costs of inpatient hospital serv-  
15           ices (as defined in subsection (a)(4))  
16           recognized under this title for the hos-  
17           pital during cost reporting periods of  
18           the hospital beginning during fiscal  
19           years 1990 and 1991 for such hos-  
20           pital (in this subparagraph referred to  
21           as the ‘base cost reporting period’),  
22           increased (in a compounded manner),  
23           by

24           “(bb) the applicable percentage  
25           increases applied to such hospital or

1                   under this paragraph for cost report-  
2                   ing periods after the base cost report-  
3                   ing period and up to and including  
4                   such first 12-month cost reporting pe-  
5                   riods, or

6                   “(II) with respect to a subsequent 12-  
7                   month cost reporting period, the target  
8                   amount for the preceding 12-month cost  
9                   reporting period, increased by the applica-  
10                  ble percentage increase under subpara-  
11                  graph (B).

12                  “(iii) Notwithstanding clause (ii)(II), if,  
13                  after 2 consecutive 12-month cost reporting pe-  
14                  riods, a hospital continues to be described in  
15                  subclauses (I) and (II) of clause (i), there shall  
16                  be substituted for the base cost reporting period  
17                  described in clause (ii)(I)(aa) the most recent  
18                  preceding 2 12-month cost reporting periods of  
19                  the hospital for which data is available (as de-  
20                  termined by the Secretary), but only if such  
21                  substituting results in an increase in the target  
22                  amount for the hospital. The substitution under  
23                  the preceding sentence may not occur more  
24                  often than every 2 years.

1           “(iv) Effective October 1, 1994, the Sec-  
2           retary shall take into account the enactment of  
3           this subparagraph in making available to the  
4           hospital the payments described in section  
5           1815(e)(2), and, shall increase such payments  
6           as if the target amount of the hospital had been  
7           established pursuant to this subparagraph as of  
8           such date.”.

9           (2) EFFECTIVE DATE.—The amendments made  
10          by this subsection shall be effective with respect to  
11          cost reporting periods beginning on or after October  
12          1, 1994.

13 **SEC. 4110. TERMINATION OF INDIRECT MEDICAL EDU-**  
14 **CATION PAYMENTS.**

15          (a) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C.  
16 1395ww(d)(5)(B)) is amended in the matter preceding  
17 clause (i) by striking “The Secretary” and inserting “For  
18 discharges occurring before January 1, 1997, the Sec-  
19 retary”.

20          (b) ADJUSTMENT TO STANDARDIZED AMOUNTS.—  
21 Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i))  
22 is amended by striking “excluding” and inserting “for dis-  
23 charges occurring before January 1, 1997, excluding”.

1 **SEC. 4111. LIMITED SERVICE HOSPITAL PROGRAM.**

2 (a) LIMITED SERVICE HOSPITAL PROGRAM.—Sec-  
3 tion 1820 (42 U.S.C. 13951–4) is amended to read as fol-  
4 lows:

5 “LIMITED SERVICE HOSPITAL PROGRAM

6 “SEC. 1820. (a) PURPOSE.—The purpose of this sec-  
7 tion is to—

8 “(1) make available alternative hospital models  
9 to small rural or isolated rural communities in which  
10 facilities are relieved of the burden of selected regu-  
11 latory requirements by limiting the scope of inpa-  
12 tient acute services required to be offered;

13 “(2) alter medicare reimbursement policy to  
14 support the financial viability of alternative facilities  
15 by limiting the financial risk faced by such small  
16 hospitals through the use of reasonable cost reim-  
17 bursement; and

18 “(3) promote linkages between facilities des-  
19 igned by the State under this section and broader  
20 programs supporting the development of and transi-  
21 tion to integrated provider networks.

22 “(b) IN GENERAL.—Any State that submits an appli-  
23 cation in accordance with subsection (c) may establish a  
24 limited service hospital program described in subsection  
25 (d).

1       “(c) APPLICATION.—A State may establish a limited  
2 service hospital program described in subsection (d) if the  
3 State submits to the Secretary at such time and in such  
4 form as the Secretary may require an application con-  
5 taining—

6               “(1) assurances that the State—

7                       “(A) has developed, or is in the process of  
8 developing, a State rural health care plan  
9 that—

10                               “(i) in the case of a State applying to  
11 establish a rural primary care hospital pro-  
12 gram (described in subsection (d)(1)(A)),  
13 provides for the creation of one or more  
14 rural health networks (as defined in sub-  
15 section (e)) in the State,

16                               “(ii) promotes regionalization of rural  
17 health services in the State, and

18                               “(iii) improves access to hospital and  
19 other health services for rural residents of  
20 the State;

21                       “(B) has developed the rural health care  
22 plan described in subparagraph (A) in consulta-  
23 tion with the hospital association of the State,  
24 rural hospitals located in the State, and the  
25 State Office of Rural Health (or, in the case of

1 a State in the process of developing such plan,  
2 that assures the Secretary that it will consult  
3 with its State hospital association, rural hos-  
4 pitals located in the State, and the State Office  
5 of Rural Health in developing such plan); and

6 “(2) assurances that the State has designated  
7 (consistent with the rural health care plan described  
8 in paragraph (1)(A)), or is in the process of desig-  
9 nating, rural nonprofit or public hospitals or facili-  
10 ties located in the State as rural primary care hos-  
11 pitals facilities or medical assistance facilities; and

12 “(3) such other information and assurances as  
13 the Secretary may require.

14 “(d) LIMITED SERVICE HOSPITAL PROGRAM DE-  
15 SCRIBED.—

16 “(1) IN GENERAL.—A State that has submitted  
17 an application in accordance with subsection (c),  
18 may establish a limited service hospital program that  
19 includes—

20 “(A) a rural primary care hospital pro-  
21 gram under which—

22 “(i) at least one facility in the State  
23 shall be designated as a rural primary care  
24 hospital in accordance with paragraph (2),  
25 and

1           “(ii) the State shall develop at least  
2           one rural health network (as defined in  
3           subsection (e)) in the State;

4           “(B) a medical assistance facility program  
5           under which at least one facility in the State  
6           shall be designated as a medical assistance fa-  
7           cility in accordance with paragraph (2); or

8           “(C) both.

9           “(2) STATE DESIGNATION OF FACILITIES.—A  
10          State may designate one or more facilities as a rural  
11          primary care hospital or medical assistance facility  
12          in accordance with subparagraph (A) or (B).

13          “(A) CRITERIA FOR DESIGNATION AS  
14          RURAL PRIMARY CARE HOSPITAL.—A State  
15          may designate a facility as a rural primary care  
16          hospital only if the facility—

17               “(i) is located in a rural area (as de-  
18               fined in section 1886(d)(2)(D)), or is lo-  
19               cated in a county whose geographic area is  
20               substantially larger than the average geo-  
21               graphic area for urban counties in the  
22               United States and whose hospital service  
23               area is characteristic of service areas of  
24               hospitals located in rural areas;

1           “(ii) at the time such facility applies  
2           to the State for designation as a rural pri-  
3           mary care hospital, is a hospital (or, in the  
4           case of a facility that closed during the 12-  
5           month period that ends on the date the fa-  
6           cility applies for such designation, at the  
7           time the facility closed), with a participa-  
8           tion agreement in effect under section  
9           1866(a);

10           “(iii) has in effect an agreement to  
11           participate with other hospitals and facili-  
12           ties in a rural health network;

13           “(iv) provides 24-hour emergency  
14           services to ill or injured persons prior to  
15           admission to the facility or prior to their  
16           transportation to a full-service hospital;

17           “(v) provides not more than 15 inpa-  
18           tient beds (meeting such conditions as the  
19           Secretary may establish) for providing  
20           acute inpatient care;

21           “(vi) provides inpatient care for a pe-  
22           riod not to exceed an average length of 96  
23           hours (unless a longer period is required  
24           because transfer to a hospital is precluded

1 because of inclement weather or other  
2 emergency conditions);

3 “(vii) meets such staffing require-  
4 ments as would apply under section  
5 1861(e), to a hospital located in a rural  
6 area, except that—

7 “(I) the facility need not meet  
8 hospital standards relating to the  
9 number of hours during a day, or  
10 days during a week, in which the fa-  
11 cility must be open and fully staffed,  
12 except insofar as the facility is re-  
13 quired to provide emergency care on a  
14 24-hour basis under clause (v) and  
15 must have nursing services available  
16 on a 24-hour basis, but need not oth-  
17 erwise staff the facility except when  
18 an inpatient is present,

19 “(II) the facility may provide any  
20 services otherwise required to be pro-  
21 vided by a full-time, onsite dietician,  
22 pharmacist, laboratory technician,  
23 medical technologist, and radiological  
24 technologist on a part-time, offsite

1 basis under arrangements as defined  
2 in section 1861(w)(1), and

3 “(III) the inpatient care de-  
4 scribed in clause (vii) may be provided  
5 by a physician’s assistant, nurse prac-  
6 titioner, or clinical nurse specialist  
7 subject to the oversight of a physician  
8 who need not be present in the facil-  
9 ity, and

10 “(viii) meets the requirements of sub-  
11 paragraphs (C) through (I) of paragraph  
12 (2) of section 1861(aa), and of clauses (ii)  
13 and (iv) of the second sentence of that  
14 paragraph, except that in determining  
15 whether a facility meets the requirements  
16 of this subparagraph, subparagraphs (E)  
17 and (F) of that paragraph shall be applied  
18 as if any reference to ‘physician’ is a ref-  
19 erence to a physician as defined in section  
20 1861(r)(1).

21 “(B) CRITERIA FOR DESIGNATION AS MED-  
22 ICAL ASSISTANCE FACILITY.—A State may des-  
23 ignate a facility as a medical assistance facility  
24 only if the facility—

1           “(i) is located in a county (or equiva-  
2           lent unit of local government)—

3                   “(I) with fewer than 6 residents  
4                   per square mile; or

5                   “(II) in a rural area (as defined  
6                   in section 1886(d)(2)(D)) that is lo-  
7                   cated more than a 35-mile or 45-  
8                   minute drive from a hospital, a rural  
9                   primary care hospital, or another fa-  
10                  cility described in this subsection;

11                  “(ii) at the time such facility applies  
12                  to the State for designation as a medical  
13                  assistance facility—

14                   “(I) is a hospital (or in the case  
15                   of a facility that closed during the 12-  
16                   month period that ends on the date  
17                   the facility applies for such designa-  
18                   tion, at the time the facility closed),  
19                   with a participation agreement in ef-  
20                   fect under section 1866(a); or

21                   “(II) is licensed in accordance  
22                   with applicable State and local laws  
23                   and regulations;

1                   “(iii) meets the requirements of  
2                   clauses (iv), (vi), and (vii) of subparagraph  
3                   (A); and

4                   “(iv) meets the requirements of sub-  
5                   paragraph (I) of paragraph (2) of section  
6                   1861(aa).

7           “(e) RURAL HEALTH NETWORK DEFINED.—For  
8           purposes of this section, the term ‘rural health network’  
9           means, with respect to a State, an organization—

10                   “(1) consisting of—

11                           “(A) at least 1 facility that the State has  
12                           designated or plans to designate as a rural pri-  
13                           mary care hospital, and

14                           “(B) at least 1 hospital that furnishes  
15                           services that a rural primary care hospital can-  
16                           not furnish, and

17                   “(2) the members of which have entered into  
18           agreements regarding—

19                           “(A) patient referral and transfer,

20                           “(B) the development and use of commu-  
21                           nications systems, including (where feasible) te-  
22                           lemetry systems and systems for electronic  
23                           sharing of patient data,

1                   “(C) the provision of emergency and non-  
2                   emergency transportation among the members,  
3                   and

4                   “(D) credentialing and quality assurance.

5                   “(f) CERTIFICATION BY THE SECRETARY.—The Sec-  
6                   retary shall certify a facility as a rural primary care hos-  
7                   pital or medical assistance facility (as the case may be)  
8                   if the facility—

9                   “(1) is located in a State that has established  
10                  a limited service hospital program in accordance  
11                  with subsection (d);

12                  “(2) is designated as a rural primary care hos-  
13                  pital or medical assistance facility by the State in  
14                  which it is located; and

15                  “(3) meets such other criteria as the Secretary  
16                  may require.

17                  “(g) PERMITTING MAINTENANCE OF SWING BEDS.—  
18                  Nothing in this section shall be construed to prohibit a  
19                  State from designating or the Secretary from certifying  
20                  a facility as a rural primary care hospital or medical as-  
21                  sistance facility solely because, at the time the facility ap-  
22                  plies to the State for designation as a rural primary care  
23                  hospital or medical assistance facility, there is in effect  
24                  an agreement between the facility and the Secretary under  
25                  section 1883 under which the facility’s inpatient hospital

1 facilities are used for the furnishing of extended care serv-  
2 ices, except that the number of beds used for the fur-  
3 nishing of such services may not exceed the total number  
4 of licensed inpatient beds at the time the facility applies  
5 to the State for such designation (minus the number of  
6 inpatient beds used for providing inpatient care in a rural  
7 primary care facility pursuant to subsection (d)(2)(A)(vi)).  
8 The Secretary may establish additional conditions of par-  
9 ticipation for rural primary care hospitals with a substan-  
10 tial number of such beds. For purposes of the first sen-  
11 tence, the number of beds of the facility used for the fur-  
12 nishing of extended care services shall not include any  
13 beds of a unit of the facility that is licensed as a distinct-  
14 part skilled nursing facility at the time the facility applies  
15 to the State for designation as a rural primary care hos-  
16 pital or medical assistance facility.

17 “(h) GRANTS.—

18 “(1) LIMITED SERVICE HOSPITAL PROGRAM.—

19 The Secretary may award grants to States that have  
20 submitted applications in accordance with subsection  
21 (c) for—

22 “(A) engaging in activities relating to plan-  
23 ning and implementing a rural health care plan;

24 “(B) in the case of a rural primary care  
25 hospital program described in subsection

1 (d)(1)(A), engaging in activities relating to  
2 planning and implementing rural health net-  
3 works; and

4 “(C) designation of facilities as rural pri-  
5 mary care hospitals or medical assistance facili-  
6 ties.

7 “(2) RURAL EMERGENCY MEDICAL SERVICES.—

8 “(A) IN GENERAL.—The Secretary may  
9 award grants to States that have submitted ap-  
10 plications in accordance with subparagraph (B)  
11 for the establishment or expansion of a pro-  
12 gram for the provision of rural emergency med-  
13 ical services.

14 “(B) APPLICATION.—An application is in  
15 accordance with this subparagraph if the State  
16 submits to the Secretary at such time and in  
17 such form as the Secretary may require an ap-  
18 plication containing the assurances described in  
19 subparagraphs (A)(ii), (A)(iii), and (B) of sub-  
20 section (c)(1) and paragraph (3) of such sub-  
21 section.

22 “(i) STUDY ON CLINICALLY BASED ALTERNATIVE TO  
23 96-HOUR RULE.—The Secretary shall conduct a study on  
24 the feasibility of admitting patients to rural primary care  
25 hospitals and medical assistance facilities on a limited

1 DRG basis instead of using the 96-hour average length  
2 of stay criteria described in subsection (d)(2)(A)(vii).

3 “(j) WAIVER OF CONFLICTING PART A PROVI-  
4 SIONS.—The Secretary is authorized to waive such provi-  
5 sions of this part and part C as are necessary to conduct  
6 the program established under this section.

7 “(k) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated from the Federal Hos-  
9 pital Insurance Trust Fund—

10 “(1) for making grants under subsection (h)(1)  
11 to States that have established a rural primary care  
12 hospital program in the State under subsection  
13 (d)(1)(A), \$15,000,000 for each of fiscal years 1993  
14 through 1995; and

15 “(2) for making grants to all States under sub-  
16 section (h), \$25,000,000 in each of the fiscal years  
17 1996 through 1999.”.

18 (b) PART A AMENDMENTS RELATING TO RURAL PRI-  
19 MARY CARE HOSPITALS AND MEDICAL ASSISTANCE FA-  
20 CILITIES.—

21 (1) DEFINITIONS.—Section 1861 (42 U.S.C.  
22 1395x) is amended by adding at the end the fol-  
23 lowing new subsection:

1 “MEDICAL ASSISTANCE FACILITY; MEDICAL ASSISTANCE  
2 FACILITY SERVICES

3 “(oo)(1) The term ‘medical assistance facility’ means  
4 a facility certified by the Secretary as a medical assistance  
5 facility under section 1820(f).

6 “(2) The term ‘medical assistance facility services’  
7 means items and services, furnished to an inpatient for  
8 a medical assistance facility by such facility, that would  
9 be inpatient hospital services if furnished to an inpatient  
10 of a hospital by a hospital.”.

11 (2) COVERAGE AND PAYMENT.—(A)(i) Section  
12 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by  
13 striking “inpatient hospital services” the first place  
14 it appears and inserting “, inpatient hospital serv-  
15 ices and inpatient medical assistance facility serv-  
16 ices”; and

17 (ii) by striking “inpatient hospital services” the  
18 second place it appears and inserting “such serv-  
19 ices”.

20 (B) Section 1814 (42 U.S.C. 1395f) is amend-  
21 ed—

22 (i) in subsection (b), by striking “inpatient  
23 rural primary care hospital services,” and in-  
24 serting “inpatient rural primary care hospital  
25 services, other than a medical assistance facility

1 providing inpatient medical assistance facility  
2 services,”; and

3 (ii) by amending subsection (l) to read as  
4 follows:

5 “(l) PAYMENT FOR INPATIENT RURAL PRIMARY  
6 CARE SERVICES AND INPATIENT MEDICAL ASSISTANCE  
7 FACILITY SERVICES.—The amount of payment under this  
8 part for inpatient rural primary care services and inpa-  
9 tient medical assistance facility services is the reasonable  
10 costs of the rural primary care hospital or medical assist-  
11 ance facility in providing such services.”.

12 (3) TREATMENT OF MEDICAL ASSISTANCE FA-  
13 CILITIES AS PROVIDERS OF SERVICES.—(A) Section  
14 1861(u) (42 U.S.C. 1395x(u)) is amended by insert-  
15 ing “medical assistance facility,” after “rural primary  
16 care hospital,”.

17 (B) The first sentence of section 1864(a) (42  
18 U.S.C. 1395aa(a)) is amended by inserting “a med-  
19 ical assistance facility, as defined in section  
20 1861(oo)(1),” after “1861(mm)(1),”.

21 (C) The third sentence of section 1865(a) of  
22 such Act (42 U.S.C. 1395bb(a)) is amended by  
23 striking “or 1861(mm)(1)” and inserting  
24 “1861(mm)(1), or 1861(oo)(1),”.

1           (4) CONFORMING AMENDMENTS.—(A) Section  
2           1128A(b)(1) (42 U.S.C. 1320a–7a(b)(1)) is amend-  
3           ed—

4                   (i) by striking “or a rural primary care  
5                   hospital” the first place it appears and insert-  
6                   ing “, a rural primary care hospital, or a med-  
7                   ical assistance facility”; and

8                   (ii) by striking “or a rural primary care  
9                   hospital” the second place it appears and in-  
10                  serting “, the rural primary care hospital, or  
11                  the medical assistance facility”.

12           (B) Section 1128B(c) (42 U.S.C. 1320a–7b(c))  
13           is amended by inserting “medical assistance facil-  
14           ity,” after “rural primary care hospital,”.

15           (C) Section 1134 (42 U.S.C. 1320b–4) is  
16           amended by striking “or rural primary care hos-  
17           pitals” each place it appears and inserting “, rural  
18           primary care hospitals, or medical assistance facili-  
19           ties”.

20           (D) Section 1138(a)(1) (42 U.S.C. 1320b–  
21           8(a)(1)) is amended—

22                   (i) in the matter preceding subparagraph  
23                   (A), by striking “or rural primary care hos-  
24                   pital” and inserting “, rural primary care hos-  
25                   pital, or medical assistance facility”, and

1           (ii) in the matter preceding clause (i) of  
2           subparagraph (A), by striking “or rural pri-  
3           mary care hospital” and inserting “, rural pri-  
4           mary care hospital, or medical assistance facil-  
5           ity”.

6           (E) Section 1164(e) (42 U.S.C. 1320e–13(e)) is  
7           amended by inserting “medical assistance facilities,”  
8           after “rural primary care hospitals,”.

9           (F) Section 1816(c)(2)(C) (42 U.S.C.  
10          1395h(c)(2)(C)) is amended by inserting “medical  
11          assistance facility,” after “rural primary care hos-  
12          pital,”.

13          (G) Section 1833 (42 U.S.C. 1395l) is amend-  
14          ed—

15                 (i) in subsection (h)(5)(A)(iii)—

16                         (I) by striking “or rural primary care  
17                         hospital” and inserting “rural primary  
18                         care hospital, or medical assistance facil-  
19                         ity”; and

20                         (II) by striking “to the hospital” and  
21                         inserting “to the hospital or the facility”;

22                 (ii) in subsection (i)(1)(A), by inserting  
23                 “medical assistance facility,” after “rural pri-  
24                 mary care hospital,”;

1 (iii) in subsection (i)(3)(A), by striking “or  
2 rural primary care hospital services” and in-  
3 serting “rural primary care hospital services, or  
4 medical assistance facility services”;

5 (iv) in subsection (l)(5)(A), by inserting  
6 “medical assistance facility,” after “rural pri-  
7 mary care hospital,” each place it appears; and

8 (v) in subsection (l)(5)(C), by striking “or  
9 rural primary care hospital” each place it ap-  
10 pears and inserting “, rural primary care hos-  
11 pital, or medical assistance facility”.

12 (H) Section 1835(e) (42 U.S.C. 1395n(e)) is  
13 amended by adding at the end the following: “A  
14 medical assistance facility shall be considered a hos-  
15 pital for purposes of this subsection.”.

16 (I) Section 1842(b)(6)(A)(ii) (42 U.S.C.  
17 1395u(b)(6)(A)(ii)) is amended by inserting “med-  
18 ical assistance facility,” after “rural primary care  
19 hospital,”.

20 (J) Section 1861 (42 U.S.C. 1395x) is amend-  
21 ed—

22 (i) in the last sentence of subsection (e), by  
23 striking “1861(mm)(1))” and inserting  
24 “1861(mm)(1)) or a medical assistance facility  
25 (as defined in section 1861(oo)(1)).”,

1 (ii) in subsection (w)(1) by inserting “med-  
2 ical assistance facility,” after “rural primary  
3 care hospital,” and

4 (iii) in subsection (w)(2), by striking “or  
5 rural primary care hospital” each place it ap-  
6 pears and inserting “, rural primary care hos-  
7 pital, or medical assistance facility”.

8 (K) Section 1862(a)(14) (42 U.S.C.  
9 1395y(a)(14)) is amended by striking “or rural pri-  
10 mary care hospital” each place it appears and in-  
11 serting “, rural primary care hospital, or medical as-  
12 sistance facility”.

13 (L) Section 1866(a)(1) (42 U.S.C  
14 1395cc(a)(1)) is amended—

15 (i) in subparagraph (F)(ii), by inserting  
16 “medical assistance facilities,” after “rural pri-  
17 mary care hospitals,”;

18 (ii) in subparagraph (H)—

19 (I) in the matter preceding clause (i),  
20 by inserting “and in the case of medical  
21 assistance facilities which provide inpatient  
22 medical assistance facility services” after  
23 “rural primary care hospital services”; and

1 (II) in clauses (i) and (ii), by striking  
2 “hospital” each place it appears and in-  
3 serting “hospital or facility”;

4 (iii) in subparagraph (I)—

5 (I) in the matter preceding clause (i),  
6 by striking “or rural primary care hos-  
7 pital” and inserting “, a rural primary  
8 care hospital, or a medical assistance facil-  
9 ity”; and

10 (II) in clause (ii), by striking “the  
11 hospital” and inserting “the hospital or the  
12 facility”; and

13 (iv) in subparagraph (N)—

14 (I) in the matter preceding clause (i),  
15 by striking “and rural primary hospitals”  
16 and inserting “, rural primary care hos-  
17 pitals, and medical assistance facilities”;

18 (II) in clause (i), by striking “or rural  
19 primary care hospital,” and inserting “,  
20 rural primary care hospital, or medical as-  
21 sistance facility,”; and

22 (III) in clause (ii), by striking “hos-  
23 pital” and inserting “hospital or facility”.

24 (M) Section 1866(a)(3) (42 U.S.C.  
25 1395cc(a)(3)) is amended—

1 (i) by striking “rural primary care hos-  
 2 pital,” each place it appears in subparagraphs  
 3 (A) and (B) and inserting “rural primary care  
 4 hospital, medical assistance facility,” and

5 (ii) in subparagraph (C)(ii)(II), by striking  
 6 “rural primary care hospitals,” each place it  
 7 appears and inserting “rural primary care hos-  
 8 pitals, medical assistance facilities”.

9 (N) Section 1867(e)(5) (42 U.S.C.  
 10 1395dd(e)(5)) is amended by striking  
 11 “1861(mm)(1)” and inserting “1861(mm)(1) or a  
 12 medical assistance facility (as defined in section  
 13 1861(oo)(1)).”.

14 (c) PART B AMENDMENTS RELATING TO RURAL PRI-  
 15 MARY CARE HOSPITALS AND MEDICAL ASSISTANCE FA-  
 16 CILITIES.—

17 (1) COVERAGE.—(A) Section 1861(oo) (42  
 18 U.S.C. 1395x(oo)) as added by subsection (b)(1), is  
 19 amended by adding at the end the following new  
 20 paragraph:

21 “(3) The term ‘outpatient medical assistance facility  
 22 services’ means medical and other health services fur-  
 23 nished by a medical assistance facility on an outpatient  
 24 basis.”.

1           (B) Section 1832(a)(2) (42 U.S.C.  
2 1395k(a)(2)) is amended—

3           (i) in subparagraph (I), by striking “and”  
4 at the end;

5           (ii) in subparagraph (J), by striking the  
6 period at the end and inserting “; and”; and

7           (iii) by adding at the end the following new  
8 subparagraph:

9           “(K) outpatient medical assistance facility  
10 services (as defined in section 1861(oo)(3)).”.

11          (2) PAYMENT.—(A) Section 1833(a) (42 U.S.C.  
12 1395l(a)) is amended—

13           (i) in paragraph (2), in the matter pre-  
14 ceding subparagraph (A), by striking “and (I)”  
15 and inserting “(I), and (K)”;

16           (ii) in paragraph (6), by striking “and” at  
17 the end;

18           (iii) in paragraph (7), by striking the pe-  
19 riod at the end and inserting “; and”; and

20           (iv) by adding at the end the following new  
21 paragraph:

22           “(8) in the case of outpatient medical assist-  
23 ance facility services, the amounts described in sec-  
24 tion 1834(g).”.

1 (B) Section 1834(g) (42 U.S.C. 1395m(g)) is  
2 amended—

3 (i) in the subsection heading by inserting  
4 “AND OUTPATIENT MEDICAL ASSISTANCE FA-  
5 CILITY SERVICES” after “SERVICES”;

6 (ii) in paragraph (1), by striking “provided  
7 during a year before 1993 in a rural primary  
8 care hospital under this part shall be deter-  
9 mined by one of the following methods as elect-  
10 ed by the rural primary care hospital” and in-  
11 serting “in a rural primary care hospital or  
12 medical assistance facility under this part shall  
13 be determined by one of the following methods  
14 as elected by the rural primary care hospital or  
15 medical assistance facility”;

16 (iii) in paragraph (1)(A)(ii), by striking  
17 “outpatient rural primary care hospital serv-  
18 ices” each place it appears and inserting “out-  
19 patient rural primary care hospital services or  
20 outpatient medical assistance facility services”;  
21 and

22 (iv) in paragraph (1)(B), by striking “hos-  
23 pital” and inserting “hospital or facility”.

24 (d) PAYMENT CONTINUED TO DESIGNATED  
25 EACHs.—

1 (1) TERMINATION OF EACH DESIGNATION.—

2 Section 1820(i)(1)(A) (42 U.S.C. 1395l(4)(i)(1)(A))

3 is amended by inserting at the end the following new

4 flush sentence:

5 “The Secretary shall not designate any hospital as

6 an essential access community hospital on or after

7 July 1, 1994.”.

8 (2) PERMITTING PAYMENT TO PRIOR DES-

9 IGNATED EACHS.—Section 1886(d)(5)(D) (42

10 U.S.C. 1395ww(d)(5)(D)) is amended—

11 (A) in clause (iii)(III), by inserting “as

12 such section was in effect as of July 1, 1994”

13 before the period at the end; and

14 (B) in clause (v), by inserting “as such

15 section was in effect as of July 1, 1994” after

16 “1820(i)(1).”

17 (3) EFFECTIVE DATE.—The amendments made

18 by this subsection shall take effect on July 1, 1994.

19 (e) TECHNICAL AMENDMENT RELATING TO PART A

20 DEDUCTIBLE, COINSURANCE AND SPELL OF ILLNESS.—

21 (1) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)), as

22 amended by subsection (b)(2)(A), is amended—

23 (A) by striking “inpatient medical assistance fa-

24 cility services” and inserting “inpatient medical as-

25 sistance facility services, inpatient rural primary

1 care hospital services, or inpatient medical assist-  
2 ance facility services”; and

3 (B) by striking “and inpatient rural primary  
4 care hospital services”.

5 (2) Sections 1813(a) and 1813(b)(3)(A) (42 U.S.C.  
6 1395e(a), 1395e(b)(3)(A)) are each amended by striking  
7 “inpatient hospital services” each place it appears and in-  
8 serting “inpatient hospital services, inpatient rural pri-  
9 mary care hospital services, or inpatient medical assist-  
10 ance facility services,”.

11 (3) Section 1813(b)(3)(B) (42 U.S.C.  
12 1395e(b)(3)(B)) is amended by striking “inpatient hos-  
13 pital services” and inserting “inpatient hospital services,  
14 inpatient rural primary care hospital services, inpatient  
15 medical assistance facility services,”.

16 (4) Section 1861(a) (42 U.S.C. 1395x(a)) is amend-  
17 ed—

18 (A) in paragraph (1), by striking “inpatient  
19 hospital services” and inserting “inpatient hospital  
20 services, inpatient rural primary care hospital serv-  
21 ices, inpatient medical assistance facility services,”;  
22 and

23 (B) in paragraph (2), by striking “hospital”  
24 and inserting “hospital, rural primary care hospital,  
25 or medical assistance facility”.

1 (f) REPEAL OF DEVELOPMENT OF PPS SYSTEM FOR  
2 INPATIENT RURAL PRIMARY CARE HOSPITAL SERV-  
3 ICES.—

4 (1) IN GENERAL.—Section 1814(l) (42 U.S.C.  
5 1395f(l)) is amended by striking paragraph (2).

6 (2) CONFORMING AMENDMENTS.—Section  
7 1814(l)(1) (42 U.S.C. 1395F(l)(1)) is amended—

8 (A) by striking “(l)(1)” and inserting  
9 “(l)”;

10 (B) by redesignating subparagraphs (A)  
11 and (B) as paragraphs (1) and (2), respectively;

12 (C) in paragraph (2), as redesignated, by  
13 striking “paragraph” and inserting “sub-  
14 section”; and

15 (D) in the last sentence, by striking “para-  
16 graph” and inserting “subsection”.

17 (g) REPEAL OF DEVELOPMENT AND IMPLEMENTA-  
18 TION OF ALL INCLUSIVE PPS SYSTEM FOR OUTPATIENT  
19 RURAL PRIMARY CARE SERVICES.—

20 (1) IN GENERAL.—Section 1834(g) (42 U.S.C.  
21 1395m(g)), as amended by subsection (c)(2)(B), is  
22 amended by striking paragraph (2).

23 (2) CONFORMING AMENDMENTS.—Section  
24 1834(g)(1) (42 U.S.C. 1395m(g)(1)) is amended—

25 (A) by striking “(1) IN GENERAL.—”

1 (B) by redesignating subparagraph (A)  
2 and clauses (i) and (ii) of such subparagraph as  
3 paragraph (1) and subparagraphs (A) and (B)  
4 of such paragraph, respectively;

5 (C) by redesignating subparagraph (B) as  
6 paragraph (2);

7 (D) in paragraph (1)(A), as redesignated,  
8 by striking “subparagraph (B)”; and

9 (E) in paragraph (1)(B), as so redesign-  
10 ated, by striking “subparagraph” and insert-  
11 ing “paragraph”.

12 (h) EFFECTIVE DATE.—Except as otherwise pro-  
13 vided, the amendments made by this section shall apply  
14 to services furnished on or after October 1, 1994.

15 **SEC. 4112. SUBACUTE CARE STUDY.**

16 (a) STUDY.—The Secretary of Health and Human  
17 Services (hereafter in this section referred to as the “Sec-  
18 retary”) shall—

19 (1) define the level and type of care that should  
20 constitute subacute care;

21 (2) determine the appropriateness of furnishing  
22 subacute care in different settings by evaluating the  
23 quality of care and patient outcomes;

24 (3) determine the cost and effectiveness of pro-  
25 viding subacute care under the medicare program

1 under title XVIII of such Act to individuals who are  
2 eligible for benefits under part A of such title;

3 (4) determine the extent to which hospital DRG  
4 prospective payment rates under section 1886(d) of  
5 such Act (42 U.S.C. 1395ww(d)) are appropriate for  
6 the less restrictive institutional settings that provide  
7 subacute care; and

8 (5) study the relationships between institutions  
9 and their payment methodologies in order to develop  
10 ways in which to maximize the continuity of care for  
11 each patient episode in which subacute care is fur-  
12 nished.

13 (b) REPORT.—Not later than October 1, 1996, the  
14 Secretary shall submit to the Congress a report on the  
15 matters studied under subsection (a).

16 **PART 3—PROVISIONS RELATING TO PART B**

17 **SEC. 4201. UPDATES FOR PHYSICIANS' SERVICES.**

18 Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is  
19 amended—

20 (1) in subparagraph (A), by inserting after  
21 “subparagraph (B)” the following: “and, in the case  
22 of 1995, specified in subparagraph (C)”;

23 (2) by redesignating subparagraph (C) as sub-  
24 paragraph (D); and

1           (3) by inserting after subparagraph (B) the fol-  
2           lowing new subparagraph:

3                   “(C) SPECIAL PROVISION FOR 1995.—For  
4                   purposes of subparagraph (A), the conversion  
5                   factor specified in this subparagraph for 1995  
6                   is—

7                           “(i) in the case of physicians’ services  
8                           included in the category of primary care  
9                           services (as defined for purposes of sub-  
10                          section (j)(1)), the conversion factor estab-  
11                          lished under this subsection for 1994 re-  
12                          duced by 1 percent and adjusted by the  
13                          update established under paragraph (3) for  
14                          1995; and

15                           “(ii) in the case of any other physi-  
16                           cians’ services, the conversion factor estab-  
17                          lished under this subsection for 1994 re-  
18                          duced by 4.0 percent and adjusted by the  
19                          update established under paragraph (3) for  
20                          1995.”.

1 **SEC. 4202. SUBSTITUTION OF REAL GDP TO ADJUST FOR**  
2 **VOLUME AND INTENSITY; REPEAL OF RE-**  
3 **STRICTION ON MAXIMUM REDUCTION PER-**  
4 **MITTED IN DEFAULT UPDATE.**

5 (a) USE OF REAL GDP TO ADJUST FOR VOLUME  
6 AND INTENSITY.—Section 1848(f)(2)(A)(iii) (42 U.S.C.  
7 1395w-4(f)(2)(A)(iii)) is amended to read as follows:

8 “(iii) 1 plus the average per capita  
9 growth in the real gross domestic product  
10 (divided by 100) for the 5-fiscal-year pe-  
11 riod ending with the previous fiscal year  
12 (increased by 1.5 percentage points for the  
13 category of services consisting of primary  
14 care services), and”.

15 (b) REPEAL OF RESTRICTION ON MAXIMUM REDUC-  
16 TION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w-  
17 4(d)(3)(B)(ii)) is amended—

18 (1) in the heading, by inserting “IN CERTAIN  
19 YEARS” after “ADJUSTMENT”;

20 (2) in the matter preceding subclause (I), by  
21 striking “for a year”;

22 (3) in subclause (I), by adding “and” at the  
23 end;

24 (4) in subclause (II), by striking “, and” and  
25 inserting a period; and

26 (5) by striking subclause (III).

1 (c) REPEAL OF PERFORMANCE STANDARD FAC-  
2 TOR.—

3 (1) IN GENERAL.—Section 1848(f)(2) is  
4 amended by striking subparagraph (B) and redesignig-  
5 nating subparagraph (C) as subparagraph (B).

6 (2) CONFORMING AMENDMENT.—Section  
7 1848(f)(2)(A) is amended in the matter following  
8 clause (iv) by striking “1, multiplied by 100” and all  
9 that follows through “subparagraph (B))” and in-  
10 sserting “1 and multiplied by 100”.

11 (d) EFFECTIVE DATE.—

12 (1) VOLUME PERFORMANCE STANDARDS.—The  
13 amendments made by subsections (a) and (c) shall  
14 apply with respect to volume performance standards  
15 established beginning with fiscal year 1995.

16 (2) REPEAL OF RESTRICTION ON MAXIMUM RE-  
17 DUCTION.—The amendments made by subsection (b)  
18 shall apply to services furnished on or after January  
19 1, 1997.

20 **SEC. 4203. PAYMENT FOR PHYSICIANS' SERVICES RELAT-**  
21 **ING TO INPATIENT STAYS IN CERTAIN HOS-**  
22 **PITALS.**

23 (a) IN GENERAL.—

1           (1) LIMITATIONS DESCRIBED.—Part B of title  
2           XVIII (42 U.S.C. 1831 et seq.) is amended by in-  
3           serting after section 1848 the following new section:

4           “LIMITATIONS ON PAYMENT FOR PHYSICIANS’ SERVICES  
5           RELATING TO INPATIENT STAYS IN CERTAIN HOSPITALS

6           “SEC. 1849. (a) DEFINITIONS.—In this section, the  
7           following definitions apply:

8           “(1) HOSPITAL.—The term ‘hospital’ means a  
9           subsection (d) hospital as defined in section  
10          1886(d)(1)(B).

11          “(2) MEDICAL STAFF.—An individual fur-  
12          nishing a physician’s service is considered to be on  
13          the medical staff of a hospital—

14                 “(A) if (in accordance with requirements  
15                 for hospitals established by the Joint Commis-  
16                 sion on Accreditation of Health Organiza-  
17                 tions)—

18                         “(i) the individual is subject to by-  
19                         laws, rules, and regulations established by  
20                         the hospital to provide a framework for the  
21                         self-governance of medical staff activities;

22                         “(ii) subject to such bylaws, rules, and  
23                         regulations, the individual has clinical  
24                         privileges granted by the hospital’s gov-  
25                         erning body; and

1           “(iii) under such clinical privileges,  
2           the individual may provide physicians’  
3           services independently within the scope of  
4           the individual’s clinical privileges, or

5           “(B) if such physician provides at least one  
6           service to a medicare beneficiary in such hos-  
7           pital.

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

11          “(4) TEACHING HOSPITAL.—The term ‘teaching  
12          hospital’ means a hospital which has a teaching pro-  
13          gram approved as specified in section 1861(b)(6).

14          “(b) SERVICES SUBJECT TO REDUCTION.—

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

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

22                         “(B) whether such hospital-specific relative  
23                         value is projected to exceed the allowable aver-  
24                         age per admission relative value applicable to

1 the hospital for the following year under sub-  
2 section (c)(1).

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

17 “(3) TIMING OF DETERMINATION; NOTICE TO  
18 HOSPITALS AND CARRIERS.—Not later than October  
19 1 of each year (beginning with 1997), the Secretary  
20 shall notify the medical executive committee of each  
21 hospital (as set forth in the Standards of the Joint  
22 Commission on the Accreditation of Health Organi-  
23 zations) of the determinations made with respect to  
24 the medical staff of such hospital under paragraph  
25 (1).

1       “(c) DETERMINATION OF ALLOWABLE AVERAGE PER  
2       ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC  
3       PER ADMISSION RELATIVE VALUES.—

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

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

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

22              “(2) HOSPITAL-SPECIFIC PER ADMISSION REL-  
23      ATIVE VALUE.—

24              “(A) IN GENERAL.—The hospital-specific  
25      per admission relative value projected for a hos-

1           pital (other than a teaching hospital) for a cal-  
2           endar year shall be equal to the average per ad-  
3           mission relative value (as determined under sec-  
4           tion 1848(c)(2)) for physicians' services fur-  
5           nished to inpatients of the hospital by the hos-  
6           pital's medical staff (excluding interns and resi-  
7           dents) during the second year preceding such  
8           calendar year, adjusted for variations in case-  
9           mix and disproportionate share status among  
10          hospitals (as determined by the Secretary under  
11          subparagraph (C)).

12                 “(B) SPECIAL RULE FOR TEACHING HOS-  
13                 PITALS.—The hospital-specific per admission  
14                 relative value projected for a teaching hospital  
15                 in a calendar year shall be equal to the sum  
16                 of—

17                         “(i) the average per admission relative  
18                         value (as determined under section  
19                         1848(c)(2)) for physicians' services fur-  
20                         nished to inpatients of the hospital by the  
21                         hospital's medical staff (excluding interns  
22                         and residents) during the second year pre-  
23                         ceding such calendar year adjusted for  
24                         variations in case-mix, disproportionate  
25                         share status, and teaching status among

1 hospitals (as determined by the Secretary  
2 under subparagraph (C)); and

3 “(ii) the equivalent per admission rel-  
4 ative value (as determined under section  
5 1848(c)(2)) for physicians’ services fur-  
6 nished to inpatients of the hospital by in-  
7 terns and residents of the hospital during  
8 the second calendar year preceding such  
9 calendar year, adjusted for variations in  
10 case-mix, disproportionate share status,  
11 and teaching status among hospitals (as  
12 determined by the Secretary under sub-  
13 paragraph (C)). The Secretary shall deter-  
14 mine such equivalent relative value unit  
15 per admission for interns and residents  
16 based on the best available data for teach-  
17 ing hospitals and may make such adjust-  
18 ment in the aggregate.

19 “(C) ADJUSTMENT FOR TEACHING AND  
20 DISPROPORTIONATE SHARE HOSPITALS.—The  
21 Secretary shall adjust the allowable per admis-  
22 sion relative values otherwise determined under  
23 this paragraph to take into account the needs  
24 of teaching hospitals and hospitals receiving ad-  
25 ditional payments under subparagraphs (F) and

1 (G) of section 1886(d)(5). The adjustment for  
2 teaching status or disproportionate share shall  
3 not be less than zero.

4 “(d) AMOUNT OF REDUCTION.—The amount of pay-  
5 ment otherwise made under this part for a physician’s  
6 service that is subject to a reduction under subsection (b)  
7 during a year shall be reduced by 15 percent, in the case  
8 of a service furnished by a member of the medical staff  
9 of the hospital for which the Secretary determines under  
10 subsection (b)(1) that the hospital medical staff’s pro-  
11 jected relative value per admission exceeds the allowable  
12 average per admission relative value.

13 “(e) RECONCILIATION OF REDUCTIONS BASED ON  
14 HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION  
15 WITH ACTUAL RELATIVE VALUES.—

16 “(1) DETERMINATION OF ACTUAL AVERAGE  
17 PER ADMISSION RELATIVE VALUE.—Not later than  
18 October 1 of each year (beginning with 1999), the  
19 Secretary shall determine the actual average per ad-  
20 mission relative value (as determined pursuant to  
21 section 1848(c)(2)) for the physicians’ services fur-  
22 nished by members of a hospital’s medical staff to  
23 inpatients of the hospital during the previous year,  
24 on the basis of claims for payment for such services  
25 that are submitted to the Secretary not later than

1 90 days after the last day of such previous year. The  
2 actual average per admission relative value shall be  
3 adjusted by the appropriate case-mix, disproportion-  
4 ate share factor, and teaching factor for the hos-  
5 pital medical staff (as determined by the Secretary  
6 under subsection (c)(2)(C)).

7 “(2) RECONCILIATION WITH REDUCTIONS  
8 TAKEN.—

9 “(A) REIMBURSEMENT.—In the case of a  
10 hospital for which the payment amounts for  
11 physicians’ services furnished by members of  
12 the hospital’s medical staff to inpatients of the  
13 hospital were reduced under this section for a  
14 year—

15 “(i) if the actual average per admis-  
16 sion relative value for such hospital’s med-  
17 ical staff during the year (as determined  
18 by the Secretary under paragraph (1)) did  
19 not exceed the allowable average per ad-  
20 mission relative value applicable to the hos-  
21 pital’s medical staff under subsection  
22 (c)(1) for the year, the Secretary shall re-  
23 imburse the fiduciary agent for the medical  
24 staff by the amount by which payments for  
25 such services were reduced for the year

1 under subsection (d), including interest at  
2 an appropriate rate determined by the Sec-  
3 retary; and

4 “(ii) if the actual average per admis-  
5 sion relative value for such hospital’s med-  
6 ical staff during the year (as determined  
7 by the Secretary under paragraph (1)) ex-  
8 ceeded the allowable average per admission  
9 relative value applicable to the hospital’s  
10 medical staff under subsection (c)(1) for  
11 the year, the Secretary shall reimburse the  
12 fiduciary agent for the medical staff, as a  
13 percent of the total amount of payment  
14 otherwise determined under this part for  
15 physicians’ services furnished during the  
16 year to inpatients of the hospital by the  
17 hospital’s medical staff (prior to the reduc-  
18 tion under subsection (d)), the difference  
19 between 15 percentage points and the ac-  
20 tual number of percentage points that the  
21 medical staff exceeded the allowable aver-  
22 age per admission relative value, including  
23 interest at any appropriate rate determined  
24 by the Secretary.

1           “(B) NO REIMBURSEMENT.—The Sec-  
2           retary shall not pay the fiduciary agent for the  
3           medical staff of a hospital any amounts by  
4           which payments for physicians’ services pro-  
5           vided by the medical staff were reduced for a  
6           year under this section if the actual average per  
7           admission relative value for such hospital’s  
8           medical staff during the year (as determined by  
9           the Secretary under paragraph (1)) exceeded  
10          the allowable average per admission relative  
11          value applicable to the hospital’s medical staff  
12          under subsection (c)(1) for the year by 15 per-  
13          centage points or more.

14          “(3) MEDICAL EXECUTIVE COMMITTEE OF A  
15          HOSPITAL.—Each medical executive committee of a  
16          hospital whose medical staff is projected to exceed  
17          the allowable relative value per admission for a year,  
18          shall have 1 year from the date of notification that  
19          such medical staff is projected to exceed the allow-  
20          able relative value per admission to designate a fidu-  
21          ciary agent for the medical staff to receive and dis-  
22          burse any appropriate amounts withheld made by  
23          the carrier.

24          “(4) ALTERNATIVE REIMBURSEMENT TO MEM-  
25          BERS OF STAFF.—At the request of a fiduciary

1 agent for the medical staff, if the fiduciary agent for  
2 the medical staff is owed the reimbursement de-  
3 scribed in paragraph (2)(A)(ii) for excess reductions  
4 in payments during a year, the Secretary shall make  
5 such reimbursement to the members of the hospital's  
6 medical staff, on a pro-rata basis according to the  
7 proportion of physicians' services furnished to inpa-  
8 tients of the hospital during the year that were fur-  
9 nished by each member of the medical staff.

10 “(f) CLAIMS TO BE SUBMITTED NOT LATER THAN  
11 90 DAYS AFTER END OF YEAR.—Notwithstanding any  
12 other provision of law, no payment may be made under  
13 this part for any physician's service furnished by a mem-  
14 ber of the medical staff of a hospital to an inpatient of  
15 the hospital during a year unless the hospital submits a  
16 claim to the Secretary for the payment for such service  
17 not later than 90 days after the last day of the year.”.

18 (2) CONFORMING AMENDMENTS.—(A) Section  
19 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is  
20 amended by inserting “(subject to reduction under  
21 section 1849)” after “1848(a)(1)”.

22 (B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-  
23 4(a)(1)(B)) is amended by striking “this sub-  
24 section,” and inserting “this subsection and section  
25 1849,”.

1 (b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL  
 2 AT WHICH SERVICE FURNISHED.—Section  
 3 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is  
 4 amended by striking “beneficiary,” and inserting “bene-  
 5 ficiary (and, in the case of a service furnished to an inpa-  
 6 tient of a hospital, report the hospital identification num-  
 7 ber on such claim form),”.

8 (c) EFFECTIVE DATE.—The amendments made by  
 9 this section shall apply to services furnished on or after  
 10 January 1, 1998.

11 **SEC. 4204. CHANGES IN UNDERSERVED AREA BONUS PAY-**  
 12 **MENTS.**

13 (a) IN GENERAL.—Section 1833(m) (42 U.S.C.  
 14 1395l(m)) is amended—

15 (1) by inserting “(1)” after “(m),”

16 (2) by inserting “described in paragraph (2)”  
 17 after “physicians’ services”,

18 (3) by striking “10 percent” and inserting “the  
 19 applicable percent”,

20 (4) by striking “service” the last place it ap-  
 21 pears and inserting “services”, and

22 (5) by adding at the end the following new  
 23 paragraph:

24 “(2)(A) The applicable percent referred to in para-  
 25 graph (1) is 20 percent in the case of primary care serv-

1 ices, as defined in section 1842(i)(4), and 10 percent for  
2 services other than primary care services furnished in  
3 health professional shortage areas located in rural areas  
4 as defined in section 1886(d)(2)(D).

5 “(B) The Secretary shall reduce payments for all  
6 services (other than primary care services) for which pay-  
7 ment may be made under this section by such percentage  
8 as the Secretary determines necessary so that, beginning  
9 on the date of the enactment of the Health Security Act,  
10 the amendments made by section 4204(e) of such Act  
11 would not result in expenditures under this section that  
12 exceed the amount of such expenditures that would have  
13 been made if such amendment had not been made.”.

14 (b) EFFECTIVE DATE.—The amendments made by  
15 paragraph (1) are effective for services furnished on or  
16 after January 1, 1995.

17 **SEC. 4205. CORRECTION OF MVPS UPWARD BIAS.**

18 (a) IN GENERAL.—Section 1848(f)(2)(A)(iv) (42  
19 U.S.C. 1395w-4(f)(2)(A)(iv)) is amended by striking “in-  
20 cluding changes in law and regulations affecting the per-  
21 centage increase described in clause (i)” and inserting “ex-  
22 cluding anticipated responses to such changes”.

23 (b) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) shall apply with respect to performance

1 standard rates of increase determined for fiscal year 1995  
2 and succeeding fiscal years.

3 **SEC. 4206. DEMONSTRATION PROJECTS FOR MEDICARE**  
4 **STATE-BASED PERFORMANCE STANDARD**  
5 **RATE OF INCREASE.**

6 Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended  
7 by adding at the end the following new paragraph:

8 “(6) STATE-BASED PERFORMANCE STANDARD  
9 RATES OF INCREASE DEMONSTRATION PROJECTS.—

10 The Secretary shall establish demonstration projects  
11 in not more than 3 States under which a State  
12 elects State-based performance standard rates of in-  
13 crease to substitute for the national performance  
14 standard rates of increase established for the year  
15 under paragraph (2). The Secretary shall develop  
16 criteria for the establishment of such demonstration  
17 projects which shall include the requirement of  
18 budget-neutrality for payments made under this part  
19 with respect to physicians’ services furnished in a  
20 State participating in the demonstration project.”.

1 **SEC. 4207. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**  
2 **MENTS FOR CERTAIN OUTPATIENT HOSPITAL**  
3 **SERVICES.**

4 (a) **AMBULATORY SURGICAL CENTER PROCE-**  
5 **DURES.**—Section 1833(i)(3)(B)(i)(II) (42 U.S.C.  
6 1395l(i)(3)(B)(i)(II)) is amended—

7 (1) by striking “of 80 percent”; and

8 (2) by striking the period at the end and insert-  
9 ing the following: “, less the amount a provider may  
10 charge as described in clause (ii) of section  
11 1866(a)(2)(A).”.

12 (b) **RADIOLOGY SERVICES AND DIAGNOSTIC PROCE-**  
13 **DURES.**—Section 1833(n)(1)(B)(i)(II) (42 U.S.C.  
14 1395l(n)(1)(B)(i)(II)) is amended—

15 (1) by striking “of 80 percent”; and

16 (2) by striking the period at the end and insert-  
17 ing the following: “, less the amount a provider may  
18 charge as described in clause (ii) of section  
19 1866(a)(2)(A).”.

20 (c) **EFFECTIVE DATE.**—The amendments made by  
21 this section shall apply to services furnished during por-  
22 tions of cost reporting periods occurring on or after July  
23 1, 1994.

1 **SEC. 4208. EYE OR EYE AND EAR HOSPITALS.**

2 Section 1833(i)(4)(A) (42 U.S.C. 1395l(i)(4)(A)) is  
3 amended in the matter following clause (iii) by striking  
4 “January 1, 1995” and inserting “September 30, 1997”.

5 **SEC. 4209. IMPOSITION OF COINSURANCE ON LABORATORY**  
6 **SERVICES.**

7 (a) **IN GENERAL.**—Paragraphs (1)(D) and (2)(D) of  
8 section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

9 (1) by striking “(or 100 percent” and all that  
10 follows through “the first opinion))”; and

11 (2) by striking “100 percent of such negotiated  
12 rate” and inserting “80 percent of such negotiated  
13 rate”.

14 (b) **EFFECTIVE DATE.**—The amendments made by  
15 subsection (a) shall apply to tests furnished on or after  
16 January 1, 1995.

17 **SEC. 4210. APPLICATION OF COMPETITIVE ACQUISITION**  
18 **PROCESS FOR PART B ITEMS AND SERVICES.**

19 (a) **GENERAL RULE.**—Part B of title XVIII is  
20 amended by inserting after section 1846 the following:

21 “**COMPETITION ACQUISITION FOR ITEMS AND SERVICES**

22 “**SEC. 1847. (a) ESTABLISHMENT OF BIDDING**  
23 **AREAS.**—

24 “(1) **IN GENERAL.**—The Secretary shall estab-  
25 lish competitive acquisition areas for the purpose of  
26 awarding a contract or contracts for the furnishing

1 under this part of the items and services described  
2 in subsection (c) on or after January 1, 1995. The  
3 Secretary may establish different competitive acqui-  
4 sition areas under this subsection for different class-  
5 es of items and services under this part.

6 “(2) CRITERIA FOR ESTABLISHMENT.—The  
7 competitive acquisition areas established under para-  
8 graph (1) shall—

9 “(A) initially be, or be within, metropolitan  
10 statistical areas; and

11 “(B) be chosen based on the availability  
12 and accessibility of suppliers and the probable  
13 savings to be realized by the use of competitive  
14 bidding in the furnishing of items and services  
15 in the area.

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

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

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

1 service under this part unless the Secretary finds  
2 that the individual or entity meets quality standards  
3 specified by the Secretary for the furnishing of such  
4 item or service.

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

10 “(A) the quantity of items and services the  
11 entity shall provide; and

12 “(B) such other terms and conditions as  
13 the Secretary may require.

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

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

21 “(2) Enteral and parenteral nutrients and sup-  
22 plies.”.

23 (b) ITEMS AND SERVICES TO BE FURNISHED ONLY  
24 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)  
25 (42 U.S.C. 1395y(a)) is amended—

1           (1) by striking “or” at the end of paragraph  
2           (15);

3           (2) by striking the period at the end of para-  
4           graph (16) and inserting “; or”; and

5           (3) by inserting after paragraph (16) the fol-  
6           lowing new paragraph:

7           “(17) where such expenses are for an item or  
8           service furnished in a competitive acquisition area  
9           (as established by the Secretary under section  
10          1847(a)) by an individual or entity other than the  
11          supplier with whom the Secretary has entered into  
12          a contract under section 1847(b) for the furnishing  
13          of such item or service in that area, unless the Sec-  
14          retary finds that such expenses were incurred in a  
15          case of urgent need.”.

16          (c) REDUCTION IN PAYMENT AMOUNTS IF COMPETI-  
17          TIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUC-  
18          TION IN PAYMENTS.—Notwithstanding any other provi-  
19          sion of title XVIII of the Social Security Act, if the estab-  
20          lishment of competitive acquisition areas under section  
21          1847 of such Act (as added by subsection (a)) and the  
22          limitation of coverage for items and services under part  
23          B of such title to items and services furnished by providers  
24          with competitive acquisition contracts under such section  
25          during 1996 does not result in a reduction of at least 10

1 percent in the projected payment amount that would have  
2 applied to the items or services under part B if the items  
3 or services had not been furnished through competitive ac-  
4 quisition under such section in such year, the Secretary  
5 shall reduce for such year the payment amount for all such  
6 services by such percentage as the Secretary determines  
7 necessary to result in such a reduction for such year.

8 (d) **EFFECTIVE DATE.**—The amendments made by  
9 this section shall apply to items and services furnished  
10 under part B of title XVIII of the Social Security Act on  
11 or after January 1, 1995.

12 **SEC. 4211. APPLICATION OF COMPETITIVE ACQUISITION**  
13 **PROCEDURES FOR LABORATORY SERVICES.**

14 (a) **IN GENERAL.**—Section 1847(c), as added by sec-  
15 tion 4210, is amended by inserting after paragraph (2)  
16 the following new paragraph:

17 “(3) Clinical diagnostic laboratory tests.”.

18 (b) **REDUCTION IN FEE SCHEDULE AMOUNTS IF**  
19 **COMPETITIVE ACQUISITION FAILS TO ACHIEVE SAV-**  
20 **INGS.**—Section 1833(h) (42 U.S.C. 1395l(h)) is amended  
21 by adding at the end the following new paragraph:

22 “(7) Notwithstanding any other provision of this sub-  
23 section, if the Secretary applies the authority provided  
24 under section 1847 to establish competitive acquisition  
25 areas for the furnishing of clinical diagnostic laboratory

1 tests during 1996 and the application of such authority  
2 does not result in a reduction of at least 10 percent in  
3 the projected payment amount that would have applied to  
4 such tests under this section in such year if the tests had  
5 not been furnished through competitive acquisition under  
6 section 1847, the Secretary shall reduce for such year each  
7 payment amount for all such tests otherwise determined  
8 under the fee schedules and negotiated rates established  
9 under this subsection by such percentage as the Secretary  
10 determines necessary to result in such a reduction for such  
11 year.”.

12 **SEC. 4212. EXPANDED COVERAGE FOR PHYSICIAN ASSIST-**  
13 **ANTS AND NURSE PRACTITIONERS.**

14 (a) **COVERAGE IN OUTPATIENT SETTINGS.**—Section  
15 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

16 (1) in clause (i)—

17 (A) by striking “or” at the end of sub-  
18 clause (II); and

19 (B) by inserting “or (IV) in an outpatient  
20 setting as defined by the Secretary” following  
21 “shortage area,”; and

22 (2) in clause (ii), by striking “section 1919(a)”  
23 and inserting “section 1919(a) or in an outpatient  
24 setting as defined by the Secretary”.

1 (b) PAYMENT BASED ON PHYSICIAN FEE SCHED-  
2 ULE.—

3 (1) Section 1833(a)(1)(O) (42 U.S.C.  
4 1395l(a)(1)(O)) is amended—

5 (A) by striking “section 1861(s)(2)(K)(iii)  
6 (relating to nurse practitioner and clinical nurse  
7 specialist services provided in a rural area)”  
8 and inserting “section 1861(s)(2)(K)”;

9 (B) by striking “for services furnished on  
10 or after January 1, 1992,” and inserting “for  
11 services described in section 1861(s)(2)(K)(iii)  
12 furnished on or after January 1, 1992, and for  
13 services described in clauses (i), (ii), and (iv) of  
14 section 1861(s)(2)(K) furnished on or after  
15 January 1, 1997,”; and

16 (C) by striking “subsection (r)(2)” and in-  
17 serting “subsection (r)(2) or subparagraph (A)  
18 or (B) of section 1842(b)(12)”.

19 (2) Section 1842(b)(12)(A) (42 U.S.C.  
20 1395u(b)(12)(A)) is amended—

21 (A) by striking “and” at the end of clause  
22 (i);

23 (B) in clause (ii)(II), by inserting “and be-  
24 fore January 1, 1997,” after “January 1,  
25 1992,”;

1 (C) by striking the period at the end of  
2 clause (ii)(II) and inserting “; and”; and

3 (D) by inserting at the end the following  
4 clause:

5 “(iii) in the case of services furnished  
6 on or after January 1, 1997—

7 (I) in the case of services per-  
8 formed as an assistant at surgery, 65  
9 percent of the amount that would oth-  
10 erwise be recognized if performed by a  
11 physician who is serving as an assist-  
12 ant at surgery, and

13 (II) in the case of other serv-  
14 ices, 85 percent of the fee schedule  
15 amount provided under section  
16 1848.”.

17 (c) RURAL NURSE PRACTITIONERS AS ASSISTANTS  
18 AT SURGERY IN URBAN AREAS.—Section  
19 1861(s)(2)(K)(ii) (42 U.S.C. 1395x(s)(2)(K)(ii)), as  
20 amended by subsection (a)(2), is further amended by add-  
21 ing “or services as an assistant at surgery furnished by  
22 a nurse practitioner whose primary practice location (as  
23 defined by the Secretary) is in a rural area (as defined  
24 in section 1886(d)(2)(D)) to an individual who resides in  
25 a rural area when the service is furnished to such indi-

1 vidual in an urban area by such practitioner when such  
2 practitioner refers such individual to an urban area for  
3 the furnishing of services” after “as defined by the Sec-  
4 retary”.

5 (d) CONFORMING AMENDMENTS.—

6 (1) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4))  
7 is amended by striking “subsection (s)(2)(K)(i)” and  
8 inserting “subsection (s)(2)(K)”.

9 (2) Section 1862(a)(14) (42 U.S.C.  
10 1395y(a)(14)), as amended by section 4108(b)(4)(K),  
11 is amended by striking “section 1861(s)(2)(K)(i)”  
12 and inserting “section 1861(s)(2)(K)”.

13 (3) Section 1866(a)(1)(H) (42 U.S.C.  
14 1395cc(a)(1)(H)), as amended by section  
15 4108(b)(4)(L)(ii), is further amended by striking  
16 “section 1861(s)(2)(K)(i)” and inserting “section  
17 1861(s)(2)(K)”.

18 (e) EFFECTIVE DATE.—The amendments made by  
19 this section shall apply to services furnished on or after  
20 January 1, 1997.

21 **SEC. 4213. ELIMINATION OF BALANCE BILLING.**

22 Effective January 1, 1996, notwithstanding any pro-  
23 vision of title XVIII of the Social Security Act (42 U.S.C.  
24 1395 et seq.), a nonparticipating physician, or nonpartici-  
25 pating supplier or other person (as such terms are defined

1 in section 1842(i)(2) of such Act (42 U.S.C. 1395u(i)(2))  
2 may not receive payment for services or items under such  
3 title.

4 **SEC. 4214. DEVELOPMENT AND IMPLEMENTATION OF RE-**  
5 **SOURCE-BASED METHODOLOGY FOR PRAC-**  
6 **TICE EXPENSES.**

7 (a) DEVELOPMENT.—

8 (1) IN GENERAL.—The Secretary of Health and  
9 Human Services shall develop a methodology for im-  
10 plementing in 1997 a resource-based system for de-  
11 termining practice expense relative value units for  
12 each physician's service. The methodology utilized  
13 shall recognize the staff, equipment, and supplies  
14 used in the provision of various medical and surgical  
15 services in various settings.

16 (2) REPORT.—The Secretary shall transmit a  
17 report by January 1, 1996, on the methodology de-  
18 veloped under paragraph (1) to the Committee on  
19 Ways and Means and the Committee on Energy and  
20 Commerce of the House of Representatives and the  
21 Committee on Finance of the Senate. The report  
22 shall include a presentation of data utilized in devel-  
23 oping the methodology and an explanation of the  
24 methodology.

25 (b) IMPLEMENTATION.—

1           (1) IN GENERAL.—Section 1848(c)(2)(C)(ii)  
2           (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is amended—

3                   (A) by inserting “for the service for years  
4                   before 1997” before “equal to”,

5                   (B) by striking the period at the end of  
6                   subclause (II) and inserting a comma, and

7                   (C) by adding after and below subclause  
8                   (II) the following:

9                           “and for years beginning with 1997 based  
10                           on the relative practice expense resources  
11                           involved in furnishing the service.”.

12           (2) CONFORMING AMENDMENT.—Section  
13           1848(c)(3)(C)(ii) (42 U.S.C. 1395w-4(c)(3)(C)(ii))  
14           is amended by striking “The practice” and inserting  
15           “For years before 1997, the practice”.

16           (3) APPLICATION OF CERTAIN PROVISIONS.—In  
17           implementing the amendment made by paragraph  
18           (1)(C), the provisions of clauses (ii)(II) and (iii) of  
19           section 1848(c)(2)(B) of the Social Security Act  
20           shall apply in the same manner as they apply to ad-  
21           justments under clause (ii)(I) of such section.

22 **SEC. 4215. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.**

23           (a) IN GENERAL.—Subparagraph (B) of section  
24           1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended by

1 striking the period at the end and inserting “, except that  
2 such percentage increase shall—

3 “(i) be reduced by 2 percentage points  
4 for each of years 1995 and 1996;

5 “(ii) be reduced by 1.5 percentage  
6 points for 1997;

7 “(iii) be reduced by 2 percentage  
8 points for 1998; and

9 “(iv) be reduced by 1 percentage  
10 points for 1999.”.

11 (b) EFFECTIVE DATE.—The amendment made by  
12 this section shall be effective on the date of the enactment  
13 of this Act.

14 **SEC. 4216. GENERAL PART B PREMIUM.**

15 Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

16 (1) in paragraph (1)(A), by striking “and prior  
17 to January 1999”; and

18 (2) in paragraph (2), by striking “prior to Jan-  
19 uary 1998”.

20 **PART 4—PROVISIONS RELATING TO PARTS A**

21 **AND B**

22 **SEC. 4301. MEDICARE SECONDARY PAYER CHANGES.**

23 (a) EXTENSION OF DATA MATCH.—

24 (1) Section 1862(b)(5)(C) (42 U.S.C.  
25 1395y(b)(5)(C)) is amended by striking clause (iii).

1           (2) Section 6103(l)(12) of the Internal Revenue  
2           Code of 1986 is amended by striking subparagraph  
3           (F).

4           (b) REPEAL OF SUNSET ON APPLICATION TO DIS-  
5           ABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN  
6           100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C.  
7           1395y(b)(1)(B)(iii)) is amended—

8           (1) in the heading, by striking “SUNSET” and  
9           inserting “EFFECTIVE DATE”; and

10          (2) by striking “, and before October 1, 1998”.

11          (c) EXTENSION OF PERIOD FOR END STAGE RENAL  
12          DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42  
13          U.S.C. 1395y(b)(1)(C)) is amended in the second sentence  
14          by striking “and on or before October 1, 1998,”.

15       **SEC. 4302. INCREASE IN MEDICARE SECONDARY PAYER**  
16                               **COVERAGE FOR END STAGE RENAL DISEASE**  
17                               **SERVICES TO 24 MONTHS.**

18          (a) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C.  
19          1395y(b)(1)(C)), as amended by section 4301(c), is  
20          amended by striking the last sentence and inserting: “Ef-  
21          fective for items and services furnished on or after Janu-  
22          ary 1, 1996 (with respect to periods beginning on or after  
23          July 1, 1994), this subparagraph shall be applied by sub-  
24          stituting ‘24-month’ for ‘12-month’ each place it ap-  
25          pears.”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) shall apply to items and services provided  
3 on or after January 1, 1996.

4 **SEC. 4303. EXPANSION OF CENTERS OF EXCELLENCE.**

5 (a) IN GENERAL.—The Secretary of Health and  
6 Human Services shall use a competitive process to con-  
7 tract with centers of excellence for cataract surgery, coro-  
8 nary artery by-pass surgery, and such other services as  
9 the Secretary determines to be appropriate. Payment  
10 under title XVIII of the Social Security Act will be made  
11 for services subject to such contracts on the basis of nego-  
12 tiated or all-inclusive rates as follows:

13 (1) The center shall cover services provided in  
14 an urban area (as defined in section 1886(d)(2)(D)  
15 of the Social Security Act) for years beginning with  
16 fiscal year 1995.

17 (2) The amount of payment made by the Sec-  
18 retary to the center under title XVIII of the Social  
19 Security Act for services covered under the contract  
20 shall be less than the aggregate amount of the pay-  
21 ments that the Secretary would have made to the  
22 center for such services had the contract not been in  
23 effect.

24 (3) The Secretary shall make payments to the  
25 center on such a basis for the following services fur-

1 nished to individuals entitled to benefits under such  
2 title:

3 (A) Facility, professional, and related serv-  
4 ices relating to cataract surgery.

5 (B) Coronary artery bypass surgery and  
6 related services.

7 (C) Such other services as the Secretary  
8 and the center may agree to cover under the  
9 contract.

10 (b) REBATE OF PORTION OF SAVINGS.—In the case  
11 of any services provided under a contract conducted under  
12 subsection (a), the Secretary shall make a payment to  
13 each individual to whom such services are furnished (at  
14 such time and in such manner as the Secretary may pro-  
15 vide) in an amount equal to 10 percent of the amount by  
16 which—

17 (1) the amount of payment that would have  
18 been made by the Secretary under title XVIII of the  
19 Social Security Act to the center for such services if  
20 the services had not been provided under the con-  
21 tract, exceeds

22 (2) the amount of payment made by the Sec-  
23 retary under such title to the center for such serv-  
24 ices.

1 **SEC. 4304. REDUCTION IN ROUTINE COST LIMITS FOR**  
2 **HOME HEALTH SERVICES.**

3 (a) REDUCTION IN UPDATE TO MAINTAIN FREEZE  
4 IN 1996.—Section 1861(v)(1)(L)(i) (42 U.S.C.  
5 1395x(v)(1)(L)(i)) is amended—

6 (1) in subclause (II), by striking “or” at the  
7 end;

8 (2) in subclause (III), by striking “112 per-  
9 cent,” and inserting “and before July 1, 1996, 112  
10 percent, or”; and

11 (3) by inserting after subclause (III) the fol-  
12 lowing new subclause:

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

18 (b) BASING LIMITS IN SUBSEQUENT YEARS ON ME-  
19 DIAN OF COSTS.—

20 (1) IN GENERAL.—Section 1861(v)(1)(L)(i) (42  
21 U.S.C. 1395x(v)(1)(L)(i)), as amended by subsection  
22 (a), is amended in the matter following subclause  
23 (IV) by striking “the mean” and inserting “the me-  
24 dian”.

25 (2) ADJUSTMENT TO LIMITS.—Section  
26 1861(v)(1)(L)(ii) (42 U.S.C. 1395x(v)(1)(L)(ii)) is

1 amended by adding at the end the following new  
2 sentence: “The effect of the amendments made by  
3 656(b) of the Health Security Act shall not be con-  
4 sidered by the Secretary in making adjustments pur-  
5 suant to this clause.”.

6 (3) EFFECTIVE DATE.—The amendments made  
7 by paragraphs (1) and (2) shall apply to cost report-  
8 ing periods beginning on or after July 1, 1997.

9 **SEC. 4305. IMPOSITION OF 20 PERCENT COINSURANCE ON**  
10 **HOME HEALTH SERVICES UNDER MEDICARE.**

11 (a) PART A.—Section 1813(a) (42 U.S.C. 1395e(a))  
12 is amended by adding at the end the following new para-  
13 graph:

14 “(5) The amount payable for a home health service  
15 furnished to an individual under this part shall be reduced  
16 by a copayment amount equal to 20 percent of the average  
17 of all the per visit costs for such service furnished under  
18 this title determined under section 1861(v)(1)(L) (as de-  
19 termined by the Secretary on a prospective basis for serv-  
20 ices furnished during a calendar year).”.

21 (b) PART B.—Section 1833(a)(2) (42 U.S.C.  
22 1395l(a)(2)), as amended by section 4108(c)(2), is amend-  
23 ed—

1           (1) in subparagraph (A), by striking “to home  
2 health services,” and by striking the comma after  
3 “opinion”;

4           (2) in subparagraph (E), by striking “and” at  
5 the end;

6           (3) in subparagraph (F), by striking the semi-  
7 colon at the end and inserting “; and”; and

8           (4) by adding at the end the following new sub-  
9 paragraph:

10                   “(G) with respect to any home health serv-  
11 ice—

12                           “(i) the lesser of —

13                                   “(I) the reasonable cost of such  
14 service, as determined under section  
15 1861(v), or

16                                   “(II) the customary charges with  
17 respect to such service,

18 less the amount a provider may charge as  
19 described in clause (ii) of section  
20 1866(a)(2)(A), or

21                           “(ii) if such service is furnished by a  
22 public provider of services, or by another  
23 provider which demonstrates to the satis-  
24 faction of the Secretary that a significant  
25 portion of its patients are low-income (and

1 requests that payment be made under this  
2 clause), free of charge or at nominal  
3 charges to the public, the amount deter-  
4 mined in accordance with section  
5 1814(b)(2),  
6 less a copayment amount equal to 20 percent of  
7 the average of all per visit costs for such service  
8 furnished under this title determined under sec-  
9 tion 1861(v)(1)(L) (as determined by the Sec-  
10 retary on a prospective basis for services fur-  
11 nished during a calendar year);”.

12 (c) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i)  
13 (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

14 (1) by striking “deduction or coinsurance” and  
15 inserting “deduction, coinsurance, or copayment”;  
16 and

17 (2) by striking “or (a)(4)” and inserting  
18 “(a)(4), or (a)(5)”.

19 (d) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to services furnished on or after  
21 July 1, 1995.

1 **SEC. 4306. TERMINATION OF GRADUATE MEDICAL EDU-**  
2 **CATION PAYMENTS.**

3 (a) IN GENERAL.—Section 1886(h) (42 U.S.C.  
4 1395ww(h)) is amended by adding at the end the following  
5 new paragraph:

6 “(6) TERMINATION OF PAYMENTS ATTRIB-  
7 UTABLE TO COSTS OF TRAINING PHYSICIANS.—Not-  
8 withstanding any other provision of this section or  
9 section 1861(v), no payment may be made under  
10 this title for direct graduate medical education costs  
11 attributable to an approved medical residency train-  
12 ing program for any cost reporting period (or por-  
13 tion thereof) beginning on or after January 1,  
14 1997.”.

15 (b) PROHIBITION AGAINST RECOGNITION OF  
16 COSTS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as  
17 amended by section 4102(b), is amended by adding at the  
18 end the following new subparagraph:

19 “(U) Such regulations shall not include any provision  
20 for specific recognition of the costs of graduate medical  
21 education for hospitals for any cost reporting period (or  
22 portion thereof) beginning on or after January 1, 1997.  
23 Nothing in the previous sentence shall be construed to af-  
24 fect in any way payments to hospitals for the costs of any  
25 approved educational activities that are not described in  
26 such sentence.”.

1 **SEC. 4307. MEDICARE SELECT.**

2 (a) AMENDMENTS TO PROVISIONS RELATING TO  
3 MEDICARE SELECT POLICIES.—

4 (1) PERMITTING MEDICARE SELECT POLICIES  
5 IN ALL STATES.—Subsection (c) of section 4358 of  
6 the Omnibus Budget Reconciliation Act of 1990 is  
7 hereby repealed.

8 (2) REQUIREMENTS OF MEDICARE SELECT  
9 POLICIES.—Section 1882(t)(1) (42 U.S.C.  
10 1395ss(t)(1)) is amended to read as follows:

11 “(1)(A) If a medicare supplemental policy meets the  
12 requirements of the 1991 NAIC Model Regulation or 1991  
13 Federal Regulation and otherwise complies with the re-  
14 quirements of this section except that—

15 “(i) the benefits under such policy are re-  
16 stricted to items and services furnished by certain  
17 entities (or reduced benefits are provided when items  
18 or services are furnished by other entities), and

19 “(ii) in the case of a policy described in sub-  
20 paragraph (C)(i)—

21 “(I) the benefits under such policy are not  
22 one of the groups or packages of benefits de-  
23 scribed in subsection (p)(2)(A),

24 “(II) except for nominal copayments im-  
25 posed for services covered under part B of this  
26 title, such benefits include at least the core

1 group of basic benefits described in subsection  
2 (p)(2)(B), and

3 “(III) an enrollee’s liability under such pol-  
4 icy for physician’s services covered under part  
5 B of this title is limited to the nominal copay-  
6 ments described in subclause (II),

7 the policy shall nevertheless be treated as meeting  
8 those requirements if the policy meets the require-  
9 ments of subparagraph (B).

10 “(B) A policy meets the requirements of this sub-  
11 paragraph if—

12 “(i) full benefits are provided for items and  
13 services furnished through a network of entities  
14 which have entered into contracts or agreements  
15 with the issuer of the policy,

16 “(ii) full benefits are provided for items and  
17 services furnished by other entities if the services are  
18 medically necessary and immediately required be-  
19 cause of an unforeseen illness, injury, or condition  
20 and it is not reasonable given the circumstances to  
21 obtain the services through the network,

22 “(iii) the network offers sufficient access,

23 “(iv) the issuer of the policy has arrangements  
24 for an ongoing quality assurance program for items  
25 and services furnished through the network,

1           “(v)(I) the issuer of the policy provides to each  
2 enrollee at the time of enrollment an explanation  
3 of—

4           “(aa) the restrictions on payment under  
5 the policy for services furnished other than by  
6 or through the network,

7           “(bb) out of area coverage under the pol-  
8 icy,

9           “(cc) the policy’s coverage of emergency  
10 services and urgently needed care, and

11           “(dd) the availability of a policy through  
12 the entity that meets the 1991 Model NAIC  
13 Regulation or 1991 Federal Regulation without  
14 regard to this subsection and the premium  
15 charged for such policy, and

16           “(II) each enrollee prior to enrollment acknowl-  
17 edges receipt of the explanation provided under sub-  
18 clause (I), and

19           “(vi) the issuer of the policy makes available to  
20 individuals, in addition to the policy described in this  
21 subsection, any policy (otherwise offered by the  
22 issuer to individuals in the State) that meets the  
23 1991 Model NAIC Regulation or 1991 Federal Reg-  
24 ulation and other requirements of this section with-  
25 out regard to this subsection.

1 “(C)(i) A policy described in this subparagraph—

2 “(I) is offered by an eligible organization (as  
3 defined in section 1876(b)),

4 “(II) is not a policy or plan providing benefits  
5 pursuant to a contract under section 1876 or an ap-  
6 proved demonstration project described in section  
7 603(c) of the Social Security Amendments of 1983,  
8 section 2355 of the Deficit Reduction Act of 1984,  
9 or section 9412(b) of the Omnibus Budget Reconcili-  
10 ation Act of 1986, and

11 “(III) provides benefits which, when combined  
12 with benefits which are available under this title, are  
13 substantially similar to benefits under policies of-  
14 fered to individuals who are not entitled to benefits  
15 under this title.

16 “(ii) In making a determination under subclause (III)  
17 of clause (i) as to whether certain benefits are substan-  
18 tially similar, there shall not be taken into account, except  
19 in the case of preventive services, benefits provided under  
20 policies offered to individuals who are not entitled to bene-  
21 fits under this title which are in addition to the benefits  
22 covered by this title and which are benefits an entity must  
23 provide in order to meet the definition of an eligible orga-  
24 nization under section 1876(b)(1).”.

1 (b) RENEWABILITY OF MEDICARE SELECT POLI-  
2 CIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is  
3 amended—

4 (1) by striking “(1) Each” and inserting  
5 “(1)(A) Except as provided in subparagraph (B),  
6 each”;

7 (2) by redesignating subparagraphs (A) and  
8 (B) as clauses (i) and (ii), respectively; and

9 (3) by adding at the end the following new sub-  
10 paragraph:

11 “(B)(i) In the case of a policy that meets the  
12 requirements of subsection (t), an issuer may cancel  
13 or nonrenew such policy with respect to an indi-  
14 vidual who leaves the service area of such policy; ex-  
15 cept that, if such individual moves to a geographic  
16 area where such issuer, or where an affiliate of such  
17 issuer, is issuing medicare supplemental policies,  
18 such individual must be permitted to enroll in any  
19 medicare supplemental policy offered by such issuer  
20 or affiliate that provides benefits comparable to or  
21 less than the benefits provided in the policy being  
22 canceled or nonrenewed. An individual whose cov-  
23 erage is canceled or nonrenewed under this subpara-  
24 graph shall, as part of the notice of termination or  
25 nonrenewal, be notified of the right to enroll in other

1 medicare supplemental policies offered by the issuer  
2 or its affiliates.

3 “(ii) For purposes of this subparagraph, the  
4 term ‘affiliate’ shall have the meaning given such  
5 term by the 1991 NAIC Model Regulation.”.

6 (c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C.  
7 1395ss(t)(2)) is amended—

8 (1) by striking “(2)” and inserting “(2)(A)”;

9 (2) by redesignating subparagraphs (A), (B),  
10 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-  
11 spectively;

12 (3) in clause (iv), as redesignated—

13 (A) by striking “paragraph (1)(E)(i)” and  
14 inserting “paragraph (1)(B)(v)(I); and

15 (B) by striking “paragraph (1)(E)(ii)” and  
16 inserting “paragraph (1)(B)(v)(II)”;

17 (4) by striking “the previous sentence” and in-  
18 serting “this subparagraph”; and

19 (5) by adding at the end the following new sub-  
20 paragraph:

21 “(B) If the Secretary determines that an issuer of  
22 a policy approved under paragraph (1) has made a mis-  
23 representation to the Secretary or has provided the Sec-  
24 retary with false information regarding such policy, the  
25 issuer is subject to a civil money penalty in an amount

1 not to exceed \$100,000 for each such determination. The  
2 provisions of section 1128A (other than the first sentence  
3 of subsection (a) and other than subsection (b)) shall  
4 apply to a civil money penalty under this subparagraph  
5 in the same manner as such provisions apply to a penalty  
6 or proceeding under section 1128A(a).”.

7 (d) EFFECTIVE DATES.—

8 (1) NAIC STANDARDS.—If, within 9 months  
9 after the date of the enactment of this Act, the Na-  
10 tional Association of Insurance Commissioners  
11 (hereafter in this subsection referred to as the  
12 “NAIC”) makes changes in the 1991 NAIC Model  
13 Regulation (as defined in section 1882(p)(1)(A) of  
14 the Social Security Act) to incorporate the additional  
15 requirements imposed by the amendments made by  
16 this section, section 1882(g)(2)(A) of such Act shall  
17 be applied in each State, effective for policies issued  
18 to policyholders on and after the date specified in  
19 paragraph (3), as if the reference to the Model Reg-  
20 ulation adopted on June 6, 1979, were a reference  
21 to the 1991 NAIC Model Regulation (as so defined)  
22 as changed under this paragraph (such changed  
23 Regulation referred to in this subsection as the  
24 “1995 NAIC Model Regulation”).

1           (2) SECRETARY STANDARDS.—If the NAIC  
2 does not make changes in the 1991 NAIC Model  
3 Regulation (as so defined) within the 9-month period  
4 specified in paragraph (1), the Secretary of Health  
5 and Human Services (hereafter in this subsection re-  
6 ferred to as the “Secretary”) shall promulgate a reg-  
7 ulation and section 1882(g)(2)(A) of the Social Se-  
8 curity Act shall be applied in each State, effective  
9 for policies issued to policyholders on and after the  
10 date specified in paragraph (3), as if the reference  
11 to the Model Regulation adopted on June 6, 1979,  
12 were a reference to the 1991 NAIC Model Regula-  
13 tion (as so defined) as changed by the Secretary  
14 under this paragraph (such changed Regulation re-  
15 ferred to in this subsection as the “1995 Federal  
16 Regulation”).

17           (3) DATE SPECIFIED.—

18           (A) IN GENERAL.—Subject to subpara-  
19 graph (B), the date specified in this paragraph  
20 for a State is the earlier of—

21                   (i) the date the State adopts the 1995  
22 NAIC Model Regulation or the 1995 Fed-  
23 eral Regulation, or

24                   (ii) 1 year after the date the NAIC or  
25 the Secretary first adopts such regulations.

1 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
2 QUIRED.—In the case of a State which the Sec-  
3 retary identifies, in consultation with the NAIC,  
4 as—

5 (i) requiring State legislation (other  
6 than legislation appropriating funds) in  
7 order for medicare supplemental policies to  
8 meet the 1995 NAIC Model Regulation or  
9 the 1995 Federal Regulation, but

10 (ii) having a legislature which is not  
11 scheduled to meet in 1995 in a legislative  
12 session in which such legislation may be  
13 considered,

14 the date specified in this paragraph is the first  
15 day of the first calendar quarter beginning after  
16 the close of the first legislative session of the  
17 State legislature that begins on or after Janu-  
18 ary 1, 1996. For purposes of the previous sen-  
19 tence, in the case of a State that has a 2-year  
20 legislative session, each year of such session  
21 shall be deemed to be a separate regular session  
22 of the State legislature.

1       **Subtitle B—Medicaid Program**

2       **PART 1—INTEGRATION OF CERTAIN MEDICAID**  
 3       **ELIGIBLES INTO REFORMED HEALTH CARE**  
 4       **SYSTEM**

5       **SEC. 4601. LIMITING COVERAGE UNDER MEDICAID OF**  
 6               **ITEMS AND SERVICES COVERED UNDER**  
 7               **STANDARD BENEFIT PACKAGE.**

8       (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et  
 9 seq.) is amended by redesignating section 1931 as section  
 10 1932 and by inserting after section 1930 the following new  
 11 section:

12               “TREATMENT OF ITEMS AND SERVICES IN THE  
 13               STANDARD BENEFIT PACKAGE

14               “SEC. 1931. (a) ITEMS AND SERVICES COVERED  
 15 UNDER STANDARD BENEFIT PACKAGE.—Except as pro-  
 16 vided in subsection (c), a State plan under this part shall  
 17 not provide medical assistance consisting of payment for  
 18 items and services in the standard benefit package de-  
 19 scribed in section 1201(a) of the Health Security Act.

20               “(b) MEDICAL ASSISTANCE NOT AFFECTED.—Sub-  
 21 section (a) shall not be construed as—

22                       “(1) affecting the eligibility of any individual  
 23 for medical assistance consisting of payment for  
 24 items and services not covered under the standard  
 25 benefits package;

1           “(2) affecting the amount, duration, and scope  
2 of any medical assistance consisting of payment for  
3 the items and services described in paragraph (1); or

4           “(3) prohibiting payment of medical assistance  
5 for items and services covered under the standard  
6 benefits package to the extent that the items and  
7 services under this part exceed the items and serv-  
8 ices covered under such package with respect to  
9 amount, duration, and scope.

10          “(c) EXCEPTIONS.—Subsection (a) shall not affect  
11 the provision of medical assistance consisting of payment  
12 for items and services in the standard benefits package—

13           “(1) which are provided to—

14           “(A) an individual eligible for medical as-  
15 sistance under the State plan who is not a pre-  
16 mium subsidy eligible individual (as defined in  
17 6002(a)(2) of the Health Security Act);

18           “(B) an individual with respect to whom  
19 supplemental security income benefits are being  
20 paid under title XVI; and

21           “(C) an individual who is eligible for bene-  
22 fits under part A of title XVIII; or

23           “(2) which consist of emergency services to cer-  
24 tain aliens under section 1903(v)(2).

25          “(d) STATE MAINTENANCE OF EFFORT.—

1 “(1) IN GENERAL.—

2 “(A) REDUCTION IN QUARTERLY PAY-  
3 MENTS.—For any calendar quarter in an appli-  
4 cable year (as defined in subparagraph (B)),  
5 the amount otherwise payable to a State under  
6 section 1903 for the quarter shall be reduced by  
7 the State maintenance of effort amount for the  
8 quarter determined under paragraph (2).

9 “(B) APPLICABLE YEAR.—For purposes of  
10 this paragraph, the term ‘applicable year’  
11 means 1997 and any succeeding year.

12 “(2) MAINTENANCE OF EFFORT AMOUNT.—

13 “(A) IN GENERAL.—The maintenance of  
14 effort amount for a State for a calendar quarter  
15 in an applicable year shall be equal to 25 per-  
16 cent of the sum of—

17 “(i) the State’s AFDC eligibles pay-  
18 ment amount for the year determined  
19 under paragraph (3); and

20 “(ii) the State’s non-cash eligibles  
21 payment amount for the year determined  
22 under paragraph (4).

23 “(3) STATE AFDC ELIGIBLES PAYMENT  
24 AMOUNT.—

1           “(A) IN GENERAL.—The AFDC eligibles  
2 payment amount for a State for a year is an  
3 amount equal to the product of—

4           “(i) the adjusted State per capita  
5 amount for the year determined under sub-  
6 paragraph (B); multiplied by

7           “(ii) the number of AFDC eligible in-  
8 dividuals receiving premium assistance  
9 under section 6002 of the Health Security  
10 Act during the year (as estimated by the  
11 Secretary).

12           “(B) ADJUSTED STATE PER CAPITA  
13 AMOUNT.—

14           “(i) IN GENERAL.—The adjusted  
15 State per capita amount for a year is the  
16 base State per capita amount determined  
17 under clause (ii) updated by the percentage  
18 change in per capita health expenditures  
19 index (as described in paragraph (5)(B))  
20 during the period beginning on October 1,  
21 1994, and ending on December 31 of the  
22 year preceding the applicable year (as de-  
23 termined by the Secretary).

24           “(ii) BASE STATE PER CAPITA  
25 AMOUNT.—The base per capita amount for

1 a State shall be an amount, as determined  
2 by the Secretary, equal to the quotient  
3 of—

4 “(I) the total expenditures from  
5 State funds made under the State  
6 plan during fiscal year 1994 with re-  
7 spect to medical assistance consisting  
8 of items and services of the type in-  
9 cluded in the standard benefit pack-  
10 age for AFDC eligible individuals; di-  
11 vided by

12 “(II) the average total number of  
13 AFDC eligible individuals who re-  
14 ceived such medical assistance under  
15 the State plan in any month during  
16 fiscal year 1994.

17 “(iii) DISPROPORTIONATE SHARE PAY-  
18 MENTS NOT INCLUDED.—In applying  
19 clause (ii), payments made under section  
20 1923 shall not be counted in the gross  
21 amount of payments.

22 “(C) AFDC ELIGIBLE DEFINED.—For  
23 purposes of this paragraph, the term ‘AFDC el-  
24 igible’ means an individual who receives aid or

1 assistance under any plan of the State approved  
2 under part A or part E of title IV.

3 “(4) NON-CASH ELIGIBLES PAYMENT  
4 AMOUNT.—

5 “(A) IN GENERAL.—The non-cash eligibles  
6 payment amount for a State for a year is an  
7 amount equal to the State’s base payment  
8 amount (determined under subparagraph (B))  
9 for the applicable year updated by the percent-  
10 age change in the health expenditures index (as  
11 described in paragraph (5)(A)) and the State  
12 population index (as described in paragraph  
13 (5)(C)) during the period beginning on October  
14 1, 1994, and ending on December 31 of the  
15 year preceding the applicable year (as deter-  
16 mined by the Secretary).

17 “(B) STATE BASE PAYMENT AMOUNT.—

18 “(i) IN GENERAL.—The base payment  
19 amount for a State for an applicable year  
20 shall be an amount, as determined by the  
21 Secretary, equal to the total expenditures  
22 from State funds made under the State  
23 plan during fiscal year 1994 with respect  
24 to medical assistance consisting of items  
25 and services of the type included in the

1 standard benefit package for non-cash eli-  
2 gible individuals who would not have re-  
3 ceived such medical assistance if the provi-  
4 sions of this section and subtitle A of title  
5 VI of the Health Security Act had been in  
6 effect in fiscal year 1994.

7 “(ii) DISPROPORTIONATE SHARE PAY-  
8 MENTS INCLUDED.—In applying clause (i),  
9 payments made under section 1923 shall  
10 be counted in the gross amount of pay-  
11 ments.

12 “(C) NON-CASH ELIGIBLE DEFINED.—For  
13 purposes of this paragraph, the term ‘non-cash  
14 eligible’ means any individual who received  
15 medical assistance under the State plan during  
16 fiscal year 1994 other than an AFDC eligible  
17 individual or an individual described in sub-  
18 section (b).

19 “(5) INDEXES.—

20 “(A) HEALTH EXPENDITURES INDEX.—  
21 The Secretary shall establish a health expendi-  
22 tures index which measures the change in na-  
23 tional health expenditures from year to year.

24 “(B) PER CAPITA HEALTH EXPENDITURES  
25 INDEX.—The Secretary shall establish a per

1           capita health expenditures index which meas-  
2           ures the change in national per capita health  
3           expenditures from year to year.

4           “(C) STATE POPULATION INDEX.—The  
5           Secretary shall establish a State population  
6           index which measures the change in the number  
7           of individuals residing in a State from year to  
8           year.”.

9           (b) NO FEDERAL FINANCIAL PARTICIPATION.—Sec-  
10          tion 1903(i) (42 U.S.C. 1396b(i)) is amended—

11           (1) by striking “or” at the end of paragraph  
12          (14),

13           (2) by striking the period at the end of para-  
14          graph (15) and inserting “; or”, and

15           (3) by inserting after paragraph (15) the fol-  
16          lowing new paragraph:

17           “(16) with respect to items and services covered  
18          under the standard benefit package described in sec-  
19          tion 1201(a) of the Health Security Act for individ-  
20          uals to whom section 1931(a) applies.”.

21           (c) EFFECTIVE DATE.—The amendments made by  
22          this section shall apply with respect to items or services  
23          furnished in a State on or after January 1, 1997.

1     **PART 2—COORDINATED CARE SERVICES FOR**  
2                   **DISABLED MEDICAID ELIGIBLES**  
3     **SEC. 4605. COORDINATED CARE SERVICES FOR DISABLED**  
4                   **MEDICAID ELIGIBLES.**

5           (a) STATE EXPENDITURES LIMITED TO CERTIFIED  
6 HEALTH PLANS.—Section 1903(m) (42 U.S.C. 1396b) is  
7 amended by adding at the end the following new para-  
8 graph:

9                   “(7) No payment shall be made under this part  
10           to a State with respect to expenditures incurred by  
11           the State for payment for services provided by an  
12           entity with a contract under this subsection unless  
13           such entity is a standard health plan (as defined in  
14           section 1011(2)(B) of the Health Security Act).”.

15           (b) MODIFICATION TO 75/25 RULE.—Section  
16 1903(m)(2)(A)(ii) (42 U.S.C. 1396b(m)(2)(A)(ii)) is  
17 amended by striking “75 percent” and inserting “50 per-  
18 cent”.

19           (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall become effective with respect to pay-  
21 ments for calendar quarters beginning on or after January  
22 1, 1997.

1     **PART 3—PAYMENTS TO HOSPITALS SERVING**

2                     **VULNERABLE POPULATIONS**

3     **SEC. 4611. REPLACEMENT OF DSH PAYMENT PROVISIONS**

4                     **WITH PROVISIONS RELATING TO PAYMENTS**

5                     **TO HOSPITALS SERVING VULNERABLE POPU-**

6                     **LATIONS.**

7             (a) AMENDMENTS TO PROVISIONS REQUIRING  
8 STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—

9                     (1) ADJUSTMENTS TO NATIONAL DSH PAYMENT  
10             LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r-  
11             4(f)(1)(B)) is amended to read as follows:

12                             “(B) NATIONAL DSH PAYMENT LIMIT.—

13                                     “(i) IN GENERAL.—Except as pro-  
14                                     vided in clause (ii), the national DSH pay-  
15                                     ment limit for a fiscal year is equal to 12  
16                                     percent of the total amount of expenditures  
17                                     under the State plans under this part for  
18                                     medical assistance during the fiscal year.

19                                     “(ii) REDUCTION IN LIMIT.—For fis-  
20                                     cal years ending in a calendar year during  
21                                     which the percentage of individuals covered  
22                                     by insurance, as determined by the Na-  
23                                     tional Health Care Cost and Coverage  
24                                     Commission established under section  
25                                     10001 of the Health Security Act—

1                   “(I) equals or exceeds 85 percent  
2 but is less than 88 percent, ‘10 per-  
3 cent’ shall be substituted for ‘12 per-  
4 cent’ in clause (i);

5                   “(II) equals or exceeds 88 per-  
6 cent but is less than 90 percent, ‘8  
7 percent’ shall be substituted for ‘12  
8 percent’ in clause (i);

9                   “(III) equals or exceeds 90 per-  
10 cent but is less than 92 percent, ‘6  
11 percent’ shall be substituted for ‘12  
12 percent’ in clause (i); and

13                   “(IV) equals or exceeds 92 per-  
14 cent, ‘4 percent’ shall be substituted  
15 for ‘12 percent’ in clause (i).

16                   (2) ADJUSTMENTS TO STATE ALLOTMENT LIM-  
17 ITS.—Section 1923(f)(2)(B) (42 U.S.C. 1396r-  
18 4(f)(2)(B)) is amended to read as follows:

19                   “(B) EXCEPTIONS.—

20                   “(i) IN GENERAL.—Except as pro-  
21 vided in clause (ii), a State DSH allotment  
22 under subparagraph (A) for a fiscal year  
23 shall not exceed 12 percent of the total  
24 amount of expenditures under the State

1 plan for medical assistance during the fis-  
2 cal year.

3 “(ii) REDUCTION IN LIMIT.—For fis-  
4 cal years ending in a calendar year during  
5 which the percentage of individuals covered  
6 by insurance, as determined by the Na-  
7 tional Health Care Cost and Coverage  
8 Commission established under section  
9 10001 of the Health Security Act—

10 “(I) equals or exceeds 85 percent  
11 but is less than 88 percent, ‘10 per-  
12 cent’ shall be substituted for ‘12 per-  
13 cent’ in clause (i);

14 “(II) equals or exceeds 88 per-  
15 cent but is less than 90 percent, ‘8  
16 percent’ shall be substituted for ‘12  
17 percent’ in clause (i);

18 “(III) equals or exceeds 90 per-  
19 cent but is less than 92 percent, ‘6  
20 percent’ shall be substituted for ‘12  
21 percent’ in clause (i); and

22 “(IV) equals or exceeds 92 per-  
23 cent, ‘4 percent’ shall be substituted  
24 for ‘12 percent’ in clause (i).

1           (3) ELIMINATION OF HIGH DSH STATES AND  
2 STATE SUPPLEMENTAL AMOUNTS.—

3           (A) IN GENERAL.—Section 1923(f)(2)(A)  
4 (42 U.S.C. 1396r-4(f)(2)(A)) is amended to  
5 read as follows:

6           “(A) IN GENERAL.—Subject to subpara-  
7 graph (B), the State DSH allotment for a fiscal  
8 year is equal to the State DSH allotment for  
9 the previous fiscal year increased by the State  
10 growth factor (as defined in paragraph (3)(B))  
11 for the fiscal year.”.

12           (B) CONFORMING AMENDMENTS.—(i) Sec-  
13 tion 1923(f) (42 U.S.C. 1396r-4(f)) is amended  
14 by striking paragraph (3) and redesignating  
15 paragraph (4) as paragraph (3).

16           (ii) Section 1923(f)(3) (42 U.S.C. 1396r-  
17 4(f)(3)), as redesignated by clause (i), is  
18 amended by striking subparagraphs (A) and  
19 (C) and redesignating subparagraphs (B), (D),  
20 and (E) as subparagraphs (A), (B), and (C).

21           (iii) Section 1923(f)(3)(B) (42 U.S.C.  
22 1396r-4(f)(3)(B)), as redesignated by clauses  
23 (i) and (ii), is amended to read as follows:

24           “(B) STATE GROWTH AMOUNT.—The term  
25 ‘State growth amount’ means, with respect to a

1 State for a fiscal year, the product of the State  
2 growth factor and the State DSH payment  
3 limit for the previous fiscal year.”.

4 (iv) Section 1923(f)(1)(A) (42 U.S.C.  
5 1396r-4(f)(1)(A) is amended by striking “(as  
6 defined in paragraph (4)(B))” and inserting  
7 “(as defined in paragraph (3)(A))”.

8 (3) TERMINATION OF REQUIREMENT ON  
9 STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—  
10 Section 1923 (42 U.S.C. 1396r-4) is amended by  
11 adding at the end the following new subsection:

12 “(h) TERMINATION OF REQUIREMENT TO MAKE  
13 PAYMENT ADJUSTMENTS.—

14 “(1) IN GENERAL.—Any requirement imposed  
15 by this section on a State to increase the rate or  
16 amount of payment for inpatient hospital services  
17 provided by a hospital which serves a dispropor-  
18 tionate number of low income patients with special  
19 needs shall terminate in the year described in para-  
20 graph (2).

21 “(2) YEAR DESCRIBED.—The year described in  
22 this paragraph is the first year beginning after the  
23 year during which the percentage of individuals cov-  
24 ered by insurance, as determined by the National  
25 Health Care Cost and Coverage Commission estab-

1 lished under section 100001 of the Health Security  
2 Act, equals or exceeds 92 percent.”.

3 (4) NO FEDERAL FINANCIAL PARTICIPATION.—  
4 Section 1903(i) (42 U.S.C. 1396b(i)), as amended  
5 by section 4601(b), is amended—

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

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

10 (C) by inserting after paragraph (16) the  
11 following new paragraph:

12 “(17) during or after the year described in sec-  
13 tion 1923(h)(2) with respect to any payment made  
14 by a State to a hospital which serves a dispropor-  
15 tionate number of low income patients with special  
16 needs that is in excess of the payment otherwise re-  
17 quired under this part.”.

18 (5) EFFECTIVE DATE.—The amendments made  
19 by this section shall be effective for calendar quar-  
20 ters beginning on or after January 1, 1997.

21 (b) PAYMENTS TO HOSPITALS SERVING VULNER-  
22 ABLE POPULATIONS.—Title XIX (42 U.S.C. 1396 et seq.)  
23 is amended by adding at the end the following new part:

1     **“PART B—PAYMENTS TO HOSPITALS SERVING**  
2                     **VULNERABLE POPULATIONS**

3     **“SEC. 1951. PAYMENTS TO HOSPITALS.**

4             “(a) ENTITLEMENT STATUS.—The Secretary shall  
5 make payments in accordance with this part to eligible  
6 hospitals described in section 1952. The preceding sen-  
7 tence constitutes budget authority in advance of appro-  
8 priations Acts and represents the obligation of the Federal  
9 Government to provide funding for such payments in the  
10 amounts, and for the fiscal years, specified in subsection  
11 (b).

12            “(b) AMOUNT OF ENTITLEMENT.—For purposes of  
13 subsection (a), the amounts and fiscal years specified in  
14 this subsection are (in the aggregate for all eligible hos-  
15 pitals) \$2,500,000,000 for the first applicable fiscal year  
16 (as defined in section 1954) and for each subsequent fiscal  
17 year.

18            “(c) PAYMENTS MADE ON QUARTERLY BASIS.—Pay-  
19 ments to an eligible hospital under this section for a year  
20 shall be made on a quarterly basis during the year.

21     **“SEC. 1952. IDENTIFICATION OF ELIGIBLE HOSPITALS.**

22            “(a) HOSPITALS IN PARTICIPATING STATES.—In  
23 order to be an eligible hospital under this part, a hospital  
24 must be located in a State that is a participating State  
25 under title I of the Health Security Act.

1       “(b) STATE IDENTIFICATION.—In accordance with  
2 the criteria described in subsection (c) and such proce-  
3 dures as the Secretary may require, each State shall iden-  
4 tify the hospitals in the State that meet such criteria and  
5 provide the Secretary with a list of such hospitals.

6       “(c) CRITERIA FOR ELIGIBILITY.—A hospital meets  
7 the criteria described in this subsection if the hospital’s  
8 low-income utilization rate for the base year under section  
9 1923(b)(3) (as such section is in effect on the day before  
10 the date of the enactment of this part) is not less than  
11 25 percent.

12 **“SEC. 1953. AMOUNT OF PAYMENTS.**

13       “(a) IN GENERAL.—The total amount available for  
14 payments under this part in a year shall be allocated to  
15 hospitals for low-income assistance in accordance with this  
16 subsection.

17       “(b) DETERMINATION OF HOSPITAL PAYMENT  
18 AMOUNT.—The amount of payment to an eligible hospital  
19 during a year shall be the equal to the hospital’s low-in-  
20 come percentage (as defined in subsection (c)) of the total  
21 amount available for payments under this part for the  
22 year.

23       “(c) LOW-INCOME PERCENTAGE DEFINED.—

24               “(1) IN GENERAL.—For purposes of this sec-  
25 tion, an eligible hospital’s ‘low-income percentage’

1 for a year is equal to the amount (expressed as a  
2 percentage) of the total low-income days for all eligi-  
3 ble hospitals for the year that are attributable to the  
4 hospital.

5 “(2) LOW-INCOME DAYS DESCRIBED.—For pur-  
6 poses of paragraph (1), an eligible hospital’s low-in-  
7 come days for a year shall be equal to the product  
8 of—

9 “(A) the total number of inpatient days for  
10 the hospital for the year (as reported to the  
11 Secretary by the State in which the hospital is  
12 located, in accordance with a reporting schedule  
13 and procedures established by the Secretary);  
14 and

15 “(B) the hospital’s low-income utilization  
16 rate for the base year under section 1923(b)(3)  
17 (as such section is in effect on the day before  
18 the date of the enactment of this part).

19 **“SEC. 1954. DEFINITIONS.**

20 “For purposes of this part:

21 “(1) BASE YEAR.—The term ‘base year’ means  
22 1996.

23 “(2) FIRST APPLICABLE FISCAL YEAR.—The  
24 term ‘first applicable fiscal year’ means first fiscal  
25 year that begins after the fiscal year ending in the

1 calendar year during which the percentage of indi-  
 2 viduals covered by insurance, as determined by the  
 3 National Health Care Cost and Coverage Commis-  
 4 sion established under section 10001 of the Health  
 5 Security Act, equals or exceeds 92 percent.”.

6 (c) CONFORMING AMENDMENTS.—(1) Title XIX (42  
 7 U.S.C. 1396 et seq.) is amended by striking the title and  
 8 inserting the following:

9 **“TITLE XIX—MEDICAL ASSIST-**  
 10 **ANCE PROGRAMS AND PAY-**  
 11 **MENTS TO HOSPITALS SERV-**  
 12 **ING VULNERABLE POPU-**  
 13 **LATIONS”**

14 **“PART A—GRANTS TO STATES FOR MEDICAL**  
 15 **ASSISTANCE PROGRAMS”.**

16 (2) Title XIX (42 U.S.C. 1396 et seq.) is amended  
 17 by striking each reference to “this title” and inserting  
 18 “this part”.

19 **PART 4—MEDICAID LONG-TERM CARE**  
 20 **PROVISIONS**

21 **SEC. 4615. INCREASED RESOURCE DISREGARD FOR INDI-**  
 22 **VIDUALS RECEIVING CERTAIN SERVICES.**

23 (a) IN GENERAL.—Section 1902(a)(10) (42 U.S.C.  
 24 1396a(a)(10)) is amended—

1           (1) by striking “and” at the end of subpara-  
2 graph (E);

3           (2) by adding “and” at the end of subpara-  
4 graph (F); and

5           (3) by adding at the end the following new sub-  
6 paragraph:

7                   “(G) provide that, in determining the eligi-  
8 bility of any unmarried individual who has ap-  
9 plied for or is receiving medical assistance con-  
10 sisting of community-based services furnished  
11 under a waiver under subsection (c) or (d) of  
12 section 1915, personal care services described in  
13 section 1905(a)(24), or home and community  
14 care for functionally disabled elderly individuals  
15 under section 1929, the first \$4,000 of re-  
16 sources may, at the option of the State, be dis-  
17 regarded.”.

18           (b) EFFECTIVE DATE.—The amendments made by  
19 subsection (a) shall apply to payments for medical assist-  
20 ance for calendar quarters beginning on or after January  
21 1, 1995.

1 **SEC. 4616. FRAIL ELDERLY DEMONSTRATION PROJECT**  
2 **WAIVERS.**

3 (a) EXPANSION OF NUMBER OF WAIVERS.—Section  
4 9412(b)(1) of the Omnibus Budget Reconciliation Act of  
5 1986 is amended by striking “15” and inserting “40”.

6 (b) DEVELOPMENT OF PROTOCOLS AND MODEL  
7 CERTIFICATION GUIDELINES.—Section 9412(b) of the  
8 Omnibus Budget Reconciliation Act of 1986 is amended  
9 by adding at the end the following new paragraphs:

10 “(5) The Secretary, in consultation with the  
11 States and organizations operating projects in ac-  
12 cordance with waivers under this subsection shall de-  
13 velop and publish a waiver protocol that will estab-  
14 lish minimum standard requirements that an organi-  
15 zation must meet to be eligible for a waiver under  
16 this subsection. In developing the protocol under the  
17 preceding sentence, the Secretary shall incorporate  
18 standards for organizations to deliver integrated  
19 acute and long-term care services for the elderly,  
20 children, and young adults.

21 “(6) The Secretary shall develop model guide-  
22 lines that shall be available to States that choose to  
23 establish a comprehensive procedure for the licen-  
24 sure and certification of an organization operating a  
25 demonstration project under a waiver granted pursu-  
26 ant to this subsection. Such guidelines shall encom-

1 pass the range of services provided by such an orga-  
2 nization.”.

3 (c) EVALUATIONS AND REPORTS.—Section 9412(b)  
4 of the Omnibus Budget Reconciliation Act of 1986, as  
5 amended by subsection (b), is amended by adding at the  
6 end the following new paragraph:

7 “(7)(A) The Secretary shall develop standard  
8 evaluation protocols to assess the cost-effectiveness  
9 and quality of service provided under—

10 “(i) demonstration projects operating on  
11 the date of the enactment of this paragraph  
12 under waivers granted pursuant to this sub-  
13 section; and

14 “(ii) demonstration projects granted waiv-  
15 ers after the date of the enactment of this para-  
16 graph.

17 “(B) The Secretary shall conduct evaluations of  
18 the demonstration projects in accordance with the  
19 protocols developed under subparagraph (A) and  
20 based on the results of such evaluations, report to  
21 the Committee on Finance of the Senate, the Com-  
22 mittee on Ways and Means of the House of Rep-  
23 resentatives, and the Subcommittee on Health and  
24 the Environment of the Committee on Energy and  
25 Commerce of the House of Representatives by—



1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to services furnished on or after  
3 January 1, 1995.

4 **SEC. 4618. ELIMINATION OF RULE REGARDING AVAIL-**  
5 **ABILITY OF BEDS IN CERTAIN INSTITUTIONS.**

6 (a) IN GENERAL.—The first sentence of section  
7 1915(c)(1) (42 U.S.C. 1396n(c)(1)) is amended by insert-  
8 ing the following before the end period: “(at the option  
9 of the State, such determination may be made without re-  
10 gard to the availability of beds in such a hospital, nursing  
11 facility, or intermediate care facility for the mentally re-  
12 tarded located in the State)”.

13 (b) EFFECTIVE DATE.—The amendment made by  
14 subsection (a) shall be effective with respect to waivers  
15 granted or renewed on or after January 1, 1995.

16 **SEC. 4619. PREADMISSION SCREENING FOR MENTALLY RE-**  
17 **TARDED INDIVIDUALS.**

18 (a) IN GENERAL.—Section 1919(b)(3)(F)(ii) (42  
19 U.S.C. 1396r(b)(3)(F)(ii)) is amended by striking “that,  
20 because” and all that follows through the period at the  
21 end and inserting “that the individual’s primary need is  
22 for medical services that are at the level provided by the  
23 nursing facility and that the nursing facility has the capa-  
24 bility to provide any specialized services necessary for ha-  
25 bilitation of the individual.”.

1 (b) EFFECTIVE DATE.—The amendment made by  
 2 subsection (a) shall apply to admissions on or after July  
 3 1, 1995.

4 **PART 5—MISCELLANEOUS**

5 **SEC. 4621. MEDICAID COVERAGE OF ALL CERTIFIED NURSE**  
 6 **PRACTITIONER AND CLINICAL NURSE SPE-**  
 7 **CIALIST SERVICES.**

8 (a) IN GENERAL.—Paragraph (21) of section  
 9 1905(a) (42 U.S.C. 1396d(a)) is amended to read as fol-  
 10 lows:

11 “(21) services furnished by all certified nurse  
 12 practitioners (as defined by the Secretary) or clinical  
 13 nurse specialists (as defined in subsection (t)) which  
 14 the certified nurse practitioner or clinical nurse spe-  
 15 cialist is legally authorized to perform under State  
 16 law (or the State regulatory mechanism provided by  
 17 State law), whether or not the certified nurse practi-  
 18 tioner or clinical nurse specialist is under the super-  
 19 vision of, or associated with, a physician or other  
 20 health care provider;”.

21 (b) CLINICAL NURSE SPECIALIST DEFINED.—Sec-  
 22 tion 1905 (42 U.S.C. 1396) is amended by adding at the  
 23 end the following new subsection:

24 “(t) The term ‘clinical nurse specialist’ means an in-  
 25 dividual who—



1 State demonstrates to the satisfaction of the  
2 Secretary (using the methods specified by the  
3 Secretary under subsection (aa)) that it is not  
4 cost-effective in the aggregate to seek such re-  
5 covery with respect to such services furnished to  
6 individuals covered under the State plan;”.

7 (b) METHODS FOR DEMONSTRATION.—Section  
8 1902(a) (42 U.S.C. 1396a(a)) is amended by adding at  
9 the end the following new subsection:

10 “(aa) The Secretary shall specify in regulations the  
11 methods by which a State may demonstrate that it is not  
12 cost-effective in the aggregate to seek reimbursement for  
13 medical assistance paid for case management services  
14 under subsection (a)(25)(B)(ii). The methods specified by  
15 the Secretary under the preceding sentence shall include  
16 allowing a State to demonstrate that case management  
17 services are not generally covered by health insurers in the  
18 State.”.

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to payments for medical assistance  
21 for calendar quarters beginning on or after January 1,  
22 1995.

1           **TITLE V—QUALITY AND**  
2           **CONSUMER PROTECTION**  
3           **Subtitle A—Quality Management**  
4           **and Improvement**

5   **SEC. 5001. NATIONAL QUALITY COUNCIL.**

6           (a) **ESTABLISHMENT.**—Not later than 1 year after  
7 the date of enactment of this Act, the Secretary of Health  
8 and Human Services shall establish a council to be known  
9 as the National Quality Council to oversee a program of  
10 quality management and improvement designed to en-  
11 hance the quality, appropriateness, and effectiveness of  
12 health care services and access to such services.

13           (b) **APPOINTMENT.**—The National Quality Council  
14 shall consist of 15 members appointed by the President,  
15 with the advice and consent of the Senate, who are broadly  
16 representative of the population of the United States and  
17 shall include the following:

18               (1) Individuals and health care providers distin-  
19               guished in the fields of medicine, public health,  
20               health care quality, and related fields of health serv-  
21               ices research. Such members shall constitute at least  
22               one-third of the Council’s membership.

23               (2) Individuals representing consumers of  
24               health care services. Such members shall constitute  
25               at least one-third of the Council’s membership.

1           (3) Other individuals representing purchasers of  
2 health care, health plans, States, and nationally rec-  
3 ognized health care accreditation organizations.

4           (c) DUTIES.—The National Quality Council shall—

5           (1) develop national goals and performance  
6 measures of quality;

7           (2) develop uniform quality goals and perform-  
8 ance measures for plans;

9           (3) oversee the design and implementation of a  
10 program of national surveys of plans and consumers;

11           (4) oversee the design and production of Con-  
12 sumer Report Cards;

13           (5) oversee Quality Improvement Foundations;

14           (6) oversee National and State-based Consumer  
15 Information and Advocacy Centers; and

16           (7) oversee the evaluation of the impact of the  
17 implementation of this Act on the quality of health  
18 care services in the United States and the access of  
19 consumers to such services.

20           (d) CONSULTATION.—In carrying out these duties,  
21 the National Quality Council shall establish a process of  
22 consultation with appropriate interested parties.

23           (e) TERMS.—

1           (1) IN GENERAL.—Except as provided in para-  
2           graph (2), members of the Council shall serve for a  
3           term of 4 years.

4           (2) STAGGERED ROTATION.—Of the members  
5           first appointed to the Council under subsection (b),  
6           the President shall appoint members to serve for a  
7           term of between 1 and 4 years so that no more than  
8           one third of the Council seats are vacated each year.

9           (3) SERVICE BEYOND TERM.—A member of the  
10          Council may continue to serve after the expiration of  
11          the term of the member until a successor is ap-  
12          pointed.

13          (f) VACANCIES.—If a member of the Council does not  
14          serve the full term applicable under subsection (e), the in-  
15          dividual appointed to fill the resulting vacancy shall be ap-  
16          pointed for the remainder of the term of the predecessor  
17          of the individual.

18          (g) CHAIR.—The President shall designate an indi-  
19          vidual to serve as the chair of the Council.

20          (h) MEETINGS.—The Council shall meet not less than  
21          once during each 4-month period and shall otherwise meet  
22          at the call of the President or the chair.

23          (i) COMPENSATION AND REIMBURSEMENT OF EX-  
24          PENSES.—Members of the Council shall receive compensa-  
25          tion for each day (including travel time) engaged in car-

1 rying out the duties of the Council. Such compensation  
2 may not be in an amount in excess of the maximum rate  
3 of basic pay payable for level IV of the Executive Schedule  
4 under section 5315 of title 5, United States Code.

5 (j) CONFLICTS OF INTEREST.—Members of the  
6 Council shall disclose upon appointment to the Council or  
7 at any subsequent time that it may occur, conflicts of in-  
8 terest.

9 (k) EXECUTIVE DIRECTOR; STAFF.—

10 (1) EXECUTIVE DIRECTOR.—

11 (A) IN GENERAL.—The Council shall,  
12 without regard to section 5311(b) of title 5,  
13 United States Code, appoint an Executive Di-  
14 rector.

15 (B) PAY.—The Executive Director shall be  
16 paid at a rate equivalent to a rate for the Sen-  
17 ior Executive Service.

18 (2) STAFF.—

19 (A) IN GENERAL.—Subject to subpara-  
20 graphs (B) and (C), the Executive Director,  
21 with the approval of the Council, may appoint  
22 and fix the pay of additional personnel.

23 (B) PAY.—The Executive Director may  
24 make such appointments without regard to the  
25 provisions of title 5, United States Code, gov-

1           erning appointments in the competitive service,  
2           and any personnel so appointed may be paid  
3           without regard to the provisions of chapter 51  
4           and subchapter III of chapter 53 of such title,  
5           relating to classification and General Schedule  
6           pay rates, except that an individual so ap-  
7           pointed may not receive pay in excess of 120  
8           percent of the annual rate of basic pay payable  
9           for GS-15 of the General Schedule.

10           (C) DETAILED PERSONNEL.—Upon re-  
11           quest of the Executive Director, the head of any  
12           Federal department or agency may detail any  
13           of the personnel of that department or agency  
14           to the Council to assist the Council in carrying  
15           out its duties under this Act.

16           (l) CONTRACT AUTHORITY.—To the extent provided  
17           in advance in appropriations Acts, the Council may con-  
18           tract with any person (including an agency of the Federal  
19           Government) for studies and analysis as required to exe-  
20           cute its functions. Any employee of the Executive Branch  
21           may be detailed to the Council to assist the Council in  
22           carrying out its duties.

23           (m) CONSULTATIONS WITH EXPERTS.—The Council  
24           may consult with any outside expert individuals or groups  
25           that the Council determines appropriate in performing its

1 duties under this section. The Council may establish advi-  
2 sory committees.

3 (n) ACCESS TO INFORMATION.—The Council may se-  
4 cure directly from any department or agency of the United  
5 States information necessary to enable it to carry out its  
6 functions, to the extent such information is otherwise  
7 available to a department or agency of the United States.  
8 Upon request of the chair, the head of that department  
9 or agency shall furnish that information to the Council.

10 (o) DELEGATION OF AUTHORITY.—Except as other-  
11 wise provided, the Council may delegate any function to  
12 such officers and employees as the Council may designate  
13 and may authorize such successive redelegations of such  
14 functions with the Council as the Council deems to be nec-  
15 essary or appropriate. No delegation of functions by the  
16 Council shall relieve the Council of responsibility for the  
17 administration of such functions.

18 (p) RULEMAKING.—The Council is authorized to es-  
19 tablish such rules as may be necessary to carry out this  
20 section.

21 (q) HEALTH CARE PROVIDER.—For purposes of this  
22 subtitle, the term “health care provider” means an indi-  
23 vidual who, or entity that, provides an item or service to  
24 an individual that is covered under the health plan (as

1 defined in section 1111) in which the individual is en-  
2 rolled.

3 **SEC. 5002. NATIONAL GOALS AND PERFORMANCE MEAS-**  
4 **URES OF QUALITY.**

5 (a) IN GENERAL.—The National Quality Council  
6 shall develop a set of national quality goals and perform-  
7 ance measures of quality for both the general population  
8 and for population subgroups defined by demographic  
9 characteristics and health status. The goals and measures  
10 shall incorporate goals identified by the Secretary of  
11 Health and Human Services for meeting public health ob-  
12 jectives utilizing, but not limited to, goals delineated in  
13 Healthy People 2000.

14 (b) SUBJECT OF MEASURES.—National measures of  
15 quality performance shall be developed under subsection  
16 (a) in a manner that provides statistical and other infor-  
17 mation on at least the following subjects:

18 (1) Outcomes of health care services and proce-  
19 dures.

20 (2) Population health status.

21 (3) Health promotion.

22 (4) Prevention of diseases, disorders, disabil-  
23 ities, injuries, and other health conditions.

24 (5) Access to care and appropriateness of care.

25 (6) Consumer satisfaction.

1 **SEC. 5003. STANDARDS AND PERFORMANCE MEASURES**  
2 **FOR HEALTH PLANS.**

3 (a) DEVELOPMENT.—

4 (1) IN GENERAL.—The National Quality Coun-  
5 cil shall establish national standards and perform-  
6 ance measures for health plans, which may be used  
7 to assess the provision of health care services and  
8 access to such services, both for the general popu-  
9 lation and population subgroups defined by demo-  
10 graphic characteristics and health status. In subject  
11 matter areas with which the National Quality Coun-  
12 cil determines that sufficient information and con-  
13 sensus exist, the Council shall establish goals for  
14 performance by health plans consistent with the na-  
15 tional goals and performance measures established  
16 under section 5002.

17 (2) MEASURES AND STANDARDS.—

18 (A) MEASURES.—Quality measures under  
19 this section shall relate, at a minimum, to:

20 (i) Access by consumers to health care  
21 services and providers.

22 (ii) Appropriateness of health care  
23 services.

24 (iii) Consumer satisfaction.

25 (iv) Outcomes of care.

1 (v) Disease prevention and health pro-  
2 motion.

3 (B) STANDARDS.—Quality standards  
4 under this section at a minimum shall relate to:

5 (i) Health plan compliance with mem-  
6 bers' rights under this Act.

7 (ii) Quality improvement and account-  
8 ability.

9 (iii) Documentation and review of pro-  
10 vider credentialing and competency.

11 (iv) Management of clinical, and ad-  
12 ministrative and financial information.

13 (b) CERTIFICATION OF PLANS.—The National Qual-  
14 ity Council shall provide information and technical assist-  
15 ance to the Secretary and the States concerning the use  
16 of national standards and performance measures devel-  
17 oped under this section for State certification of health  
18 plans.

19 **SEC. 5004. PLAN DATA ANALYSIS AND CONSUMER SURVEYS.**

20 (a) IN GENERAL.—The National Quality Council  
21 shall oversee the design and conduct of periodic surveys  
22 of health care consumers and plans to gather information  
23 concerning the quality measures established under sec-  
24 tions 5002 and 5003. The surveys shall monitor consumer  
25 reaction to the implementation of this Act and, in coordi-

1 nation with relevant data from health plans and other  
2 sources, be designed to assess the impact of this Act both  
3 for the general population of the United States and for  
4 populations vulnerable to discrimination or to receiving in-  
5 adequate care due to health status, demographic charac-  
6 teristics, or geographic location.

7       (b) SURVEY ADMINISTRATION AND DATA ANAL-  
8 YSIS.—The National Quality Council shall approve a  
9 standard design for the consumer surveys and sampling  
10 of relevant plan data described in subsection (a) which  
11 shall be administered by the Administrator of the Agency  
12 for Health Care Policy and Research or such other appro-  
13 priate entity as the Council shall designate on a plan-by-  
14 plan and State-by-State basis. Sufficient consumer survey  
15 and plan data shall be collected and verified to provide  
16 for reliable and valid analysis. A State may add survey  
17 questions on quality measures of local interest to surveys  
18 conducted in the State. The plan-level survey shall include  
19 a subset of consumer survey questions related to consumer  
20 satisfaction, perceived health status, access, and such  
21 other survey items designated by the Council.

22       (c) SAMPLING STRATEGIES.—The National Quality  
23 Council shall approve sampling strategies under sub-  
24 section (a) that ensure that appropriate survey samples  
25 adequately measure populations that are considered to be

1 at risk of receiving inadequate health care or may be dif-  
2 ficult to reach through consumer-sampling methods, in-  
3 cluding individuals who—

4 (1) fail to enroll in a health plan;

5 (2) resign from a plan; or

6 (3) are vulnerable to discrimination or to receiv-  
7 ing inadequate care due to health status, demo-  
8 graphic characteristics, or geographic location.

9 (d) SURVEY INTEGRATION.—To the extent feasible,  
10 the consumer and plan surveys developed under this sec-  
11 tion shall be integrated with existing Federal surveys.

12 **SEC. 5005. EVALUATION AND REPORTING OF QUALITY PER-**  
13 **FORMANCE.**

14 (a) HEALTH PLAN REPORTS.—Each State annually  
15 shall publish and make available to the public and Con-  
16 sumer Information and Advocacy Centers a performance  
17 report, in a standard format designated by the National  
18 Quality Council, outlining the performance of each health  
19 plan offered in the State with respect to the set of national  
20 measures of quality performance developed under sections  
21 5002 and 5003. The report shall include—

22 (1) the results of a smaller number of such  
23 measures for health care providers if the available  
24 information is statistically meaningful; and

1           (2) the results of consumer surveys and an  
2           analysis of the plan data collected in section 5004.

3           (b) CONSUMER REPORT CARDS.—The health plan re-  
4           ports under subsection (a) shall be summarized in a con-  
5           sumer report card as specified by the National Quality  
6           Council and made available by the State through the Con-  
7           sumer Information and Advocacy Centers to all individuals  
8           in the State.

9           (c) QUALITY REPORTS.—The National Quality Coun-  
10          cil annually shall provide recommendations to the Con-  
11          gress, the National Health Benefits Board, and the Sec-  
12          retary in the form of a summary report that—

13                 (1) outlines in a standard format the perform-  
14                 ance of each State;

15                 (2) discusses State-level and national trends re-  
16                 lating to health care quality; and

17                 (3) presents data for each State from health  
18                 plan reports and consumer surveys that were con-  
19                 ducted during the year.

20   **SEC. 5006. DEVELOPMENT AND DISSEMINATION OF PRAC-**  
21                                   **TICE GUIDELINES.**

22          The National Quality Council may advise the Sec-  
23          retary and the Administrator of the Agency for Health  
24          Care Policy and Research concerning priorities for the de-  
25          velopment and periodic review and updating of clinically

1 relevant guidelines established under section 912 of the  
2 Public Health Service Act.

3 **SEC. 5007. RESEARCH ON HEALTH CARE QUALITY.**

4 The National Quality Council may make rec-  
5 ommendations to the Secretary and the Administrator of  
6 the Agency for Health Care Policy and Research con-  
7 cerning priorities for research with respect to the quality,  
8 appropriateness, and effectiveness of health care.

9 **SEC. 5008. QUALITY IMPROVEMENT FOUNDATIONS.**

10 (a) ESTABLISHMENT.—The National Quality Council  
11 shall oversee the operation of quality improvement founda-  
12 tions in performing the duties specified in subsection (c).

13 (b) STRUCTURE AND MEMBERSHIP.—

14 (1) GRANT PROCESS.—The Secretary, in con-  
15 sultation with the Council, shall, through a competi-  
16 tive grantmaking process, award grants for the es-  
17 tablishment and operation of a quality improvement  
18 foundation in each State or region (as defined in  
19 paragraph (2)(B)).

20 (2) ESTABLISHMENT OF GEOGRAPHIC AREAS.—

21 The Secretary shall establish throughout the United  
22 States geographic areas with respect to which grants  
23 under this section will be made. In establishing such  
24 areas, the Secretary shall take into account the fol-  
25 lowing criteria:

1 (A) STATE AREAS.—Each State shall gen-  
2 erally be designated as a geographic area for  
3 purposes of this paragraph.

4 (B) MULTI-STATE AREAS.—The Secretary  
5 may establish geographic areas comprised of  
6 multiple contiguous States only where the Sec-  
7 retary determines that volume of activity or  
8 other relevant factors justifies such an estab-  
9 lishment.

10 (3) ELIGIBLE APPLICANTS.—To be eligible to  
11 receive a grant for the establishment of a quality im-  
12 provement foundation under paragraph (1), an ap-  
13 plicant entity shall meet the following conditions:

14 (A) NOT-FOR-PROFIT.—The entity shall be  
15 a not-for-profit entity operating within the  
16 State or region involved.

17 (B) BOARD.—The entity shall have a  
18 board which includes—

19 (i) representatives of health care pro-  
20 viders from throughout the State or region  
21 involved, including both practicing pro-  
22 viders and experts in the field of quality  
23 measurement and improvement, which to-  
24 gether shall comprise at least one-fourth of  
25 the advisory board's membership;

1 (ii) at least one representative of Aca-  
2 demic Health Centers or Schools of Public  
3 Health as defined in section 799 of the  
4 Public Health Service Act operating within  
5 the State or region involved (or operating  
6 outside of the State or region if no such  
7 Centers or schools operate within the State  
8 or region), which shall comprise up to one-  
9 fourth of the membership;

10 (iii) representatives of consumers re-  
11 siding within the State or region involved,  
12 who shall comprise one-fourth of the mem-  
13 bership; and

14 (iv) representatives of purchasers of  
15 health care, health plans, and other inter-  
16 ested parties residing within the State or  
17 region involved, and representatives of the  
18 State or States within a region.

19 (C) STAFFING.—Each entity shall have  
20 sufficient, competent staff of experts possessing  
21 the skills and knowledge necessary to enable the  
22 foundation to perform its duties.

23 (c) DUTIES.—

24 (1) IN GENERAL.—Each quality improvement  
25 foundation shall carry out the duties described in

1 paragraph (2) for the State or region in which the  
2 foundation is located. The foundation shall establish  
3 a program of activities incorporating such duties and  
4 shall be able to demonstrate the involvement of a  
5 broad cross-section of the providers and health care  
6 institutions throughout the State or region. A foun-  
7 dation may apply for and conduct research described  
8 in section 5007.

9 (2) DUTIES DESCRIBED.—The duties described  
10 in this paragraph include the following:

11 (A) Collaboration with and technical assist-  
12 ance to providers and health plans in ongoing  
13 efforts to improve the quality of health care  
14 provided to individuals in the State.

15 (B) Population-based monitoring of prac-  
16 tice patterns and patient outcomes, on an other  
17 than a case-by-case basis.

18 (C) Developing programs in lifetime learn-  
19 ing for health professionals to improve the qual-  
20 ity of health care by ensuring that health pro-  
21 fessionals remain informed about new knowl-  
22 edge, acquire new skills, and adopt new roles as  
23 technology and societal demands change.

24 (D) Disseminating information about suc-  
25 cessful quality improvement programs, practice

1 guidelines, and research findings, including in-  
2 formation on innovative staffing of health pro-  
3 fessionals.

4 (E) Assist in developing innovative patient  
5 education systems that enhance patient involve-  
6 ment in decisions relating to their health care,  
7 including an emphasis on shared decision-  
8 making between patients and health care pro-  
9 viders.

10 (F) Issuing a report to the public regard-  
11 ing the foundation's activities for the previous  
12 year including areas of success during the pre-  
13 vious year and areas for opportunities in im-  
14 proving health outcomes for the community,  
15 and the adoption of guidelines.

16 (G) Providing notice to the State or appro-  
17 priate entity if the foundation determines, after  
18 reasonable opportunities for improvement, that  
19 the quality of a provider or plan remains so in-  
20 adequate that the patients or enrollees of such  
21 a provider or plan are subject to potential harm  
22 in utilizing the services of such provider or serv-  
23 ices under such plan.

24 (d) RESTRICTIONS ON DISCLOSURE.—The restric-  
25 tions on disclosure of information under section 1160 of

1 the Social Security Act shall apply to quality improvement  
2 foundations under this section, except that—

3 (1) such foundations shall make data available  
4 to qualified organizations and individuals for re-  
5 search for public benefit;

6 (2) individuals and qualified organizations shall  
7 meet standards consistent with the Public Health  
8 Service Act and policies regarding the conduct of  
9 scientific research, including provisions related to  
10 confidentiality, privacy, protection of humans and  
11 shall pay reasonable costs for data; and

12 (3) such foundations may exchange information  
13 with other quality improvement foundations.

14 **SEC. 5009. CONSUMER INFORMATION AND ADVOCACY.**

15 (a) ESTABLISHMENT.—

16 (1) IN GENERAL.—The Secretary shall establish  
17 (by grant or contract) and oversee a National Center  
18 of Consumer Information and Advocacy to provide  
19 technical assistance, adequate training and support  
20 to States and Consumer Information and Advocacy  
21 Centers in each State (hereafter referred to in this  
22 section as the “Center”) to carry out the duties of  
23 this section, including providing public education to  
24 consumers concerning this Act.

1           (2) REQUIREMENTS FOR NATIONAL CENTER.—

2           The National Center of Consumer Information and  
3           Advocacy shall be a national non-profit organization  
4           with public education and health policy expertise and  
5           shall have sufficient staff to carry out its duties and  
6           a demonstrated ability to represent and work with a  
7           broad spectrum of consumers, including vulnerable  
8           and underserved populations.

9           (3) STATE-BASED CENTERS.—The Consumer  
10          Information and Advocacy Center in each State shall  
11          disseminate State reports on quality performance (as  
12          defined in section 5005(4)) and health plan con-  
13          sumer report cards (as defined in section 5005(2))  
14          in order to facilitate consumer choice of health  
15          plans, perform public outreach and provide edu-  
16          cation and assistance regarding consumer rights and  
17          responsibilities under this Act, and assist consumers  
18          in dealing with problems that arise with consumer  
19          purchasing cooperatives, large group purchasers,  
20          health plans, insurance agencies, and health care  
21          providers operating in such State.

22          (b) CONTRACTS.—

23                 (1) SOLICITATION.—The Secretary shall solicit  
24                 contracts from private non-profit organizations  
25                 based in each State to fulfill the duties of the Center

1 in the State. The Secretary may develop such regu-  
2 lations and guidelines as necessary to oversee the  
3 process of considering and awarding competitive con-  
4 tracts under this section. In awarding such con-  
5 tracts, the Secretary shall consult with the National  
6 Center of Consumer Information and Advocacy and  
7 shall, at a minimum, consider the demonstrated abil-  
8 ity of the organization to represent and work with  
9 a broad spectrum of consumers, including vulnerable  
10 and underserved populations.

11 (2) CONTRACT PERIOD.—The contract period  
12 for the State-based Consumer Information and Ad-  
13 vocacy Centers and the National Center of Con-  
14 sumer Information and Advocacy under this section  
15 shall be not less than 4 years and not more than 7  
16 years.

17 (c) FUNCTIONS AND RESPONSIBILITIES.—

18 (1) DISSEMINATION OF REPORTS.—Each Cen-  
19 ter shall disseminate State reports on quality per-  
20 formance (as defined in section 5005(2)) and health  
21 plan consumer report cards (as defined in section  
22 5005(2)) in order to facilitate consumer choice of  
23 health plans.

24 (2) STAFF, OFFICES AND HOTLINES.—Each  
25 Center shall have sufficient staff, local offices

1 throughout the State, and a State-wide toll-free hot-  
2 line to carry out the advocacy duties of this section.  
3 Through direct contact and the hotline, the Center  
4 shall provide the following services in the State, in-  
5 cluding appropriate assistance to individuals with  
6 limited English language ability—

7 (A) outreach and education relating to con-  
8 sumer rights and responsibilities under this Act,  
9 including such rights and services available  
10 through the Center;

11 (B) assistance with enrollment in health  
12 plans, or obtaining services or reimbursement  
13 from health plans;

14 (C) assistance with filing an application for  
15 premium or cost sharing subsidies;

16 (D) information to enrollees about existing  
17 grievance procedures and coordination with  
18 other entities to assist in identifying, inves-  
19 tigating, and resolving enrollee grievances under  
20 this Act (including grievances before State med-  
21 ical boards);

22 (E) referrals to appropriate local providers  
23 of legal assistance and to appropriate State and  
24 Federal agencies which may be of assistance to  
25 aggrieved individuals in the area; and

1           (F) conduct public hearings no less fre-  
2           quently than once a year to identify and ad-  
3           dress community health care needs.

4           (d) ACCESS TO INFORMATION.—The Secretary and  
5 the States shall ensure that, for purposes of carrying out  
6 the Center’s duties under this section, the Center (and of-  
7 ficers and employees of the Center in local offices) have  
8 appropriate access to necessary information subject to  
9 protections for confidentiality of enrollee information.  
10 Each Center shall have the capability to accept electronic  
11 quality data from plans as required under subtitle B.

12          (e) EVALUATION AND REPORT.—The Secretary shall  
13 have the right to evaluate the quality and effectiveness of  
14 the organization in carrying out the functions specified in  
15 the contract. The Center shall report to the Secretary and  
16 the State annually on the nature and patterns of consumer  
17 complaints received in the Center and its local offices dur-  
18 ing each year and any policy, regulatory, and legislative  
19 recommendations for needed improvements together with  
20 a record of the activities of the Center.

21          (f) CONFLICTS OF INTEREST.—The Secretary shall  
22 ensure that no individual involved in the designation of  
23 a State Center, the Center itself, or of any delegate thereof  
24 is subject to a conflict of interest, including affiliation with  
25 (through ownership or common control) a health care fa-

1 cility, managed care organization, health insurance com-  
2 pany or association of health care facilities or providers.  
3 No grantee under this section may have a direct involve-  
4 ment with the licensing, certification, or accreditation of  
5 a health care facility, a health care plan, or a provider  
6 of health care services .

7 (g) LEGAL COUNSEL.—The Secretary shall ensure  
8 that adequate legal counsel is available, and is able, with-  
9 out conflict of interest, to assist the Center, and the local  
10 offices thereof in the performance of their official duties.

11 (h) COORDINATION.—The Center shall coordinate its  
12 activities with all appropriate entities including Quality  
13 Improvement Foundations (established under section  
14 5008) and the State agencies designated to carry out cli-  
15 ent advocacy activities pursuant to section 2106.

16 (i) CONSTRUCTION.—Nothing in this section shall re-  
17 place grievance procedures established or otherwise re-  
18 quired under this Act.

19 **SEC. 5010. AUTHORIZATION OF APPROPRIATIONS.**

20 (a) NATIONAL QUALITY COUNCIL.—For the purpose  
21 of carrying out this subtitle with respect to the establish-  
22 ment and activities of the National Quality Council, there  
23 are authorized to be appropriated \$4,000,000 for each of  
24 the fiscal years 1995 through 2000.

1 (b) QUALITY IMPROVEMENT FOUNDATIONS.—For  
2 the purpose of carrying out section 5008, the are author-  
3 ized to be appropriated \$100,000,000 for fiscal year 1996,  
4 \$200,000,000 for fiscal year 1997, and \$300,000,000 for  
5 each of the fiscal years 1998 through 2000.

6 (c) CONSUMER INFORMATION AND ADVOCACY CEN-  
7 TERS.—For the purpose of carrying out section 5009, the  
8 are authorized to be appropriated \$100,000,000 for fiscal  
9 year 1996, \$200,000,000 for fiscal year 1997,  
10 \$300,000,000 for each of the fiscal years 1998 through  
11 2000, of which \$4,000,000 for each fiscal year shall be  
12 made available to the National Center of Consumer Infor-  
13 mation and Advocacy.

14 **SEC. 5011. ROLE OF HEALTH PLANS IN QUALITY MANAGE-**  
15 **MENT.**

16 Each health plan shall—

17 (1) measure and disclose performance on qual-  
18 ity measures as designated by this Act;

19 (2) furnish information required under subtitles  
20 B and of this title and provide such other reports  
21 and information on the quality of care delivered by  
22 health care providers who are members of a provider  
23 network of the plan as may be required under this  
24 Act; and

1           (3) maintain quality management systems  
2           that—

3                   (A) use the national measures of quality  
4                   performance developed by the National Quality  
5                   Council under section 5003; and

6                   (B) measure the quality of health care fur-  
7                   nished to enrollees under the plan by all health  
8                   care providers of the plan where practical.

9   **SEC. 5012. INFORMATION ON HEALTH CARE PROVIDERS.**

10          (a) STATE OBLIGATIONS.—Each State shall make  
11          available to consumers, upon request, information con-  
12          cerning providers of health care services or supplies. Such  
13          information shall include—

14                   (1) the identity of any provider that has been  
15                   convicted, under Federal or State law, of a criminal  
16                   offense relating to fraud, corruption, breach of fidu-  
17                   ciary responsibility, or other financial misconduct in  
18                   connection with the delivery of a health care service  
19                   or supply;

20                   (2) the identity of any provider that has been  
21                   convicted, under Federal or State law, of a criminal  
22                   offense relating to neglect or abuse of patients in  
23                   connection with the delivery of a health care service  
24                   or supply;

1           (3) the identity of any provider that has been  
2 convicted, under Federal or State law, of a criminal  
3 offense relating to the unlawful manufacture, dis-  
4 tribution, prescription, or dispensing of a controlled  
5 substance; and

6           (4) the identity of any provider whose license to  
7 provide health care services or supplies has been re-  
8 voked, suspended, restricted, or not renewed, by a  
9 State licensing authority for reasons relating to the  
10 provider's professional competence, professional per-  
11 formance, or financial integrity, or any provider who  
12 surrendered such a license while a formal discipli-  
13 nary proceeding was pending before such an author-  
14 ity, if the proceeding concerned the provider's pro-  
15 fessional competence, professional performance, or  
16 financial integrity.

17           (b) PUBLIC AVAILABILITY OF INFORMATION IN NA-  
18 TIONAL PRACTITIONER DATA BANK ON DEFENDANTS,  
19 AWARDS, AND SETTLEMENTS.—

20           (1) IN GENERAL.—Section 427(a) of the Health  
21 Care Quality Improvement Act (42 U.S.C. 11137  
22 (a)) is amended by adding at the end the following  
23 new sentence: “Not later the January 1, 1996, the  
24 Secretary shall promulgate regulations under which  
25 individuals seeking to enroll in health plans under

1 the Health Security Act shall be able to obtain infor-  
2 mation reported under this part with respect to phy-  
3 sicians and other licensed health practitioners par-  
4 ticipating in such plans for whom information has  
5 been reported under this part on repeated occa-  
6 sions.”.

7 (2) ACCESS TO DATA BANK FOR POINT-OF-  
8 SERVICE CONTRACTORS UNDER MEDICARE.—Section  
9 427(a) of such Act (42 U.S.C. 11137(a)) is amend-  
10 ed—

11 (A) by inserting “to sponsors of point-of-  
12 service networks under section 1990 of the So-  
13 cial Security Act,” and

14 (B) in the heading, by inserting “RE-  
15 LATED” after “CARE”.

16 **SEC. 5013. CONFORMING AMENDMENTS TO PUBLIC**  
17 **HEALTH SERVICE ACT.**

18 Title IX of the Public Health Service Act is amend-  
19 ed—

20 (1) in section 903(a)(4) (42 U.S.C. 299a-  
21 1(a)(4)), by inserting “and Quality Improvement  
22 Foundations” after “health agencies”;

23 (2) in section 904(c)(1) (42 U.S.C. 299a-  
24 2(c)(1)), by inserting “the National Quality Council  
25 and” after “in consultation with”;

1           (3) in section 912(b)(4) (42 U.S.C. 299b–  
2 1(b)(4))—

3           (A) by inserting “outcomes,” before  
4 “risks”; and

5           (B) by inserting before the semicolon “to  
6 the extent feasible given the availability of unbi-  
7 ased, reliable, and valid data”;

8           (4) in section 914 (42 U.S.C. 299b–3)—

9           (A) in subsection (a)(2)(B)—

10           (i) by inserting “the National Quality  
11 Council,” after “shall consult with”; and

12           (ii) by inserting before the period  
13 “and relevant sections of the Health Secu-  
14 rity Act”;

15           (B) in subsection (c), by inserting “Quality  
16 Improvement Foundations and other” after  
17 “carried out through”; and

18           (C) in subsection (f)—

19           (i) by striking “TO ADMINISTRATOR”  
20 in the subsection heading;

21           (ii) by striking “Administrator” and  
22 inserting “National Quality Council and  
23 the”; and

24           (5) in section 927 (42 U.S.C. 299c–6), by add-  
25 ing at the end thereof the following new paragraphs:

1           “(5) The term ‘National Quality Council’ means  
2           the Council established under section 5001 of the  
3           Health Security Act.

4           “(6) The term “Quality Improvement Founda-  
5           tions” means the Foundations established under sec-  
6           tion 5008 of the Health Security Act.”.

## 7           **Subtitle B—Administrative** 8           **Simplification**

### 9           **PART 1—PURPOSE AND DEFINITIONS**

#### 10       **SEC. 5101. PURPOSE.**

11       It is the purpose of this subtitle to improve the effi-  
12       ciency and effectiveness of the health care system, includ-  
13       ing the medicare program under title XVIII of the Social  
14       Security Act and the medicaid program under title XIX  
15       of such Act, by encouraging the development of a health  
16       information network through the establishment of stand-  
17       ards and requirements for the electronic transmission of  
18       certain health information.

#### 19       **SEC. 5102. DEFINITIONS.**

20       For purposes of this subtitle:

21           (1) **CODE SET.**—The term “code set” means  
22       any set of codes used for encoding data elements,  
23       such as tables of terms, medical concepts, medical  
24       diagnostic codes, or medical procedure codes.

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

6           (3) HEALTH CARE PROVIDER.—The term  
7           “health care provider” includes a provider of services  
8           (as defined in section 1861(u) of the Social Security  
9           Act), a provider of medical or other health services  
10          (as defined in section 1861(s) of the Social Security  
11          Act), and any other person furnishing health care  
12          services or supplies.

13          (4) HEALTH INFORMATION.—The term “health  
14          information” means any information, whether oral  
15          or recorded in any form or medium that—

16                (A) is created or received by a health care  
17                provider, health plan, health oversight agency  
18                (as defined in section 5202), health researcher,  
19                public health authority (as defined in section  
20                5202), employer, life insurer, school or univer-  
21                sity, or health information network service cer-  
22                tified under section 5141; and

23                (B) relates to the past, present, or future  
24                physical or mental health or condition of an in-  
25                dividual, the provision of health care to an indi-

1           vidual, or the past, present, or future payment  
2           for the provision of health care to an individual.

3           (5) HEALTH INFORMATION NETWORK.—The  
4           term “health information network” means the health  
5           information system that is formed through the appli-  
6           cation of the requirements and standards established  
7           under this subtitle.

8           (6) HEALTH INFORMATION PROTECTION ORGA-  
9           NIZATION.—The term “health information protection  
10          organization” means a private entity or an entity op-  
11          erated by a State that accesses standard data ele-  
12          ments of health information through the health in-  
13          formation network, processes such information into  
14          non-identifiable health information, and may store  
15          such information.

16          (7) HEALTH INFORMATION NETWORK SERV-  
17          ICE.—The term “health information network serv-  
18          ice”—

19                  (A) means a private entity or an entity op-  
20                  erated by a State that enters into contracts  
21                  to—

22                          (i) process or facilitate the processing  
23                          of nonstandard data elements of health in-  
24                          formation into standard data elements;

1 (ii) provide the means by which per-  
2 sons are connected to the health informa-  
3 tion network for purposes of meeting the  
4 requirements of this subtitle, including the  
5 holding of standard data elements of  
6 health information;

7 (iii) provide authorized access to  
8 health information through the health in-  
9 formation network; or

10 (iv) provide specific information proc-  
11 essing services, such as automated coordi-  
12 nation of benefits and claims transaction  
13 routing; and

14 (B) includes a health information protec-  
15 tion organization.

16 (8) HEALTH PLAN.—The term “health plan”  
17 has the meaning given such term in section  
18 1011(1)(A) except that such term shall include  
19 clauses (iii), (iv), (v), (vi), and (viii) of such section.

20 (9) NON-IDENTIFIABLE HEALTH INFORMA-  
21 TION.—The term “non-identifiable health informa-  
22 tion” means health information that is not protected  
23 health information as defined in section 5202.

1           (10) HEALTH RESEARCHER.—The term “health  
2 researcher” shall have the meaning given such term  
3 under section 5202.

4           (11) PATIENT MEDICAL RECORD INFORMA-  
5 TION.—The term “patient medical record informa-  
6 tion” means health information derived from a clin-  
7 ical encounter that relates to the physical or mental  
8 condition of an individual.

9           (12) STANDARD.—The term “standard” when  
10 referring to an information transaction or to data  
11 elements of health information means the trans-  
12 action or data elements meet any standard adopted  
13 by the Secretary under part 2 that applies to such  
14 information transaction or data elements.

15   **PART 2—STANDARDS FOR DATA ELEMENTS AND**  
16                           **INFORMATION TRANSACTIONS**

17   **SEC. 5111. GENERAL REQUIREMENTS ON SECRETARY.**

18           (a) IN GENERAL.—The Secretary shall adopt stand-  
19 ards and modifications to standards under this subtitle  
20 that are—

21           (1) consistent with the objective of reducing the  
22 costs of providing and paying for health care; and

23           (2) in use and generally accepted or developed  
24 or modified by the standards setting organizations

1 accredited by the American National Standard Insti-  
2 tute (ANSI).

3 (b) INITIAL STANDARDS.—The Secretary may de-  
4 velop an expedited process for the adoption of initial  
5 standards under this subtitle.

6 (c) FAILSAFE.—If the Secretary is unable to adopt  
7 standards or modified standards in accordance with sub-  
8 section (a) that meet the requirements of this subtitle—

9 (1) the Secretary may develop or modify such  
10 standards and, after providing public notice and  
11 after an adequate period for public comment, adopt  
12 such standards; and

13 (2) if the Secretary adopts standards under  
14 paragraph (1), the Secretary shall submit a report  
15 to the appropriate committees of Congress on the  
16 actions taken by the Secretary under this subsection.

17 (d) PAPER FORMATS.—The Secretary may develop  
18 methods by which a person may use the standards adopted  
19 by the Secretary under this subtitle with respect to health  
20 information that is in written rather than electronic form.

21 **SEC. 5112. STANDARDS FOR DATA ELEMENTS OF HEALTH**  
22 **INFORMATION.**

23 (a) IN GENERAL.—The Secretary shall adopt stand-  
24 ards necessary to make data elements of the following

1 health information uniform and compatible for electronic  
2 transmission through the health information network:

3 (1) the health information that is appropriate  
4 for transmission in connection with transactions de-  
5 scribed in subsections (a), (b), and (d) of section  
6 5121;

7 (2) the quality information required to be sub-  
8 mitted by a health plan under title I and subtitle A  
9 of this title; and

10 (3) patient medical record information.

11 (b) ADDITIONS.—The Secretary may make additions  
12 to the sets of data elements adopted under subsection (a)  
13 as the Secretary determines appropriate in a manner that  
14 minimizes the disruption and cost of compliance with such  
15 additions.

16 (c) CERTAIN DATA ELEMENTS.—

17 (1) UNIQUE HEALTH IDENTIFIERS.—The Sec-  
18 retary shall establish a system to provide for a  
19 standard unique health identifier for each individual,  
20 employer, health plan, and health care provider for  
21 use in the health care system. The personal health  
22 identifier for an individual shall be an encrypted  
23 form of the social security account number assigned  
24 to the individual by the Secretary under section  
25 205(c)(2) of the Social Security Act.

1 (2) CODE SETS.—

2 (A) IN GENERAL.—The Secretary, in con-  
3 sultation with experts from the private sector  
4 and Federal agencies, shall—

5 (i) select code sets for appropriate  
6 data elements from among the code sets  
7 that have been developed by private and  
8 public entities; or

9 (ii) establish code sets for such data  
10 elements if no code sets for the data ele-  
11 ments have been developed.

12 (B) DISTRIBUTION.—The Secretary shall  
13 establish efficient and low-cost procedures for  
14 distribution of code sets and modifications to  
15 such code sets under section 5115(c).

16 **SEC. 5113. INFORMATION TRANSACTION STANDARDS.**

17 (a) IN GENERAL.—The Secretary shall adopt tech-  
18 nical standards relating to the method by which data ele-  
19 ments of health information that have been standardized  
20 under section 5112 may be transmitted electronically, in-  
21 cluding standards with respect to the format in which such  
22 data elements shall be transmitted.

23 (b) SPECIAL RULE FOR COORDINATION OF BENE-  
24 FITS.—Any standards adopted by the Secretary under  
25 paragraph (1) that relate to coordination of benefits shall

1 provide that a claim for reimbursement for medical serv-  
2 ices furnished is tested by an algorithm specified by the  
3 Secretary against all records of enrollment and eligibility  
4 for the individual who received such services to determine  
5 any primary and secondary obligors for payment.

6 (c) ELECTRONIC SIGNATURE.—The Secretary, in co-  
7 ordination with the Secretary of Commerce, shall promul-  
8 gate regulations specifying procedures for the electronic  
9 transmission and authentication of signatures, compliance  
10 with which will be deemed to satisfy State and Federal  
11 statutory requirements for written signatures with respect  
12 to information transactions required by this Act and writ-  
13 ten signatures on medical records and prescriptions.

14 **SEC. 5114. STANDARDS RELATING TO WRITTEN CLAIMS**  
15 **SUBMITTED BY INDIVIDUALS AND WRITTEN**  
16 **EXPLANATIONS OF BENEFITS.**

17 The Secretary shall adopt standard methods and for-  
18 mats which—

19 (1) may be used by an individual to submit a  
20 written claim when the individual's health care pro-  
21 vider does not submit the claim; and

22 (2) shall be used by health plans to submit a  
23 written explanation of benefits to an enrollee.

1 **SEC. 5115. TIMETABLES FOR ADOPTION OF STANDARDS.**

2 (a) INITIAL STANDARDS FOR DATA ELEMENTS.—

3 The Secretary shall adopt standards relating to—

4 (1) the data elements for the information de-  
5 scribed in section 5112(a)(1) not later than 9  
6 months after the date of the enactment of this sub-  
7 title (except in the case of standards with respect to  
8 data elements for claims attachments which shall be  
9 adopted not later than 24 months after the date of  
10 the enactment of this subtitle);

11 (2) the data elements for the information de-  
12 scribed in section 5112(a)(2) not later than 9  
13 months after the date of the enactment of this sub-  
14 title;

15 (3) data elements for patient medical record in-  
16 formation not earlier than 24 months and not later  
17 than 7 years after the date of the enactment of this  
18 subtitle; and

19 (4) any addition to a set of data elements, in  
20 conjunction with making such an addition.

21 (b) INITIAL STANDARDS FOR INFORMATION TRANS-  
22 ACTIONS.—The Secretary shall adopt standards relating  
23 to information transactions under section 5113 not later  
24 than 9 months after the date of the enactment of this sub-  
25 title (except in the case of standards for claims attach-

1 ments which shall be adopted not later than 24 months  
2 after the date of the enactment of this subtitle).

3 (c) STANDARDS FOR WRITTEN CLAIMS AND EXPLA-  
4 NATIONS OF BENEFITS.—The Secretary shall adopt  
5 standard methods and formats described in section 5114  
6 not later than 9 months after the date of the enactment  
7 of this subtitle.

8 (d) MODIFICATIONS TO STANDARDS.—

9 (1) IN GENERAL.—Except as provided in para-  
10 graph (2), the Secretary shall review the standards  
11 adopted under this subtitle and shall adopt modified  
12 standards as determined appropriate, but no more  
13 frequently than once every 6 months. Any modifica-  
14 tion to standards shall be completed in a manner  
15 which minimizes the disruption and cost of compli-  
16 ance.

17 (2) SPECIAL RULES.—

18 (A) MODIFICATIONS DURING FIRST 12-  
19 MONTH PERIOD.—Except with respect to addi-  
20 tions and modifications to code sets under sub-  
21 paragraph (B), the Secretary shall not adopt  
22 any modifications to standards adopted under  
23 this subtitle during the 12-month period begin-  
24 ning on the date such standards are adopted  
25 unless the Secretary determines that a modi-

1           fication is necessary in order to permit compli-  
2           ance with requirements relating to the stand-  
3           ards.

4                   (B) ADDITIONS AND MODIFICATIONS TO  
5           CODE SETS.—

6                   (i) IN GENERAL.—The Secretary shall  
7           ensure that procedures exist for the rou-  
8           tine maintenance, testing, enhancement,  
9           and expansion of code sets to accommodate  
10          changes in biomedical science and health  
11          care delivery.

12                   (ii) ADDITIONAL RULES.—If a code  
13          set is modified under this subsection, the  
14          modified code set shall include instructions  
15          on how data elements that were encoded  
16          prior to the modification are to be con-  
17          verted or translated so as to preserve the  
18          value of the data elements. Any modifica-  
19          tion to a code set under this subsection  
20          shall be implemented in a manner that  
21          minimizes the disruption and cost of com-  
22          plying with such modification.

23                   (e) EVALUATION OF STANDARDS.—The Secretary  
24          may establish a process to measure or verify the consist-  
25          ency of standards adopted or modified under this subtitle.

1 Such process may include demonstration projects and  
 2 analysis of the cost of implementing such standards and  
 3 modifications.

4 **PART 3—REQUIREMENTS WITH RESPECT TO**  
 5 **CERTAIN TRANSACTIONS AND INFORMATION**

6 **SEC. 5121. REQUIREMENTS WITH RESPECT TO CERTAIN**  
 7 **TRANSACTIONS AND INFORMATION.**

8 (a) REQUIREMENTS ON PLANS AND PROVIDERS RE-  
 9 LATING TO FINANCIAL AND ADMINISTRATIVE TRANS-  
 10 ACTIONS.—If a health care provider or a health plan con-  
 11 ducts any of the following transactions, such transactions  
 12 shall be standard transactions and the information trans-  
 13 mitted or received in connection with such transaction  
 14 shall be in the form of standard data elements:

15 (1) Claims (including coordination of benefits).

16 (2) Claims attachments.

17 (3) Responses to research inquiries by a health  
 18 researcher.

19 (4) Other transactions determined appropriate  
 20 by the Secretary consistent with the goal of reducing  
 21 administrative costs.

22 (b) REQUIREMENT ONLY ON PLANS RELATING TO  
 23 FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a  
 24 person desires to conduct any of the following transactions  
 25 with a health plan as a standard transaction, the health

1 plan shall conduct such standard transaction and the in-  
2 formation transmitted or received in connection with such  
3 transaction shall be in the form of standard data elements:

4 (1) Enrollment and disenrollment.

5 (2) Eligibility.

6 (3) Payment and remittance advice.

7 (4) Premium payments.

8 (5) First report of injury.

9 (6) Claims status.

10 (7) Referral certification and authorization.

11 (8) Other transactions determined appropriate  
12 by the Secretary consistent with the goal of reducing  
13 administrative costs.

14 (c) REQUIREMENT ON PLANS RELATING TO QUALITY  
15 INFORMATION.—Any quality information required to be  
16 submitted by a health plan under title I or subtitle A of  
17 this title shall be in the form of standard data elements  
18 and the transmission of such data shall be in the form  
19 of a standard transaction.

20 (d) REQUIREMENT ONLY ON PURCHASING COOPERA-  
21 TIVES.—If a person desires to conduct any of the following  
22 transactions with a purchasing cooperative (as defined in  
23 section 1013(12)) as a standard transaction, the coopera-  
24 tive shall conduct such standard transaction and the infor-

1 mation transmitted or received in connection with such  
2 transaction shall be in the form of standard data elements:

3 (1) Enrollment and disenrollment.

4 (2) Premium payments.

5 (e) REQUIREMENT WITH RESPECT TO DISCLOSURE  
6 OF INFORMATION.—

7 (1) IN GENERAL.—A health plan or health care  
8 provider shall make the standard data elements  
9 transmitted or received by such plan or provider in  
10 connection with the transactions described in sub-  
11 sections (a), (b), and (c) or acquired under section  
12 5164(a) available for disclosure as authorized by this  
13 subtitle.

14 (2) SPECIAL RULE.—In the case of a health  
15 care provider that does not file claims, such provider  
16 shall be responsible for making standard data ele-  
17 ments for encounter information available for disclo-  
18 sure as authorized by this subtitle.

19 (f) SATISFACTION OF REQUIREMENTS.—A health  
20 care provider, health plan, or consumer purchasing cooper-  
21 ative may satisfy the requirement imposed on such pro-  
22 vider, plan, or cooperative under subsection (a), (b), (c),  
23 (d), or (e) by—

24 (1) directly transmitting standard data ele-  
25 ments;

1           (2) submitting nonstandard data elements to a  
2 health information network service certified under  
3 section 5141 for processing into standard data ele-  
4 ments and transmission; or

5           (3) in the case of a provider, submitting data  
6 elements to a plan which satisfies the requirements  
7 imposed on such provider on the provider's behalf.

8       (g) TIMELINESS.—A health care provider or health  
9 plan shall be determined to have satisfied a requirement  
10 imposed under this section only if the action required is  
11 completed in a timely manner, as determined by the Sec-  
12 retary. In setting standards for timeliness, the Secretary  
13 shall take into consideration the age and the amount of  
14 information being requested.

15 **SEC. 5122. TIMETABLES FOR COMPLIANCE WITH REQUIRE-**  
16 **MENTS.**

17       (a) INITIAL COMPLIANCE.—

18           (1) IN GENERAL.—Not later than 12 months  
19 after the date on which standards are adopted under  
20 part 2 with respect to a type of transaction or data  
21 elements for a type of health information, a health  
22 plan, health care provider, or purchasing cooperative  
23 shall comply with the requirements of this subtitle  
24 with respect to such transaction or information.

1           (2) ADDITIONAL DATA ELEMENTS.—Not later  
2 than 12 months after the date on which the Sec-  
3 retary adopts an addition to a set of data elements  
4 for health information under part 2, a health plan,  
5 health care provider, or purchasing cooperative shall  
6 comply with the requirements of this subtitle using  
7 such data elements.

8           (b) COMPLIANCE WITH MODIFIED STANDARDS.—

9           (1) IN GENERAL.—If the Secretary adopts a  
10 modified standard under part 2, a health plan,  
11 health care provider, or purchasing cooperative shall  
12 be required to comply with the modified standard at  
13 such time as the Secretary determines appropriate  
14 taking into account the time needed to comply due  
15 to the nature and extent of the modification.

16           (2) SPECIAL RULE.—In the case of modifica-  
17 tions to standards that do not occur within the 12-  
18 month period beginning on the date such standards  
19 are adopted, the time determined appropriate by the  
20 Secretary under paragraph (1) shall be no sooner  
21 than the last day of the 90-day period beginning on  
22 the date such modified standard is adopted and no  
23 later than the last day of the 12 month period begin-  
24 ning on the date such modified standard is adopted.

1       **PART 4—ACCESSING HEALTH INFORMATION**

2       **SEC. 5131. ACCESSING HEALTH INFORMATION FOR AU-**  
3                                   **THORIZED PURPOSES.**

4           (a) **IN GENERAL.**—The Secretary shall adopt tech-  
5 nical standards for appropriate persons, including health  
6 plans, health care providers, health information network  
7 services certified under section 5141, health researchers,  
8 and Federal and State agencies, to locate and access the  
9 health information that is available through the health in-  
10 formation network due to the requirements of this subtitle.  
11 Such technical standards shall ensure that any request to  
12 locate or access information shall be authorized under sub-  
13 title C.

14           (b) **PROCUREMENT RULE FOR GOVERNMENT AGEN-**  
15 **CIES.**—

16               (1) **IN GENERAL.**—Health information protec-  
17 tion organizations certified under section 5141 shall  
18 make available to a Federal or State agency pursu-  
19 ant to a Federal Acquisition Regulation (or an  
20 equivalent State system), any non-identifiable health  
21 information that is requested by such agency.

22               (2) **CERTAIN INFORMATION AVAILABLE AT LOW**  
23 **COST.**—If a health information protection organiza-  
24 tion described in paragraph (1) needs information  
25 from a health plan or health care provider in order  
26 to comply with a request of a Federal or State agen-

1 cy that is necessary to comply with a requirement  
2 under this Act, such plan or provider shall make  
3 such information available to such organization for  
4 a charge that does not exceed the reasonable cost of  
5 transmitting the information. If requested, a health  
6 information protection organization that receives in-  
7 formation under the preceding sentence must make  
8 such information available to any other such organi-  
9 zation that is certified under section 5141 for a  
10 charge that does not exceed the reasonable cost of  
11 transmitting the information.

12 (c) **FUNCTIONAL SEPARATION.**—The standards  
13 adopted by the Secretary under subsection (a) shall ensure  
14 that any health information disclosed under such sub-  
15 section shall not, after such disclosure, be used or released  
16 for an administrative, regulatory, or law enforcement pur-  
17 pose unless such disclosure was made for such purpose.

18 (d) **PUBLIC USE FUNCTIONS.**—Nothing in this sub-  
19 title shall be construed to limit the authority of a Federal  
20 or State agency to make non-identifiable health informa-  
21 tion available for public use functions.

22 **SEC. 5132. RESPONDING TO ACCESS REQUESTS.**

23 (a) **IN GENERAL.**—The Secretary may adopt, and  
24 modify as appropriate, standards under which a health  
25 care provider or health plan shall respond to requests for

1 access to health information consistent with this subtitle  
2 and subtitle C.

3 (b) STANDARDS DESCRIBED.—The standards under  
4 subsection (a) shall provide—

5 (1) for a standard format under which a pro-  
6 vider or plan will respond to each request either by  
7 satisfying the request or responding with an expla-  
8 nation of the specific restriction which results in a  
9 failure to satisfy the request; and

10 (2) that any restrictions will not prevent a plan  
11 or provider from responding to a request in a timely  
12 manner taking into account the age and amount of  
13 the information being requested.

14 (c) CONSTRUCTION.—Nothing in this section shall be  
15 construed as permitting a health care provider or health  
16 plan to refuse to disclose any health information that is  
17 required to be disclosed by law.

18 **SEC. 5133. LENGTH OF TIME INFORMATION SHOULD BE AC-**  
19 **CESSIBLE.**

20 The Secretary shall adopt standards with respect to  
21 the length of time any standard data elements for a type  
22 of health information should be accessible through the  
23 health information network.

1 **SEC. 5134. TIMETABLES FOR ADOPTION OF STANDARDS**  
2 **AND COMPLIANCE.**

3 (a) INITIAL STANDARDS.—The Secretary shall adopt  
4 standards under this part not later than 9 months after  
5 the date of the enactment of this subtitle and such stand-  
6 ards shall be effective upon adoption.

7 (b) MODIFICATIONS TO STANDARDS.—

8 (1) IN GENERAL.—Except as provided in para-  
9 graph (2), the Secretary shall review the standards  
10 adopted under this part and shall adopt modified  
11 standards as determined appropriate, but no more  
12 frequently than once every 6 months. Any modifica-  
13 tion to standards shall be completed in a manner  
14 which minimizes the disruption and cost of compli-  
15 ance. Any modifications to standards adopted under  
16 this part shall be effective upon adoption.

17 (2) SPECIAL RULE.—The Secretary shall not  
18 adopt modifications to any standards adopted under  
19 this part during the 12-month period beginning on  
20 the date such standards are adopted unless the Sec-  
21 retary determines that a modification is necessary in  
22 order to permit compliance with the requirements of  
23 this part.

1 **PART 5—STANDARDS AND CERTIFICATION FOR**  
2 **HEALTH INFORMATION NETWORK**

3 **SEC. 5141. STANDARDS AND CERTIFICATION FOR HEALTH**  
4 **INFORMATION NETWORK SERVICES.**

5 (a) **STANDARDS FOR OPERATION.**—The Secretary  
6 shall establish standards with respect to the operation of  
7 health information network services, including standards  
8 ensuring that—

9 (1) such services develop, operate, and cooper-  
10 ate with one another to form the health information  
11 network;

12 (2) such services meet all of the requirements  
13 under subtitle C that are applicable to such services;

14 (3) such services make public information con-  
15 cerning their performance, as measured by uniform  
16 indicators such as accessibility, transaction respon-  
17 siveness, administrative efficiency, reliability, de-  
18 pendability, and any other indicator determined ap-  
19 propriate by the Secretary;

20 (4) such services have security procedures that  
21 are consistent with the privacy requirements under  
22 subtitle C, including secure methods of access to and  
23 transmission of data;

24 (5) such services, if they are part of a larger or-  
25 ganization, have policies and procedures in place  
26 which isolate their activities with respect to proc-

1       essing information in a manner that prevents access  
2       to such information by such larger organization.

3       (b) CERTIFICATION BY THE SECRETARY.—

4           (1) ESTABLISHMENT.—Not later than 12  
5       months after the date of the enactment of this sub-  
6       title, the Secretary shall establish a certification pro-  
7       cedure for health information network services which  
8       ensures that certified services are qualified to meet  
9       the requirements of this subtitle and the standards  
10      established by the Secretary under this section. Such  
11      certification procedure shall be implemented in a  
12      manner that minimizes the costs and delays of oper-  
13      ations for such services.

14          (2) APPLICATION.—Each entity desiring to be  
15      certified as a health information network service  
16      shall apply to the Secretary for certification in a  
17      form and manner determined appropriate by the  
18      Secretary.

19          (3) AUDITS AND REPORTS.—The procedure es-  
20      tablished under paragraph (1) shall provide for au-  
21      dits by the Secretary and reports by an entity cer-  
22      tified under this section as the Secretary determines  
23      appropriate in order to monitor such entity's compli-  
24      ance with the requirements of this subtitle, subtitle

1 C, and the standards established by the Secretary  
2 under this section.

3 (4) RECERTIFICATION.—A health information  
4 network service must be recertified under this sub-  
5 section at least every 3 years.

6 (c) LOSS OF CERTIFICATION.—

7 (1) MANDATORY TERMINATION.—Except as  
8 provided in paragraph (3), if a health information  
9 network service violates a requirement imposed on  
10 such service under subtitle C, its certification under  
11 this section shall be terminated unless the Secretary  
12 determines that appropriate corrective action has  
13 been taken.

14 (2) DISCRETIONARY TERMINATION.—If a health  
15 information network service violates a requirement  
16 or standard imposed under this subtitle and a pen-  
17 alty has been imposed under section 5151, the Sec-  
18 retary shall review the certification of such service  
19 and may terminate such certification.

20 (3) CONDITIONAL CERTIFICATION.—The Sec-  
21 retary may establish a procedure under which a  
22 health information network service may remain cer-  
23 tified on a conditional basis if the service is oper-  
24 ating consistently with a plan intended to correct  
25 any violations described in paragraphs (1) or (2).

1 Such procedure may provide for the appointment of  
2 a trustee to continue operation of the service until  
3 the requirements for full certification are met.

4 (d) CERTIFICATION BY PRIVATE ENTITIES.—The  
5 Secretary may designate private entities to conduct the  
6 certification procedures established by the Secretary under  
7 this section. A health information network service certified  
8 by such an entity in accordance with such designation  
9 shall be considered to be certified by the Secretary.

10 **SEC. 5142. ENSURING AVAILABILITY OF INFORMATION.**

11 The Secretary shall establish a procedure under  
12 which a health plan or health care provider which does  
13 not have the ability to transmit standard data elements  
14 directly or does not have access to a health information  
15 network service certified under section 5141 shall be able  
16 to make health information available for disclosure as au-  
17 thorized by this subtitle.

18 **PART 6—PENALTIES**

19 **SEC. 5151. GENERAL PENALTY FOR FAILURE TO COMPLY**  
20 **WITH REQUIREMENTS AND STANDARDS.**

21 (a) IN GENERAL.—Except as provided in subsection  
22 (b), the Secretary shall impose on any person that violates  
23 a requirement or standard imposed under this subtitle a  
24 penalty of not more than \$1,000 for each violation. The  
25 provisions of section 1128A of the Social Security Act

1 (other than subsections (a) and (b) and the second sen-  
2 tence of subsection (f)) shall apply to the imposition of  
3 a civil money penalty under this subsection in the same  
4 manner as such provisions apply to the imposition of a  
5 penalty under section 1128A of such Act.

6 (b) LIMITATIONS.—

7 (1) NONCOMPLIANCE NOT DISCOVERED EXER-  
8 CISING REASONABLE DILIGENCE.—A penalty may  
9 not be imposed under subsection (a) if it is estab-  
10 lished to the satisfaction of the Secretary that the  
11 person liable for the penalty did not know, and by  
12 exercising reasonable diligence would not have  
13 known, that such person failed to comply with the  
14 requirement or standard described in subsection (a).

15 (2) FAILURES DUE TO REASONABLE CAUSE.—

16 (A) IN GENERAL.—Except as provided in  
17 subparagraphs (B) and (C), a penalty may not  
18 be imposed under subsection (a) if—

19 (i) the failure to comply was due to  
20 reasonable cause and not to willful neglect;  
21 and

22 (ii) the failure to comply is corrected  
23 during the 30-day period beginning on the  
24 1st date the person liable for the penalty  
25 knew, or by exercising reasonable diligence

1 would have known, that the failure to com-  
2 ply occurred.

3 (B) EXTENSION OF PERIOD.—

4 (i) NO PENALTY.—The period re-  
5 ferred to in subparagraph (A)(ii) may be  
6 extended as determined appropriate by the  
7 Secretary based on the nature and extent  
8 of the failure to comply.

9 (ii) ASSISTANCE.—If the Secretary  
10 determines that a health plan, health care  
11 provider, or purchasing cooperative failed  
12 to comply because such person was unable  
13 to comply, the Secretary may provide tech-  
14 nical assistance to such person. Such as-  
15 sistance shall be provided in any manner  
16 determined appropriate by the Secretary.

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

1           **PART 7—MISCELLANEOUS PROVISIONS**

2   **SEC. 5161. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

3           (a) DATA ELEMENT STANDARDS.—A person may not  
4 impose a standard on another person that is in addition  
5 to the standards adopted by the Secretary under section  
6 5112 unless—

7           (1) such person voluntarily agrees to such  
8 standard; or

9           (2) a waiver is granted under subsection (e) to  
10 impose such standard.

11          (b) TRANSACTIONS AND ACCESS STANDARDS.—A  
12 person may not impose a standard on another person that  
13 is in addition to the standards adopted by the Secretary  
14 under section 5113 or 5131 unless such person voluntarily  
15 agrees to such standard.

16          (c) CONDITIONS FOR WAIVERS.—

17           (1) IN GENERAL.—A person may request a  
18 waiver from the Secretary in order to require an-  
19 other person to comply with a standard that is in  
20 addition to the standards adopted by the Secretary  
21 under section 5112.

22           (2) CONSIDERATION OF WAIVER REQUESTS.—  
23 No waiver may be granted unless the Secretary de-  
24 termines that the value of the data to be exchanged  
25 for research or other purposes significantly out-  
26 weighs the administrative cost of the additional

1 standard taking into consideration the burden of the  
2 timing of the imposition of the additional standard.

3 (3) ANONYMOUS REPORTING.—If a person at-  
4 tempts to impose a standard in addition to the  
5 standards adopted by the Secretary under section  
6 5112, the person on whom such additional standard  
7 is being imposed may contact the Secretary. The  
8 Secretary shall develop a procedure under which the  
9 contacting person shall remain anonymous. The Sec-  
10 retary shall notify the person imposing the addi-  
11 tional standard that the additional standard may not  
12 be imposed unless the other person voluntarily  
13 agrees to such standard or a waiver is obtained  
14 under this subsection.

15 **SEC. 5162. EFFECT ON STATE LAW.**

16 (a) IN GENERAL.—A provision, requirement, or  
17 standard under this subtitle shall supersede any contrary  
18 provision of State law, including—

19 (1) a provision of State law that requires med-  
20 ical or health plan records (including billing informa-  
21 tion) to be maintained or transmitted in written  
22 rather than electronic form, and

23 (2) a provision of State law which provides for  
24 requirements or standards that are more stringent

1 than the requirements or standards under this sub-  
2 title;  
3 except where the Secretary determines that the provision  
4 is necessary to prevent fraud and abuse, with respect to  
5 controlled substances, or for other purposes.

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

12 **SEC. 5164. HEALTH INFORMATION CONTINUITY.**

13 (a) INFORMATION HELD BY HEALTH PLANS AND  
14 PROVIDERS.—If a health plan or health care provider  
15 takes any action that would threaten the continued avail-  
16 ability of the standard data elements of health information  
17 held by such plan or provider, such data elements shall  
18 be obtained by the State in which such plan or provider  
19 is located. The State shall ensure that such data elements  
20 are transferred to a health plan or health care provider  
21 in accordance with procedures established by the Sec-  
22 retary.

23 (b) INFORMATION HELD BY HEALTH INFORMATION  
24 NETWORK SERVICES.—If a health information network  
25 service certified under section 5141 loses its certified sta-

1 tus or takes any action that would threaten the continued  
2 availability of the standard data elements of health infor-  
3 mation held by such service, such data elements shall be  
4 transferred to another health information network service  
5 certified under section 5141, as designated by the Sec-  
6 retary.

7 **SEC. 5165. PROTECTION OF COMMERCIAL INFORMATION.**

8 In adopting standards under this subtitle, the Sec-  
9 retary shall not require disclosure of trade secrets and  
10 confidential commercial information by entities operating  
11 in the health information network except as required by  
12 law.

13 **SEC. 5166. PAYMENT FOR HEALTH CARE SERVICES OR**  
14 **HEALTH PLAN PREMIUMS.**

15 Nothing in this subtitle shall be construed to prohibit  
16 payments for health care services or health plan premiums  
17 from being made by debit, credit, or other payment cards  
18 or numbers or other electronic payment means.

19 **SEC. 5167. HEALTH SECURITY CARDS.**

20 (a) IN GENERAL.—The Secretary shall establish  
21 standards relating to the form of health security cards  
22 issued by health plans and the information to be encoded  
23 electronically on such cards.

24 (b) FORM DESCRIBED.—The standard form for a  
25 health security card shall be a card which—

1           (1) is made of plastic or a similar durable ma-  
2           terial with a useful life of at least 5 years;

3           (2) is resistant to counterfeiting;

4           (3) can store information that can be encoded  
5           and retrieved electronically;

6           (4) can be produced in a cost-effective manner  
7           and used in all types of health care locations; and

8           (5) specifies on its face the social security ac-  
9           count number assigned to the individual who is the  
10          cardholder by the Secretary under section 205(e)(2)  
11          of the Social Security Act.

12          (b) INFORMATION DESCRIBED.—The information  
13          electronically encoded on a health security card shall in-  
14          clude the identity of the individual to whom the card was  
15          issued, including such individual's personal health identi-  
16          fier specified under section 5112(e)(1), and may include  
17          any other information that the Secretary determines may  
18          be useful in order for the card to serve the purpose of  
19          easing access to and paying for health care services. A  
20          health plan shall make available to an individual card-  
21          holder, upon demand by such individual, a printed copy  
22          of all information electronically encoded on such individ-  
23          ual's health security card.

1 **SEC. 5168. MISUSE OF HEALTH SECURITY CARD OR PER-**  
2 **SONAL HEALTH IDENTIFIER.**

3 (a) HEALTH SECURITY CARD.—A person who—

4 (1) requires the display of, requires the use of,  
5 or uses a health security card for any purpose other  
6 than obtaining or paying for health care;

7 (2) falsely makes, forges, counterfeits or alters  
8 a health security card;

9 (3) without lawful authority prints, photo-  
10 graphs, or makes any impression in the likeness of  
11 any health security card; or

12 (4) sells, transfers, or otherwise delivers a false,  
13 forged, counterfeited, or altered health security card  
14 knowing that the card is false, forged, counterfeited,  
15 or altered;

16 shall be fined not more than \$25,000, imprisoned not  
17 more than 2 years, or both.

18 (b) PERSONAL HEALTH IDENTIFIER.—A person who  
19 requires the disclosure of, requires the use of, or uses an  
20 individual's personal health identifier for any purpose that  
21 is not authorized by the Secretary, shall be fined not more  
22 than \$25,000, imprisoned not more than 2 years, or both.

23 **SEC. 5169. DIRECT BILLING FOR CLINICAL LABORATORY**  
24 **SERVICES.**

25 (a) IN GENERAL.—

1           (1) REQUIREMENT.—Except as provided in  
2           paragraph (2), in the case of a claim for payment  
3           for a clinical diagnostic laboratory test for which  
4           payment may otherwise be made, payment may be  
5           made only to the person who, or entity which, per-  
6           formed or supervised the test.

7           (2) EXCEPTION.—Payment for a clinical diag-  
8           nostic laboratory test may be made to a physician  
9           with whom the physician who performed the test  
10          shares a practice.

11          (b) ADDITIONAL EXCEPTIONS.—The Secretary may,  
12          by regulation, establish exceptions to the requirement  
13          under subsection (a)(1) that are in addition to the excep-  
14          tion under subsection (a)(2). In establishing such excep-  
15          tions the Secretary shall take into account—

16                (1) circumstances in which an individual’s pri-  
17                vacy might be violated; or

18                (2) the need for confidentiality on the part of  
19                the person furnishing the test.

20       **SEC. 5170. AUTHORIZATION OF APPROPRIATIONS.**

21          There are authorized to be appropriated such sums  
22          as may be necessary to carry out the purposes of this sub-  
23          title.

1       **PART 8—ASSISTANCE TO THE SECRETARY**

2       **SEC. 5171. GENERAL REQUIREMENT ON SECRETARY.**

3       In complying with any requirements imposed under  
4 this subtitle, the Secretary shall rely on recommendations  
5 of the Health Information Advisory Committee established  
6 under section 5172 and shall consult with appropriate  
7 Federal agencies.

8       **SEC. 5172. HEALTH INFORMATION ADVISORY COMMITTEE.**

9       (a) **ESTABLISHMENT.**—There is established a com-  
10 mittee to be known as the Health Care Information Advi-  
11 sory Committee.

12       (b) **DUTY.**—

13               (1) **IN GENERAL.**—The committee shall—

14                       (A) provide assistance to the Secretary in  
15 complying with the requirements imposed on  
16 the Secretary under this subtitle and subtitle C;

17                       (B) be generally responsible for advising  
18 the Secretary and the Congress on the status of  
19 the health information network; and

20                       (C) make recommendations to correct any  
21 problems that may occur in the network's im-  
22 plementation and ongoing operations and to re-  
23 fine and improve the network.

24               (2) **TECHNICAL ASSISTANCE.**—In performing  
25 its duties under this subsection, the committee shall

1 receive technical assistance from appropriate Federal  
2 agencies.

3 (c) MEMBERSHIP.—

4 (1) IN GENERAL.—The committee shall consist  
5 of 15 members to be appointed by the President not  
6 later than 60 days after the date of the enactment  
7 of this subtitle. The President shall designate 1  
8 member as the Chair.

9 (2) EXPERTISE.—The membership of the com-  
10 mittee shall consist of individuals who are of recog-  
11 nized standing and distinction and who possess the  
12 demonstrated capacity to discharge the duties im-  
13 posed on the committee.

14 (3) TERMS.—Each member of the committee  
15 shall be appointed for a term of 5 years, except that  
16 the members first appointed shall serve staggered  
17 terms such that the terms of no more than 3 mem-  
18 bers expire at one time.

19 (4) VACANCIES.—

20 (A) IN GENERAL.—A vacancy on the com-  
21 mittee shall be filled in the manner in which the  
22 original appointment was made and shall be  
23 subject to any conditions which applied with re-  
24 spect to the original appointment.

1 (B) FILLING UNEXPIRED TERM.—An indi-  
2 vidual chosen to fill a vacancy shall be ap-  
3 pointed for the unexpired term of the member  
4 replaced.

5 (C) EXPIRATION OF TERMS.—The term of  
6 any member shall not expire before the date on  
7 which the member's successor takes office.

8 (5) CONFLICTS OF INTEREST.—Members of the  
9 committee shall disclose upon appointment to the  
10 committee or at any subsequent time that it may  
11 occur, conflicts of interest.

12 (d) MEETINGS.—

13 (1) IN GENERAL.—Except as provided in para-  
14 graph (2), the committee shall meet at the call of  
15 the Chair.

16 (2) INITIAL MEETING.—Not later than 30 days  
17 after the date on which all members of the com-  
18 mittee have been appointed, the committee shall hold  
19 its first meeting.

20 (3) QUORUM.—A majority of the members of  
21 the committee shall constitute a quorum, but a less-  
22 er number of members may hold hearings.

23 (e) POWER TO HOLD HEARINGS.—The committee  
24 may hold such hearings, sit and act at such times and  
25 places, take such testimony, and receive such evidence as

1 the committee considers advisable to carry out the pur-  
2 poses of this section.

3 (f) OTHER ADMINISTRATIVE PROVISIONS.—Subpara-  
4 graphs (C), (D), and (H) of section 1886(e)(6) of the So-  
5 cial Security Act shall apply to the committee in the same  
6 manner as they apply to the Prospective Payment Assess-  
7 ment Commission.

8 (g) REPORTS.—

9 (1) IN GENERAL.—The committee shall annu-  
10 ally prepare and submit to Congress and the Sec-  
11 retary a report including at least an analysis of—

12 (A) the status of the health information  
13 network established under this subtitle, includ-  
14 ing whether the network is fulfilling the pur-  
15 pose described in section 5101;

16 (B) the savings and costs of the network;

17 (C) the activities of health information net-  
18 work services certified under section 5141,  
19 health care providers, health plans, and other  
20 entities using the network to exchange health  
21 information;

22 (D) the extent to which entities described  
23 in subparagraph (C) are meeting the standards  
24 adopted under this subtitle and working to-

1           gether to form an integrated network that  
2           meets the needs of its users;

3           (E) the extent to which entities described  
4           in subparagraph (C) are meeting the privacy  
5           and security protections of subtitle C;

6           (F) the number and types of penalties as-  
7           sessed for noncompliance with the standards  
8           adopted under this subtitle;

9           (G) whether the Federal Government and  
10          State Governments are receiving information of  
11          sufficient quality to meet their responsibilities  
12          under the Health Security Act;

13          (H) any problems with respect to imple-  
14          mentation of the network;

15          (I) the extent to which timetables under  
16          this subtitle for the adoption and implementa-  
17          tion of standards are being met; and

18          (J) any legislative recommendations re-  
19          lated to the health information network.

20          (2) AVAILABILITY TO THE PUBLIC.—Any infor-  
21          mation in the report submitted to Congress under  
22          paragraph (1) shall be made available to the public  
23          unless such information may not be disclosed by law.

1 (h) DURATION.—Notwithstanding section 14(a) of  
2 the Federal Advisory Committee Act, the committee shall  
3 continue in existence until otherwise provided by law.

4 (i) AUTHORIZATION OF APPROPRIATIONS.—

5 (1) IN GENERAL.—There are authorized to be  
6 appropriated such sums as may be necessary to  
7 carry out the purposes of this section.

8 (2) AVAILABILITY.—Any sums appropriated  
9 under the authorization contained in this subsection  
10 shall remain available, without fiscal year limitation,  
11 until expended.

12 **PART 9—DEMONSTRATION PROJECTS FOR COM-**  
13 **MUNITY-BASED CLINICAL INFORMATION**  
14 **SYSTEMS**

15 **SEC. 5181. GRANTS FOR DEMONSTRATION PROJECTS.**

16 (a) IN GENERAL.—The Secretary may make grants  
17 for demonstration projects to promote the development  
18 and use of electronically integrated community-based clin-  
19 ical information systems and computerized patient medical  
20 records.

21 (b) APPLICATIONS.—

22 (1) SUBMISSION.—To apply for a grant under  
23 this part for any fiscal year, an applicant shall sub-  
24 mit an application to the Secretary in accordance  
25 with the procedures established by the Secretary.

1           (2) CRITERIA FOR APPROVAL.—The Secretary  
2           may not approve an application submitted under  
3           paragraph (1) unless the application includes assur-  
4           ances satisfactory to the Secretary regarding the fol-  
5           lowing:

6                   (A) USE OF EXISTING TECHNOLOGY.—

7           Funds received under this part will be used to  
8           apply telecommunications and information sys-  
9           tems technology that is in existence on the date  
10          the application is submitted in a manner that  
11          improves the quality of health care, reduces the  
12          costs of such care, and protects the privacy and  
13          confidentiality of information relating to the  
14          physical or mental condition of an individual.

15                  (B) USE OF EXISTING INFORMATION SYS-

16          TEMS.—Funds received under this part will be  
17          used—

18                   (i) to enhance telecommunications or  
19                   information systems that are operating on  
20                   the date the application is submitted;

21                   (ii) to integrate telecommunications or  
22                   information systems that are operating on  
23                   the date the application is submitted; or

24                   (iii) to connect additional users to  
25                   telecommunications or information net-

1                   works or systems that are operating on the  
2                   date the application is submitted.

3                   (C) MATCHING FUNDS.—The applicant  
4                   shall make available funds for the demonstra-  
5                   tion project in an amount that equals at least  
6                   20 percent of the cost of the project.

7                   (c) GEOGRAPHIC DIVERSITY.—In making any grants  
8                   under this part, the Secretary shall, to the extent prac-  
9                   ticable, make grants to persons representing different geo-  
10                  graphic areas of the United States, including urban and  
11                  rural areas.

12                  (d) REVIEW AND SANCTIONS.—The Secretary shall  
13                  review at least annually the compliance of a person receiv-  
14                  ing a grant under this part with the provisions of this  
15                  part. The Secretary shall establish a procedure for deter-  
16                  mining whether such a person has failed to comply sub-  
17                  stantially within the provisions of this part and the sanc-  
18                  tions to be imposed for any such noncompliance.

19                  (e) ANNUAL REPORT.—The Secretary shall submit  
20                  an annual report to the President for transmittal to Con-  
21                  gress containing a description of the activities carried out  
22                  under this part.

23                  (g) AUTHORIZATION OF APPROPRIATIONS.—There  
24                  are authorized to be appropriated such sums as may be  
25                  necessary to carry out the purposes of this section.

1 **PART 10—MEDICARE AND MEDICAID COVERAGE**

2 **DATA BANK**

3 **SEC. 5191. REPEAL OF MEDICARE AND MEDICAID COV-**  
4 **ERAGE DATA BANK.**

5 (a) REPEAL OF DATA BANK.—Section 1144 of the  
6 Social Security Act (42 U.S.C. 1320b–14), as added by  
7 section 13581 of the Omnibus Budget Reconciliation Act  
8 of 1993, is repealed.

9 (b) CONFORMING AMENDMENTS.—

10 (1) MEDICARE.—Section 1862(b)(5) of such  
11 Act (42 U.S.C. 1395y(b)(5)) is amended—

12 (A) in subparagraph (B), by striking “the  
13 information received under” and all that follows  
14 and inserting “the information received under  
15 subparagraph (A) for the purposes of carrying  
16 out this subsection.”; and

17 (B) in subparagraph (C)(i), by striking  
18 “subparagraph (B)(i)” and inserting “subpara-  
19 graph (B)”.

20 (2) MEDICAID.—Section 1902(a)(25)(A)(i) of  
21 such Act (42 U.S.C. 1396(a)(25)(A)(i)) is amended  
22 by striking “(including the use of information col-  
23 lected by the Medicare and Medicaid Coverage Data  
24 Bank under section 1144 and any additional meas-  
25 ures as specified” and inserting “(as specified”.

1           (3) CONFORMING AMENDMENT RELATED TO  
2 DATA MATCHES.—Subsection (a)(8)(B) of section  
3 552a of title 5, United States Code, is amended—

4           (A) in clause (v), by adding “; or” at the  
5 end;

6           (B) in clause (vi), by striking “; or” and  
7 inserting a semicolon; and

8           (C) by striking clause (vii).

9           (4) CONFORMING AMENDMENT TO ERISA.—

10           (A) Section 101 of the Employee Retirement  
11 Income Security Act of 1974 (29 U.S.C.  
12 1031) is amended—

13           (i) by striking subsection (f); and

14           (ii) by redesignating subsection (g) as  
15 subsection (f).

16           (B) Section 502(a) of such Act (29 U.S.C.  
17 1132(a)) is amended—

18           (i) in paragraph (6), by striking the  
19 semicolon at the end and inserting “; or”;

20           (ii) in paragraph (7), by striking “;  
21 or” and inserting a period; and

22           (iii) by striking paragraph (8).

23           (C) Section 502(c) of such Act (29 U.S.C.  
24 1132(c)) is amended by striking paragraph (4).

1 (D) Section 502(e)(1) of such Act (29  
2 U.S.C. 1132(e)(1)) is amended by striking “fi-  
3 duciary, or any person referred to in section  
4 101(f)(1)” and inserting “or fiduciary”.

## 5 **Subtitle C—Privacy of Health** 6 **Information**

### 7 **PART 1—FINDINGS AND DEFINITIONS**

#### 8 **SEC. 5201. FINDINGS AND PURPOSES.**

9 (a) FINDINGS.—The Congress finds as follows:

10 (1) The improper disclosure of individually  
11 identifiable health care information may cause sig-  
12 nificant harm to an individual’s interests in privacy,  
13 health care, and reputation and may unfairly affect  
14 the ability of an individual to obtain employment,  
15 education, insurance, and credit.

16 (2) The movement of people and health care re-  
17 lated information across State lines, the availability  
18 of, access to, and exchange of health care related in-  
19 formation with Federally funded health care sys-  
20 tems, the medicare program under title XVIII of the  
21 Social Security Act, and the medicaid program  
22 under title XIX of such Act, through automated  
23 data banks and networks, and the emergence of  
24 other multistate health care providers and payors

1 create a need for a uniform Federal law governing  
2 the disclosure of health care information.

3 (b) PURPOSE.—The purpose of this subtitle is to es-  
4 tablish effective mechanisms to protect the privacy of indi-  
5 viduals with respect to individually identifiable health care  
6 information that is created or maintained as part of health  
7 treatment, enrollment, payment, testing, or research proc-  
8 esses.

9 **SEC. 5202. DEFINITIONS.**

10 (a) TERMS RELATING TO PROTECTED HEALTH IN-  
11 FORMATION.—In this subtitle:

12 (1) PROTECTED HEALTH INFORMATION.—The  
13 term “protected health information” means any in-  
14 formation, including demographic information col-  
15 lected from an individual, whether oral or recorded  
16 in any form or medium, that—

17 (A) is created or received by a health care  
18 provider, health plan, health oversight agency,  
19 health researcher, public health authority, em-  
20 ployer, life insurer, school or university, or cer-  
21 tified health information network service; and

22 (B) relates to the past, present, or future  
23 physical or mental health or condition of an in-  
24 dividual, the provision of health care to an indi-  
25 vidual, or the past, present, or future payment

1 for the provision of health care to an individual,  
2 and—

3 (i) identifies an individual; or

4 (ii) with respect to which there is a  
5 reasonable basis to believe that the infor-  
6 mation can be used to identify an indi-  
7 vidual.

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

13 (b) TERMS RELATING TO HEALTH CARE SYSTEM  
14 PARTICIPANTS.—In this subtitle:

15 (1) HEALTH INFORMATION TRUSTEE.—The  
16 term “health information trustee” means—

17 (A) a health care provider, health plan,  
18 health oversight agency, certified health infor-  
19 mation network service, employer, life insurer,  
20 or school or university insofar as it creates, re-  
21 ceives, maintains, uses, or transmits protected  
22 health information;

23 (B) any person who obtains protected  
24 health information under section 5213, 5217,  
25 5218, 5221, 5222, 5226, or 5231; and

1 (C) any employee or agent of a person cov-  
2 ered under subparagraph (A) or (B).

3 (2) HEALTH CARE.—The term “health care”—

4 (A) means—

5 (i) a preventative, diagnostic, thera-  
6 peutic, rehabilitative, maintenance, or pal-  
7 liative care, counseling, service, or proce-  
8 dure—

9 (I) with respect to the physical or  
10 mental condition of an individual; or

11 (II) affecting the structure or  
12 function of the human body or any  
13 part of the human body; or

14 (ii) any sale or dispensing of a drug,  
15 device, equipment, or other item to an indi-  
16 vidual, or for the use of an individual, pur-  
17 suant to a prescription; but

18 (B) does not include any item or service  
19 that is not furnished for the purpose of exam-  
20 ining, maintaining, or improving the health of  
21 an individual.

22 (3) HEALTH CARE PROVIDER.—The term  
23 “health care provider” means a person who is li-  
24 censed, certified, registered, or otherwise authorized  
25 by law to provide an item or service that constitutes

1 health care in the ordinary course of business or  
2 practice of a profession.

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

5 (A) performs or oversees the performance  
6 of an assessment, evaluation, determination, or  
7 investigation relating to the licensing, accredita-  
8 tion, or certification of health care  
9 providers; or

10 (B)(i) performs or oversees the perform-  
11 ance of an assessment, evaluation, determina-  
12 tion, or investigation relating to the effective-  
13 ness of, compliance with, or applicability of  
14 legal, fiscal, medical, or scientific standards or  
15 aspects of performance related to the delivery  
16 of, or payment for, health care or relating to  
17 health care fraud or fraudulent claims for pay-  
18 ment regarding health; and

19 (ii) is a public agency, acting on behalf of  
20 a public agency, acting pursuant to a require-  
21 ment of a public agency, or carrying out activi-  
22 ties under a Federal or State law governing the  
23 assessment, evaluation, determination, or inves-  
24 tigation described in clause (i).

1           (5) HEALTH PLAN.—The term “health plan”  
2 shall have the meaning given such term under sec-  
3 tion 5102.

4           (6) HEALTH RESEARCHER.—The term “health  
5 researcher” means a person who conducts a bio-  
6 medical, public health, epidemiological, health serv-  
7 ices, or health statistics research project or a re-  
8 search project on social and behavioral factors relat-  
9 ing to health.

10          (7) INSTITUTIONAL REVIEW BOARD.—The term  
11 “institutional review board” means—

12           (A) a board established in accordance with  
13 regulations of the Secretary under section  
14 491(a) of the Public Health Service Act;

15           (B) a similar board established by the Sec-  
16 retary for the protection of human subjects in  
17 research conducted by the Secretary; or

18           (C) a similar board established under regu-  
19 lations of a Federal Government authority other  
20 than the Secretary.

21          (8) PUBLIC HEALTH AUTHORITY.—The term  
22 “public health authority” means an authority or in-  
23 strumentality of the United States, a State, or a po-  
24 litical subdivision of a State that is (A) responsible  
25 for public health matters; and (B) engaged in such

1 activities as injury reporting, public health surveil-  
2 lance, and public health investigation or interven-  
3 tion.

4 (c) REFERENCES TO CERTIFIED ENTITIES.—In this  
5 subtitle:

6 (1) CERTIFIED HEALTH INFORMATION NET-  
7 WORK SERVICE.—The term “certified health infor-  
8 mation network service” means a health information  
9 service (as defined under section 5102) that is cer-  
10 tified under section 5141.

11 (2) CERTIFIED HEALTH INFORMATION PROTEC-  
12 TION ORGANIZATION.—The term “certified health  
13 information protection organization” means a health  
14 information protection organization (as defined in  
15 section 5102) that is certified under section 5141.

16 (d) OTHER TERMS.—In this subtitle:

17 (1) INDIVIDUAL REPRESENTATIVE.—The term  
18 “individual representative” means any individual le-  
19 gally empowered to make decisions concerning the  
20 provision of health care to an individual (where the  
21 individual lacks the legal capacity under State law to  
22 make such decisions) or the administrator or execu-  
23 tor of the estate of a deceased individual.

24 (2) LAW ENFORCEMENT INQUIRY.—The term  
25 “law enforcement inquiry” means an investigation or

1 official proceeding inquiring into whether there is a  
2 violation of, or failure to comply with, any criminal  
3 or civil statute or any regulation, rule, or order  
4 issued pursuant to such a statute.

5 (3) PERSON.—The term “person” includes an  
6 authority of the United States, a State, or a political  
7 subdivision of a State.

## 8 **PART 2—AUTHORIZED DISCLOSURES**

### 9 **Subpart A—General Provisions**

#### 10 **SEC. 5206. GENERAL RULES REGARDING DISCLOSURE.**

11 (a) GENERAL RULE.—A health information trustee  
12 may disclose protected health information only for a pur-  
13 pose that is authorized under this subtitle.

14 (b) DISCLOSURE WITHIN A TRUSTEE.—A health in-  
15 formation trustee may disclose protected health informa-  
16 tion to an officer, employee, or agent of the trustee, but  
17 only for a purpose that is compatible with and related to  
18 the purpose for which the information was collected or re-  
19 ceived by that trustee.

20 (c) SCOPE OF DISCLOSURE.—

21 (1) IN GENERAL.—Every disclosure of protected  
22 health information by a health information trustee  
23 shall be limited to the minimum amount of informa-  
24 tion necessary to accomplish the purpose for which  
25 the information is disclosed.

1           (2) REGULATIONS.—The Secretary, after notice  
2           and opportunity for public comment, may issue reg-  
3           ulations under paragraph (1), which shall take into  
4           account the technical capabilities of the record sys-  
5           tems used to maintain protected health information  
6           and the costs of limiting disclosure.

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

10          (e) USE AND REDISCLOSURE OF INFORMATION.—  
11          The protected health information received under a disclo-  
12          sure permitted by the subtitle may not be used or disclosed  
13          unless the use or disclosure is necessary to fulfill the pur-  
14          pose for which the information was obtained and is not  
15          otherwise prohibited by law. Protected health information  
16          about an individual that is disclosed under this subtitle  
17          may not be used in, or disclosed to any person for use  
18          in, any administrative, civil, or criminal action or inves-  
19          tigation directed against the individual unless specifically  
20          permitted by this subtitle.

21          (f) IDENTIFICATION OF DISCLOSED INFORMATION AS  
22          PROTECTED INFORMATION.—

23                 (1) IN GENERAL.—Except with respect to pro-  
24                 tected health information that is disclosed under sec-  
25                 tion 5213 and except as provided in paragraph (2),

1 a health information trustee may not disclose pro-  
2 tected health information unless such information is  
3 clearly identified as protected health information  
4 that is subject to this subtitle.

5 (2) ROUTINE DISCLOSURES SUBJECT TO WRIT-  
6 TEN AGREEMENT.—A health information trustee  
7 who routinely discloses protected health information  
8 to a person may satisfy the identification require-  
9 ment in paragraph (1) through a written agreement  
10 between the trustee and the person with respect to  
11 the protected health information.

12 (g) CONSTRUCTION.—Nothing in this subtitle shall  
13 be construed to limit the ability of a health information  
14 trustee to charge a reasonable fee for the disclosure or  
15 reproduction of health information.

16 (h) INFORMATION IN WHICH PROVIDERS ARE IDEN-  
17 TIFIED.—The Secretary, after notice and opportunity for  
18 public comment, may issue regulations protecting informa-  
19 tion identifying providers in order to promote the avail-  
20 ability of health care services.

21 **SEC. 5207. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**  
22 **TECTED HEALTH INFORMATION.**

23 (a) WRITTEN AUTHORIZATIONS.—A health informa-  
24 tion trustee may disclose protected health information  
25 pursuant to an authorization executed by the individual

1 who is the subject of the information, if each of the fol-  
2 lowing requirements is met:

3           (1) WRITING.—The authorization is in writing,  
4           signed by the individual who is the subject of the in-  
5           formation, and dated on the date of such signature.

6           (2) SEPARATE FORM.—The authorization is not  
7           on a form used to authorize or facilitate the provi-  
8           sion of, or payment for, health care.

9           (3) TRUSTEE DESCRIBED.—The trustee is spe-  
10          cifically named or generically described in the au-  
11          thorization as authorized to disclose such informa-  
12          tion.

13          (4) RECIPIENT DESCRIBED.—The person to  
14          whom the information is to be disclosed is specifi-  
15          cally named or generically described in the author-  
16          ization as a person to whom such information may  
17          be disclosed.

18          (5) STATEMENT OF INTENDED DISCLOSURES.—  
19          The authorization contains an acknowledgment that  
20          the individual who is the subject of the information  
21          has read a statement of the disclosures that the per-  
22          son to receive the protected health information in-  
23          tends to make, which statement shall be in writing,  
24          on a form that is distinct from the authorization for  
25          disclosure, and which statement must be received by

1 the individual authorizing the disclosure on or before  
2 such authorization is executed.

3 (6) INFORMATION DESCRIBED.—The informa-  
4 tion to be disclosed is described in the authorization.

5 (7) EXPIRATION DATE SPECIFIED.—The au-  
6 thorization specifies a date or event upon which the  
7 authorization expires, which shall not exceed 2 years  
8 from the date of the execution of the authorization.

9 (8) AUTHORIZATION TIMELY RECEIVED.—The  
10 authorization is received by the trustee during a pe-  
11 riod described in subsection (c)(1).

12 (9) DISCLOSURE TIMELY MADE.—The dislo-  
13 sure occurs during a period described in subsection  
14 (c)(2).

15 (b) AUTHORIZATIONS REQUESTED IN CONNECTION  
16 WITH PROVISION OF HEALTH CARE.—

17 (1) IN GENERAL.—A health information trustee  
18 may not request that an individual provide to any  
19 other person an authorization described in sub-  
20 section (a) on a day on which—

21 (A) the trustee provides health care to the  
22 individual requested to provide the authoriza-  
23 tion; or

24 (B) in the case of a trustee that is a health  
25 facility, the individual is admitted into the facil-

1           ity as a resident or inpatient in order to receive  
2           health care.

3           (2) EXCEPTION.—Paragraph (1) does not apply  
4           if a health information trustee requests that an indi-  
5           vidual provide an authorization described in sub-  
6           section (a) for the purpose of assisting the individual  
7           in obtaining counseling or social services from a per-  
8           son other than the trustee.

9           (c) TIME LIMITATIONS ON AUTHORIZATIONS.—

10           (1) RECEIPT BY TRUSTEE.—For purposes of  
11           subsection (a)(8), an authorization is timely received  
12           if it is received by the trustee during—

13                   (A) the 1-year period beginning on the  
14                   date on which the authorization is signed under  
15                   subsection (a)(1), if the authorization permits  
16                   the disclosure of protected health information to  
17                   a person who provides health counseling or so-  
18                   cial services to individuals; or

19                   (B) the 30-day period beginning on the  
20                   date on which the authorization is signed under  
21                   subsection (a)(1), if the authorization permits  
22                   the disclosure of protected health information to  
23                   a person other than a person described in sub-  
24                   paragraph (A).

1           (2) DISCLOSURE BY TRUSTEE.—For purposes  
2 of subsection (a)(9), a disclosure is timely made if  
3 it occurs before the date or event specified in the au-  
4 thorization upon which the authorization expires.

5           (d) REVOCATION OR AMENDMENT OF AUTHORIZA-  
6 TION.—

7           (1) IN GENERAL.—An individual may in writing  
8 revoke or amend an authorization described in sub-  
9 section (a), in whole or in part, at any time, except  
10 when—

11                   (A) disclosure of protected health informa-  
12 tion has been authorized to permit validation of  
13 expenditures for health care; or

14                   (B) action has been taken in reliance on  
15 the authorization.

16           (2) NOTICE OF REVOCATION.—A health infor-  
17 mation trustee who discloses protected health infor-  
18 mation pursuant to an authorization that has been  
19 revoked shall not be subject to any liability or pen-  
20 alty under this subtitle if—

21                   (A) the reliance was in good faith;

22                   (B) the trustee had no notice of the rev-  
23 ocation; and

24                   (C) the disclosure was otherwise in accord-  
25 ance with the requirements of this subtitle.

1 (e) DECEASED INDIVIDUAL.—The Secretary shall de-  
2 velop and establish through regulation a procedure for ob-  
3 taining protected health information relating to a deceased  
4 individual when there is no individual representative for  
5 such individual.

6 (f) MODEL AUTHORIZATIONS.—The Secretary, after  
7 notice and opportunity for public comment, shall develop  
8 and disseminate model written authorizations of the type  
9 described in subsection (a) and model statements of in-  
10 tended disclosures of the type described in subsection  
11 (a)(5).

12 (g) COPY.—A health information trustee who dis-  
13 closes protected health information pursuant to an author-  
14 ization under this section shall maintain a copy of the au-  
15 thorization.

16 **SEC. 5208. CERTIFIED HEALTH INFORMATION NETWORK**  
17 **SERVICES.**

18 (a) IN GENERAL.—A health information trustee may  
19 disclose protected health information to a certified health  
20 information network service acting as an agent of the  
21 trustee for any purpose permitted by this subtitle. Such  
22 a service, acting as an agent of a trustee, may disclose  
23 protected health information to another person as per-  
24 mitted under this subtitle to facilitate the completion of

1 the purpose for which such information was disclosed to  
2 the service.

3 (b) CERTIFIED HEALTH INFORMATION PROTECTION  
4 ORGANIZATIONS.—A health information trustee may dis-  
5 close protected health information to a certified health in-  
6 formation protection organization for the purpose of cre-  
7 ating non-identifiable health information (as defined in  
8 section 5102).

9 **Subpart B—Specific Disclosures Relating to Patient**

10 **SEC. 5211. DISCLOSURES FOR TREATMENT AND FINANCIAL**  
11 **AND ADMINISTRATIVE TRANSACTIONS.**

12 (a) HEALTH CARE TREATMENT.—A health care pro-  
13 vider, health plan, employer, or person who receives pro-  
14 tected health information under section 5213, may dis-  
15 close protected health information to a health care pro-  
16 vider for the purpose of providing health care to an indi-  
17 vidual if the individual who is the subject of the informa-  
18 tion has not previously objected in writing to the dislo-  
19 sure.

20 (b) DISCLOSURE TO HEALTH PLANS FOR FINANCIAL  
21 AND ADMINISTRATIVE PURPOSES.—A health care pro-  
22 vider or employer may disclose protected health informa-  
23 tion to a health plan for the purpose of providing for the  
24 payment for, or reviewing the payment of, health care fur-  
25 nished to an individual.

1 (c) DISCLOSURE BY HEALTH PLANS FOR FINANCIAL  
2 AND ADMINISTRATIVE PURPOSES.—A health plan may  
3 disclose protected health information to a health care pro-  
4 vider or a health plan for the purpose of providing for  
5 the payment for, or reviewing the payment of, health care  
6 furnished to an individual.

7 **SEC. 5212. NEXT OF KIN AND DIRECTORY INFORMATION.**

8 (a) NEXT OF KIN.—A health care provider or person  
9 who receives protected health information under section  
10 5213 may disclose protected health information to the  
11 next of kin, an individual representative of the individual  
12 who is the subject of the information, or an individual with  
13 whom that individual has a close personal relationship if—

14 (1) the individual who is the subject of the in-  
15 formation—

16 (A) has been notified of the individual's  
17 right to object and has not objected to the dis-  
18 closure;

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

21 (C) exigent circumstances exist such that  
22 it would not be practicable to notify the indi-  
23 vidual of the right to object; and

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

1 (b) DIRECTORY INFORMATION.—A health care pro-  
2 vider and a person receiving protected health information  
3 under section 5213 may disclose protected health informa-  
4 tion to any person if—

5 (1) the information does not reveal specific in-  
6 formation about the physical or mental condition of  
7 the individual who is the subject of the information  
8 or health care provided to that person;

9 (2) the individual who is the subject of the in-  
10 formation—

11 (A) has been notified of the individual's  
12 right to object and has not objected to the dis-  
13 closure;

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

16 (C) exigent circumstances exist such that  
17 it would not be practicable to notify the indi-  
18 vidual of the right to object; and

19 (3) the information consists only of 1 or more  
20 of the following items:

21 (A) The name of the individual who is the  
22 subject of the information.

23 (B) If the individual who is the subject of  
24 the information is receiving health care from a

1 health care provider on a premises controlled by  
2 the provider—

3 (i) the location of the individual on  
4 the premises; and

5 (ii) the general health status of the in-  
6 dividual, described as critical, poor, fair,  
7 stable, or satisfactory or in terms denoting  
8 similar conditions.

9 (d) IDENTIFICATION OF DECEASED INDIVIDUAL.—A  
10 health care provider, health plan, employer, or life insurer,  
11 may disclose protected health information if necessary to  
12 assist in the identification of a deceased individual.

13 **SEC. 5213. EMERGENCY CIRCUMSTANCES.**

14 (a) IN GENERAL.—A health care provider, health  
15 plan, employer, or person who receives protected health  
16 information under this section may disclose protected  
17 health information in emergency circumstances when nec-  
18 essary to protect the health or safety of an individual from  
19 imminent harm.

20 (b) SCOPE OF DISCLOSURE.—The disclosure of pro-  
21 tected health information under this section shall be lim-  
22 ited to persons who need the information to take action  
23 to protect the health or safety of the individual.

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

3 **SEC. 5216. OVERSIGHT.**

4 (a) IN GENERAL.—A health information trustee may  
5 disclose protected health information to a health oversight  
6 agency for an oversight function authorized by law.

7 (b) USE IN ACTION AGAINST INDIVIDUALS.—Not-  
8 withstanding section 5206(e), protected health informa-  
9 tion about an individual that is disclosed under this sec-  
10 tion may be used in, or disclosed to any person for use  
11 in, any administrative, civil, or criminal action or inves-  
12 tigation directed against the individual who is the subject  
13 of the information if the action or investigation arises out  
14 of and is directly related to receipt of health care or pay-  
15 ment for health care or an action involving a fraudulent  
16 claim related to health.

17 **SEC. 5217. PUBLIC HEALTH.**

18 A health care provider, health plan, public health au-  
19 thority, employer, or person who receives protected health  
20 information under section 5213 may disclose protected  
21 health information to a public health authority or other  
22 person authorized by law for use in a legally authorized—

- 23 (1) disease or injury reporting;  
24 (2) public health surveillance; or  
25 (3) public health investigation or intervention.

1 **SEC. 5218. HEALTH RESEARCH.**

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

6 (1) requires use of the protected health infor-  
7 mation for the effectiveness of the project; and

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

12 (b) RESEARCH REQUIRING DIRECT CONTACT.—A  
13 health information trustee may disclose protected health  
14 information to a health researcher for a research project  
15 that includes direct contact with an individual who is the  
16 subject of protected health information if an institutional  
17 review board determines that—

18 (1) the research project meets the requirements  
19 of paragraphs (1) and (2) of subsection (a);

20 (2) direct contact is necessary to accomplish the  
21 research purpose; and

22 (3) the direct contact will be made in a manner  
23 that minimizes the risk of harm, embarrassment, or  
24 other adverse consequences to the individual.

25 (c) USE OF HEALTH INFORMATION NETWORK.—

1           (1) IN GENERAL.—A health information trustee  
2           may disclose protected health information to a  
3           health researcher using the health information net-  
4           work (as defined in section 5102) only if an institu-  
5           tional review board certified by the Secretary under  
6           paragraph (2) determines that the research project  
7           engaged in by the health researcher meets the re-  
8           quirements of this section.

9           (2) CERTIFICATION OF INSTITUTIONAL REVIEW  
10          BOARDS.—

11           (A) REGULATIONS.—The Secretary, after  
12           notice and opportunity for public comment,  
13           shall issue regulations establishing certification  
14           requirements for institutional review boards  
15           under this subtitle. Such regulations shall be  
16           based on regulations issued under section  
17           491(a) of the Public Health Service Act and  
18           shall ensure that institutional review boards  
19           certified under this paragraph have the quali-  
20           fications to access and protect the confiden-  
21           tiality of research subjects.

22           (B) CERTIFICATION.—The Secretary shall  
23           certify an institutional review board that meets  
24           the certification requirements established by the  
25           Secretary under subparagraph (A).

1 (d) OBLIGATIONS OF RECIPIENT.—A person who re-  
2 ceives protected health information pursuant to subsection  
3 (a)—

4 (1) shall remove or destroy, at the earliest op-  
5 portunity consistent with the purposes of the project,  
6 information that would enable an individual to be  
7 identified, unless—

8 (A) an institutional review board has de-  
9 termined that there is a health or research jus-  
10 tification for retention of such identifiers; and

11 (B) there is an adequate plan to protect  
12 the identifiers from disclosure that is incon-  
13 sistent with this section; and

14 (2) shall use protected health information solely  
15 for purposes of the health research project for which  
16 disclosure was authorized under this section.

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

19 **SEC. 5221. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

20 A health care provider, health plan, health oversight  
21 agency, or employer may disclose protected health infor-  
22 mation—

23 (1) pursuant to the Federal Rules of Civil Pro-  
24 cedure, the Federal Rules of Criminal Procedure, or  
25 comparable rules of other courts or administrative

1 agencies in connection with litigation or proceedings  
2 to which the individual who is the subject of the in-  
3 formation is a party and in which the individual has  
4 placed the individual's physical or mental condition  
5 in issue;

6 (2) to a court, and to others ordered by a court,  
7 if the protected health information is developed in  
8 response to a court-ordered physical or mental exam-  
9 ination; or

10 (3) pursuant to a law requiring the reporting of  
11 specific medical information to law enforcement au-  
12 thorities.

13 **SEC. 5222. LAW ENFORCEMENT.**

14 (a) IN GENERAL.—A health care provider, health  
15 plan, health oversight agency, employer, or person who re-  
16 ceives protected health information under section 5213  
17 may disclose protected health information to a law en-  
18 forcement agency (other than a health oversight agency  
19 governed by section 5216) if the information is requested  
20 for use—

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

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

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

4           (b) CERTIFICATION.—When a law enforcement agen-  
5           cy (other than a health oversight agency) requests that  
6           a health information trustee disclose protected health in-  
7           formation under this section, the law enforcement agency  
8           shall provide the trustee with a written certification that—

9                   (1) specifies the information requested;

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

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

14           (c) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—  
15           Notwithstanding section 5206(e), protected health infor-  
16           mation about an individual that is disclosed to a law en-  
17           forcement agency under this section may be used in, or  
18           disclosed for, an administrative, civil, or criminal action  
19           or investigation against the individual if the action or in-  
20           vestigation arises out of and is directly related to the ac-  
21           tion or investigation for which the information was ob-  
22           tained.

1       **Subpart E—Disclosure Pursuant to Government**

2                       **Subpoena or Warrant**

3       **SEC. 5226. GOVERNMENT SUBPOENAS AND WARRANTS.**

4           (a) IN GENERAL.—A health care provider, health  
5 plan, health oversight agency, employer, or person who re-  
6 ceives protected health information under section 5213  
7 may disclose protected health information under this sec-  
8 tion if the disclosure is pursuant to—

9               (1) a subpoena issued under the authority of a  
10 grand jury, and the trustee is provided a written cer-  
11 tification by the grand jury seeking the information  
12 that the grand jury has complied with the applicable  
13 access provisions of section 5227;

14               (2) an administrative subpoena or a judicial  
15 subpoena or warrant, and the trustee is provided a  
16 written certification by the person seeking the infor-  
17 mation that the person has complied with the appli-  
18 cable access provisions of section 5227; or

19               (3) an administrative subpoena or a judicial  
20 subpoena or warrant, and the disclosure otherwise  
21 meets the conditions of section 5216, 5217, 5221, or  
22 5222.

23       (b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

24               (1) ACTIONS OR INVESTIGATIONS.—Notwith-  
25 standing section 5206(c), protected health informa-  
26 tion about an individual that is received under sub-

1 section (a) may be disclosed for, or used in, any ad-  
2 ministrative, civil, or criminal action or investigation  
3 against the individual if the action or investigation  
4 arises out of and is directly related to the inquiry for  
5 which the information was obtained.

6 (2) SPECIAL RULE.—Protected health informa-  
7 tion about an individual that is received under sub-  
8 section (a)(3) may not be disclosed by the recipient  
9 unless the recipient complies with the conditions and  
10 restrictions on disclosure with which the recipient  
11 would have been required to comply if the disclosure  
12 had been made under section 5216, 5217, 5221, or  
13 5222.

14 **SEC. 5227. ACCESS PROCEDURES FOR LAW ENFORCEMENT**  
15 **SUBPOENAS AND WARRANTS.**

16 (a) PROBABLE CAUSE REQUIREMENT.—A govern-  
17 ment authority may not obtain protected health informa-  
18 tion about an individual under paragraph (1) or (2) of  
19 section 5226(a) for use in a law enforcement inquiry un-  
20 less there is probable cause to believe that the information  
21 is relevant to a legitimate law enforcement inquiry being  
22 conducted by the government authority.

23 (b) WARRANTS.—A government authority that ob-  
24 tains protected health information about an individual  
25 under circumstances described in subsection (a) and pur-

1 suant to a warrant shall, not later than 30 days after the  
2 date the warrant was executed, serve the individual with,  
3 or mail to the last known address of the individual, a no-  
4 tice that protected health information about the individual  
5 was so obtained, together with a notice of the individual's  
6 right to challenge the warrant in accordance with section  
7 5228.

8 (c) SUBPOENAS.—Except as provided in subsection  
9 (d), a government authority may not obtain protected  
10 health information about an individual under cir-  
11 cumstances described in subsection (a) and pursuant to  
12 a subpoena unless a copy of the subpoena has been served  
13 on the individual on or before the date of return of the  
14 subpoena, together with a notice of the individual's right  
15 to challenge the subpoena in accordance with section  
16 5228, and—

17 (1) 15 days have passed since the date of serv-  
18 ice on the individual and within that time period the  
19 individual has not initiated a challenge in accordance  
20 with section 5228; or

21 (2) disclosure is ordered by a court after chal-  
22 lenge under section 5228.

23 (d) APPLICATION FOR DELAY.—

24 (1) IN GENERAL.—A government authority may  
25 apply ex parte and under seal to an appropriate

1 court to delay (for an initial period of not longer  
2 than 90 days) serving a notice or copy of a subpoena  
3 required under subsection (b) or (c) with respect to  
4 a law enforcement inquiry. The government author-  
5 ity may apply to the court for extensions of the  
6 delay.

7 (2) REASONS FOR DELAY.—An application for  
8 a delay, or extension of a delay, under this sub-  
9 section shall state, with reasonable specificity, the  
10 reasons why the delay or extension is being sought.

11 (3) EX PARTE ORDER.—The court shall enter  
12 an ex parte order delaying or extending the delay of  
13 notice, an order prohibiting the disclosure of the re-  
14 quest for, or disclosure of, the protected health in-  
15 formation, and an order requiring the disclosure of  
16 the protected health information if the court finds  
17 that—

18 (A) the inquiry being conducted is within  
19 the lawful jurisdiction of the government au-  
20 thority seeking the protected health informa-  
21 tion;

22 (B) there is probable cause to believe that  
23 the protected health information being sought is  
24 relevant to a legitimate law enforcement in-  
25 quiry;

1 (C) the government authority's need for  
2 the information outweighs the privacy interest  
3 of the individual who is the subject of the infor-  
4 mation; and

5 (D) there is reasonable ground to believe  
6 that receipt of notice by the individual will re-  
7 sult in—

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

10 (ii) flight from prosecution;

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

13 or

14 (iv) intimidation of potential wit-  
15 nesses.

16 **SEC. 5228. CHALLENGE PROCEDURES FOR LAW ENFORCE-**  
17 **MENT WARRANTS AND SUBPOENAS.**

18 (a) MOTION TO QUASH.—Within 15 days after the  
19 date of service of a notice of execution or a copy of a sub-  
20 poena of a government authority seeking protected health  
21 information about an individual under paragraph (1) or  
22 (2) of section 5226(a), the individual may file a motion  
23 to quash—

1           (1) in the case of a State judicial warrant or  
2           subpoena, in the court which issued the warrant or  
3           subpoena;

4           (2) in the case of a warrant or subpoena issued  
5           under the authority of a State that is not a State  
6           judicial warrant or subpoena, in a court of com-  
7           petent jurisdiction; or

8           (3) in the case of any other warrant or sub-  
9           poena issued under the authority of a Federal court  
10          or the United States, in the United States district  
11          court for the district in which the individual resides  
12          or in which the warrant or subpoena was issued.

13          (b) COPY.—A copy of the motion shall be served by  
14          the individual upon the government authority by reg-  
15          istered or certified mail.

16          (c) PROCEEDINGS.—The government authority may  
17          file with the court such papers, including affidavits and  
18          other sworn documents, as sustain the validity of the war-  
19          rant or subpoena. The individual may file with the court  
20          reply papers in response to the government authority's fil-  
21          ing. The court, upon the request of the individual or the  
22          government authority or both, may proceed in camera.  
23          The court may conduct such proceedings as it deems ap-  
24          propriate to rule on the motion, but shall endeavor to ex-  
25          pedite its determination.

1           (d) STANDARD FOR DECISION.—A court may deny  
2 a motion under subsection (a) if it finds there is probable  
3 cause to believe the protected health information is rel-  
4 evant to a legitimate law enforcement inquiry being con-  
5 ducted by the government authority, unless the court finds  
6 the individual’s privacy interest outweighs the government  
7 authority’s need for the information. The individual shall  
8 have the burden of demonstrating that the individual’s pri-  
9 vacy interest outweighs the need by the government au-  
10 thority for the information.

11           (e) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
12 PRIVACY INTEREST.—In reaching its determination, the  
13 court shall consider—

14           (1) the particular purpose for which the infor-  
15 mation was collected;

16           (2) the degree to which disclosure of the infor-  
17 mation will embarrass, injure, or invade the privacy  
18 of the individual;

19           (3) the effect of the disclosure on the individ-  
20 ual’s future health care;

21           (4) the importance of the inquiry being con-  
22 ducted by the government authority, and the impor-  
23 tance of the information to that inquiry; and

24           (5) any other factor deemed relevant by the  
25 court.

1 (f) ATTORNEY'S FEES.—In the case of a motion  
2 brought under subsection (a) in which the individual has  
3 substantially prevailed, the court may assess against the  
4 government authority a reasonable attorney's fee and  
5 other litigation costs (including expert's fees) reasonably  
6 incurred.

7 (g) NO INTERLOCUTORY APPEAL.—A ruling denying  
8 a motion to quash under this section shall not be deemed  
9 to be a final order, and no interlocutory appeal may be  
10 taken therefrom by the individual. An appeal of such a  
11 ruling may be taken by the individual within such period  
12 of time as is provided by law as part of any appeal from  
13 a final order in any legal proceeding initiated against the  
14 individual arising out of or based upon the protected  
15 health information disclosed.

16 **Subpart F—Disclosure Pursuant to Private Party**

17 **Subpoena**

18 **SEC. 5231. PRIVATE PARTY SUBPOENAS.**

19 A health care provider, health plan, employer, or per-  
20 son who receives protected health information under sec-  
21 tion 5213 may disclose protected health information under  
22 this section if the disclosure is pursuant to a subpoena  
23 issued on behalf of a private party who has complied with  
24 the access provisions of section 5232.

1 **SEC. 5232. ACCESS PROCEDURES FOR PRIVATE PARTY SUB-**  
 2 **POENAS.**

3 A private party may not obtain protected health in-  
 4 formation about an individual pursuant to a subpoena un-  
 5 less a copy of the subpoena together with a notice of the  
 6 individual's right to challenge the subpoena in accordance  
 7 with section 5233 has been served upon the individual on  
 8 or before the date of return of the subpoena, and—

9 (1) 15 days have passed since the date of serv-  
 10 ice on the individual, and within that time period the  
 11 individual has not initiated a challenge in accordance  
 12 with section 5233; or

13 (2) disclosure is ordered by a court under sec-  
 14 tion 5233.

15 **SEC. 5233. CHALLENGE PROCEDURES FOR PRIVATE PARTY**  
 16 **SUBPOENAS.**

17 (a) MOTION TO QUASH SUBPOENA.—Within 15 days  
 18 after service of a copy of the subpoena seeking protected  
 19 health information under section 5231, the individual who  
 20 is the subject of the protected health information may file  
 21 in any court of competent jurisdiction a motion to quash  
 22 the subpoena and serve a copy of the motion on the person  
 23 seeking the information.

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

1           (1) there is reasonable ground to believe the in-  
2           formation is relevant to a lawsuit or other judicial  
3           or administrative proceeding; and

4           (2) the need of the respondent for the informa-  
5           tion outweighs the privacy interest of the individual.

6           (c) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
7           PRIVACY INTEREST.—In determining under subsection  
8           (b) whether the need of the respondent for the information  
9           outweighs the privacy interest of the individual, the court  
10          shall consider—

11           (1) the particular purpose for which the infor-  
12          mation was collected;

13           (2) the degree to which disclosure of the infor-  
14          mation would embarrass, injure, or invade the pri-  
15          vacy of the individual;

16           (3) the effect of the disclosure on the individ-  
17          ual's future health care;

18           (4) the importance of the information to the  
19          lawsuit or proceeding; and

20           (5) any other relevant factor.

21          (d) ATTORNEY'S FEES.—In the case of a motion  
22          brought under subsection (a) in which the individual has  
23          substantially prevailed, the court may assess against the  
24          respondent a reasonable attorney's fee and other litigation

1 costs and expenses (including expert's fees) reasonably in-  
2 curred.

3 **PART 3—PROCEDURES FOR ENSURING SECURITY**  
4 **OF PROTECTED HEALTH INFORMATION**  
5 **Subpart A—Establishment of Safeguards**

6 **SEC. 5236. ESTABLISHMENT OF SAFEGUARDS.**

7 (a) IN GENERAL.—A health information trustee shall  
8 establish and maintain appropriate administrative, tech-  
9 nical, and physical safeguards—

10 (1) to ensure the integrity and confidentiality of  
11 protected health information created or received by  
12 the trustee; and

13 (2) to protect against any anticipated threats or  
14 hazards to the security or integrity of such informa-  
15 tion.

16 (b) REGULATIONS.—The Secretary shall promulgate  
17 regulations regarding security measures for protected  
18 health information.

19 **SEC. 5237. ACCOUNTING FOR DISCLOSURES.**

20 (a) IN GENERAL.—

21 (1) REQUIREMENT TO CREATE OR MAINTAIN  
22 RECORD.—A health information trustee shall create  
23 and maintain, with respect to any protected health  
24 information disclosed in exceptional circumstances  
25 (as described in paragraph (2)), a record of—

1 (A) the date and purpose of the disclosure;

2 (B) the name of the person to whom or to  
3 which the disclosure was made;

4 (C) the address of the person to whom or  
5 to which the disclosure was made or the loca-  
6 tion to which the disclosure was made; and

7 (D) the information disclosed, if the re-  
8 cording of the information disclosed is prac-  
9 ticable, taking into account the technical capa-  
10 bilities of the system used to maintain the  
11 record and the costs of such maintenance.

12 (2) EXCEPTIONAL CIRCUMSTANCES DE-  
13 SCRIBED.—For purposes of paragraph (1) protected  
14 health information is disclosed in exceptional cir-  
15 cumstances if the disclosure—

16 (A) is not a routine part of doing business,  
17 as determined in accordance with guidelines  
18 promulgated by the Secretary; or

19 (B) is permitted under sections 5213 and  
20 5217.

21 (b) DISCLOSURE RECORD PART OF INFORMATION.—  
22 A record created and maintained under paragraph (a)  
23 shall be maintained as part of the protected health infor-  
24 mation to which the record pertains.

1 **Subpart B—Review of Protected Health Information**  
2 **By Subjects of the Information**

3 **SEC. 5241. INSPECTION OF PROTECTED HEALTH INFORMA-**  
4 **TION.**

5 (a) IN GENERAL.—Except as provided in subsection  
6 (c), a health care provider or health plan—

7 (1) shall permit an individual who is the subject  
8 of protected health information to inspect any such  
9 information that the provider or plan maintains;

10 (2) shall permit the individual to have a copy  
11 of the information;

12 (3) shall permit a person who has been des-  
13 igned in writing by the individual who is the sub-  
14 ject of the information to inspect, or to have a copy  
15 of, the information on behalf of the individual or to  
16 accompany the individual during the inspection; and

17 (4) may offer to explain or interpret informa-  
18 tion that is inspected or copied under this sub-  
19 section.

20 (b) ADDITIONAL REQUESTS.—Except as provided in  
21 subsection (c), a health plan or health care provider shall,  
22 upon written request of an individual—

23 (1) determine the identity of previous providers  
24 to the individual; and

25 (2) obtain protected health information regard-  
26 ing the individual.

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

5           (1) MENTAL HEALTH TREATMENT NOTES.—

6       The information consists of psychiatric, psycho-  
7 logical, or mental health treatment notes, and the  
8 provider or plan determines, based on reasonable  
9 medical judgment, that inspection or copying of the  
10 notes would cause sufficient harm to the individual  
11 who is the subject of the notes so as to outweigh the  
12 desirability of permitting access, and the provider or  
13 plan has not disclosed the notes to any person not  
14 directly engaged in treating the individual, except  
15 with the authorization of the individual or under  
16 compulsion of law.

17           (2) INFORMATION ABOUT OTHERS.—The infor-

18 mation relates to an individual other than the indi-  
19 vidual seeking to inspect or have a copy of the infor-  
20 mation and the provider or plan determines, based  
21 on reasonable medical judgment, that inspection or  
22 copying of the information would cause sufficient  
23 harm to 1 or both of the individuals so as to out-  
24 weigh the desirability of permitting access.

1           (3) ENDANGERMENT TO LIFE OR SAFETY.—

2           The provider or plan determines that disclosure of  
3           the information could reasonably be expected to en-  
4           danger the life or physical safety of any individual.

5           (4) CONFIDENTIAL SOURCE.—The information  
6           identifies or could reasonably lead to the identifica-  
7           tion of a person (other than a health care provider)  
8           who provided information under a promise of con-  
9           fidentiality to a health care provider concerning the  
10          individual who is the subject of the information.

11          (5) ADMINISTRATIVE PURPOSES.—The informa-  
12          tion—

13                (A) is used by the provider or plan solely  
14                for administrative purposes and not in the pro-  
15                vision of health care to the individual who is the  
16                subject of the information; and

17                (B) has not been disclosed by the provider  
18                or plan to any other person.

19          (d) INSPECTION AND COPYING OF SEGREGABLE POR-  
20          TION.—A health care provider or health plan shall permit  
21          inspection and copying under subsection (a) of any reason-  
22          ably segregable portion of a record after deletion of any  
23          portion that is exempt under subsection (c).

24          (e) CONDITIONS.—A health care provider or health  
25          plan may require a written request for the inspection and

1 copying of protected health information under this sub-  
2 section. The health care provider or health plan may re-  
3 quire a cost reimbursement for such inspection and copy-  
4 ing.

5 (f) STATEMENT OF REASONS FOR DENIAL.—If a  
6 health care provider or health plan denies a request for  
7 inspection or copying under this section, the provider or  
8 plan shall provide the individual who made the request (or  
9 the individual’s designated representative) with a written  
10 statement of the reasons for the denial.

11 (g) DEADLINE.—A health care provider or health  
12 plan shall comply with or deny a request for inspection  
13 or copying of protected health information under this sec-  
14 tion within the 30-day period beginning on the date on  
15 which the provider or plan receives the request.

16 **SEC. 5242. AMENDMENT OF PROTECTED HEALTH INFORMA-**  
17 **TION.**

18 (a) IN GENERAL.—A health care provider or health  
19 plan shall, within the 45-day period beginning on the date  
20 on which the provider or plan receives from an individual  
21 a written request that the provider or plan correct or  
22 amend the information—

23 (1) make the correction or amendment re-  
24 quested;

1           (2) inform the individual of the correction or  
2 amendment that has been made; and

3           (3) inform any person who is identified by the  
4 individual, who is not an officer, employee or agent  
5 of the provider or plan, and to whom the uncor-  
6 rected or unamended portion of the information was  
7 previously disclosed, of the correction or amendment  
8 that has been made.

9           (b) REFUSAL TO CORRECT.—If the provider or plan  
10 refuses to make the corrections, the provider or plan shall  
11 inform the individual of—

12           (1) the reasons for the refusal of the provider  
13 or plan to make the correction or amendment;

14           (2) any procedures for further review of the re-  
15 fusal; and

16           (3) the individual's right to file with the pro-  
17 vider or plan a concise statement setting forth the  
18 requested correction or amendment and the individ-  
19 ual's reasons for disagreeing with the refusal of the  
20 provider or plan.

21           (c) BASES FOR REQUEST TO CORRECT OR AMEND.—  
22 An individual may request correction or amendment of  
23 protected health information about the individual under  
24 paragraph (a) if the information is not timely, accurate,  
25 relevant to the system of records, or complete.

1 (d) STATEMENT OF DISAGREEMENT.—After an indi-  
2 vidual has filed a statement of disagreement under para-  
3 graph (b)(3), the provider or plan, in any subsequent dis-  
4 closure of the disputed portion of the information—

5 (1) shall include a copy of the individual’s  
6 statement; and

7 (2) may include a concise statement of the rea-  
8 sons of the provider or plan for not making the re-  
9 quested correction or amendment.

10 (e) RULE OF CONSTRUCTION.—This section shall not  
11 be construed to require a health care provider or health  
12 plan to conduct a formal, informal, or other hearing or  
13 proceeding concerning a request for a correction or  
14 amendment to protected health information the provider  
15 or plan maintains.

16 (f) CORRECTION.—For purposes of paragraph (a), a  
17 correction is deemed to have been made to protected  
18 health information when information that is not timely,  
19 accurate, relevant to the system of records, or complete  
20 is clearly marked as incorrect or when supplementary cor-  
21 rect information is made part of the information.

22 **SEC. 5243. NOTICE OF INFORMATION PRACTICES.**

23 (a) PREPARATION OF WRITTEN NOTICE.—A health  
24 care provider or health plan shall prepare a written notice  
25 of information practices describing the following:

1           (1) PERSONAL RIGHTS OF AN INDIVIDUAL.—

2           The rights under this subpart of an individual who  
3           is the subject of protected health information, in-  
4           cluding the right to inspect and copy such informa-  
5           tion and the right to seek amendments to such infor-  
6           mation, and the procedures for authorizing disclo-  
7           sures of protected health information and for revok-  
8           ing such authorizations.

9           (2) PROCEDURES OF PROVIDER OR PLAN.—The  
10          procedures established by the provider or plan for  
11          the exercise of the rights of individuals about whom  
12          protected health information is maintained.

13          (3) AUTHORIZED DISCLOSURES.—The disclo-  
14          sures of protected health information that are au-  
15          thorized.

16          (b) DISSEMINATION OF NOTICE.—A health care pro-  
17          vider or health plan—

18                (1) shall, upon request, provide any individual  
19                with a copy of the notice of information practices de-  
20                scribed in subsection (a); and

21                (2) shall make reasonable efforts to inform indi-  
22                viduals in a clear and conspicuous manner of the ex-  
23                istence and availability of the notice.

24          (c) MODEL NOTICE.—The Secretary, after notice and  
25          opportunity for public comment, shall develop and dissemi-

1 nate a model notice of information practices for use by  
 2 health care providers and health plans under this section.

3 **Subpart C—Standards for Electronic Disclosures**

4 **SEC. 5246. STANDARDS FOR ELECTRONIC DISCLOSURES.**

5 The Secretary shall promulgate standards for dis-  
 6 closing protected health information in accordance with  
 7 this subtitle in electronic form. Such standards shall in-  
 8 clude standards relating to the creation, transmission, re-  
 9 ceipt, and maintenance, of any written document required  
 10 or authorized under this subtitle.

11 **PART 4—SANCTIONS**

12 **Subpart A—No Sanctions for Permissible Actions**

13 **SEC. 5251. NO LIABILITY FOR PERMISSIBLE DISCLOSURES.**

14 A health information trustee who makes a disclosure  
 15 of protected health information about an individual that  
 16 is permitted by this subtitle shall not be liable to the indi-  
 17 vidual for the disclosure under common law.

18 **SEC. 5252. NO LIABILITY FOR INSTITUTIONAL REVIEW**

19 **BOARD DETERMINATIONS.**

20 If the members of an institutional review board make  
 21 a determination in good faith that—

22 (1) a health research project is of sufficient im-  
 23 portance to outweigh the intrusion into the privacy  
 24 of an individual; and

1           (2) the effectiveness of the project requires use  
2           of protected health information,  
3 the members, the board, and the parent institution of the  
4 board shall not be liable to the individual as a result of  
5 the determination.

6 **SEC. 5253. RELIANCE ON CERTIFIED ENTITY.**

7           If a health information trustee contracts with a cer-  
8 tified health information network service to make a dislo-  
9 sure of any protected health information on behalf of such  
10 trustee in accordance with this subtitle and such service  
11 makes a disclosure of such information that is in violation  
12 of this subtitle, the trustee shall not be liable to the indi-  
13 vidual who is the subject of the information for such un-  
14 lawful disclosure.

15                                   **Subpart B—Civil Sanctions**

16 **SEC. 5256. CIVIL PENALTY.**

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

22           (b) PROCEDURES FOR IMPOSITION OF PENALTIES.—  
23 Section 1128A of the Social Security Act, other than sub-  
24 sections (a) and (b) and the second sentence of subsection  
25 (f) of that section, shall apply to the imposition of a civil

1 monetary penalty under this section in the same manner  
2 as such provisions apply with respect to the imposition of  
3 a penalty under section 1128A of such Act.

4 **SEC. 5257. CIVIL ACTION.**

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

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

10 (2) punitive damages;

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

13 (4) costs of litigation; and

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

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

20 **Subpart C—Criminal Sanctions**

21 **SEC. 5261. WRONGFUL DISCLOSURE OF PROTECTED**  
22 **HEALTH INFORMATION.**

23 (a) OFFENSE.—A person who knowingly—

24 (1) obtains protected health information relat-  
25 ing to an individual in violation of this subtitle; or

1           (2) discloses protected health information to an-  
2           other person in violation of this subtitle,  
3 shall be punished as provided in subsection (b).

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

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

8           (2) if the offense is committed under false pre-  
9           tenses, be fined not more than \$100,000, imprisoned  
10          not more than 5 years, or both; and

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

16           **PART 5—ADMINISTRATIVE PROVISIONS**

17           **SEC. 5266. RELATIONSHIP TO OTHER LAWS.**

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

20          (b) LAWS RELATING TO PUBLIC OR MENTAL  
21 HEALTH.—Nothing in this subtitle shall be construed to  
22 preempt or operate to the exclusion of any State law relat-  
23 ing to public health or mental health that prevents or reg-  
24 ulates disclosure of protected health information otherwise  
25 allowed under this subtitle.

1 (c) PRIVILEGES.—Nothing in this subtitle is intended  
2 to preempt or modify State common or statutory law to  
3 the extent such law concerns a privilege of a witness or  
4 person in a court of the State. This subtitle does not su-  
5 persede or modify Federal common or statutory law to the  
6 extent such law concerns a privilege of a witness or person  
7 in a court of the United States. Authorizations pursuant  
8 to section 5207 shall not be construed as a waiver of any  
9 such privilege.

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

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

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

17 (3) subpart II of part E of title XXVI of the  
18 Public Health Service Act (relating to notifications  
19 of emergency response employees of possible expo-  
20 sure to infectious diseases); or

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

23 **SEC. 5267. RIGHTS OF INCOMPETENTS.**

24 (a) EFFECT OF DECLARATION OF INCOMPETENCE.—  
25 Except as provided in section 5268, if an individual has

1 been declared to be incompetent by a court of competent  
2 jurisdiction, the rights of the individual under this subtitle  
3 shall be exercised and discharged in the best interests of  
4 the individual through the individual's representative.

5 (b) NO COURT DECLARATION.—Except as provided  
6 in section 5268, if a health care provider determines that  
7 an individual, who has not been declared to be incom-  
8 petent by a court of competent jurisdiction, suffers from  
9 a medical condition that prevents the individual from act-  
10 ing knowingly or effectively on the individual's own behalf,  
11 the right of the individual to authorize disclosure may be  
12 exercised and discharged in the best interest of the indi-  
13 vidual by the individual's representative.

14 **SEC. 5268. EXERCISE OF RIGHTS.**

15 (a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-  
16 BLE.—In the case of an individual—

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

19 or

20 (2) who, acting alone, has the legal right, as de-  
21 termined by State law, to apply for and obtain a  
22 type of medical examination, care, or treatment and  
23 who has sought such examination, care, or treat-  
24 ment, the individual shall exercise all rights of an in-  
25 dividual under this subtitle with respect to protected

1 health information relating to such examination,  
2 care, or treatment.

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

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

8 (2) 14, 15, 16, or 17 years of age, the rights  
9 of inspection and amendment, and the right to au-  
10 thorize disclosure of protected health information of  
11 the individual may be exercised either by the indi-  
12 vidual or by the parent or legal guardian of the indi-  
13 vidual.

14 **Subtitle D—Expanded Efforts To**  
15 **Combat Health Care Fraud and**  
16 **Abuse Affecting Federal Outlay**  
17 **Programs**

18 **PART 1—IMPROVED ENFORCEMENT**

19 **SEC. 5301. HEALTH CARE FRAUD AND ABUSE AFFECTING**  
20 **FEDERAL OUTLAY PROGRAMS.**

21 (a) IN GENERAL.—Not later than January 1, 1995,  
22 the Secretary and the Attorney General of the United  
23 States shall establish a joint program—

1           (1) to coordinate Federal, State, and local law  
2 enforcement programs to control fraud and abuse af-  
3 fecting Federal outlay programs,

4           (2) to conduct investigations (including con-  
5 sumer complaint investigations), audits, evaluations,  
6 and inspections relating to the delivery of and pay-  
7 ment for health care in the United States, and

8           (3) to facilitate the enforcement of this subtitle  
9 and other statutes applicable to health care fraud  
10 and abuse.

11       (b) COORDINATION WITH LAW ENFORCEMENT  
12 AGENCIES.—In carrying out the program under sub-  
13 section (a), the Secretary and the Attorney General shall  
14 consult with, and arrange for the sharing of data and re-  
15 sources with Federal, State and local law enforcement  
16 agencies, State Medicaid Fraud Control Units, and State  
17 agencies responsible for the licensing and certification of  
18 health care providers.

19       (c) COORDINATION WITH PURCHASING COOPERA-  
20 TIVES AND CERTIFIED HEALTH PLANS.—In carrying out  
21 the program under subsection (a), the Secretary and the  
22 Attorney General shall consult with, and arrange for the  
23 sharing of data with representatives of purchasing co-  
24 operatives and certified standard health plans.

1 (d) AUTHORITIES OF ATTORNEY GENERAL AND SEC-  
2 RETARY.—In carrying out duties under subsection (a), the  
3 Attorney General and the Secretary shall—

4 (1) conduct, supervise, and coordinate audits,  
5 civil and criminal investigations, inspections, and  
6 evaluations relating to the program established  
7 under such subsection;

8 (2) have access (including on-line access as re-  
9 quested and available) to all records available to pur-  
10 chasing cooperatives and certified standard health  
11 plans relating to the activities described in para-  
12 graph (1) (subject to restrictions based on the con-  
13 fidentiality of certain information under subtitles B  
14 and C of this title); and

15 (3) issue advisory opinions, fraud alerts, and  
16 other appropriate educational material to assist in  
17 compliance with the provisions of this subtitle.

18 (e) QUALIFIED IMMUNITY FOR PROVIDING INFORMA-  
19 TION.—The provisions of section 1157(a) of the Social Se-  
20 curity Act (relating to limitation on liability) shall apply  
21 to a person providing information or communications to  
22 the Secretary or the Attorney General in conjunction with  
23 their performance of duties under this section, in the same  
24 manner as such section applies to information provided  
25 to organizations with a contract under part 2.

1           (f) USE OF POWERS UNDER INSPECTOR GENERAL  
2 ACT OF 1978.—In carrying out duties and responsibilities  
3 under the program established under subsection (a), the  
4 Inspector General is authorized to exercise all powers  
5 granted under the Inspector General Act of 1978 to the  
6 same manner and extent as provided in that Act.

7           (g) DEFINITIONS.—In this subtitle:

8               (1) CERTIFIED STANDARD HEALTH PLANS;  
9 PURCHASING COOPERATIVES.—The terms “certified  
10 standard health plan” and “purchasing cooperative”  
11 have the meanings given such terms by sections  
12 1011(2) and 1013(16), respectively.

13               (2) FEDERAL OUTLAY PROGRAMS.—The term  
14 “Federal outlay programs” means—

15                   (A) any program under title XVIII of the  
16 Social Security Act,

17                   (B) any State health care program (as de-  
18 fined in section 1128(h) of the Social Security  
19 Act),

20                   (C) any program under the Public Health  
21 Service Act, and

22                   (D) any program under this Act, including  
23 any State program approved under title I which  
24 certifies standard health plans, supplemental

1 health benefits plans, and long-term care poli-  
2 cies.

3 (3) INSPECTOR GENERAL.—The term “Inspec-  
4 tor General” means the Inspector General of the De-  
5 partment of Health and Human Services.

6 **SEC. 5302. ESTABLISHMENT OF FEDERAL OUTLAY PRO-**  
7 **GRAM FRAUD AND ABUSE CONTROL AC-**  
8 **COUNT.**

9 (a) ESTABLISHMENT.—

10 (1) IN GENERAL.—There is hereby established  
11 an account to be known as the “Federal Outlay Pro-  
12 gram Fraud and Abuse Control Account” (in this  
13 section referred to as the “Anti-Fraud Account”).  
14 The Anti-Fraud Account shall consist of—

15 (A) such gifts and bequests as may be  
16 made as provided in paragraph (2);

17 (B) such amounts as may be deposited in  
18 the Anti-Fraud Account as provided in section  
19 5311(d)(2) and title IX of the Social Security  
20 Act; and

21 (C) such amounts as are transferred to the  
22 Anti-Fraud Account under paragraph (3).

23 (2) AUTHORIZATION TO ACCEPT GIFTS.—The  
24 Anti-Fraud Account is authorized to accept on be-  
25 half of the United States money gifts and bequests

1       made unconditionally to the Anti-Fraud Account, for  
2       the benefit of the Anti-Fraud Account or any activ-  
3       ity financed through the Anti-Fraud Account.

4           (3) TRANSFER OF AMOUNTS.—

5           (A) IN GENERAL.—Subject to the limita-  
6       tion in subparagraph (B), the Secretary of the  
7       Treasury shall transfer to the Anti-Fraud Ac-  
8       count an amount equal to the sum of the fol-  
9       lowing:

10           (i) Criminal fines imposed in cases in-  
11       volving a Federal health care offense (as  
12       defined in subsection (d)).

13           (ii) Penalties and damages imposed  
14       under the False Claims Act (31 U.S.C.  
15       3729 et seq.), in cases involving claims re-  
16       lated to the provision of health care items  
17       and services (other than funds awarded to  
18       a relator or for restitution).

19           (iii) Administrative penalties and as-  
20       sessments imposed under section 5311 (ex-  
21       cept as otherwise provided by law).

22           (iv) Amounts resulting from the for-  
23       feiture of property by reason of a Federal  
24       health care offense.

1           (B) LIMITATION.—The Secretary of the  
2 Treasury shall not transfer more than the  
3 \$75,000,000, plus 50 percent of the excess (if  
4 any) of the amount described in subparagraph  
5 (A) for any fiscal year (beginning in fiscal year  
6 1995).

7 (b) USE OF FUNDS.—

8           (1) IN GENERAL.—Amounts in the Anti-Fraud  
9 Account shall be available without appropriation and  
10 until expended as determined jointly by the Sec-  
11 retary and the Attorney General of the United  
12 States in carrying out the Federal Outlay Program  
13 Fraud and Abuse Control Program established  
14 under section 5301 (including the administration of  
15 the Program), and may be used to cover costs in-  
16 curred in operating the Program, including costs  
17 of—

18           (A) prosecuting health care matters  
19 (through criminal, civil, and administrative pro-  
20 ceedings);

21           (B) investigations;

22           (C) financial and performance audits of  
23 health care programs and operations;

24           (D) inspections and other evaluations;

25           (E) rewards paid under section 5304; and

1 (F) provider and consumer education (in-  
2 cluding the provision of advisory opinions) re-  
3 garding compliance with the provisions of this  
4 subtitle.

5 Twenty percent of the amounts available in the Anti-  
6 Fraud Account for any fiscal year shall be used for  
7 costs described in subparagraph (F).

8 (2) FUNDS USED TO SUPPLEMENT AGENCY AP-  
9 PROPRIATIONS.—It is intended that disbursements  
10 made from the Anti-Fraud Account to any Federal  
11 agency be used to increase and not supplant the re-  
12 cipient agency’s appropriated operating budget.

13 (c) ANNUAL REPORT.—The Secretary and the Attor-  
14 ney General shall submit jointly an annual report to Con-  
15 gress on the amount of revenue which is generated and  
16 disbursed by the Anti-Fraud Account in each fiscal year.

17 (d) FEDERAL HEALTH CARE OFFENSE DEFINED.—  
18 For purposes of subsection (a)(3)(A)(i), the term “Federal  
19 health care offense” means a violation of, or a criminal  
20 conspiracy to violate—

21 (1) sections 226, 668, 1033, or 1347 of title  
22 18, United States Code;

23 (2) section 1128B of the Social Security Act;

24 (3) sections 287, 371, 664, 666, 1001, 1027,  
25 1341, 1343, or 1954 of title 18, United States Code,

1 if the violation or conspiracy relates to health care  
2 fraud;

3 (4) sections 501 or 511 of the Employee Retirement  
4 Income Security Act of 1974, if the violation  
5 or conspiracy relates to health care fraud; or

6 (5) sections 301, 303(a)(2), or 303 (b) or (e)  
7 of the Federal Food Drug and Cosmetic Act, if the  
8 violation or conspiracy relates to health care fraud.

9 **SEC. 5303. USE OF FUNDS BY INSPECTOR GENERAL.**

10 (a) REIMBURSEMENTS FOR INVESTIGATIONS.—

11 (1) IN GENERAL.—The Inspector General is au-  
12 thorized to receive and retain for current use reim-  
13 bursement for the costs of conducting investigations,  
14 when such restitution is ordered by a court, volun-  
15 tarily agreed to by the payer, or otherwise.

16 (2) CREDITING.—Funds received by the Inspec-  
17 tor General as reimbursement for costs of con-  
18 ducting investigations shall be deposited to the cred-  
19 it of the appropriation from which initially paid, or  
20 to appropriations for similar purposes currently  
21 available at the time of deposit, and shall remain  
22 available for obligation for 1 year from the date of  
23 their deposit.

24 (3) EXCEPTION FOR FORFEITURES.—This sub-  
25 section does not apply to investigative costs paid to

1 the Inspector General from the Department of Jus-  
2 tice Asset Forfeiture Fund, which monies shall be  
3 deposited and expended in accordance with sub-  
4 section (b).

5 (b) HHS OFFICE OF INSPECTOR GENERAL ASSET  
6 FORFEITURE PROCEEDS FUND.—

7 (1) IN GENERAL.—There is hereby established  
8 the “HHS Office of Inspector General Asset For-  
9 feiture Proceeds Fund”, to be administered by the  
10 Inspector General, which shall be available to the In-  
11 spector General without fiscal year limitation for ex-  
12 penses relating to the investigation of matters within  
13 the jurisdiction of the Inspector General.

14 (2) DEPOSITS.—There shall be deposited in the  
15 Fund all proceeds from forfeitures that have been  
16 transferred to the Inspector General from the De-  
17 partment of Justice Asset Forfeiture Fund under  
18 section 524 of title 28, United States Code.

19 **SEC. 5304. REWARDS FOR INFORMATION LEADING TO**  
20 **PROSECUTION AND CONVICTION.**

21 (a) IN GENERAL.—In special circumstances, the Sec-  
22 retary and the Attorney General of the United States may  
23 jointly make a payment of up to \$10,000 to a person who  
24 furnishes information unknown to the Government relat-

1 ing to a possible prosecution of a Federal health care of-  
2 fense (as defined in section 5302(d)).

3 (b) INELIGIBLE PERSONS.—A person is not eligible  
4 for a payment under subsection (a) if—

5 (1) the person is a current or former officer or  
6 employee of a Federal or State government agency  
7 or instrumentality who furnishes information discov-  
8 ered or gathered in the course of government em-  
9 ployment;

10 (2) the person knowingly participated in the of-  
11 fense;

12 (3) the information furnished by the person  
13 consists of allegations or transactions that have been  
14 disclosed to the public—

15 (A) in a criminal, civil, or administrative  
16 proceeding;

17 (B) in a congressional, administrative, or  
18 General Accounting Office report, hearing,  
19 audit, or investigation; or

20 (C) by the news media, unless the person  
21 is the original source of the information; or

22 (4) when, in the judgment of the Attorney Gen-  
23 eral, it appears that a person whose illegal activities  
24 are being prosecuted or investigated could benefit  
25 from the award.

1 (c) DEFINITION.—For the purposes of subsection  
 2 (b)(3)(C), the term “original source” means a person who  
 3 has direct and independent knowledge of the information  
 4 that is furnished and has voluntarily provided the informa-  
 5 tion to the government prior to disclosure by the news  
 6 media.

7 (d) NO JUDICIAL REVIEW.—Neither the failure of  
 8 the Secretary and the Attorney General to authorize a  
 9 payment under subsection (a) nor the amount authorized  
 10 shall be subject to judicial review.

11 **PART 2—CIVIL PENALTIES AND RIGHTS OF**  
 12 **ACTION**

13 **SEC. 5311. CIVIL MONETARY PENALTIES.**

14 (a) ACTIONS SUBJECT TO PENALTY.—

15 (1) IN GENERAL.—Any person who is deter-  
 16 mined by the Secretary to have committed any ac-  
 17 tion with respect to a certified standard health plan  
 18 or certified long-term care plan or long-term care  
 19 services provided under this Act that would subject  
 20 the person to a penalty under paragraphs (1)  
 21 through (11) of section 1128A of the Social Security  
 22 Act if the action was taken with respect to title V,  
 23 XVIII, XIX, or XX of such Act, shall be subject to  
 24 a penalty in accordance with subsection (b).

1           (2) TREATMENT OF AMOUNTS RECOVERED.—

2           Any amounts recovered under the preceding sen-  
3           tence shall be paid to the Secretary and such por-  
4           tions of the amounts recovered as is determined to  
5           have been improperly paid from a certified standard  
6           health plan or certified long-term care policy for the  
7           delivery of or payment for health care items or serv-  
8           ices shall be repaid to such plan or policy (and en-  
9           rollees of such plan or policy as appropriate) and the  
10          remainder of the amounts recovered shall be depos-  
11          ited in the Federal Outlays Program Fraud and  
12          Abuse Control Account established under section  
13          5302.

14          (b) PENALTIES.—

15               (1) GENERAL RULE.—In the case of a person  
16               who the Secretary determines has committed an ac-  
17               tion described in subsection (a), the person shall be  
18               subject to the civil monetary penalty (together with  
19               any additional assessment) to which the person  
20               would be subject to under section 1128A of the So-  
21               cial Security Act if the action was taken with respect  
22               to title V, XVIII, XIX, or XX of such Act.

23               (2) PENALTIES DESCRIBED.—Section 1128A(a)  
24               of the Social Security Act (42 U.S.C. 1320a-7a(a))  
25               is amended—

1 (A) by striking “\$2,000” and inserting  
2 “\$10,000”; and

3 (B) by striking “twice the amount  
4 claimed” and inserting “3 times the amount  
5 claimed”.

6 (3) INTEREST ON PENALTIES.—Section  
7 1128A(f) of such Act (42 U.S.C. 1320a-7a(f)) is  
8 amended by adding after the first sentence the fol-  
9 lowing: “Interest shall accrue on the penalties and  
10 assessments imposed by a final determination of the  
11 Secretary in accordance with an annual rate estab-  
12 lished by the Secretary under the Federal Claims  
13 Collection Act. The rate of interest charged shall be  
14 the rate in effect on the date the determination be-  
15 comes final and shall remain fixed at that rate until  
16 the entire amount due is paid. In addition, the Sec-  
17 retary is authorized to recover the costs of collection  
18 in any case where such penalties and assessments  
19 are not paid within 30 days after the determination  
20 becomes final, or in the case of a compromised  
21 amount, where payments are more than 90 days  
22 past due. In lieu of actual costs, the Secretary is au-  
23 thorized to impose a charge of up to 10 percent of  
24 the amount of such penalties and assessments owed  
25 to cover the costs of collection.”.

1 (c) ADDITIONAL OFFENSES.—

2 (1) IN GENERAL.—Section 1128A(a) of the So-  
3 cial Security Act (42 U.S.C. 1320a–7a(a)) is amend-  
4 ed—

5 (A) by striking “or” at the end of para-  
6 graphs (1) and (2);

7 (B) by striking the comma at the end of  
8 paragraph (2) and inserting a semicolon; and

9 (C) by inserting after paragraph (3) the  
10 following new paragraphs:

11 “(4) offers, pays, or transfers remuneration to  
12 any individual eligible for benefits under title XVIII  
13 of this Act, or under a Federal outlay program (as  
14 defined in section 5301(g)(1) of the Health Security  
15 Act) that such person knows or should know is likely  
16 to influence such individual to order or receive from  
17 a particular provider, practitioner, or supplier any  
18 item or service for which payment may be made, in  
19 whole or in part, under title XVIII, or a Federal  
20 outlay program;

21 “(5) in the case of a person who is not an orga-  
22 nization, agency, or other entity, who is excluded  
23 from participating in a program under title XVIII or  
24 a Federal outlay program in accordance with this  
25 section, section 1128, or section 1156 and who, dur-

1       ing the period of exclusion, retains either a direct or  
2       indirect ownership or control interest of 5 percent or  
3       more in, or an ownership or control interest (as de-  
4       fined in section 1124(a)(3)) in, or who is an officer,  
5       director, agent, or managing employee (as defined in  
6       section 1126(b)) of, an entity that is participating in  
7       a program under title XVIII;

8               “(6) engages in a practice that circumvents a  
9       payment methodology intended to reimburse for two  
10      or more discreet medical items or services at a single  
11      or fixed amount, including but not limited to, mul-  
12      tiple admissions or readmission to hospitals and  
13      other institutions reimbursed on a diagnosis reim-  
14      bursement grouping basis;

15              “(7) engages in a practice which has the effect  
16      of limiting (as compared to other plan enrollees) the  
17      appropriate utilization of health care services cov-  
18      ered by law or under the service contract by title  
19      XIX or other publicly subsidized patients, including  
20      but not limited to differential standards for the loca-  
21      tion and hours of service offered by providers par-  
22      ticipating in the plan;

23              “(8) fails to comply with a quality assurance  
24      program or a utilization review activity;

1           “(9) employs or contracts with any individual  
2 or entity who is excluded from participating in a  
3 program under title XVIII or a Federal outlay pro-  
4 gram in accordance with this section, section 1128,  
5 or section 1156, for the provision of any services (in-  
6 cluding but not limited to health care, utilization re-  
7 view, medical social work, or administrative), or em-  
8 ploys or contracts with any entity for the direct or  
9 indirect provision of such services, through such an  
10 excluded individual or entity; or

11           “(10) submits false or fraudulent statements,  
12 data or information, or claims to the Secretary, the  
13 Secretary of Labor, any other Federal agency, a  
14 State health care agency, a purchasing cooperative  
15 (under subtitle \_\_\_\_ of title \_\_\_\_ of the Health Se-  
16 curity Act), or any other Federal, State or local  
17 agency charged with implementation or oversight of  
18 a certified health plan under this Act or a public  
19 program that the person knows or should know is  
20 fraudulent;”.

21           (2)     REMUNERATION     DEFINED.—Section  
22 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is  
23 amended by adding at the end the following new  
24 paragraph:

1           “(6) The term ‘remuneration’ includes the waiv-  
2 er of coinsurance and deductible amounts (or any  
3 part thereof), and transfers of items or services for  
4 free or for other than fair market value, except that  
5 such term does not include the waiver of coinsurance  
6 or deductible amounts by a person or entity, if—

7           “(A) the waiver is not offered as part of  
8 any advertisement or solicitation;

9           “(B) the person does not routinely waive  
10 coinsurance or deductible amounts; and

11           “(C) the person—

12           “(i) waives the coinsurance and de-  
13 ductible amounts after determining in good  
14 faith that the individual is indigent;

15           “(ii) fails to collect coinsurance or de-  
16 ductible amounts after making reasonable  
17 collection efforts; or

18           “(iii) provides for any permissible  
19 waiver as specified in section 1128B(b)(3)  
20 or in regulations issued by the Secretary.”.

21           (3) CLAIM FOR ITEM OR SERVICE BASED ON IN-  
22 CORRECT CODING OR MEDICALLY UNNECESSARY  
23 SERVICES.—Section 1128A(a)(1) of such Act (42  
24 U.S.C. 1320a-7a(a)(1)) is amended—

1 (A) in subparagraph (A), by striking  
2 “claimed,” and inserting the following:  
3 “claimed, including any person who presents or  
4 causes to be presented a claim for an item or  
5 service which includes a procedure or diagnosis  
6 code that the person knows or should know will  
7 result in a greater payment to the person than  
8 the code applicable to the item or service actu-  
9 ally provided or actual patient medical condi-  
10 tion,”;

11 (B) in subparagraph (C), by striking “or”  
12 at the end;

13 (C) in subparagraph (D), by striking “;  
14 or” and inserting “, or”;

15 (D) by inserting after subparagraph (D)  
16 the following new subparagraph:

17 “(E) is for a medical or other item or serv-  
18 ice that a person knows or should know is not  
19 medically necessary; or”.

20 (c) PROCEDURES FOR IMPOSITION OF PENALTIES.—

21 (1) APPLICABILITY OF PROCEDURES UNDER SO-  
22 CIAL SECURITY ACT.—Except as otherwise provided  
23 in paragraph (2), the provisions of section 1128A of  
24 the Social Security Act (other than subsections (a)  
25 and (b) and the second sentence of subsection (f))

1 shall apply to the imposition of a civil monetary pen-  
2 alty, assessment, or exclusion under this section in  
3 the same manner as such provisions apply with re-  
4 spect to the imposition of a penalty, assessment, or  
5 exclusion under section 1128A of such Act.

6 (4) AUTHORITY OF SECRETARY OF LABOR TO  
7 IMPOSE PENALTIES, ASSESSMENTS, AND EXCLU-  
8 SIONS.—

9 (A) IN GENERAL.—The Secretary of Labor  
10 may initiate an action to impose a civil mone-  
11 tary penalty, assessment, or exclusion under  
12 this section with respect to actions relating to  
13 a certified multistate self-insured health plan if  
14 authorized by the Attorney General of the  
15 United States and the Secretary pursuant to  
16 regulations promulgated by the Secretary in  
17 consultation with the Attorney General.

18 (B) REGULATIONS DESCRIBED.—Under  
19 the regulations promulgated under subpara-  
20 graph (A), the Attorney General and the Sec-  
21 retary shall review an action proposed by the  
22 Secretary of Labor, and not later than 60 days  
23 after receiving notice of the proposed action  
24 from the Secretary of Labor, shall—

- 1 (i) approve the proposed action to be  
2 taken by the Secretary of Labor;
- 3 (ii) disapprove the proposed action; or  
4 (iii) assume responsibility for initi-  
5 ating a criminal, civil, or administrative ac-  
6 tion based on the information provided in  
7 the notice.

8 (C) ACTION DEEMED APPROVED.—If the  
9 Attorney General and the Secretary fail to re-  
10 spond to a proposed action by the Secretary of  
11 Labor within the period described in paragraph  
12 (2), the Attorney General and the Secretary  
13 shall be deemed to have approved the proposed  
14 action to be taken by the Secretary of Labor.

15 (e) NOTIFICATION OF LICENSING AUTHORITIES.—  
16 Whenever the Secretary's determination to impose a pen-  
17 alty, assessment, or exclusion under this section becomes  
18 final, the Secretary shall notify the appropriate State or  
19 local licensing agency or organization (including the agen-  
20 cy specified in section 1864(a) and 1902(a)(33) of the So-  
21 cial Security Act) that such a penalty, assessment, or ex-  
22 clusion has become final and the reasons therefore.

1 **SEC. 5312. PERMITTING PARTIES TO BRING ACTIONS ON**  
2 **OWN BEHALF.**

3 (a) IN GENERAL.—Subject to subsections (b) and (c),  
4 a certified standard health plan (as defined in section  
5 1011(2)) or an experience-rated employer (as defined in  
6 section 1011(5)(E)) that suffers harm or monetary loss  
7 exceeding the sum or value of \$10,000 (excluding interest)  
8 as a result of any activity of an individual or entity which  
9 makes the individual or entity subject to a civil monetary  
10 penalty under section 5311 may, in a civil action against  
11 the individual or entity in the United States District  
12 Court, obtain treble damages and costs including attor-  
13 neys' fees against the individual or entity and such equi-  
14 table relief as is appropriate.

15 (b) REQUIREMENTS FOR BRINGING ACTION.—A per-  
16 son may bring a civil action under this section only if—

17 (1) the person provides the Secretary with writ-  
18 ten notice of—

19 (A) the person's intent to bring an action  
20 under this section,

21 (B) the identities of the individuals or enti-  
22 ties the person intends to name as defendants  
23 to the action, and

24 (C) all information the person possesses  
25 regarding the activity that is the subject of the  
26 action that may materially affect the Sec-

1           retary’s decision to initiate a proceeding to im-  
2           pose a civil monetary penalty under section  
3           5311 against the defendants, and

4           (2) one of the following conditions is met:

5                   (A) During the 60-day period that begins  
6                   on the date the Secretary receives the written  
7                   notice described in paragraph (1), the Secretary  
8                   does not notify the person that the Secretary  
9                   intends to initiate an investigation to determine  
10                  whether to impose a civil monetary penalty  
11                  under section 5311 against the defendants.

12                  (B) The Secretary notifies the person dur-  
13                  ing the 60-day period described in subpara-  
14                  graph (A) that the Secretary intends to initiate  
15                  an investigation to determine whether to impose  
16                  a civil monetary penalty under such section  
17                  against the defendants, and the Secretary sub-  
18                  sequently notifies the person that the Secretary  
19                  no longer intends to initiate an investigation or  
20                  proceeding to impose a civil monetary penalty  
21                  against the defendants.

22                  (C) After the expiration of the 1-year pe-  
23                  riod that begins on the date written notice is  
24                  provided to the Secretary, the Secretary has not

1           initiated a proceeding to impose a civil mone-  
2           etary penalty against the defendants.

3           (c) TREATMENT OF EXCESS AWARDS.—If a person  
4 is awarded any amounts in an action brought under this  
5 section that are in excess of the damages suffered by the  
6 person as a result of the defendant’s activities, 20 percent  
7 of such amounts shall be withheld from the person for pay-  
8 ment into the Federal Outlays Program Fraud and Abuse  
9 Control Account established under section 5302.

10          (d) STATUTE OF LIMITATIONS.—No action may be  
11 brought under this section more than 6 years after the  
12 date of the activity with respect to which the action is  
13 brought.

14          (e) NO LIMITATION ON OTHER ACTIONS.—Nothing  
15 in this section shall limit the right of any person to pursue  
16 any other right of action or remedy available under the  
17 law.

18          (f) PENDANT JURISDICTION.—Nothing in this sec-  
19 tion shall be construed, by reason of a claim arising under  
20 this section, to confer on the Courts of the United States  
21 jurisdiction over any State law claim.

22 **SEC. 5313. EXCLUSION FROM PROGRAM PARTICIPATION.**

23          (a) MANDATORY EXCLUSION.—

24               (1) IN GENERAL.—Except as provided in para-  
25               graph (2), the Secretary shall exclude an individual

1 or entity from participating in any applicable health  
2 plan if the individual or entity—

3 (A) is excluded from participation in a  
4 public program under, or is otherwise described  
5 in, section 1128(a) of the Social Security Act  
6 (relating to individuals and entities convicted of  
7 health care-related crimes or patient abuse);

8 (B) has been convicted after the date of  
9 the enactment of this section, under Federal or  
10 State law, in connection with the delivery of a  
11 health care item or service of a criminal offense  
12 consisting of a felony relating to fraud, theft,  
13 embezzlement, breach of fiduciary responsi-  
14 bility, or other financial misconduct; or

15 (C) has been convicted after such date,  
16 under Federal or State law, of a criminal of-  
17 fense consisting of a felony relating to the un-  
18 lawful manufacture, distribution, prescription,  
19 or dispensing of a controlled substance.

20 (2) WAIVER PERMITTED.—

21 (A) IN GENERAL.—When, in the opinion of the  
22 Secretary, mandatory exclusion under paragraph (1)  
23 of an individual or entity would significantly harm  
24 the public health or pose a significant risk to the  
25 public health, the Secretary may waive such exclu-

1 sion and shall apply such other appropriate penalties  
2 as authorized under this subtitle.

3 (B) APPLICATION FOR WAIVER OF EXCLU-  
4 SION.—

5 (i) IN GENERAL.—An individual or entity  
6 subject to mandatory exclusion under this sub-  
7 section may apply to the Secretary, in a manner  
8 specified by the Secretary in regulations, for  
9 waiver of the exclusion.

10 (ii) SECRETARIAL RESPONSE.—The Sec-  
11 retary may waive the exclusion for the reasons  
12 described in subparagraph (A).

13 (b) PERMISSIVE EXCLUSION.—The Secretary may  
14 exclude and individual or entity from participating in any  
15 applicable health plan if the individual or entity—

16 (1) is excluded from participation in a public  
17 program under, or is otherwise described in, section  
18 1128(b) of the Social Security Act (other than para-  
19 graphs (3), (6)(A), (6)(C), (6)(D), (10), or (13) of  
20 such section);

21 (2) has been convicted after the date of the en-  
22 actment of this section, under Federal or State law,  
23 in connection with the delivery of a health care item  
24 or service of a criminal offense consisting of a mis-  
25 demeanor relating to fraud, theft, embezzlement,

1 breach of fiduciary responsibility, or other financial  
2 misconduct; or

3 (3) has been convicted after the date of the en-  
4 actment of this section, under Federal or State law,  
5 of a criminal offense consisting of a misdemeanor re-  
6 lating to the unlawful manufacture, distribution,  
7 prescription, or dispensing of a controlled substance.

8 (c) PERIOD OF EXCLUSION.—

9 (1) NOTICE OF EXCLUSION.—An exclusion  
10 under this section shall be effective at such time and  
11 upon such reasonable notice to the public and to the  
12 individual or entity excluded as may be specified in  
13 regulations consistent with paragraph (2).

14 (2) EFFECTIVE DATE OF EXCLUSION.—Such an  
15 exclusion shall be effective with respect to services  
16 furnished to an individual on or after the effective  
17 date of the exclusion.

18 (3) PERIOD OF EXCLUSION.—

19 (A) IN GENERAL.—The Secretary shall  
20 specify, in the notice of exclusion under para-  
21 graph (1), the minimum period (or, in the case  
22 of an exclusion of an individual excluded from  
23 participation in a public program under, or is  
24 otherwise described in, section 1128(b)(12) of

1 the Social Security Act, the period) of the ex-  
2 clusion.

3 (B) MINIMUM PERIOD FOR MANDATORY  
4 EXCLUSIONS.—In the case of a mandatory ex-  
5 clusion under subsection (a), the minimum pe-  
6 riod of exclusion shall be not less than 2 years.

7 (C) MINIMUM PERIOD FOR CERTAIN PER-  
8 MISSIVE EXCLUSIONS.—

9 (i) FRAUD, OBSTRUCTION OF INVES-  
10 TIGATION, AND CONTROLLED SUBSTANCE  
11 CONVICTION.—In the case of an exclusion  
12 of an individual excluded from participa-  
13 tion in a public program under, or is other-  
14 wise described in, paragraph (1) or (2) of  
15 section 1128(b) of the Social Security Act  
16 or paragraph (1), (2), or (3) of subsection  
17 (b) of this section, the period of exclusion  
18 shall be a minimum of 1 year, unless the  
19 Secretary determines that a longer period  
20 is necessary because of aggravating cir-  
21 cumstances.

22 (ii) SUSPENSIONS.—In the case of an  
23 exclusion of an individual or entity ex-  
24 cluded from participation in a public pro-  
25 gram under, or is otherwise described in,

1 paragraph (4), (5)(A), or (5)(B) of section  
2 1128(b) of the Social Security Act, the pe-  
3 riod of the exclusion shall not be less than  
4 the period during which the individual's or  
5 entity's license to provide health care is re-  
6 voked, suspended or surrendered, or the in-  
7 dividual or the entity is excluded or sus-  
8 pended from a Federal or State health  
9 care program.

10 (iii) UNNECESSARY SERVICES.—In the  
11 case of an exclusion of an individual or en-  
12 tity described in paragraph (6)(B) of sec-  
13 tion 1128(b) of the Social Security Act,  
14 the period of the exclusion shall be not less  
15 than 1 year.

16 (d) NOTICE TO ENTITIES ADMINISTERING PUBLIC  
17 PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR  
18 HEALTH CARE ITEMS OR SERVICES.—

19 (1) IN GENERAL.—The Secretary shall exercise  
20 the authority under this section in a manner that re-  
21 sults in an individual's or entity's exclusion from all  
22 certified standard health plans under such program  
23 for the delivery of or payment for health care items  
24 or services.

1           (2) NOTIFICATION.—The Secretary shall  
2 promptly notify each sponsor of an applicable health  
3 plan and each entity that administers a State health  
4 care program described in section 1128(h) of the So-  
5 cial Security Act of the fact and circumstances of  
6 each exclusion (together with the period thereof) ef-  
7 fected against an individual or entity under this sec-  
8 tion or under section 5311(b)(3).

9           (e) NOTICE TO STATE LICENSING AGENCIES.—The  
10 provisions of section 1128(e) of the Social Security Act  
11 shall apply to this section in the same manner as such  
12 provisions apply to sections 1128 and 1128A of such Act.

13           (f) NOTICE, HEARING, AND JUDICIAL REVIEW.—

14           (1) IN GENERAL.—Subject to paragraph (2),  
15 any individual or entity that is excluded (or directed  
16 to be excluded) from participation under this section  
17 is entitled to reasonable notice and opportunity for  
18 a hearing thereon by the Secretary to the same ex-  
19 tent as is provided in section 205(b) of the Social  
20 Security Act, and to judicial review of the Sec-  
21 retary's final decision after such hearing as is pro-  
22 vided in section 205(g) of such Act, except that such  
23 action shall be brought in the Court of Appeals of  
24 the United States for the judicial circuit in which  
25 the individual or entity resides, or has a principal

1 place of business, or, if the individual or entity does  
2 not reside or have a principal place of business with-  
3 in any such judicial circuit, in the United States  
4 Court of Appeals for the District of Columbia Cir-  
5 cuit.

6 (2) ADMINISTRATIVE HEARING.—Unless the  
7 Secretary determines that the health or safety of in-  
8 dividuals receiving services warrants the exclusion  
9 taking effect earlier, any individual or entity that is  
10 the subject of an adverse determination based on  
11 paragraphs (6)(B), (7), (8), (9), (11), (12), (14), or  
12 (15) of section 1128(b) of the Social Security Act,  
13 shall be entitled to a hearing by an administrative  
14 law judge (as provided under section 205(b) of the  
15 Social Security Act) on the determination before any  
16 exclusion based upon the determination takes effect.  
17 If a hearing is requested, the exclusion shall be ef-  
18 fective upon the issuance of an order by the adminis-  
19 trative law judge upholding the determination of the  
20 Secretary to exclude.

21 (g) CONVICTED DEFINED.—In this section, the term  
22 “convicted” has the meaning given such term in section  
23 1128(i) of the Social Security Act.

24 (h) REQUEST FOR EXCLUSION.—

1           (1) IN GENERAL.—The sponsor of any standard  
2 health plan, the board of any purchasing coopera-  
3 tive, and the Secretary of Labor in the case of a  
4 multistate self-insured health plan may request that  
5 the Secretary of Health and Human Services exclude  
6 an individual or entity with respect to actions under  
7 a certified health plan in accordance with this sec-  
8 tion.

9           (2) RESPONSE BY SECRETARY.—

10           (A) IN GENERAL.—An individual or entity  
11 excluded (or directed to be excluded) from par-  
12 ticipation under this section or section  
13 5411(b)(3) may apply to the Secretary, in a  
14 manner specified by the Secretary in regula-  
15 tions and at the end of the minimum period of  
16 exclusion (or, in the case of an individual or en-  
17 tity described in section 1128(b)(12) of the So-  
18 cial Security Act, the period of exclusion) pro-  
19 vided under this section or section 5411(b)(3)  
20 and at such other times as the Secretary may  
21 provide, for termination of the exclusion.

22           (B) SECRETARIAL RESPONSE.—The Sec-  
23 retary may terminate the exclusion if the Sec-  
24 retary determines, on the basis of the conduct  
25 of the applicant which occurred after the date

1 of the notice of exclusion or which was un-  
2 known to the Secretary at the time of the exclu-  
3 sion, that—

4 (i) there is no basis under this section  
5 or section 5411(b)(3) for a continuation of  
6 the exclusion, and

7 (ii) there are reasonable assurances  
8 that the types of actions which formed the  
9 basis for the original exclusion have not re-  
10 curred and will not recur.

11 (C) NOTIFICATION OF TERMINATION.—

12 The Secretary shall promptly notify each spon-  
13 sor of an applicable health plan and each entity  
14 that administers a State health care program  
15 described in section 1128(h) of the Social Secu-  
16 rity Act of each termination of exclusion made  
17 under this paragraph.

18 (i) EFFECT OF EXCLUSION.—Notwithstanding any  
19 other provision of this Act, no payment may be made  
20 under a certified standard health plan for the delivery of  
21 or payment for any item or service (other than an emer-  
22 gency item or service, not including items or services fur-  
23 nished in an emergency room of a hospital) furnished—

24 (1) by an individual or entity during the period  
25 when such individual or entity is excluded pursuant

1 to this section from participation in a certified  
2 standard health plan; or

3 (2) at the medical direction or on the prescrip-  
4 tion of a physician during the period when the physi-  
5 cian is excluded pursuant to this section from par-  
6 ticipation in a certified health plan and the person  
7 furnishing the item or service knew or had reason to  
8 know of the exclusion (after a reasonable time period  
9 after reasonable notice has been furnished to the  
10 person).

### 11 **PART 3—AMENDMENTS TO CRIMINAL LAW**

#### 12 **SEC. 5321. HEALTH CARE FRAUD.**

13 (a) IN GENERAL.—Chapter 63 of title 18, United  
14 States Code, is amended by adding at the end the fol-  
15 lowing:

#### 16 **“§ 1347. Health care fraud**

17 “(a) Whoever knowingly executes, or attempts to exe-  
18 cute, a scheme or artifice—

19 “(1) to defraud any purchasing cooperative,  
20 certified standard health plan, certified long-term  
21 care insurance policy, or other person, in connection  
22 with the delivery of or payment for health care bene-  
23 fits, items, or services; or

24 “(2) to obtain, by means of false or fraudulent  
25 pretenses, representations, or promises, any of the

1 money or property owned by, or under the custody  
2 or control of, any purchasing cooperative, certified  
3 standard health plan, certified long-term care insur-  
4 ance policy, or person in connection with the delivery  
5 of or payment for health care benefits, items, or  
6 services;

7 shall be fined under this title or imprisoned not more than  
8 10 years, or both. If the violation results in serious bodily  
9 injury (as defined in section 1365 of this title) such person  
10 shall be imprisoned for any term of years.

11 “(b) As used in this section the terms ‘purchasing  
12 cooperative’, ‘certified standard health plan’, and ‘certified  
13 long-term care insurance policy’ have the meanings given  
14 those terms in sections 1013(16), 1011(2), and 1011(4)  
15 of the Health Security Act, respectively.”.

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

“1347. Health care fraud.”.

19 **SEC. 5322. THEFT OR EMBEZZLEMENT.**

20 (a) IN GENERAL.—Chapter 31 of title 18, United  
21 States Code, is amended by adding at the end the fol-  
22 lowing:

1 **“§ 668. Theft or embezzlement in connection with**  
2 **health care**

3 “(a) Whoever embezzles, steals, willfully and unlaw-  
4 fully converts to the use of any person other than the  
5 rightful owner, or intentionally misapplies any of the mon-  
6 eys, securities, premiums, credits, property, or other assets  
7 of a purchasing cooperative, certified standard health  
8 plan, certified long-term care insurance policy, or of any  
9 fund connected with such a cooperative, plan, or policy,  
10 shall be fined under this title or imprisoned not more than  
11 10 years, or both.

12 “(b) As used in this section, the terms ‘purchasing  
13 cooperative’, ‘certified standard health plan’, and ‘certified  
14 long-term care insurance policy’ have the meanings given  
15 those terms in sections 1013(16), 1011(2), and 1011(4)  
16 of the Health Security Act, respectively.”.

17 (b) CLERICAL AMENDMENT.—The table of sections  
18 at the beginning of chapter 31 of title 18, United States  
19 Code, is amended by adding at the end the following:

“668. Theft or embezzlement in connection with health care.”.

20 **SEC. 5323. FALSE STATEMENTS.**

21 (a) IN GENERAL.—Chapter 47 of title 18, United  
22 States Code, is amended by adding at the end the fol-  
23 lowing:

1 **“§ 1033. False statements relating to health care mat-**  
 2 **ters**

3 “(a) Whoever, in any matter involving a purchasing  
 4 cooperative, certified standard health plan, or certified  
 5 long-term care insurance policy, knowingly and willfully  
 6 falsifies, conceals, or covers up by any trick, scheme, or  
 7 device a material fact, or makes any false, fictitious, or  
 8 fraudulent statements or representations, or makes or  
 9 uses any false writing or document knowing the same to  
 10 contain any false, fictitious, or fraudulent statement or  
 11 entry, shall be fined under this title or imprisoned not  
 12 more than 5 years, or both.

13 “(b) As used in this section, the terms ‘purchasing  
 14 cooperative’, ‘certified standard health plan’, and ‘certified  
 15 long-term care insurance policy’ have the meanings given  
 16 those terms in sections 1013(16), 1011(2), and 1011(4)  
 17 of the Health Security Act, respectively.”.

18 (b) CLERICAL AMENDMENT.—The table of sections  
 19 at the beginning of chapter 47 of title 18, United States  
 20 Code, is amended by adding at the end the following:

“1033. False statements relating to health care matters.”.

21 **SEC. 5324. BRIBERY AND GRAFT.**

22 (a) IN GENERAL.—Chapter 11 of title 18, United  
 23 States Code, is amended by adding at the end the fol-  
 24 lowing:

1 **“§ 226. Bribery and graft in connection with health**  
2 **care**

3 “(a) Whoever—

4 “(1) directly or indirectly, corruptly gives, of-  
5 fers, or promises anything of value to a health care  
6 official, or offers or promises a health care official  
7 to give anything of value to any other person, with  
8 intent—

9 “(A) to influence any of the health care of-  
10 ficial’s actions, decisions, or duties relating to a  
11 purchasing cooperative, certified standard  
12 health plan, or certified long-term care insur-  
13 ance policy;

14 “(B) to influence such an official to com-  
15 mit or aid in the committing, or collude in or  
16 allow, any fraud, or make opportunity for the  
17 commission of any fraud, on a purchasing coop-  
18 erative, certified standard health plan, or cer-  
19 tified long-term care insurance policy; or

20 “(C) to induce such an official to engage  
21 in any conduct in violation of the lawful duty of  
22 such official; or

23 “(2) being a health care official, directly or in-  
24 directly, corruptly demands, seeks, receives, accepts,  
25 or agrees to accept anything of value personally or

1 for any other person or entity, the giving of which  
2 violates paragraph (1) of this subsection;  
3 shall be fined under this title or imprisoned not more than  
4 15 years, or both.

5 “(b) Whoever, otherwise than as provided by law for  
6 the proper discharge of any duty, directly or indirectly  
7 gives, offers, or promises anything of value to a health  
8 care official, for or because of any of the health care offi-  
9 cial’s actions, decisions, or duties relating to a purchasing  
10 cooperative, certified standard health plan, or certified  
11 long-term care insurance policy, shall be fined under this  
12 title or imprisoned not more than two years, or both.

13 “(c) As used in this section—

14 “(1) the term ‘health care official’ means—

15 “(A) an administrator, officer, trustee, fi-  
16 duciary, custodian, counsel, agent, or employee  
17 of any purchasing cooperative, certified stand-  
18 ard health plan, or certified long-term care in-  
19 surance policy;

20 “(B) an officer, counsel, agent, or em-  
21 ployee, of an organization that provides services  
22 under contract to any purchasing cooperative,  
23 certified standard health plan, or certified long-  
24 term care insurance policy;

1           “(C) an official or employee of a State  
2           agency having regulatory authority over any  
3           purchasing cooperative, certified standard  
4           health plan, or certified long-term care insur-  
5           ance policy;

6           “(D) an officer, counsel, agent, or em-  
7           ployee of a health care sponsor;

8           “(2) the term ‘health care sponsor’ means any  
9           individual or entity serving as the sponsor of a cer-  
10          tified health plan for purposes of the Health Secu-  
11          rity Act, and includes the joint board of trustees or  
12          other similar body used by two or more employers  
13          to administer a certified standard health plan for  
14          purposes of such Act; and

15          “(3) the terms ‘purchasing cooperative’, ‘cer-  
16          tified standard health plan’, and ‘certified long-term  
17          care insurance policy’ have the meanings given those  
18          terms in sections 1013(16), 1011(2), and 1011(4) of  
19          the Health Security Act, respectively.”.

20          (b) CLERICAL AMENDMENT.—The table of chapters  
21          at the beginning of chapter 11 of title 18, United States  
22          Code, is amended by adding at the end the following:

“226. Bribery and graft in connection with health care.”.

1 **SEC. 5325. INJUNCTIVE RELIEF RELATING TO HEALTH**  
2 **CARE OFFENSES.**

3 Section 1345(a)(1) of title 18, United States Code,  
4 is amended—

5 (1) by striking “or” at the end of subparagraph  
6 (A);

7 (2) by inserting “or” at the end of subpara-  
8 graph (B); and

9 (3) by adding at the end the following:

10 “(C) committing or about to commit a Federal  
11 health care offense (as defined in section 5302(d) of  
12 the Health Security Act);”.

13 **SEC. 5326. GRAND JURY DISCLOSURE.**

14 Section 3322 of title 18, United States Code, is  
15 amended—

16 (1) by redesignating subsections (c) and (d) as  
17 subsections (d) and (e), respectively; and

18 (2) by inserting after subsection (b) the fol-  
19 lowing:

20 “(c) A person who is privy to grand jury information  
21 concerning a health law violation—

22 “(1) received in the course of duty as an attor-  
23 ney for the Government; or

24 “(2) disclosed under rule 6(e)(3)(A)(ii) of the  
25 Federal Rules of Criminal Procedure;

1 may disclose that information to an attorney for the Gov-  
 2 ernment to use in any civil proceeding related to a Federal  
 3 health care offense (as defined in section 5302(d) of the  
 4 Health Security Act).”.

5 **SEC. 5327. FORFEITURES FOR VIOLATIONS OF FRAUD STAT-**  
 6 **UTES.**

7 Section 982(a) of title 18, United States Code, is  
 8 amended by inserting after paragraph (5) the following:

9 “(6) The court, in imposing sentence on a person con-  
 10 victed of a Federal health care offense (as defined in sec-  
 11 tion 5302(d) of the Health Security Act), shall order such  
 12 person to forfeit to the United States any property, real  
 13 or personal, constituting or traceable to the gross proceeds  
 14 obtained, directly or indirectly, as a result of the commis-  
 15 sion of the offense.”.

16 **PART 4—AMENDMENTS TO CIVIL FALSE CLAIMS**  
 17 **ACT**

18 **SEC. 5331. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.**

19 Section 3729 of title 31, United States Code, is  
 20 amended—

21 (1) in subsection (a)(7), by inserting “or to a  
 22 certified standard health plan or certified long-term  
 23 care insurance policy” after “property to the Gov-  
 24 ernment”;

1           (2) in the matter following subsection (a)(7), by  
 2           inserting “or certified standard health plan or cer-  
 3           tified long-term care insurance policy” before “sus-  
 4           tains because of the act of that person,”;

5           (3) at the end of the first sentence of sub-  
 6           section (a), by inserting “or certified standard  
 7           health plan or certified long-term care insurance pol-  
 8           icy” before “sustains because of the act of the per-  
 9           son.”;

10          (4) in subsection (c)—

11           (A) by inserting “the term” after “sec-  
 12           tion,”; and

13           (B) by adding at the end the following:  
 14           “The term also includes any request or demand,  
 15           whether under contract or otherwise, for money  
 16           or property which is made or presented to a  
 17           certified standard health plan or certified long-  
 18           term care insurance policy.”; and

19          (5) by adding at the end the following:

20          “(f) CERTIFIED STANDARD HEALTH PLAN AND CER-  
 21          TIFIED LONG-TERM CARE INSURANCE POLICY DE-  
 22          FINED.—For purposes of this section, the terms ‘pur-  
 23          chasing cooperative’, ‘certified standard health plan’, and  
 24          ‘certified long-term care insurance policy’ have the mean-

1 ings given those terms in sections 1013(16), 1011(2), and  
2 1011(4) of the Health Security Act, respectively.”.

### 3 **PART 5—EFFECTIVE DATE**

#### 4 **SEC. 5341. EFFECTIVE DATE.**

5 Except as otherwise provided in this subtitle, the pro-  
6 visions of, and amendments made by, this subtitle shall  
7 be effective on and after January 1, 1996.

## 8 **Subtitle E—Medical Liability** 9 **Reform**

### 10 **PART 1—SYSTEM REFORMS**

#### 11 **SEC. 5401. FEDERAL TORT REFORM.**

12 (a) APPLICABILITY.—

13 (1) IN GENERAL.—Except as provided in sec-  
14 tion 5402, this subtitle shall apply with respect to  
15 any medical malpractice liability action brought in  
16 any State or Federal court, except that this subtitle  
17 shall not apply to a claim or action for damages  
18 arising from a vaccine-related injury or death to the  
19 extent that title XXI of the Public Health Service  
20 Act applies to the claim or action.

21 (2) PREEMPTION.—The provisions of this sub-  
22 title shall preempt any State law to the extent that  
23 such law is inconsistent with the limitations con-  
24 tained in such provisions.

1           (3) EFFECT ON SOVEREIGN IMMUNITY AND  
2 CHOICE OF LAW OR VENUE.—Nothing in this sub-  
3 title shall be construed to—

4           (A) waive or affect any defense of sov-  
5 ereign immunity asserted by any State under  
6 any provision of law;

7           (B) waive or affect any defense of sov-  
8 ereign immunity asserted by the United States;

9           (C) affect the applicability of any provision  
10 of the Foreign Sovereign Immunities Act of  
11 1976;

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

15           (E) affect the right of any court to trans-  
16 fer venue or to apply the law of a foreign nation  
17 or to dismiss a claim of a foreign nation or of  
18 a citizen of a foreign nation on the ground of  
19 inconvenient forum.

20           (4) FEDERAL COURT JURISDICTION NOT ES-  
21 TABLISHED ON FEDERAL QUESTION GROUNDS.—  
22 Nothing in this subtitle shall be construed to estab-  
23 lish any jurisdiction in the district courts of the  
24 United States over medical malpractice liability ac-

1 tions on the basis of section 1331 or 1337 of title  
2 28, United States Code.

3 (b) DEFINITIONS.—In this subtitle, the following  
4 definitions apply:

5 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
6 TEM; ADR.—The term “alternative dispute resolu-  
7 tion system” or “ADR” means a system that pro-  
8 vides for the resolution of medical malpractice claims  
9 in a manner other than through medical malpractice  
10 liability actions.

11 (2) CLAIMANT.—The term “claimant” means  
12 any person who alleges a medical malpractice claim,  
13 and any person on whose behalf such a claim is al-  
14 leged, including the decedent in the case of an action  
15 brought through or on behalf of an estate.

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

22 (4) HEALTH CARE PROVIDER.—The term  
23 “health care provider” means any organization or  
24 institution that is engaged in the delivery of health  
25 care services in a State and that is required by the

1 laws or regulations of the State to be licensed or cer-  
2 tified by the State to engage in the delivery of such  
3 services in the State.

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

8 (6) MEDICAL MALPRACTICE LIABILITY AC-  
9 TION.—The term “medical malpractice liability ac-  
10 tion” means a cause of action brought in a State or  
11 Federal court against a health care provider or  
12 health care professional by which the plaintiff brings  
13 a medical malpractice claim.

14 (7) MEDICAL MALPRACTICE CLAIM.—The term  
15 “medical malpractice claim” means a claim brought  
16 against a health care provider or health care profes-  
17 sional in which a claimant alleges that injury was  
18 caused by the provision of (or the failure to provide)  
19 health care services, except that such term does not  
20 include—

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

23 (B) any claim based on an allegation that  
24 a product is defective that is brought against

1 any individual or entity that is not a health  
2 care professional or health care provider; or

3 (C) any claim brought pursuant to subtitle

4 F.

5 **SEC. 5402. STATE-BASED ALTERNATIVE DISPUTE RESOLU-**  
6 **TION MECHANISMS.**

7 (a) APPLICATION TO MALPRACTICE CLAIMS UNDER  
8 PLANS.—Prior to or immediately following the commence-  
9 ment of any medical malpractice action, the parties shall  
10 participate in the alternative dispute resolution system ad-  
11 ministered by the State under subsection (b). Such partici-  
12 pation shall be in lieu of any other provision of Federal  
13 or State law or any contractual agreement made by or on  
14 behalf of the parties prior to the commencement of the  
15 medical malpractice action.

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

18 (1) maintain or adopt at least one of the alter-  
19 native dispute resolution methods satisfying the re-  
20 quirements specified under subsection (c) and (d) for  
21 the resolution of medical malpractice claims arising  
22 from the provision of (or failure to provide) health  
23 care services to individuals enrolled in a standard  
24 health plan; and

1           (2) clearly disclose to enrollees (and potential  
2 enrollees) the availability and procedures for con-  
3 sumer grievances, including a description of the al-  
4 ternative dispute resolution method or methods  
5 adopted under this subsection.

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

8           (1) IN GENERAL.—The Attorney General, in  
9 consultation with the Secretary, shall, by regulation,  
10 develop alternative dispute resolution methods for  
11 the use by States in resolving medical malpractice  
12 claims under subsection (a). Such methods shall in-  
13 clude at least the following:

14           (A) ARBITRATION.—The use of arbitra-  
15 tion, a nonjury adversarial dispute resolution  
16 process which may, subject to subsection (d),  
17 result in a final decision as to facts, law, liabil-  
18 ity or damages.

19           (B) CLAIMANT-REQUESTED BINDING ARBI-  
20 TRATION.—For claims involving a sum of  
21 money that falls below a threshold amount set  
22 by the Secretary, the use of arbitration not sub-  
23 ject to subsection (d). Such binding arbitration  
24 shall be at the sole discretion of the claimant.

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

5           (D) EARLY NEUTRAL EVALUATION.—The  
6 use of early neutral evaluation, in which the  
7 parties make a presentation to a neutral attor-  
8 ney or other neutral evaluator for an assess-  
9 ment of the merits, to encourage settlement. If  
10 the parties do not settle as a result of assess-  
11 ment and proceed to trial, the neutral eval-  
12 uator’s opinion shall be kept confidential.

13           (2) STANDARDS FOR ESTABLISHING METH-  
14 ODS.—In developing alternative dispute resolution  
15 methods under paragraph (1), the Attorney General  
16 shall assure that the methods promote the resolution  
17 of medical malpractice claims in a manner that—

18                   (A) is affordable for the parties involved;

19                   (B) provides for timely resolution of  
20 claims;

21                   (C) provides for the consistent and fair  
22 resolution of claims; and

23                   (D) provides for reasonably convenient ac-  
24 cess to dispute resolution for individuals en-  
25 rolled in plans.

1           (3) WAIVER AUTHORITY.—Upon application of  
2           a State, the Attorney General, in consultation with  
3           the Secretary, may grant the State the authority to  
4           fulfill the requirement of subsection (b) by adopting  
5           a mechanism other than a mechanism established by  
6           the Attorney General pursuant to this subsection,  
7           except that such mechanism must meet the stand-  
8           ards set forth in paragraph (2).

9           (d) FURTHER REDRESS.—Except with respect to the  
10          claimant-requested binding arbitration method set forth in  
11          subsection (c)(1)(B), and notwithstanding any other provi-  
12          sion of a law or contractual agreement, a plan enrollee  
13          dissatisfied with the determination reached as a result of  
14          an alternative dispute resolution method applied under  
15          this section may, after the final resolution of the enrollee’s  
16          claim under the method, initiate or resume a cause of ac-  
17          tion to seek damages or other redress with respect to the  
18          claim to the extent otherwise permitted under State law.  
19          The results of any alternative dispute resolution procedure  
20          are inadmissible at any subsequent trial, as are all state-  
21          ments, offers, and other communications made during  
22          such procedures, unless otherwise admissible under State  
23          law.

1 **SEC. 5403. REQUIREMENT OF CERTIFICATE OF MERIT.**

2 (a) **REQUIRING SUBMISSION WITH COMPLAINT.—**

3 Except as provided in subsection (c) and subject to the  
4 penalties of subsection (e), no medical malpractice liability  
5 action may be brought by any individual unless, at the  
6 time the individual commences such action, the individual  
7 or the individual's attorney submits an affidavit declaring  
8 that—

9 (1) the individual (or the individual's attorney)  
10 has consulted and reviewed the facts of the claim  
11 with a qualified specialist (as defined in subsection  
12 (d));

13 (2) the individual or the individual's attorney  
14 has obtained a written report by a qualified spe-  
15 cialist that clearly identifies the individual and that  
16 includes the specialist's determination that, based  
17 upon a review of the available medical record and  
18 other relevant material, a reasonable medical inter-  
19 pretation of the facts supports a finding that the  
20 claim against the defendant is meritorious and based  
21 on good cause; and

22 (3) on the basis of the qualified specialist's re-  
23 view and consultation, the individual (or the individ-  
24 ual's attorney) has concluded that the claim is meri-  
25 torious and based on good cause.

1 (b) IDENTITY OF SPECIALIST.—Only upon a showing  
2 of good cause may a court order that the identity of the  
3 specialist used for purposes of subsection (a) be revealed.  
4 In such an event, such identity shall be reviewed by the  
5 court on an in camera basis only.

6 (c) EXTENSION IN CERTAIN INSTANCES.—

7 (1) IN GENERAL.—Subject to paragraph (2),  
8 subsection (a) shall not apply with respect to an in-  
9 dividual who brings a medical malpractice liability  
10 action without submitting an affidavit described in  
11 such subsection if—

12 (A) despite good faith efforts, the indi-  
13 vidual is unable to obtain the written report be-  
14 fore the expiration of the applicable statute of  
15 limitations;

16 (B) despite good faith efforts, at the time  
17 the individual commences the action, the indi-  
18 vidual has been unable to obtain medical  
19 records or other information necessary, pursu-  
20 ant to any applicable law, to prepare the writ-  
21 ten report requested; or

22 (C) the court of competent jurisdiction de-  
23 termines that the affidavit requirement shall be  
24 extended upon a showing of good cause.

1           (2) DEADLINE FOR SUBMISSION WHERE EX-  
2           TENSION APPLIES.—In the case of an individual who  
3           brings an action to which paragraph (1) applies, the  
4           action shall be dismissed unless the individual sub-  
5           mits the affidavit described in subsection (a) not  
6           later than—

7                   (A) in the case of an action to which sub-  
8                   paragraph (A) of paragraph (1) applies, 90  
9                   days after commencing the action; or

10                   (B) in the case of an action to which sub-  
11                   paragraph (B) of paragraph (1) applies, 90  
12                   days after obtaining the information described  
13                   in such subparagraph or when good cause for  
14                   an extension no longer exists.

15           (d) QUALIFIED SPECIALIST DEFINED.—

16                   (1) IN GENERAL.—As used in subsection (a),  
17                   the term “qualified specialist” means, with respect  
18                   to a medical malpractice liability action, a health  
19                   care professional who is reasonably believed by the  
20                   individual bringing the action (or the individual’s at-  
21                   torney) to have expertise in the same or substan-  
22                   tially similar area of practice to that involved in the  
23                   action.

1           (2) EVIDENCE OF EXPERTISE.—For purposes  
2 of paragraph (1), evidence of required expertise may  
3 include evidence that the individual—

4           (A) practices (or has practiced) or teaches  
5 (or has taught) in the same or substantially  
6 similar area of health care or medicine to that  
7 involved in the action; or

8           (B) is otherwise qualified by experience or  
9 demonstrated competence in the relevant prac-  
10 tice area.

11       (e) SANCTIONS FOR SUBMITTING FALSE AFFI-  
12 DAVIT.—Upon the motion of any party or on its own ini-  
13 tiative, the court in a medical malpractice liability action  
14 may impose a sanction on a party, the party’s attorney,  
15 or both, for—

16           (1) any knowingly false statement made in an  
17 affidavit described in subsection (a);

18           (2) making any false representations in order to  
19 obtain a qualified specialist’s report; or

20           (3) failing to have the qualified specialist’s writ-  
21 ten report in his or her custody and control;

22 and may require that the sanctioned party reimburse the  
23 other party to the action for costs and reasonable attor-  
24 ney’s fees.

1 **SEC. 5404. LIMITATION ON AMOUNT OF ATTORNEY'S CON-**  
2 **TINGENCY FEES.**

3 (a) IN GENERAL.—An attorney who represents, on  
4 a contingency fee basis, a plaintiff in a medical mal-  
5 practice liability action may not charge, demand, receive,  
6 or collect for services rendered in connection with such ac-  
7 tion (including the resolution of the claim that is the sub-  
8 ject of the action under any alternative dispute resolution  
9 system) in excess of—

10 (1)  $33\frac{1}{3}$  percent of the first \$150,000 of the  
11 total amount recovered by judgment or settlement in  
12 such action; plus

13 (2) 25 percent of any amount recovered above  
14 the amount described in paragraph (1);

15 unless otherwise determined under State law. Such  
16 amount shall be computed after deductions are made for  
17 all the expenses associated with the claim other than those  
18 attributable to the normal operating expenses of the attor-  
19 ney.

20 (b) CALCULATION OF PERIODIC PAYMENTS.—In the  
21 event that a judgment or settlement includes periodic or  
22 future payments of damages, the amount recovered for  
23 purposes of computing the limitation on the contingency  
24 fee under subsection (a) may, in the discretion of the  
25 court, be based on the cost of the annuity or trust estab-  
26 lished to make the payments. In any case in which an an-

1 nuity or trust is not established to make such payments,  
2 such amount shall be based on the present value of the  
3 payments.

4 (c) CONTINGENCY FEE DEFINED.—As used in this  
5 section, the term “contingency fee” means any fee for pro-  
6 fessional legal services which is, in whole or in part, con-  
7 tingent upon the recovery of any amount of damages,  
8 whether through judgment or settlement.

9 **SEC. 5405. PERIODIC PAYMENT OF AWARDS.**

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

19 (b) FAILURE OR INABILITY TO PAY.—With respect  
20 to an award of damages described in subsection (a), if a  
21 defendant fails to make payments in a timely fashion, or  
22 if the defendant becomes or is at risk of becoming insol-  
23 vent, upon such a showing the claimant may petition the  
24 court for an order requiring that remaining balance be dis-

1 counted to present value and paid to the claimant in a  
2 lump-sum.

3 (c) MODIFICATION OF PAYMENT SCHEDULE.—The  
4 court shall retain authority to modify the payment sched-  
5 ule based on changed circumstances.

6 (d) FUTURE DAMAGES DEFINED.—As used in this  
7 section, the term “future damages” means any economic  
8 or noneconomic loss other than that incurred or accrued  
9 as of the time of judgment.

10 **SEC. 5406. FEDERAL STUDY ON MEDICAL NEGLIGENCE.**

11 (a) STUDY.—To improve the level of empirical data  
12 on the incidence and effect of medical negligence in the  
13 United States, the Secretary of Health and Human Serv-  
14 ices shall commission and oversee a nationwide inter-  
15 disciplinary study to evaluate—

16 (1) the incidence of injuries resulting from med-  
17 ical treatment, including a determination of the per-  
18 centage of such injuries that resulted from the neg-  
19 ligence of a physician, other health care provider or  
20 health care institution;

21 (2) the costs of medical expenses and lost wages  
22 to the victims of medical negligence and their fami-  
23 lies, and their compensation for such losses under  
24 the current malpractice system;

1 (3) methods to reduce the incidence and costs  
2 of medical negligence; and

3 (4) methods to promote the efficient and fair  
4 resolution of legal claims stemming from the inci-  
5 dence of medical negligence.

6 (b) ACCESS TO RECORDS.—For the purposes of the  
7 study conducted under subsection (a), the Secretary of  
8 Health and Human Services shall have the powers nec-  
9 essary to access hospital patients' records while maintain-  
10 ing patient confidentiality.

11 (c) REPORT TO CONGRESS.—Not later than 3 years  
12 after the commission of the study under subsection (a),  
13 the study shall be completed and the Secretary of Health  
14 and Human Services shall prepare and submit to Congress  
15 a report describing the findings of the study.

16 **PART 2—DEMONSTRATION PROJECT RELATING**  
17 **TO MEDICAL MALPRACTICE LIABILITY**

18 **SEC. 5411. PILOT PROGRAM APPLYING PRACTICE GUIDE-**  
19 **LINES TO MEDICAL MALPRACTICE LIABILITY**  
20 **ACTIONS.**

21 (a) ESTABLISHMENT.—Not later than 1 year after  
22 the Secretary of Health and Human Services determines  
23 that appropriate practice guidelines are available and were  
24 developed with the input of health care providers, legal  
25 professionals and consumer representatives, the Secretary

1 shall establish pilot programs under which the Secretary  
2 shall provide funds (in such amounts as the Secretary de-  
3 termines appropriate) to one or more eligible States to de-  
4 termine the effect of applying practice guidelines in the  
5 resolution of medical malpractice liability actions.

6 (b) ELIGIBILITY OF STATE.—To be eligible to partici-  
7 pate in a pilot program under subsection (a), a State shall  
8 prepare and submit to the Secretary an application at  
9 such time, in such manner, and containing such informa-  
10 tion as the Secretary may require, including—

11 (1) assurances that, under the law of the State,  
12 in the resolution of any medical malpractice liability  
13 action, compliance or noncompliance with an appro-  
14 priate practice guideline shall be admissible by either  
15 party at trial as presumptive evidence-of nonliability  
16 or liability for medical negligence; and

17 (2) such other information and assurances as  
18 the Secretary may require.

19 (c) REPORTS TO CONGRESS.—Not later than 3  
20 months after the last day of each year for which a pilot  
21 program established under subsection (a) is in effect, the  
22 Secretary of Health and Human Services shall prepare  
23 and submit to Congress a report describing the operation  
24 of the program during the year for which the report is  
25 submitted. Such report shall contain such recommenda-

1 tions as the Secretary considers appropriate, include rec-  
2 ommendations relating to revisions to the laws governing  
3 medical practice liability.

4 **SEC. 5412. ENTERPRISE LIABILITY DEMONSTRATION**  
5 **PROJECT.**

6 (a) **ESTABLISHMENT.**—The Secretary of Health and  
7 Human Services shall establish a demonstration project  
8 under which the Secretary shall provide funds (in such  
9 amount as the Secretary considers appropriate) to one or  
10 more eligible States to demonstrate whether substituting  
11 liability for medical malpractice on the part of the health  
12 plan in which a physician participates for the personal li-  
13 ability of the physician will result in improvements in the  
14 quality of care provided under the plan, reductions in de-  
15 fensive medical practices, and better risk management.

16 (b) **ELIGIBILITY OF STATE.**—A State is eligible to  
17 participate in the demonstration project established under  
18 subsection (a) if the State submits an application to the  
19 Secretary (at such time and in such form as the Secretary  
20 may require) containing such information and assurances  
21 as the Secretary may require, including assurances that  
22 the State—

23 (1) has entered into an agreement with a health  
24 plan (other than a fee-for-service plan) operating in  
25 the State under which the plan assumes legal liabil-

1       ity with respect to any medical malpractice claim  
 2       arising from the provision of (or failure to provide)  
 3       services under the plan by any physician partici-  
 4       pating in the plan;

5           (2) has provided that, under the law of the  
 6       State, a physician participating in a plan that has  
 7       entered into an agreement with the State under  
 8       paragraph (1) may not be liable in damages or oth-  
 9       erwise for such a claim and the plan may not require  
 10      such physician to indemnify the plan for any such li-  
 11      ability; and

12           (3) will provide the Secretary with such reports  
 13      on the operation of the project as the Secretary may  
 14      require.

15      (c) AUTHORIZATION OF APPROPRIATIONS.—There  
 16      are authorized to be appropriated such sums as may be  
 17      necessary to carry out demonstration projects under this  
 18      section.

## 19                   **Subtitle F—Remedies and** 20                   **Enforcement**

### 21      **PART 1—REVIEW OF BENEFIT DETERMINATIONS**

#### 22                   **FOR ENROLLED INDIVIDUALS**

#### 23                   **Subpart A—General Rules**

#### 24      **SEC. 5501. HEALTH PLAN CLAIMS PROCEDURE.**

25      (a) DEFINITIONS.—For purposes of this section—

1           (1) CLAIM.—The term “claim” means a claim  
2           for payment or provision of benefits under a health  
3           plan, a request for preauthorization of items or serv-  
4           ices which is submitted to a health plan prior to re-  
5           ceipt of the items or services, or the denial, reduc-  
6           tion or termination of any service or request for a  
7           referral or reimbursement.

8           (2) INDIVIDUAL CLAIMANT.—The term “indi-  
9           vidual claimant” with respect to a claim means any  
10          individual who submits the claim to a health plan in  
11          connection with the individual’s enrollment under  
12          the plan, or on whose behalf the claim is submitted  
13          to the plan by a provider.

14          (3) PROVIDER CLAIMANT.—The term “provider  
15          claimant” with respect to a claim means any pro-  
16          vider who submits the claim to a health plan with  
17          respect to items or services provided to an individual  
18          enrolled under the plan.

19          (b) GENERAL RULES GOVERNING TREATMENT OF  
20 CLAIMS.—

21           (1) ADEQUATE NOTICE OF DISPOSITION OF  
22 CLAIM.—In any case in which a claim is submitted  
23          in complete form to a health plan, the plan shall  
24          provide to the individual claimant and any provider  
25          claimant with respect to the claim a written notice

1 of the plan's approval or denial of the claim within  
2 15 days after the date of the submission of the  
3 claim. The notice to the individual claimant shall be  
4 written in language calculated to be understood by  
5 the typical individual enrolled under the plan and in  
6 a form which takes into account accessibility to the  
7 information by individuals whose primary language  
8 is not English. In the case of a denial of the claim,  
9 the notice shall be provided within 5 days after the  
10 date of the determination to deny the claim, and  
11 shall set forth the specific reasons for the denial.  
12 Such notice shall include an explanation of the spe-  
13 cific reasons and facts underlying the decision to re-  
14 duce or fail to provide services or pay the claim. The  
15 notice of a denial shall clearly explain the right to  
16 appeal the denial under paragraph (2) and a de-  
17 scription of the process for appealing such decision  
18 sufficient to allow the claimant to initiate an appeal  
19 and submit evidence to the decision maker in sup-  
20 port of the position of the claimant. Failure by any  
21 plan to comply with the requirements of this para-  
22 graph with respect to any claim submitted to the  
23 plan shall be treated as approval by the plan of the  
24 claim.

1           (2) PLAN'S DUTY TO REVIEW DENIALS UPON  
2           TIMELY REQUEST.—The plan shall review its denial  
3           of the claim if an individual claimant or provider  
4           claimant with respect to the claim submits to the  
5           plan a written request for reconsideration of the  
6           claim after receipt of written notice from the plan of  
7           the denial. The plan shall allow any such claimant  
8           not less than 60 days, after receipt of written notice  
9           from the plan of the denial, to submit the claimant's  
10          request for reconsideration of the claim.

11          (3) TIME LIMIT FOR REVIEW.—The plan shall  
12          complete any review required under paragraph (2),  
13          and shall provide the individual claimant and any  
14          provider claimant with respect to the claim written  
15          notice of the plan's decision on the claim after re-  
16          consideration pursuant to the review, within 30 days  
17          after the date of the receipt of the request for recon-  
18          sideration.

19          (4) DE NOVO REVIEWS.—Any review required  
20          under paragraph (2)—

21                  (A) shall be de novo,

22                  (B) shall be conducted by an individual  
23                  who did not make the initial decision denying  
24                  the claim and who is authorized to approve the  
25                  claim, and

1 (C) shall include review by a qualified phy-  
2 sician in the same speciality as the treating  
3 physician if the resolution of any issues involved  
4 requires medical expertise.

5 (c) TREATMENT OF URGENT REQUESTS TO PLANS  
6 FOR PREAUTHORIZATION.—

7 (1) IN GENERAL.—This subsection applies in  
8 the case of any claim submitted by an individual  
9 claimant or a provider claimant consisting of a re-  
10 quest for preauthorization of items or services which  
11 is accompanied by an attestation that—

12 (A) failure to immediately provide the  
13 items or services could reasonably be expected  
14 to result in—

15 (i) placing the health of the individual  
16 claimant (or, with respect to an individual  
17 claimant who is a pregnant woman, the  
18 health of the woman or her unborn child)  
19 in serious jeopardy,

20 (ii) serious impairment to bodily func-  
21 tions, or

22 (iii) serious dysfunction of any bodily  
23 organ or part,

24 or

1           (B) immediate provision of the items or  
2           services is necessary because the individual  
3           claimant has made or is at serious risk of mak-  
4           ing an attempt to harm such individual claim-  
5           ant or another individual.

6           (2) SHORTENED TIME LIMIT FOR CONSIDER-  
7           ATION OF REQUESTS FOR PREAUTHORIZATION.—  
8           Notwithstanding subsection (b)(1), a health plan  
9           shall approve or deny any claim described in para-  
10          graph (1) within 12 hours after submission of the  
11          claim to the plan. Failure by the plan to comply with  
12          the requirements of this paragraph with respect to  
13          the claim shall be treated as approval by the plan of  
14          the claim.

15          (3) EXPEDITED EXHAUSTION OF PLAN REM-  
16          EDIES.—Any claim described in paragraph (1) which  
17          is denied by the plan shall be treated as a claim with  
18          respect to which all remedies under the plan pro-  
19          vided pursuant to this section are exhausted, irre-  
20          spective of any review provided under subsection  
21          (b)(2).

22          (4) DENIAL OF PREVIOUSLY AUTHORIZED  
23          CLAIMS NOT PERMITTED.—In any case in which a  
24          health plan approves a claim described in paragraph  
25          (1)—

1 (A) the plan may not subsequently deny  
2 payment or provision of benefits pursuant to  
3 the claim, unless the plan makes a showing of  
4 an intentional misrepresentation of a material  
5 fact by the individual claimant, and

6 (B) in the case of a violation of subpara-  
7 graph (A) in connection with the claim, all rem-  
8 edies under the plan provided pursuant to this  
9 section with respect to the claim shall be treat-  
10 ed as exhausted.

11 (d) TIME LIMIT FOR DETERMINATION OF INCOM-  
12 PLETENESS OF CLAIM.—For purposes of this section—

13 (1) any claim submitted by an individual claim-  
14 ant and accepted by a provider serving under con-  
15 tract with a health plan and any claim described in  
16 subsection (b)(1) shall be treated with respect to the  
17 individual claimant as submitted in complete form,  
18 and

19 (2) any other claim for benefits under the plan  
20 shall be treated as filed in complete form as of 10  
21 days after the date of the submission of the claim,  
22 unless the plan provides to the individual claimant  
23 and any provider claimant, within such period, a  
24 written notice of any required matter remaining to  
25 be filed in order to complete the claim.

1 Any filing by the individual claimant or the provider claim-  
2 ant of additional matter requested by the plan pursuant  
3 to paragraph (2) shall be treated for purposes of this sec-  
4 tion as an initial filing of the claim.

5 (e) ADDITIONAL NOTICE AND DISCLOSURE RE-  
6 QUIREMENTS FOR HEALTH PLANS.—In the case of a de-  
7 nial of a claim for benefits under a health plan, the plan  
8 shall include, together with the specific reasons provided  
9 to the individual claimant and any provider claimant  
10 under subsection (b)(1)—

11 (1) if the denial is based in whole or in part on  
12 a determination that the claim is for an item or  
13 service which is not covered by the comprehensive  
14 benefit package or exceeds payment rates under the  
15 applicable fee schedule, the factual basis for the de-  
16 termination,

17 (2) if the denial is based in whole or in part on  
18 exclusion of coverage with respect to services be-  
19 cause the services are determined to comprise an ex-  
20 perimental treatment or investigatory procedure, the  
21 medical basis for the determination and a descrip-  
22 tion of the process used in making the determina-  
23 tion, and

24 (3) if the denial is based in whole or in part on  
25 a determination that the treatment is not medically

1 necessary or appropriate or is inconsistent with the  
2 plan's practice guidelines, the medical basis for the  
3 determination, the guidelines used in making the de-  
4 termination, and a description of the process used in  
5 making the determination.

6 (f) WAIVER OF RIGHTS PROHIBITED.—A health plan  
7 may not require any party to waive any right under the  
8 plan or this Act as a condition for approval of any claim  
9 under the plan, except to the extent otherwise specified  
10 in a formal settlement agreement.

11 **SEC. 5502. REVIEW IN AREA COMPLAINT REVIEW OFFICES**  
12 **OF GRIEVANCES BASED ON ACTS OR PRAC-**  
13 **TICES BY HEALTH PLANS.**

14 (a) COMPLAINT REVIEW OFFICES.—

15 (1) IN GENERAL.—In accordance with rules  
16 which shall be prescribed by the Secretary of Labor,  
17 each State shall establish and maintain a complaint  
18 review office for each community rating area estab-  
19 lished by such State. According to designations  
20 which shall be made by each State under regulations  
21 of the Secretary of Labor, the complaint review of-  
22 fice for a community rating area established by such  
23 State shall also serve as the complaint review office  
24 for large group sponsors operating in the State with  
25 respect to individuals who are enrolled under health

1 plans maintained by such sponsors and who reside  
2 within the area of the community rating area.

3 (2) HEALTH SYSTEMS NOT ESTABLISHED BY  
4 STATES.—In the case of any health care system es-  
5 tablished in any State by the Secretary of Health  
6 and Human Services, the Secretary of Health and  
7 Human Services shall assume all duties and obliga-  
8 tions of such State under this part in accordance  
9 with the applicable regulations of the Secretary of  
10 Labor under this part.

11 (b) FILINGS OF COMPLAINTS BY AGGRIEVED PER-  
12 SONS.—In the case of any person who is aggrieved by—

13 (1) any act or practice engaged in by any  
14 health plan which consists of or results in denial of  
15 payment or provision of benefits under the plan or  
16 delay in the payment or provision of benefits, or

17 (2) any act or practice engaged in by any other  
18 plan maintained in a community rating area or by  
19 a large group sponsor which consists of or results in  
20 denial of payment or provision of benefits under a  
21 supplemental benefit policy or a cost sharing policy  
22 or delay in the payment or provision of the benefits,  
23 if the claimant alleges that the denial or delay consists  
24 of a failure to comply with the terms of the plan (including  
25 the provision of benefits in full when due in accordance

1 with the terms of the plan), or with the applicable require-  
2 ments of this Act, such person may file a complaint with  
3 the appropriate complaint review office.

4 (c) EXHAUSTION OF PLAN REMEDIES.—Any com-  
5 plaint including a claim to which section 5501 applies may  
6 not be filed until the complainant has exhausted all rem-  
7 edies provided under the plan with respect to the claim  
8 in accordance with such section.

9 (d) FORM OF COMPLAINT.—The complaint shall be  
10 in writing under oath or affirmation, shall set forth the  
11 complaint in a manner calculated to give notice of the na-  
12 ture of the complaint, and shall contain such information  
13 as may be prescribed in regulations of the Secretary of  
14 Labor.

15 (e) NOTICE OF FILING.—The complaint review office  
16 shall serve by certified mail a notice of the complaint (in-  
17 cluding the date, place, and circumstances of the alleged  
18 violation) on the person or persons alleged in the com-  
19 plaint to have committed the violation within 10 days after  
20 the filing of the complaint.

21 (f) TIME LIMITATION.—Complaints may not be  
22 brought under this section with respect to any violation  
23 later than one year after the date on which the com-  
24 plaining party knows or should have reasonably known

1 that a violation has occurred. This subsection shall not  
2 prevent the subsequent amending of a complaint.

3 **SEC. 5503. INITIAL PROCEEDINGS IN COMPLAINT REVIEW**  
4 **OFFICES.**

5 (a) ELECTIONS.—Whenever a complaint is brought  
6 to the complaint review office under section 5502(b), the  
7 complaint review office shall provide the complainant with  
8 an opportunity, in such form and manner as shall be pre-  
9 scribed in regulations of the Secretary of Labor, to elect  
10 one of the following:

11 (1) To forego further proceedings in the com-  
12 plaint review office and rely on remedies available in  
13 a court of competent jurisdiction.

14 (2) To submit the complaint as a dispute under  
15 the Early Resolution Program established under  
16 subpart B and thereby suspend further review pro-  
17 ceedings under this section pending termination of  
18 proceedings under the Program.

19 (3) In any case in which an election under  
20 paragraph (1) or (2) is not made, or an election  
21 under paragraph (2) was made but resolution of all  
22 matters in the complaint was not obtained upon ter-  
23 mination of proceedings pursuant to the election by  
24 settlement agreement or otherwise, to proceed with  
25 the complaint to a hearing in the complaint review

1 office under section 5504 regarding the unresolved  
2 matters.

3 (b) DUTY OF COMPLAINT REVIEW OFFICE.—The  
4 complaint review office shall provide (in a linguistically ap-  
5 propriate manner) an explanation to complainants bring-  
6 ing complaints to the office concerning the legal and other  
7 ramifications of each option available under this section.

8 (c) EFFECT OF PARTICIPATION IN EARLY RESOLU-  
9 TION PROGRAM.—Any matter in a complaint brought to  
10 the complaint review office which is included in a dispute  
11 which is timely submitted to the Early Resolution Pro-  
12 gram established under subpart B shall not be assigned  
13 to a hearing under section 5504 unless the proceedings  
14 under the Program with respect to the dispute are termi-  
15 nated without settlement or resolution of the dispute with  
16 respect to such matter. Upon termination of any pro-  
17 ceedings regarding a dispute submitted to the Program,  
18 the applicability of this section to any matter in a com-  
19 plaint which was included in the dispute shall not be af-  
20 fected by participation in the proceedings, except to the  
21 extent otherwise required under the terms of any settle-  
22 ment agreement or other formal resolution obtained in the  
23 proceedings.

1 **SEC. 5504. HEARINGS BEFORE HEARING OFFICERS IN COM-**  
2 **PLAINT REVIEW OFFICES.**

3 (a) HEARING PROCESS.—

4 (1) ASSIGNMENT OF COMPLAINTS TO HEARING  
5 OFFICERS AND NOTICE TO PARTIES.—

6 (A) IN GENERAL.—In the case of an elec-  
7 tion under section 5503(a)(3)—

8 (i) the complaint review office shall  
9 assign the complaint, and each motion in  
10 connection with the complaint, to a hearing  
11 officer employed by the State in the office;  
12 and

13 (ii) the hearing officer shall have the  
14 power to issue and cause to be served upon  
15 the plan named in the complaint a copy of  
16 the complaint and a notice of hearing be-  
17 fore the hearing officer at a place fixed in  
18 the notice, not less than 5 days after the  
19 serving of the complaint.

20 (B) QUALIFICATIONS FOR HEARING OFFI-  
21 CERS.—No individual may serve in a complaint  
22 review office as a hearing officer unless the in-  
23 dividual meets standards which shall be pre-  
24 scribed by the Secretary of Labor. Such stand-  
25 ards shall include experience, training, ability to  
26 communicate with the enrollee, affiliations, dili-

1           gence, absence of actual or potential conflicts of  
2           interest, and other qualifications deemed rel-  
3           evant by the Secretary of Labor. At no time  
4           shall a hearing officer have any official, finan-  
5           cial, or personal conflict of interest with respect  
6           to issues in controversy before the hearing offi-  
7           cer.

8           (2) AMENDMENT OF COMPLAINTS.—Any such  
9           complaint may be amended by the hearing officer  
10          conducting the hearing, upon the motion of the com-  
11          plainant, in the hearing officer's discretion at any  
12          time prior to the issuance of an order based thereon.

13          (3) ANSWERS.—The party against whom the  
14          complaint is filed shall have the right to file an an-  
15          swer to the original or amended complaint and to  
16          appear in person or otherwise and give testimony at  
17          the place and time fixed in the complaint.

18          (b) ADDITIONAL PARTIES.—In the discretion of the  
19          hearing officer conducting the hearing, any other person  
20          may be allowed to intervene in the proceeding and to  
21          present testimony.

22          (c) HEARINGS.—

23                  (1) DE NOVO HEARING.—Each hearing officer  
24          shall hear complaints and motions de novo.

1           (2) TESTIMONY.—The testimony taken by the  
2 hearing officer shall be reduced to writing. There-  
3 after, the hearing officer, in his or her discretion,  
4 upon notice may provide for the taking of further  
5 testimony or hear argument.

6           (3) AUTHORITY OF HEARING OFFICERS.—The  
7 hearing officer may compel by subpoena the attend-  
8 ance of witnesses and the production of evidence at  
9 any designated place or hearing. In case of contu-  
10 macy or refusal to obey a subpoena lawfully issued  
11 under this paragraph and upon application of the  
12 hearing officer, an appropriate district court of the  
13 United States may issue an order requiring compli-  
14 ance with the subpoena and any failure to obey the  
15 order may be punished by the court as a contempt  
16 thereof. The hearing officer may also seek enforce-  
17 ment of the subpoena in a State court of competent  
18 jurisdiction.

19           (4) EXPEDITED HEARINGS.—Notwithstanding  
20 section 5503 and the preceding provisions of this  
21 section, upon receipt of a complaint containing a  
22 claim described in section 5501(c)(1), the complaint  
23 review office shall promptly provide the complainant  
24 with the opportunity to make an election under sec-  
25 tion 5503(a)(3) and assignment to a hearing on the

1 complaint before a hearing officer. The complaint re-  
2 view office shall ensure that such a hearing com-  
3 mences not later than 24 hours after receipt of the  
4 complaint by the complaint hearing office and not  
5 later than 3 days after the receipt of a complaint,  
6 the Complaint Review Office shall provide a decision.

7 (d) DECISION OF HEARING OFFICER.—

8 (1) IN GENERAL.—Not later than 120 days  
9 after the date on which a complaint is assigned  
10 under this section, the hearing officer shall decide if  
11 the preponderance of the evidence justifies the denial  
12 of services and whether to decide in favor of the  
13 complainant with respect to each alleged act or prac-  
14 tice. Each such decision—

15 (A) shall include the hearing officer's find-  
16 ings of fact, and

17 (B) shall constitute the hearing officer's  
18 final disposition of the proceedings.

19 (2) DECISIONS FINDING IN FAVOR OF COM-  
20 PLAINANT.—If the hearing officer's decision includes  
21 a determination that any party named in the com-  
22 plaint has engaged in or is engaged in an act or  
23 practice described in section 5502(b), the hearing of-  
24 ficer shall issue and cause to be served on such  
25 party an order which requires such party—

1 (A) to cease and desist from such act or  
2 practice,

3 (B) to provide the benefits due under the  
4 terms of the plan and to otherwise comply with  
5 the terms of the plan and the applicable re-  
6 quirements of this Act,

7 (C) to pay to the complainant prejudgment  
8 interest on the actual costs incurred in obtain-  
9 ing the items and services at issue in the com-  
10 plaint,

11 (D) to pay to the prevailing complainant a  
12 reasonable attorney's fee, reasonable expert wit-  
13 ness fees, and other reasonable costs relating to  
14 the hearing on the charges on which the com-  
15 plainant prevails, and

16 (E) to provide other appropriate relief.

17 (3) DECISIONS NOT IN FAVOR OF COMPLAIN-  
18 ANT.—If the hearing officer's decision includes a de-  
19 termination that the party named in the complaint  
20 has not engaged in or is not engaged in an act or  
21 practice referred to in section 5502(b), the hearing  
22 officer—

23 (A) shall include in the decision a dismissal  
24 of the charge in the complaint relating to the  
25 act or practice, and

1           (B) upon a finding that such charge is  
2           frivolous, shall issue and cause to be served on  
3           the complainant an order which requires the  
4           complainant to pay to such party a reasonable  
5           attorney's fee, reasonable expert witness fees,  
6           and other reasonable costs relating to the pro-  
7           ceedings on such charge.

8           (4) SUBMISSION AND SERVICE OF DECISIONS.—

9           The hearing officer shall submit each decision to the  
10          complaint review office at the conclusion of the pro-  
11          ceedings and the office shall cause a copy of the de-  
12          cision to be served on the parties to the proceedings.

13          (e) FINAL DECISION.—The decision of the hearing  
14          officer shall be final and binding upon all parties.

15          (f) COURT ENFORCEMENT OF ORDERS.—

16                (1) IN GENERAL.—The complainant may peti-  
17                tion any court of competent jurisdiction for enforce-  
18                ment of the order. In any such proceeding, the order  
19                of the hearing officer shall not be subject to review.

20                (2) AWARDING OF COSTS.—In any action for  
21                court enforcement under this subsection, a prevailing  
22                complainant shall be entitled to a reasonable attor-  
23                ney's fee, reasonable expert witness fees, and other  
24                reasonable costs relating to such action.

1 **SEC. 5505. CIVIL MONEY PENALTIES.**

2 (a) DENIAL OR DELAY IN PAYMENT OR PROVISION  
3 OF BENEFITS.—

4 (1) IN GENERAL.—The Secretary of Labor may  
5 assess a civil penalty against any health plan, or  
6 against any other plan in connection with benefits  
7 provided thereunder under a supplemental benefit  
8 policy or a cost sharing policy, for unreasonable de-  
9 nial or delay in the payment or provision of benefits  
10 thereunder, in an amount not to exceed—

11 (A) \$25,000 per violation, or \$75,000 per  
12 violation in the case of a finding of bad faith  
13 on the part of the plan, and

14 (B) in the case of a finding of a pattern  
15 or practice of such violations engaged in by the  
16 plan, \$1,000,000 in addition to the total  
17 amount of penalties assessed under subpara-  
18 graph (A) with respect to such violations.

19 For purposes of subparagraph (A), each violation  
20 with respect to any single individual shall be treated  
21 as a separate violation.

22 (2) CIVIL ACTION TO ENFORCE CIVIL PEN-  
23 ALTY.—The Secretary of Labor may commence a  
24 civil action in any court of competent jurisdiction to  
25 enforce a civil penalty assessed under paragraph (1).

1           (3) SUPPLEMENTAL PLANS.—Nothing in this  
 2           section shall be construed to limit the rights and  
 3           remedies available under State law with respect to  
 4           supplemental benefit plans.

5           (b) CIVIL PENALTIES FOR CERTAIN OTHER AC-  
 6           TIONS.—The Secretary of Labor may assess a civil penalty  
 7           described in section 5505(b)(1) against any experience-  
 8           rated health plan, or against any other plan sponsored by  
 9           a large employer group purchaser in connection with bene-  
 10          fits provided thereunder under a cost sharing policy, for  
 11          any action described in section 5505(a). The Secretary of  
 12          Labor may initiate proceedings to impose such penalty in  
 13          the same manner as the Secretary of Health and Human  
 14          Services may initiate proceedings under section 5505 with  
 15          respect to actions described in section 5505(a).

16                   **Subpart B—Early Resolution Programs**

17           **SEC. 5511. ESTABLISHMENT OF EARLY RESOLUTION PRO-**  
 18                   **GRAMS IN COMPLAINT REVIEW OFFICES.**

19           (a) ESTABLISHMENT OF PROGRAMS.—Each State  
 20           shall establish and maintain an Early Resolution Program  
 21           in each complaint review office in such State. The Pro-  
 22           gram shall include—

23                   (1) the establishment and maintenance of fo-  
 24                   rums for mediation of disputes in accordance with  
 25                   this subpart, and

1           (2) the establishment and maintenance of such  
2 forums for other forms of alternative dispute resolu-  
3 tion (including binding arbitration) as may be pre-  
4 scribed in regulations of the Secretary of Labor.

5 Each State shall ensure that the standards applied in  
6 Early Resolution Programs administered in such State  
7 which apply to any form of alternative dispute resolution  
8 described in paragraph (2) and which relate to time re-  
9 quirements, qualifications of facilitators, arbitrators, or  
10 other mediators, and confidentiality are at least equivalent  
11 to the standards which apply to mediation proceedings  
12 under this subpart.

13           (b) DUTIES OF COMPLAINT REVIEW OFFICES.—  
14 Each complaint review office in a State—

15           (1) shall administer its Early Resolution Pro-  
16 gram in accordance with regulations of the Secretary  
17 of Labor,

18           (2) shall, pursuant to subsection (a)(1)—

19           (A) recruit and train individuals to serve  
20 as facilitators for mediation proceedings under  
21 the Early Resolution Program from attorneys  
22 who have the requisite expertise for such serv-  
23 ice, which shall be specified in regulations of  
24 the Secretary of Labor,

1 (B) provide meeting sites, maintain  
 2 records, and provide facilitators with adminis-  
 3 trative support staff, and

4 (C) establish and maintain attorney refer-  
 5 ral panels,

6 (3) shall ensure that, upon the filing of a com-  
 7 plaint with the office, the complainant is adequately  
 8 apprised of the complainant's options for review  
 9 under this part, and

10 (4) shall monitor and evaluate the Program on  
 11 an ongoing basis.

12 **SEC. 5512. INITIATION OF PARTICIPATION IN MEDIATION**  
 13 **PROCEEDINGS.**

14 (a) **ELIGIBILITY OF CASES FOR SUBMISSION TO**  
 15 **EARLY RESOLUTION PROGRAM.**—A dispute may be sub-  
 16 mitted to the Early Resolution Program only if the fol-  
 17 lowing requirements are met with respect to the dispute:

18 (1) **NATURE OF DISPUTE.**—The dispute con-  
 19 sists of—

20 (A) an assertion by an individual enrolled  
 21 under a health plan of one or more claims  
 22 against the health plan for payment or provi-  
 23 sion of benefits, or against any other health  
 24 plan with respect to benefits provided under a  
 25 supplemental benefit policy or a cost sharing

1 policy, based on alleged coverage under the  
2 plan; and

3 (B) a denial by the plan of the claims, or  
4 a denial of appropriate reimbursement based on  
5 the claims, by the plan.

6 (2) NATURE OF DISPUTED CLAIM.—Each claim  
7 consists of—

8 (A) a claim for payment or provision of  
9 benefits under the plan; or

10 (B) a request for information or docu-  
11 ments the disclosure of which is required under  
12 this Act (including claims of entitlement to dis-  
13 closure based on colorable claims to rights to  
14 benefits under the plan).

15 (b) FILING OF ELECTION.—A complainant with a  
16 dispute which is eligible for submission to the Early Reso-  
17 lution Program may make the election under section  
18 5503(a)(2) to submit the dispute to mediation proceedings  
19 under the Program not later than 15 days after the date  
20 the complaint is filed with the complaint review office  
21 under section 5502(b).

22 (c) AGREEMENT TO PARTICIPATE.—

23 (1) ELECTION BY CLAIMANT.—A complainant  
24 may elect participation in the mediation proceedings  
25 only by entering into a written participation agree-

1 ment (including an agreement to comply with the  
2 rules of the Program and consent for the complaint  
3 review office to contact the health plan regarding the  
4 agreement), and by releasing plan records to the  
5 Program for the exclusive use of the facilitator as-  
6 signed to the dispute.

7 (2) PARTICIPATION BY PLANS OR HEALTH BEN-  
8 EFITS CONTRACTORS.—Each party whose partici-  
9 tion in the mediation proceedings has been elected  
10 by a claimant pursuant to paragraph (1) shall par-  
11 ticipate in, and cooperate fully with, the proceedings.  
12 The claims review office shall provide such party  
13 with a copy of the participation agreement described  
14 in paragraph (1), together with a written description  
15 of the Program. Such party shall submit the copy of  
16 the agreement, together with its authorized signa-  
17 ture signifying receipt of notice of the agreement, to  
18 the claims review office, and shall include in the sub-  
19 mission to the claims review office a copy of the  
20 written record of the plan claims procedure com-  
21 pleted pursuant to section 5501 with respect to the  
22 dispute and all relevant plan documents. The rel-  
23 evant documents shall include all documents under  
24 which the plan is or was administered or operated,  
25 including copies of any insurance contracts under

1       which benefits are or were provided and any fee or  
2       reimbursement schedules for health care providers.

3   **SEC. 5513. MEDIATION PROCEEDINGS.**

4       (a) **ROLE OF FACILITATOR.**—In the course of medi-  
5   ation proceedings under the Early Resolution Program,  
6   the facilitator assigned to the dispute shall prepare the  
7   parties for a conference regarding the dispute and serve  
8   as a neutral mediator at such conference, with the goal  
9   of achieving settlement of the dispute.

10      (b) **PREPARATIONS FOR CONFERENCE.**—In advance  
11   of convening the conference, after identifying the nec-  
12   essary parties and confirming that the case is eligible for  
13   the Program, the facilitator shall analyze the record of the  
14   claims procedure conducted pursuant to section 5501 and  
15   any position papers submitted by the parties to determine  
16   if further case development is needed to clarify the legal  
17   and factual issues in dispute, and whether there is any  
18   need for additional information and documents.

19      (c) **CONFERENCE.**—Upon convening the conference,  
20   the facilitator shall assist the parties in identifying undis-  
21   puted issues and exploring settlement. If settlement is  
22   reached, the facilitator shall assist in the preparation of  
23   a written settlement agreement. If no settlement is  
24   reached, the facilitator shall present the facilitator's eval-  
25   uation, including an assessment of the parties' positions,

1 the likely outcome of further administrative action or liti-  
2 gation, and suggestions for narrowing the issues in dis-  
3 pute.

4 (d) TIME LIMIT.—The facilitator shall ensure that  
5 mediation proceedings with respect to any dispute under  
6 the Early Resolution Program shall be completed within  
7 120 days after the election to participate. The parties may  
8 agree to one extension of the proceedings by not more than  
9 30 days if the proceedings are suspended to obtain an  
10 agency ruling or to reconvene the conference in a subse-  
11 quent session.

12 (e) INAPPLICABILITY OF FORMAL RULES.—Formal  
13 rules of evidence shall not apply to mediation proceedings  
14 under the Early Resolution Program. All statements made  
15 and evidence presented in the proceedings shall be admis-  
16 sible in the proceedings. The facilitator shall be the sole  
17 judge of the proper weight to be afforded to each submis-  
18 sion. The parties to mediation proceedings under the Pro-  
19 gram shall not be required to make statements or present  
20 evidence under oath.

21 (f) REPRESENTATION.—Parties may participate pro  
22 se or be represented by attorneys throughout the pro-  
23 ceedings of the Early Resolution Program.

24 (g) CONFIDENTIALITY.—

1           (1) IN GENERAL.—Under regulations of the  
2       Secretary of Labor, rules similar to the rules under  
3       section 574 of title 5, United States Code (relating  
4       to confidentiality in dispute resolution proceedings)  
5       shall apply to the mediation proceedings under the  
6       Early Resolution Program.

7           (2) CIVIL REMEDIES.—The Secretary of Labor  
8       may assess a civil penalty against any person who  
9       discloses information in violation of the regulations  
10      prescribed pursuant to paragraph (1) in the amount  
11      of three times the amount of the claim involved. The  
12      Secretary of Labor may bring a civil action to en-  
13      force such civil penalty in any court of competent ju-  
14      risdiction.

15 **SEC. 5514. LEGAL EFFECT OF PARTICIPATION IN MEDI-**  
16 **ATION PROCEEDINGS.**

17       (a) PROCESS NONBINDING.—Findings and conclu-  
18      sions made in the mediation proceedings of the Early Res-  
19      olution Program shall be treated as advisory in nature and  
20      nonbinding. Except as provided in subsection (b), the  
21      rights of the parties under subpart A shall not be affected  
22      by participation in the Program.

23       (b) RESOLUTION THROUGH SETTLEMENT AGREE-  
24      MENT.—If a case is settled through participation in medi-  
25      ation proceedings under the Program, the facilitator shall

1 assist the parties in drawing up an agreement which shall  
2 constitute, upon signature of the parties, a binding con-  
3 tract between the parties, which shall be enforceable under  
4 section 5515.

5 (c) PRESERVATION OF RIGHTS OF NON-PARTIES.—  
6 The settlement agreement shall not have the effect of  
7 waiving or otherwise affecting any rights to review under  
8 subpart A, or any other right under this Act or the plan,  
9 with respect to any person who is not a party to the settle-  
10 ment agreement.

11 **SEC. 5515. ENFORCEMENT OF SETTLEMENT AGREEMENTS.**

12 (a) ENFORCEMENT.—Any party to a settlement  
13 agreement entered pursuant to mediation proceedings  
14 under this subpart may petition any court of competent  
15 jurisdiction for the enforcement of the agreement, by filing  
16 in the court a written petition praying that the agreement  
17 be enforced. In such a proceeding, the order of the hearing  
18 officer shall not be subject to review.

19 (b) COURT REVIEW.—It shall be the duty of the court  
20 to advance on the docket and to expedite to the greatest  
21 possible extent the disposition of any petition filed under  
22 this section, with due deference to the role of settlement  
23 agreements under this part in achieving prompt resolution  
24 of disputes involving health plans.

1 (c) AWARDING OF ATTORNEY'S FEES AND OTHER  
2 COSTS AND EXPENSES.—In any action by an individual  
3 enrolled under a health plan for court enforcement under  
4 this section, a prevailing plaintiff shall be entitled to rea-  
5 sonable costs and expenses (including a reasonable attor-  
6 ney's fee and reasonable expert witness fees) on the  
7 charges on which the plaintiff prevails.

8 **SEC. 5516. DUE PROCESS FOR HEALTH CARE PROVIDERS.**

9 (a) PUBLICLY AVAILABLE STANDARDS AND PROC-  
10 ESS.—Each health plan shall establish and utilize—

11 (1) publicly available standards for contracting  
12 with health care providers; and

13 (2) a publicly available process for dismissing  
14 such providers or failing to renew contracts with  
15 such providers.

16 (b) NOTICE REQUIREMENT.—

17 (1) IN GENERAL.—The process established by a  
18 health plan under subsection (a) shall include rea-  
19 sonable notification to a health care provider of a  
20 decision to dismiss such provider or not to renew a  
21 contract with such provider before such decision  
22 takes effect.

23 (2) EXCEPTION.—The notice required under  
24 paragraph (1) shall not apply if failure to dismiss a

1 provider or renewing a provider's contract would ad-  
2 versely affect the health or safety of a patient.

3 (3) CONTENTS OF NOTICE.—Each notice to a  
4 health care provider under paragraph (1) shall con-  
5 tain the reasons for the dismissal or failure to  
6 renew. Such reasons shall be consistent with the  
7 standards established under subsection (a).

8 (c) REVIEW.—The process established by a health  
9 plan under subsection (a) shall include an opportunity for  
10 review of the health plan's action by a health care provider  
11 who is dismissed by a health plan or with respect to whom  
12 a health plan fails to renew a contract. Such review shall  
13 be conducted by—

14 (1) the provider's peers who have contracts  
15 with, or are employed by, the health plan; and

16 (2) if there is mutual consent of the provider  
17 and the health plan, one or more enrollees in the  
18 health plan.

19 A health care provider may have an attorney present in  
20 connection with any review under this subsection if the  
21 provider notifies the health plan that an attorney will be  
22 present in advance of the review proceeding.

23 (d) EFFECT ON OTHER LAWS.—The provisions of  
24 this section shall not supersede any other provision of Fed-  
25 eral or State law.

1           **PART 2—ADDITIONAL REMEDIES AND**  
2                           **ENFORCEMENT PROVISIONS**

3   **SEC. 5531. JUDICIAL REVIEW OF FEDERAL ACTION ON**  
4                           **STATE SYSTEMS.**

5           (a) **IN GENERAL.**—Any State that is aggrieved by a  
6 determination by the Secretary under subpart B of part  
7 1 of subtitle E of title I shall be entitled to judicial review  
8 of such determination in accordance with this section.

9           (b) **JUDICIAL REVIEW.**—

10           (1) **JURISDICTION.**—The courts of appeals of  
11 the United States (other than the United States  
12 Court of Appeals for the Federal Circuit) shall have  
13 jurisdiction to review a determination described in  
14 subsection (a), to affirm the determination, or to set  
15 it aside, in whole or in part. A judgment of a court  
16 of appeals in such an action shall be subject to re-  
17 view by the Supreme Court of the United States  
18 upon certiorari or certification as provided in section  
19 1254 of title 28, United States Code.

20           (2) **PETITION FOR REVIEW.**—A State that de-  
21 sires judicial review of a determination described in  
22 subsection (a) shall, within 30 days after it has been  
23 notified of such determination, file with the United  
24 States court of appeals for the circuit in which the  
25 State is located a petition for review of such deter-  
26 mination. A copy of the petition shall be transmitted

1 by the clerk of the court to the Secretary, and the  
2 Secretary shall file in the court the record of the  
3 proceedings on which the determination or action  
4 was based, as provided in section 2112 of title 28,  
5 United States Code.

6 (3) SCOPE OF REVIEW.—The findings of fact of  
7 the Secretary, if supported by substantial evidence,  
8 shall be conclusive; but the court, for good cause  
9 shown, may remand the case to the Secretary to  
10 take further evidence, and the Secretary may make  
11 new or modified findings of fact and may modify its  
12 previous action, and shall certify to the court the  
13 record of the further proceedings. Such new or modi-  
14 fied findings of fact shall likewise be conclusive if  
15 supported by substantial evidence.

16 **SEC. 5532. CIVIL ENFORCEMENT.**

17 Unless otherwise provided in this Act, the district  
18 courts of the United States shall have jurisdiction of civil  
19 actions brought by—

20 (1) the Secretary of Labor to enforce any final  
21 order of such Secretary or to collect any civil mone-  
22 tary penalty assessed by such Secretary under this  
23 Act; and

24 (2) the Secretary of Health and Human Serv-  
25 ices to enforce any final order of such Secretary or

1 to collect any civil monetary penalty assessed by  
2 such Secretary under this Act.

3 **SEC. 5533. PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.**

4 Section 507(a)(8) of title 11, United States Code, is  
5 amended to read as follows:

6 “(8) Eighth, allowed unsecured claims—

7 “(A) based upon any commitment by the  
8 debtor to the Federal Deposit Insurance Cor-  
9 poration, the Resolution Trust Corporation, the  
10 Director of the Office of Thrift Supervision, the  
11 Comptroller of the Currency, or the Board of  
12 Governors of the Federal Reserve System, or  
13 their predecessors or successors, to maintain  
14 the capital of an insured depository institution;  
15 or

16 “(B) for payments under title X of the  
17 Health Security Act owed to a State.”.

18 **SEC. 5534. PRIVATE RIGHT TO ENFORCE STATE RESPON-**  
19 **SIBILITIES.**

20 The failure of a participating State to carry out a  
21 responsibility applicable to participating States under this  
22 Act constitutes a deprivation of rights secured by this Act  
23 for the purposes of section 1977 of the Revised Statutes  
24 of the United States (42 U.S.C. 1983). In an action  
25 brought under such section, the court shall exercise juris-

1 diction without regard to whether the aggrieved person  
2 has exhausted any administrative or other remedies that  
3 may be provided by law.

4 **SEC. 5535. PRIVATE RIGHT TO ENFORCE FEDERAL RESPON-**  
5 **SIBILITIES IN OPERATING A SYSTEM IN A**  
6 **STATE.**

7 (a) IN GENERAL.—The failure of the Secretary of  
8 Health and Human Services to carry out a responsibility  
9 under subpart C of part 1 of subtitle E of title I, confers  
10 an enforceable right of action on any person who is ag-  
11 grieved by such failure. Such a person may commence a  
12 civil action against the Secretary in an appropriate State  
13 court or district court of the United States.

14 (b) EXHAUSTION OF REMEDIES.—In an action under  
15 subsection (a), the court shall exercise jurisdiction without  
16 regard to whether the aggrieved person has exhausted any  
17 administrative or other remedies that may be provided by  
18 law.

19 (c) RELIEF.—In an action under subsection (a), if  
20 the court finds that a failure described in such subsection  
21 has occurred, the aggrieved person may recover compen-  
22 satory damages and the court may award any other appro-  
23 priate relief.

24 (d) ATTORNEY'S FEES.—In an action under sub-  
25 section (a), the court, in its discretion, may allow the pre-

1 vailing party, other than the United States, a reasonable  
2 attorney's fee (including expert fees) as part of the costs,  
3 and the United States shall be liable for costs the same  
4 as a private person.

5 **SEC. 5536. ENFORCEMENT OF CONSUMER PROTECTIONS.**

6 (a) COVERED VIOLATIONS.—The provisions of this  
7 section shall apply with respect to a health plan that fails  
8 to fulfill a duty imposed on the plan under section 1122  
9 and subtitle A of this title.

10 (b) ADMINISTRATIVE ENFORCEMENT AND CIVIL  
11 PENALTIES.—The penalties described in section  
12 1867(d)(1) of the Social Security Act and the procedures  
13 described in section 1128A of such Act (other than the  
14 first two sentences of subsection (a) and subsection (b))  
15 shall apply to health plans described in subsection (a). In  
16 addition to such penalties, an amount not to exceed  
17 \$1,000,000 may be assessed in the case of a finding of  
18 a pattern or practice of such violations. The Secretary  
19 shall establish procedures whereby, when a consumer has  
20 disenrolled from a health plan violating the duties de-  
21 scribed in subsection (a), successor health plans may re-  
22 cover from the original health plan for health care costs  
23 attributable to such violations.

24 (c) CORRECTION OF SUBSTANTIAL VIOLATIONS.—  
25 Upon an administrative or judicial finding of a substantial

1 violation of the duties described in subsection (a), the  
2 State or court may—

3 (1) inform all current enrollees of the plan of  
4 the violation and that they may disenroll imme-  
5 diately from that plan and enroll with another com-  
6 munity-rated health plan; and

7 (2) notify the health plan that it shall imme-  
8 diately cease enrollment activities until it has ob-  
9 tained certifications from the appropriate certifying  
10 entity or court that the violation has been corrected.

11 Such actions shall not be taken without providing the  
12 health plan with a reasonable opportunity to correct such  
13 violations, except where providing such an opportunity  
14 would risk health or safety.

15 **SEC. 5537. DISCRIMINATION CLAIMS.**

16 (a) CIVIL ACTION BY AGGRIEVED PERSON.—

17 (1) IN GENERAL.—Any person who is aggrieved  
18 by a violation of section 1602 may commence a civil  
19 action against the party or parties committing such  
20 violation in an appropriate State court or district  
21 court of the United States.

22 (2) STANDARDS.—The standards used to deter-  
23 mine whether a violation has occurred in a complaint  
24 alleging discrimination on the basis of age or dis-  
25 ability under section 1602 shall be the standards ap-

1       plied under the Age Discrimination Act of 1975 (42  
2       U.S.C. 6101 et seq.) and the Americans with Dis-  
3       abilities Act of 1990 (42 U.S.C. 12101 et seq.).

4           (3) RELIEF.—In any action under paragraph  
5       (1), if the court finds a violation of section 1602, the  
6       court may award such equitable and injunctive relief  
7       as it deems appropriate, and may award to the ag-  
8       grieved person any sums lost as a result of the viola-  
9       tion. If the court finds that the party or parties  
10      committing a violation engaged in intentional dis-  
11      crimination in violation of section 1602, the ag-  
12      grieved person may recover compensatory damages.  
13      If the court finds that the party or parties commit-  
14      ting such violation did so with malice or reckless in-  
15      difference to the federally protected rights of the ag-  
16      grieved person, the aggrieved person may recover  
17      punitive damages under this section against a de-  
18      fendant other than a government, government agen-  
19      cy or political subdivision.

20           (4) ATTORNEYS' FEES.—In any action under  
21      paragraph (1), the court, in its discretion, may allow  
22      the prevailing party, other than the United States,  
23      a reasonable attorney's fee (including expert fees  
24      and other litigation expenses) as part of the costs,

1 and the United States shall be liable for costs the  
2 same as a private person.

3 (b) ACTION BY SECRETARY.—Whenever the Sec-  
4 retary of Health and Human Services finds that a party  
5 has failed to comply with section 1602 or with an applica-  
6 ble regulation issued under such section, the Secretary  
7 shall notify the party. If within a reasonable period of time  
8 the party fails or refuses to comply, the Secretary may—

9 (1) refer the matter to the Attorney General  
10 with a recommendation that an appropriate civil ac-  
11 tion be instituted;

12 (2) terminate or limit the participation of such  
13 party in the programs authorized by this Act;

14 (3) withhold Federal financial assistance to the  
15 party; or

16 (4) take such other action as may be provided  
17 by law.

18 (c) ACTION BY ATTORNEY GENERAL.—When a mat-  
19 ter is referred to the Attorney General under subsection  
20 (b)(1), the Attorney General may bring a civil action in  
21 a district court of the United States for such relief as may  
22 be appropriate, including injunctive relief. In a civil action  
23 under this section, the court—

24 (1) may grant any equitable relief that the  
25 court considers to be appropriate;

1           (2) may award such other relief as the court  
2           considers to be appropriate, including in cases of in-  
3           tentional discrimination compensatory and punitive  
4           damages; and

5           (3) may, to vindicate the public interest when  
6           requested by the Attorney General, assess a civil  
7           money penalty against the party in an amount—

8                   (A) not exceeding \$50,000 for a first viola-  
9                   tion; and

10                   (B) not exceeding \$100,000 for any subse-  
11                   quent violation.

12 **SEC. 5538. NONDISCRIMINATION IN FEDERALLY ASSISTED**  
13 **PROGRAMS.**

14           Federal payments under this Act shall be treated as  
15 Federal financial assistance for purposes of section 504  
16 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section  
17 303 of the Age Discrimination Act of 1975 (42 U.S.C.  
18 6102), and section 601 of the Civil Rights Act of 1964  
19 (42 U.S.C. 2000d).

20 **SEC. 5539. CIVIL AND ADMINISTRATION ACTION BY ESSEN-**  
21 **TIAL COMMUNITY PROVIDER.**

22           (a) IN GENERAL.—An electing essential community  
23 provider (as defined in section 1466(d)) who is aggrieved  
24 by the failure of a health plan to fulfill a duty imposed  
25 on the plan by section 1466 may commence a civil action

1 against the plan in an appropriate State court or district  
2 court of the United States.

3 (b) RELIEF.—In an action under subsection (a), if  
4 the court finds that the health plan has failed to fulfill  
5 a duty imposed on the plan by section 1466, the electing  
6 essential community provider may recover compensatory  
7 damages and the court may order any other appropriate  
8 relief.

9 (c) ATTORNEY'S FEES.—In any action under sub-  
10 section (a), the court, in its discretion, may allow the pre-  
11 vailing party, other than the United States, a reasonable  
12 attorney's fee (including expert fees) as part of the costs,  
13 and the United States shall be liable for costs the same  
14 as a private person.

15 (d) STATE COMPLAINT SYSTEM REQUIRED.—Prior  
16 to commencing an action under subsection (a), the ag-  
17 grieved essential community provider may first elect to  
18 utilize the administrative process provided under this sub-  
19 section as follows:

20 (1) The Secretary shall prescribe regulations  
21 governing administrative grievance actions by essen-  
22 tial community providers that shall be consistent  
23 with the requirements of section 5504 and that shall  
24 provide for the consolidation of complaints (at the  
25 election of the essential community providers) in

1 cases involving multiple complaints against a single  
2 health plan.

3 (2) A State shall make available to each elect-  
4 ing essential community provider that is aggrieved  
5 by an action of a health plan under section 1466,  
6 the opportunity to file a complaint in the complaint  
7 review office established under section 5502. In the  
8 case of essential community providers located in a  
9 cooperative established in any State by the Sec-  
10 retary, the Secretary shall assume all of the duties  
11 and obligations of such State under this section.

12 **SEC. 5540. FACIAL CONSTITUTIONAL CHALLENGES.**

13 (a) JURISDICTION.—The United States District  
14 Court for the District of Columbia shall have original and  
15 exclusive jurisdiction of any civil action brought to invali-  
16 date this Act or a provision of this Act on the ground of  
17 its being repugnant to the Constitution of the United  
18 States on its face and for every purpose. In any action  
19 described in this subsection, the district court may not  
20 grant any temporary order or preliminary injunction re-  
21 straining the enforcement, operation, or execution of this  
22 Act or any provision of this Act.

23 (b) CONVENING OF THREE-JUDGE COURT.—An ac-  
24 tion described in subsection (a) shall be heard and deter-

1 mined by a district court of three judges in accordance  
2 with section 2284 of title 28, United States Code.

3 (c) CONSOLIDATION.—When actions described in  
4 subsection (a) involving a common question of law or fact  
5 are pending before a district court, the court shall order  
6 all the actions consolidated.

7 (d) DIRECT APPEAL TO SUPREME COURT.—In any  
8 action described in subsection (a), an appeal may be taken  
9 directly to the Supreme Court of the United States from  
10 any final judgment, decree, or order in which the district  
11 court—

12 (1) holds this Act or any provision of this Act  
13 invalid; and

14 (2) makes a determination that its holding will  
15 materially undermine the application of the Act as  
16 whole.

17 (e) CONSTRUCTION.—This section does not limit—

18 (1) the right of any person—

19 (A) to a litigation concerning the Act or  
20 any portion of the Act; or

21 (B) to petition the Supreme Court for re-  
22 view of any holding of a district court by writ  
23 of certiorari at any time before the rendition of  
24 judgment in a court of appeals; or

1           (2) the authority of the Supreme Court to grant  
2           a writ of certiorari for the review described in para-  
3           graph (1)(B).

4 **SEC. 5541. TREATMENT OF PLANS AS PARTIES IN CIVIL AC-**  
5 **TIONS.**

6           (a) IN GENERAL.—A health plan may sue or be sued  
7 under this Act as an entity. Service of summons, sub-  
8 poena, or other legal process of a court or hearing officer  
9 upon a trustee or an administrator of any such plan in  
10 his or her capacity as such shall constitute service upon  
11 the plan. In a case where a plan has not designated in  
12 applicable plan documents an individual as agent for the  
13 service of legal process, service upon the Secretary of  
14 Health and Human Services (in the case of a community-  
15 rated health plan) or the Secretary of Labor (in the case  
16 of an experienced-rated health plan) shall constitute such  
17 service. The Secretary, not later than 15 days after receipt  
18 of service under the preceding sentence, shall notify the  
19 administrator or any trustee of the plan of receipt of such  
20 service.

21           (b) OTHER PARTIES.—Any money judgment under  
22 this Act against a plan referred to in subsection (a) shall  
23 be enforceable only against the plan as an entity and shall  
24 not be enforceable against any other person unless liability

1 against such person is established in his individual capac-  
2 ity under this Act.

3 **SEC. 5542. WHISTLEBLOWER PROTECTIONS.**

4 (a) IN GENERAL.—A health plan may not discharge,  
5 discriminate or otherwise take adverse action against any  
6 employee with respect to compensation, terms, conditions  
7 or privileges of employment because the employee (or any  
8 person acting pursuant to the request of the employee)  
9 provided information to any Federal, State or private su-  
10 pervisory agency or entity regarding a possible violation  
11 of any provision of this Act or any regulation issued under  
12 this Act.

13 (b) CIVIL ACTION.—An employee or former employee  
14 who believes that such employee has been discharged, dis-  
15 criminated or otherwise subject to adverse action in viola-  
16 tion of subsection (a) may file a civil action in the appro-  
17 priate United States district court within 2 years of the  
18 date of such discharge, discrimination or adverse action.

19 (c) DETERMINATION OF COURT.—If a court in an ac-  
20 tion under subsection (b) determines that a violation of  
21 subsection (a) has occurred, the court may order the  
22 health care entity or plan that committed the violation—

23 (1) to reinstate the employee to his or her  
24 former position;



1           “(2) The Clayton Act (15 U.S.C. 12 et seq.).

2           “(3) Federal Trade Commission Act (15 U.S.C.  
3 41 et seq.).

4           “(4) The Act of June 19, 1936 (49 Stat. 1526;  
5 15 U.S.C. 21a et seq.), known as the Robinson-Pat-  
6 man Antidiscrimination Act.”.

7           (b) EFFECTIVE DATE.—The amendment made by  
8 subsection (a) shall take effect on the first day of the sixth  
9 month beginning after the date of the enactment of this  
10 Act.

11           **TITLE VI—INDIVIDUAL AND**  
12           **EMPLOYER SUBSIDIES**  
13           **Subtitle A—Individual Premium**  
14           **and Cost-Sharing Assistance**

15           **SEC. 6001. REQUIREMENT TO OPERATE STATE PROGRAM.**

16           (a) IN GENERAL.—A participating State shall have  
17 in effect a program for furnishing premium assistance and  
18 cost-sharing assistance in accordance with this subtitle for  
19 calendar years beginning after 1996.

20           (b) DESIGNATION OF STATE AGENCY.—A State may  
21 designate any appropriate State agency to administer the  
22 program under this subtitle.

23           **SEC. 6002. ASSISTANCE WITH STANDARD HEALTH PLAN**  
24           **PREMIUMS.**

25           (a) ELIGIBILITY.—

1           (1) IN GENERAL.—An eligible individual (as de-  
2           fined in section 6008(4)) who has been determined  
3           by a State under section 6004 to be a premium sub-  
4           sidy eligible individual (as defined in paragraph (2))  
5           shall be eligible for premium assistance in the  
6           amount determined under subsection (b).

7           (2) PREMIUM SUBSIDY ELIGIBLE INDI-  
8           VIDUAL.—For purposes of this subtitle, the term  
9           “premium subsidy eligible individual” means any of  
10          the following individuals:

11           (A) INDIVIDUALS WITH INCOMES BELOW A  
12          CERTAIN INCOME THRESHOLD.—An eligible in-  
13          dividual who has a family income determined  
14          under section 6008(3) which does not exceed  
15          200 percent of the poverty line (as defined in  
16          section 6008(5)).

17           (B) CHILDREN.—An eligible individual  
18          who—

19           (i) is a child (as defined in section  
20           6008(2));

21           (ii) has a family income determined  
22           under section 6008(3) which does not ex-  
23           ceed 240 percent of the poverty line; and

24           (iii) has not been enrolled in a health  
25           plan during the 6-month period ending on

1 the date the individual submits an applica-  
2 tion to the State for premium assistance  
3 under this subtitle.

4 (C) PREGNANT WOMEN.—An eligible indi-  
5 vidual who—

6 (i) is a pregnant woman (as defined in  
7 section 6008(6));

8 (ii) has a family income determined  
9 under section 6008(3) which does not ex-  
10 ceed 240 percent of the poverty line; and

11 (iii) is not enrolled in a health plan on  
12 the date the individual submits an applica-  
13 tion to the State for premium assistance  
14 under this subtitle.

15 (3) SPECIAL RULE WITH RESPECT TO CHIL-  
16 DREN AND PREGNANT WOMEN.—An eligible indi-  
17 vidual may not be a premium subsidy eligible indi-  
18 vidual described in subparagraphs (B) or (C) of  
19 paragraph (2) if an employer contribution of at least  
20 80 percent of the premium under a standard health  
21 plan that is available to the individual through the  
22 employer is made or offered to be made on behalf of  
23 the individual.

24 (b) AMOUNT OF ASSISTANCE.—

25 (1) IN GENERAL.—

1 (A) FORMULA.—The amount of premium  
2 assistance for a month for a premium subsidy  
3 eligible individual is—

4 (i) the least of —

5 (I) the subsidy percentage speci-  
6 fied in paragraph (2) multiplied by  
7  $\frac{1}{12}$ th of the annual premium paid for  
8 coverage under a standard health plan  
9 in which the individual is enrolled;

10 (II) the subsidy percentage speci-  
11 fied in paragraph (2) multiplied by  
12  $\frac{1}{12}$ th of the weighted average annual  
13 premium rate (as defined in subpara-  
14 graph (B)) for all community-rated  
15 standard health plans offered in the  
16 community rating area in which the  
17 individual resides; or

18 (III) the subsidy percentage spec-  
19 ified in paragraph (2) multiplied by  
20  $\frac{1}{12}$ th of the annual reference pre-  
21 mium for the community rating area  
22 in which the individual resides (as de-  
23 fined in subparagraph (C)); minus

24 (ii) the amount of any employer con-  
25 tribution made or offered to be made on

1           behalf of the individual for coverage under  
2           the standard health plan that is available  
3           to the individual through an employer.

4           (B) WEIGHTED AVERAGE ANNUAL PRE-  
5           MIUM RATE.—For purposes of this paragraph,  
6           the term “weighted average annual premium  
7           rate” means the average premium for the com-  
8           munity-rated standard health plans offered in  
9           the community rating area in which the indi-  
10          vidual resides, weighted to reflect the total en-  
11          rollment of community-rated eligible individuals  
12          among such plans.

13          (C) REFERENCE PREMIUM.—For purposes  
14          of this paragraph, the term “reference pre-  
15          mium” means the reference premium estab-  
16          lished under section 4512 of the Internal Rev-  
17          enue Code of 1986.

18          (D) SPECIAL RULES FOR DETERMINING  
19          AMOUNT OF EMPLOYER CONTRIBUTIONS.—For  
20          purposes of determining the amount of an em-  
21          ployer contribution under subparagraph (A),  
22          the following rules shall apply:

23                  (i) FAMILY CONTRIBUTIONS.—If an  
24                  employer makes a contribution on behalf of  
25                  a family (rather than any particular indi-

1           vidual) such contribution shall be allocated  
2           ratably among the individuals in the fam-  
3           ily.

4           (ii) GREATEST EMPLOYER CONTRIBU-  
5           TION AVAILABLE.—The employer contribu-  
6           tion with respect to any individual is the  
7           largest employer contribution offered to be  
8           made on behalf of the individual by the in-  
9           dividual’s employer or any employer of any  
10          member of the individual’s family.

11          (2) SUBSIDY PERCENTAGE.—For purposes of  
12          paragraph (1)(A), the term “subsidy percentage”  
13          means the following:

14                (A) INDIVIDUALS WITH INCOMES BELOW  
15                CERTAIN INCOME THRESHOLD.—

16                (i) IN GENERAL.—Except as provided  
17                in clauses (ii) and (iii), for a premium sub-  
18                sidy eligible individual described in sub-  
19                section (a)(2)(A), 100 percent reduced  
20                (but not below zero) by .80 percentage  
21                points for each 1 percentage point (or por-  
22                tion thereof) by which such individual’s  
23                family income exceeds 100 percent of the  
24                poverty line.

1 (ii) AFDC RECIPIENTS.—For a pre-  
2 mium subsidy eligible individual described  
3 in subsection (a)(2)(A) who is a member of  
4 a family receiving aid to families with de-  
5 pendent children under part A or E of title  
6 IV of the Social Security Act, the subsidy  
7 percentage shall be 100 percent.

8 (iii) NON-CASH MEDICAID ELIGI-  
9 BLES.—

10 (I) IN GENERAL.—For a pre-  
11 mium subsidy eligible individual de-  
12 scribed in subsection (a)(2)(A) who is  
13 a non-cash medicaid eligible described  
14 in subclause (II), the subsidy percent-  
15 age shall be 100 percent during the 6-  
16 month period beginning on January 1,  
17 1997.

18 (II) NON-CASH MEDICAID ELIGI-  
19 BLE.—The non-cash medicaid eligibles  
20 described in this subclause are indi-  
21 viduals receiving medical assistance  
22 under the State plan under title XIX  
23 of the Social Security Act as of De-  
24 cember 31, 1996, who are not individ-  
25 uals—

1 (aa) who are members of a  
2 family receiving aid to families  
3 with dependent children under  
4 part A or E of title IV of the So-  
5 cial Security Act;

6 (bb) with respect to whom  
7 supplemental security income  
8 benefits are being paid under  
9 title XVI of such Act; or

10 (cc) eligible for benefits  
11 under part A of title XVIII of  
12 such Act.

13 (B) CHILDREN AND PREGNANT WOMEN.—

14 For a premium subsidy eligible individual de-  
15 scribed in subparagraph (B) or (C) of sub-  
16 section (a)(2), 100 percent reduced (but not  
17 below zero) by 1.82 percentage points for each  
18 1 percentage point (or portion thereof) by which  
19 such individuals family income exceeds 185 per-  
20 cent of the poverty line.

21 (c) PAYMENTS.—

22 (1) IN GENERAL.—The amount of the premium  
23 assistance available to a premium subsidy eligible in-  
24 dividual under subsection (b) shall be paid by the  
25 State in which the individual resides directly to the

1 standard health plan in which the individual is en-  
 2 rolled. Payments under the preceding sentence shall  
 3 commence in the first month during which the indi-  
 4 vidual is enrolled in a certified standard health plan  
 5 and determined under section 6004 to be a premium  
 6 subsidy eligible individual.

7 (2) SPECIAL RULE WITH RESPECT TO FAMILIES  
 8 WITH MULTIPLE CHILDREN.—If a family includes  
 9 more than 1 child described in subsection (a)(2)(B),  
 10 no premium assistance may be paid to a plan under  
 11 paragraph (1) on behalf of any such child unless  
 12 such assistance is paid on behalf of all such children.

13 (3) ADMINISTRATIVE ERRORS.—A State is fi-  
 14 nancially responsible for premium assistance paid  
 15 based on an eligibility determination error to the ex-  
 16 tent the State's error rate for eligibility determina-  
 17 tions exceeds a maximum permissible error rate to  
 18 be specified by the Secretary.

19 **SEC. 6003. ASSISTANCE WITH COST-SHARING FOR STAND-**  
 20 **ARD HEALTH PLANS.**

21 (a) NON-AFDC LOW-INCOME INDIVIDUALS.—

22 (1) INDIVIDUALS WORKING FOR COMMUNITY-  
 23 RATED EMPLOYERS.—

24 (A) IN GENERAL.—If a non-AFDC low-in-  
 25 come individual described in subparagraph (B)

1 is enrolled in a community-rated standard  
2 health plan providing a high cost-sharing sched-  
3 ule, such individual shall be eligible for cost-  
4 sharing assistance consisting of a reduction in  
5 the cost-sharing under such plan to the level of  
6 a plan providing a low cost-sharing schedule.

7 (B) INDIVIDUAL DESCRIBED.—A non-  
8 AFDC low-income individual described in this  
9 subparagraph is an individual who is employed  
10 by a community-rated employer and who is un-  
11 able to enroll in a standard health plan—

12 (i) with a premium at or below the  
13 weighted average premium rate for all  
14 community-rated standard health plans of-  
15 fered through the purchasing cooperative  
16 offered by the individual's employer, and

17 (ii) providing a low or combination  
18 cost-sharing schedule.

19 (2) INDIVIDUALS WORKING FOR EXPERIENCE-  
20 RATED EMPLOYERS.—

21 (A) IN GENERAL.—If a non-AFDC low-in-  
22 come individual described in subparagraph (B)  
23 is enrolled in an experience-rated standard  
24 health plan providing a high cost-sharing sched-  
25 ule, such individual shall be eligible for cost-

1 sharing assistance consisting of a reduction in  
2 the cost-sharing under such plan to the level of  
3 a plan providing a low cost-sharing schedule.

4 (B) INDIVIDUAL DESCRIBED.—A non-  
5 AFDC low-income individual described in this  
6 subparagraph is an individual who is employed  
7 by an experience-rated employer and who is un-  
8 able to enroll in a standard health plan offered  
9 by such employer providing a low or combina-  
10 tion cost-sharing schedule.

11 (3) NON-WORKING INDIVIDUALS.—

12 (A) IN GENERAL.—If a non-AFDC low-in-  
13 come individual described in subparagraph (B)  
14 is enrolled in a community-rated standard plan  
15 providing a high cost-sharing schedule, such in-  
16 dividual shall be eligible for cost-sharing assist-  
17 ance consisting of a reduction in the cost-shar-  
18 ing under such plan to the level of a plan pro-  
19 viding a low cost-sharing schedule.

20 (B) INDIVIDUAL DESCRIBED.—A non-  
21 AFDC low-income individual described in this  
22 subparagraph is an individual who is not em-  
23 ployed and who is unable to enroll in a stand-  
24 ard health plan—

1 (i) with a premium at or below the  
2 weighted average premium rate for all  
3 community-rated standard health plans of-  
4 fered in the community rating area in  
5 which the individual resides, and

6 (ii) providing a low or combination  
7 cost-sharing schedule.

8 (4) NON-AFDC LOW-INCOME INDIVIDUAL.—For  
9 purposes of this subsection, the term “non-AFDC  
10 low-income individual” means an eligible individual  
11 who—

12 (A) has a family income determined under  
13 section 6008(3) which does not exceed 150 per-  
14 cent of the poverty line; and

15 (B) is not a member of a family receiving  
16 aid to families with dependent children under  
17 part A or E of title IV of the Social Security  
18 Act.

19 (b) AFDC RECIPIENTS.—

20 (1) LOW OR COMBINATION COST-SHARING  
21 PLAN.—An AFDC recipient enrolled in a commu-  
22 nity-rated standard plan—

23 (A) with a premium at or below the  
24 weighted average premium rate for all commu-  
25 nity rated-standard health plans offered in the

1 community rating area in which the individual  
2 resides, and

3 (B) providing a low or combination cost-  
4 sharing schedule,

5 shall be eligible for cost-sharing assistance consisting  
6 of a reduction in the amount of copayment applied  
7 with respect to an item or service in an amount  
8 equal to 20 percent of the copayment amount other-  
9 wise applicable under the plan, rounded to the near-  
10 est dollar.

11 (2) HIGH COST-SHARING PLAN.—If an AFDC  
12 recipient is unable to enroll in a health plan de-  
13 scribed in paragraph (1) and such individual is en-  
14 rolled in a community-rated standard plan providing  
15 a high cost-sharing schedule, such individual shall be  
16 eligible for cost-sharing assistance consisting of a re-  
17 duction in the cost-sharing under such plan to the  
18 level of a plan providing a low cost-sharing schedule.

19 (3) AFDC RECIPIENT.—For purposes of this  
20 subsection, the term “AFDC recipient” means an el-  
21 igible individual who is a member of a family receiv-  
22 ing aid to families with dependent children under  
23 part A or E of title IV of the Social Security Act.

24 (c) NOTIFICATION OF HEALTH PLANS.—If a State  
25 determines that an individual is eligible for cost-sharing

1 assistance under this section, the State shall notify the  
2 standard health plan in which such individual is enrolled  
3 of such determination in a timely manner.

4 **SEC. 6004. ELIGIBILITY DETERMINATIONS.**

5 (a) IN GENERAL.—The Secretary shall promulgate  
6 regulations specifying requirements for State programs  
7 under this subtitle with respect to determining eligibility  
8 for premium and cost-sharing assistance.

9 (b) SPECIFICATIONS FOR REGULATIONS.—The regu-  
10 lations promulgated by the Secretary under subsection (a)  
11 shall include the following requirements:

12 (1) FREQUENCY OF APPLICATIONS.—A State  
13 program shall provide that an individual may file an  
14 application for assistance with an agency designated  
15 by the State at any time, in person or by mail.

16 (2) APPLICATION FORM.—A State program  
17 shall provide for the use of an application form de-  
18 veloped by the Secretary under subsection (c).

19 (3) DISTRIBUTION OF APPLICATIONS.—A State  
20 program shall make applications accessible at loca-  
21 tions where individuals are most likely to obtain the  
22 applications.

23 (4) REQUIREMENT TO SUBMIT REVISED APPLI-  
24 CATION.—A State program shall require individuals  
25 to submit revised applications to reflect changes in

1 estimated family incomes, including changes in em-  
2 ployment status of family members, during the year.  
3 The State shall revise the amount of any premium  
4 assistance based on such a revised application.

5 (5) VERIFICATION.—A State program shall pro-  
6 vide for verification of the information supplied in  
7 applications under this subtitle. Such verification  
8 may include examining return information disclosed  
9 to the State for such purpose under section  
10 6103(l)(15) of the Internal Revenue Code of 1986.

11 (c) ADMINISTRATION OF STATE PROGRAMS.—

12 (1) IN GENERAL.—The Secretary shall establish  
13 standards for States operating programs under this  
14 subtitle which ensure that such programs are oper-  
15 ated in a uniform manner with respect to application  
16 procedures, data processing systems, and such other  
17 administrative activities as the Secretary determines  
18 to be necessary.

19 (2) APPLICATION FORMS.—The Secretary shall  
20 develop an application form for assistance which  
21 shall—

22 (A) be simple in form and understandable  
23 to the average individual;

24 (B) require the provision of information  
25 necessary to make a determination as to wheth-

1 er an individual is eligible for assistance, includ-  
 2 ing a declaration of estimated income by the in-  
 3 dividual based, at the election of the indi-  
 4 vidual—

5 (i) on multiplying by a factor of 4 the  
 6 individual's family income for the 3-month  
 7 period immediately preceding the month in  
 8 which the application is made; or

9 (ii) on estimated income for the entire  
 10 year for which the application is submitted;  
 11 and

12 (C) require attachment of such documenta-  
 13 tion as deemed necessary by the Secretary in  
 14 order to ensure eligibility for assistance.

15 (d) EFFECTIVENESS OF ELIGIBILITY.—A determina-  
 16 tion by a State that an individual is a premium subsidy  
 17 eligible individual or an individual eligible for cost-sharing  
 18 assistance shall be effective for the calendar year for which  
 19 such determination is made unless a revised application  
 20 submitted under subsection (b)(4) indicates that an indi-  
 21 vidual is no longer eligible for assistance.

22 (e) PENALTIES FOR MATERIAL MISREPRESENTA-  
 23 TIONS.—

24 (1) IN GENERAL.—Any individual who know-  
 25 ingly makes a material misrepresentation of infor-

1 mation in an application for assistance under this  
2 subtitle shall be liable to the Federal Government  
3 for the amount any assistance received by individual  
4 on the basis of a misrepresentation and interest on  
5 such amount at a rate specified by the Secretary,  
6 and, shall, in addition, be liable to the Federal Gov-  
7 ernment for \$2,000 or, if greater, 3 times the  
8 amount any assistance received by individual on the  
9 basis of a misrepresentation.

10 (2) COLLECTION OF PENALTY AMOUNTS.—A  
11 State which receives an application for assistance  
12 with respect to which a material misrepresentation  
13 has been made shall collect the penalty amount re-  
14 quired under paragraph (1) and submit such amount  
15 to the Secretary in a timely manner.

16 **SEC. 6005. END-OF-YEAR RECONCILIATION FOR PREMIUM**  
17 **ASSISTANCE.**

18 (a) IN GENERAL.—

19 (1) REQUIREMENT TO FILE STATEMENT.—An  
20 individual who received premium assistance under  
21 this subtitle from a State for any month in a cal-  
22 endar year shall file with the State an income rec-  
23 onciliation statement to verify the individual's family  
24 income for the year. Such a statement shall be filed  
25 at such time, and contain such information, as the

1 State may specify in accordance with regulations  
2 promulgated by the Secretary.

3 (2) NOTICE OF REQUIREMENT.—A State shall  
4 provide a written notice of the requirement under  
5 paragraph (1) at the end of the year to an individual  
6 who received premium assistance under this subtitle  
7 from such State in any month during the year.

8 (b) RECONCILIATION OF PREMIUM ASSISTANCE  
9 BASED ON ACTUAL INCOME.—

10 (1) IN GENERAL.—Based on and using the in-  
11 come reported in the reconciliation statement filed  
12 under subsection (a) with respect to an individual,  
13 the State shall compute the amount of premium as-  
14 sistance that should have been provided under this  
15 subtitle with respect to the individual for the year  
16 involved.

17 (2) OVERPAYMENT OF ASSISTANCE.—If the  
18 total amount of the premium assistance provided  
19 was greater than the amount computed under para-  
20 graph (1), the individual is liable to the State to pay  
21 an amount equal to the amount of the excess pay-  
22 ment. Any amount collected by a State under this  
23 paragraph shall be submitted to the Secretary in a  
24 timely manner.

1           (3) UNDERPAYMENT OF ASSISTANCE.—If the  
2 total amount of the premium assistance provided  
3 was less than the amount computed under para-  
4 graph (1), the State shall pay to the individual an  
5 amount equal to the amount of the deficit.

6           (4) STATE OPTION.—A State may, in accord-  
7 ance with regulations promulgated by the Secretary,  
8 establish a procedure under which any overpayments  
9 or underpayments of premium assistance determined  
10 under paragraphs (2) and (3) with respect to an in-  
11 dividual for a year may be collected or paid, as ap-  
12 propriate, through adjustments to the premium as-  
13 sistance furnished to such individual in the suc-  
14 ceeding year.

15          (c) VERIFICATION.—Each State may use such infor-  
16 mation as it has available to verify income of individuals  
17 with applications filed under this subtitle, including return  
18 information disclosed to the State for such purpose under  
19 section 6103(l)(15) of the Internal Revenue Code of 1986.

20          (d) PENALTIES FOR FAILURE TO FILE.—In the case  
21 of an individual who is required to file a statement under  
22 this section in a year who fails to file such a statement,  
23 the entire amount of the premium assistance provided in  
24 such year shall be considered an excess amount under sub-  
25 section (b)(2) and such individual shall not be eligible for

1 premium assistance under this subtitle until such state-  
2 ment is filed. A State, using rules established by the Sec-  
3 retary, shall waive the application of this subsection if the  
4 individual establishes, to the satisfaction of the State  
5 under such rules, good cause for the failure to file the  
6 statement on a timely basis.

7 (e) PENALTIES FOR FALSE INFORMATION.—Any in-  
8 dividual who provides false information in a statement  
9 filed under subsection (a) is subject to the same penalties  
10 as are provided under section 6004(e) for a misrepresenta-  
11 tion of material fact described in such section.

12 **SEC. 6006. ENROLLMENT OUTREACH.**

13 (a) IN GENERAL.—The Secretary shall promulgate  
14 regulations under which each State operating a program  
15 for premium assistance under this subtitle shall have in  
16 effect an enrollment outreach system under which individ-  
17 uals may be determined eligible for such assistance by  
18 health care providers who furnish services to such individ-  
19 uals.

20 (b) SPECIFICATIONS FOR REGULATIONS.—The regu-  
21 lations promulgated by the Secretary under subsection (a)  
22 shall include the following requirements:

23 (1) HEALTH CARE PROVIDERS.—Each State  
24 shall permit only the classes or categories of health  
25 care providers determined appropriate by the Sec-

1       retary (referred to in this subsection as “eligible  
2       health care providers”) to participate in an enroll-  
3       ment outreach system established by the State.

4               (2) APPLICATION FOR ASSISTANCE.—Each  
5       State shall develop and make available to eligible  
6       health care providers in the State an enrollment  
7       package for distribution to potentially eligible indi-  
8       viduals which includes a simple form for individuals  
9       who receive services from such providers to apply for  
10      premium assistance. Such form shall—

11               (A) permit an individual completing the  
12      form to make a declaration that the individual  
13      is eligible for a full subsidy under section 6002;  
14      and

15               (B) permit an individual to enroll in a  
16      community-rated standard health plan offered  
17      in the community rating area in which the indi-  
18      vidual resides.

19               (3) SUBMISSION OF COMPLETED APPLICA-  
20      TION.—An individual who receives an enrollment ap-  
21      plication form from an eligible health care provider  
22      may complete the form and submit it to the individ-  
23      ual’s provider or the State agency operating the pro-  
24      gram for premium assistance under this subtitle. If  
25      a health care provider receives an application under

1 this section the provider shall submit the application  
2 to the State agency administering the premium as-  
3 sistance program under this subtitle within a period  
4 of time determined appropriate by the Secretary in  
5 regulations.

6 (4) SELECTION OF HEALTH PLAN.—An indi-  
7 vidual may select a community-rated standard health  
8 plan with which to enroll on the date the individual  
9 submits an application form under this section or  
10 the individual may make such selection at a later  
11 date determined appropriate by the Secretary in reg-  
12 ulations. If an individual fails to select a health plan  
13 with which to enroll by the date determined appro-  
14 priate by the Secretary, the State agency shall select  
15 such a plan for the individual.

16 (5) EFFECTIVE DATE OF ENROLLMENT.—An  
17 individual who is enrolled in a community-rated  
18 standard health plan in accordance with the enroll-  
19 ment eligibility system established under this section  
20 shall be an enrollee of the plan as of the date the  
21 individual submits an application to the State agen-  
22 cy or a health care provider.

23 (6) PERIOD OF ELIGIBILITY.—An individual  
24 who submits an application to a health care provider  
25 under an enrollment outreach system under this sec-

1       tion shall be eligible for premium assistance under  
2       this subtitle for the period beginning on the date  
3       such application is submitted and ending 60 days  
4       after such date.

5               (7) NO STATE RESPONSIBILITY FOR ADMINIS-  
6       TRATIVE ERRORS.—Section 6002(c)(3) shall not  
7       apply to any eligibility determinations made under  
8       this section.

9               (8) NO RECONCILIATION REQUIRED.—The rec-  
10      onciliation provisions of section 6005 shall not apply  
11      to any premium assistance paid on behalf of an indi-  
12      vidual during a period of eligibility for such assist-  
13      ance under this section.

14              (9) REQUIREMENT ON STATES.—During a pe-  
15      riod of eligibility for premium assistance under this  
16      section, an individual shall be given an opportunity  
17      by a State to apply for continuing eligibility for pre-  
18      mium assistance under this subtitle.

19   **SEC. 6007. PAYMENTS TO STATES.**

20              (a) IN GENERAL.—

21                      (1) PAYMENTS FROM THE SECRETARY.—A  
22      State operating a program for furnishing premium  
23      assistance under this subtitle shall be entitled to re-  
24      ceive payments from the Secretary in an amount  
25      equal to the premium assistance paid on behalf of

1 individuals eligible for such assistance under this  
2 subtitle. Such payments shall be made at such time  
3 and in such form as provided in regulations promul-  
4 gated by the Secretary.

5 (2) STATE ENTITLEMENT.—This subsection  
6 constitutes budget authority in advance of appro-  
7 priations Acts, and represents the obligation of the  
8 Federal Government to provide payments to States  
9 operating programs under this subtitle in accordance  
10 with this section.

11 (b) STATE ASSESSMENTS FOR ADMINISTRATION  
12 COSTS.—A State operating a program for furnishing pre-  
13 mium and cost-sharing assistance under this subtitle may  
14 impose a premium assessment on the insured health plans  
15 offered in the State in an amount not to exceed one per-  
16 cent of the amount of the premium. Amounts collected  
17 pursuant to this subsection may only be used to cover the  
18 administrative costs of the State in operating such pro-  
19 gram.

20 (c) AUDITS.—The Secretary shall conduct regular  
21 audits of the activities under the State programs con-  
22 ducted under this subtitle.

23 **SEC. 6008. DEFINITIONS AND DETERMINATIONS OF IN-**  
24 **COME.**

25 For purposes of this subtitle:

1           (1) STANDARD HEALTH PLAN.—The term  
2 “standard health plan” means a health plan (as de-  
3 fined in section 1011(2)(B)) providing the standard  
4 benefits package as described in section 1201(a).

5           (2) CHILD.—The term “child” means an indi-  
6 vidual who is under 19 years of age.

7           (3) DETERMINATIONS OF INCOME.—

8           (A) FAMILY INCOME.—The term “family  
9 income” means, with respect to an individual  
10 who—

11                   (i) is not a dependent (as defined in  
12 subparagraph (B)) of another individual,  
13 the sum of the modified adjusted gross in-  
14 comes (as defined in subparagraph (D))  
15 for the individual, the individual’s spouse,  
16 and children who are dependents of the in-  
17 dividual; or

18                   (ii) is a dependent of another indi-  
19 vidual, the sum of the modified adjusted  
20 gross incomes for the other individual, the  
21 other individual’s spouse, and children who  
22 are dependents of the other individual.

23           (B) DEPENDENT.—The term “dependent”  
24 shall have the meaning given such term under

1 section 152 of the Internal Revenue Code of  
2 1986.

3 (C) SPECIAL RULE FOR FOSTER CHIL-  
4 DREN.—For purposes of subparagraph (A), a  
5 child who is placed in foster care by a State  
6 agency shall not be considered a dependent of  
7 another individual.

8 (D) MODIFIED ADJUSTED GROSS IN-  
9 COME.—The term “modified adjusted gross in-  
10 come” means adjusted gross income (as defined  
11 in section 62(a) of the Internal Revenue Code  
12 of 1986)—

13 (i) determined without regard to sec-  
14 tions 135, 162(l), 911, 931, and 933 of  
15 such Code, and

16 (ii) increased by—

17 (I) the amount of interest re-  
18 ceived or accrued by the individual  
19 during the taxable year which is ex-  
20 empt from tax, and

21 (II) the amount of the social se-  
22 curity benefits (as defined in section  
23 86(d) of such Code) received during  
24 the taxable year to the extent not in-

1                   cluded in gross income under section  
2                   86 of such Code.

3           The determination under the preceding sen-  
4           tence shall be made without regard to any car-  
5           ryover or carryback.

6                   (E) SPECIAL RULE FOR INDIVIDUALS TEM-  
7                   PORARILY UNEMPLOYED.—

8                   (i) IN GENERAL.—For purposes of de-  
9                   termining eligibility for premium assistance  
10                  under this subtitle for an individual who  
11                  becomes unemployed, such individual's  
12                  spouse, and children who are dependents of  
13                  such individual, the family income for such  
14                  individuals determined under subparagraph  
15                  (A) shall be reduced—

16                   (I) for each month before and  
17                   after the period of unemployment, by  
18                   an amount equal to the lesser of the  
19                   gross wages of the individual for the  
20                   month or  $\frac{1}{12}$ th of the amount equal  
21                   to 75 percent of the poverty line for  
22                   an individual; and

23                   (II) for each month after the  
24                   date the individual becomes unem-  
25                   ployed, by an amount equal to any

1 unemployment compensation under an  
2 unemployment compensation law of a  
3 State or of the United States received  
4 by or on behalf of the unemployed in-  
5 dividual.

6 (ii) LIMITATION.—Clause (i) shall no  
7 longer apply to an individual on the earlier  
8 of—

9 (I) the date on which the period  
10 of unemployment ends; or

11 (II) the end of the 6-month pe-  
12 riod beginning on the first day of the  
13 first month during which the indi-  
14 vidual receives premium assistance  
15 under this subtitle that would not be  
16 available to such individual if the pro-  
17 visions of clause (i) did not apply.

18 (iii) SPECIAL RULE.—Clause (i) shall  
19 not apply if an employer contribution of at  
20 least 80 percent of the premium under a  
21 standard health plan is available to the un-  
22 employed individual through an employer  
23 of a member of the individual's family.

24 (4) ELIGIBLE INDIVIDUAL.—

1 (A) IN GENERAL.—The term “eligible indi-  
2 vidual” means an individual who is residing in  
3 the United States and who is—

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

6 (ii) an alien permanently residing in  
7 the United States under color of law (as  
8 defined in subparagraph (C)).

9 (B) EXCLUSION.—The term “eligible indi-  
10 vidual” shall not include an individual who is  
11 an inmate of a public institution (except as a  
12 patient of a medical institution).

13 (C) ALIEN PERMANENTLY RESIDING IN  
14 THE UNITED STATES UNDER COLOR OF LAW.—  
15 The term “alien permanently residing in the  
16 United States under color of law” means an  
17 alien lawfully admitted for permanent residence  
18 (within the meaning of section 101(a)(20) of  
19 the Immigration and Nationality Act), and in-  
20 cludes any of the following:

21 (i) An alien who is admitted as a ref-  
22 ugee under section 207 of the Immigration  
23 and Nationality Act.

24 (ii) An alien who is granted asylum  
25 under section 208 of such Act.

1 (iii) An alien whose deportation is  
2 withheld under section 243(h) of such Act.

3 (iv) An alien who is admitted for tem-  
4 porary residence under section 210, 210A,  
5 or 245A of such Act.

6 (v) An alien who has been paroled  
7 into the United States under section  
8 212(d)(5) of such Act for an indefinite pe-  
9 riod or who has been granted extended vol-  
10 untary departure as a member of a nation-  
11 ality group.

12 (vi) An alien who is the spouse or un-  
13 married child under 21 years of age of a  
14 citizen of the United States, or the parent  
15 of such a citizen if the citizen is over 21  
16 years of age, and with respect to whom an  
17 application for adjustment to lawful per-  
18 manent residence is pending.

19 (5) POVERTY LINE.—The term “poverty line”  
20 means, for a family for a year, the official poverty  
21 line (as defined by the Office of Management and  
22 Budget, and revised annually in accordance with sec-  
23 tion 673(2) of the Omnibus Budget Reconciliation  
24 Act of 1981) applicable to a family of the size in-  
25 volved.

1 (6) PREGNANT WOMAN.—

2 (A) IN GENERAL.—The term “pregnant  
3 woman” includes a woman deemed to be a  
4 pregnant woman under subparagraph (B).

5 (B) PERIOD AFTER TERMINATION OF  
6 PREGNANCY.—For purposes of this subtitle, a  
7 woman shall be deemed to be a pregnant  
8 woman during the period beginning on the date  
9 of the termination of the pregnancy and ending  
10 on the first day of the first month that begins  
11 more than 90 days after such date.

## 12 **Subtitle B—Employer Subsidies**

### 13 **SEC. 6101. PURPOSE.**

14 It is the purpose of this subtitle to provide subsidies  
15 to eligible employers to assist such employers in providing,  
16 or expanding the provision of, health care coverage for the  
17 employees of such employers.

### 18 **SEC. 6102. ELIGIBLE EMPLOYERS.**

19 (a) IN GENERAL.—To be eligible for a subsidy under  
20 this subtitle an employer shall—

21 (1) comply with the requirements of part 1 of  
22 subtitle D of title I;

23 (2) contribute to the cost of health care cov-  
24 erage for all employees of the same class (limited to  
25 full- or part-time) employed by the employer;

1           (3) contribute not less than 50 percent of the  
2 cost of health care coverage for each class of family  
3 enrollment for each employee so covered; and

4           (4) prepare and submit to the Secretary of  
5 Labor an application, at such time, in such manner  
6 and containing such information as the Secretary  
7 may require.

8 (b) APPLICATION OF REQUIREMENTS.—

9           (1) IN GENERAL.—The requirements of para-  
10 graphs (2) and (3) of subsection (a) shall only apply  
11 with respect to the employees described in paragraph  
12 (2).

13           (2) COVERAGE OF EMPLOYEES.—The employees  
14 described in this paragraph are those employees—

15                   (A) for which the employer is contributing  
16 to the costs of health care coverage; and

17                   (B) for which the employer did not make  
18 such a contribution prior to the date of enact-  
19 ment of this Act.

20           (c) SOLE PROPRIETORSHIPS.—A sole proprietorship  
21 with not less than 3 full-time employees (including the sole  
22 proprietor) shall be eligible for a subsidy under this sub-  
23 title if such proprietorship reports the payment of wages  
24 (as defined in the Internal Revenue Code of 1986), in the  
25 year prior to the year for which the subsidy is applied for,

1 in an amount required under regulations promulgated by  
2 the Secretary of Labor.

3 (d) INELIGIBILITY.—

4 (1) SELF-EMPLOYED.—A self-employed indi-  
5 vidual (as such term is defined in section 1011(e))  
6 shall not be eligible for a subsidy under this subtitle.

7 (2) EMPLOYEE LEASING FIRMS.—An employer  
8 that is an employee leasing firm shall not be eligible  
9 for a subsidy under this subtitle. The Secretary of  
10 Labor shall promulgate regulations defining the  
11 term “employee leasing firm”.

12 (3) STATE OR LOCAL GOVERNMENTS.—An em-  
13 ployer that is a State or local government shall not  
14 be eligible for a subsidy under this section.

15 **SEC. 6103. EMPLOYER CERTIFICATION.**

16 (a) REQUIREMENT.—An employer that submits an  
17 application under section 6102(a)(4) shall certify that  
18 such employer, prior to the date of enactment of this Act,  
19 did not contribute to the costs of health care coverage for  
20 the employees for which the employer is applying for the  
21 subsidy.

22 (b) CONTRIBUTION LIMIT.—For purposes of sub-  
23 section (a), an employer shall be treated as having contrib-  
24 uted to the health care coverage of an employee if the

1 amount of such contribution is \$500 or more (as  
2 annualized).

3 (c) UNION SICKNESS FUNDS.—For purposes of this  
4 subtitle, employers that contribute to union sickness funds  
5 on behalf of their employees shall be deemed to have con-  
6 tributed to the costs of health care coverage for the em-  
7 ployees of such employer.

8 (d) REGULATIONS.—For purposes of this section, the  
9 Secretary of Labor shall promulgate regulations to enable  
10 an employer to determine whether and to what extent an  
11 employer contributed to the costs of an employee's health  
12 care coverage prior to the date of enactment of this Act.  
13 An employer shall utilize such regulations in submitting  
14 a certification under this section.

15 **SEC. 6104. AMOUNT OF SUBSIDY.**

16 (a) IN GENERAL.—With respect to an employee for  
17 which a subsidy application submitted by an employer has  
18 been approved by the Secretary of Labor under this sub-  
19 title, the employer shall receive a subsidy (to be paid over  
20 a 5-year period) in an amount that equals—

21 (1) with respect to the first 3 years after the  
22 date of enactment of this Act—

23 (A)(i) in the case of a community-rated  
24 employer, 50 percent of the lesser of—

1 (I) the weighted average premium  
2 rate (as defined in section 6002(b)(1)(C))  
3 for the purchasing cooperative through  
4 which the employer has contributed to the  
5 employee's health care coverage (for the  
6 year involved);

7 (II) the community-rate of the stand-  
8 ard health plan under which the employee  
9 received coverage (for the year involved);  
10 or

11 (III) the weighted average premium  
12 rate of the community rating area in which  
13 the employee resides; or

14 (ii) in the case of an experience-rated em-  
15 ployer, 50 percent of the lesser of—

16 (I) the weighted average premium  
17 rate of the community rating area in which  
18 the employee resides; or

19 (II) the premium rate for the experi-  
20 ence-rated plan under which the employee  
21 received coverage (for the year involved);

22 less

23 (B) 12 percent of the wages of the em-  
24 ployee (for the year involved);

1           (2) with respect to the fourth year after the  
2 date of enactment of this Act—

3           (A) 37.5 percent of the lesser of the  
4 amounts referred to in subparagraph (A) of  
5 paragraph (1) (for the type of employer and the  
6 year involved); less

7           (B) 12 percent of the wages of the em-  
8 ployee (for the year involved); and

9           (3) with respect to the fifth year after the date  
10 of enactment of this Act—

11           (A) 25 percent of the lesser of the amounts  
12 referred to in subparagraph (A) of paragraph  
13 (1) (for the type of employer and the year in-  
14 volved); less

15           (B) 12 percent of the wages of the em-  
16 ployee (for the year involved).

17 (b) LIMITATIONS.—

18           (1) AMOUNT OF CONTRIBUTION.—If, in apply-  
19 ing the formula under subsection (a), the Secretary  
20 of Labor determines that an employer's contribu-  
21 tions to the health care coverage costs of its employ-  
22 ees exceeds 50 percent of the weighted average pre-  
23 mium rate for the purchasing cooperative through  
24 which the employer has so contributed (for the year  
25 involved), the Secretary shall notify such employer

1 that such employer is not eligible for a subsidy  
2 under this subtitle.

3 (2) PART-TIME EMPLOYEES.—With respect to  
4 subsidies for health care coverage for part-time em-  
5 ployee, the Secretary of Labor shall develop a for-  
6 mula for the pro-rata reduction in such subsidies  
7 based on the formula described in subsection (a) and  
8 the hours of work performed by the employee.

9 (3) SINGLE SUBSIDY.—An employer shall not  
10 be eligible to receive more than one subsidy under  
11 this section. The Secretary of Labor shall promul-  
12 gate regulations to ensure that no employer will re-  
13 ceive a second or subsequent subsidy under this sub-  
14 title regardless of whether such employer had pre-  
15 viously received the previous subsidy as an employer  
16 in a capacity different from that of the employer's  
17 present capacity.

18 **SEC. 6105. DEFINITION.**

19 For purposes of this Act, an employee who is em-  
20 ployed by an employer—

21 (1) for at least 120 hours in a month shall be  
22 deemed to be employed on a full-time basis with re-  
23 spect to that month, or

1 (2) for at least 40 hours, but less than 120  
 2 hours, in a month shall be deemed to be employed  
 3 on a part-time basis.

4 **TITLE VII—REVENUE**  
 5 **PROVISIONS**

6 **SEC. 7000. AMENDMENT OF 1986 CODE.**

7 Except as otherwise expressly provided, whenever in  
 8 this title an amendment or repeal is expressed in terms  
 9 of an amendment to, or repeal of, a section or other provi-  
 10 sion, the reference shall be considered to be made to a  
 11 section or other provision of the Internal Revenue Code  
 12 of 1986.

13 **Subtitle A—Financing Provisions**

14 **PART 1—INCREASE IN TAX ON TOBACCO**

15 **PRODUCTS**

16 **SEC. 7101. INCREASE IN EXCISE TAXES ON TOBACCO**  
 17 **PRODUCTS.**

18 (a) CIGARETTES.—Subsection (b) of section 5701 is  
 19 amended by striking paragraph (1) and all that follows  
 20 and inserting the following:

21 “(1) SMALL CIGARETTES.—On cigarettes,  
 22 weighing not more than 3 pounds per thousand, the  
 23 amount per thousand determined under the fol-  
 24 lowing table:

<b>“In the case of cigarettes removed—</b>	<b>The tax per thousand is—</b>
After July 31, 1995, and before January 1, 1997 .....	\$19.50

<b>“In the case of cigarettes removed—</b>	<b>The tax per thousand is—</b>
During 1997 .....	\$24.50
During 1998 .....	\$29.50
After December 31, 1998 .....	\$34.50.

1           “(2) LARGE CIGARETTES.—On cigarettes,  
 2 weighing more than 3 pounds per thousand, removed  
 3 at any time, an amount per thousand equal to 2.1  
 4 times the tax per thousand imposed by paragraph  
 5 (1) on cigarettes removed at such time; except that,  
 6 if more than 6½ inches in length, they shall be tax-  
 7 able at the rate prescribed for cigarettes weighing  
 8 not more than 3 pounds per thousand, counting each  
 9 2¾ inches, or fraction thereof, of the length of each  
 10 as one cigarette.”

11           (b) CIGARS.—Paragraphs (1) and (2) of section  
 12 5701(a) are amended to read as follows:

13           “(1) SMALL CIGARS.—On cigars, weighing not  
 14 more than 3 pounds per thousand, the amount per  
 15 thousand determined under the following table:

<b>“In the case of cigars removed—</b>	<b>The tax per thousand is—</b>
After July 31, 1995, and before January 1, 1997 .....	\$1.83
During 1997 .....	\$2.30
During 1998 .....	\$2.77
After December 31, 1998 .....	\$3.23.

16           “(2) LARGE CIGARS.—On cigars, weighing more  
 17 than 3 pounds per thousand, the applicable percent-  
 18 age (determined under the following table) of the  
 19 price for which sold but not more than the applica-

1 ble limitation (determined under such table) per  
 2 thousand:

<b>“In the case of cigars removed—</b>	<b>The applicable percentage is—</b>	<b>The limitation is—</b>
After July 31, 1995 and before January 1, 1997 .....	21 percent	\$48.75
During 1997 .....	26 percent	\$61.26
During 1998 .....	31 percent	\$73.74
After December 31, 1998 .....	37 percent	\$86.25.”

3 (c) CIGARETTE PAPERS.—Subsection (c) of section  
 4 5701 is amended—

5 (1) by striking “0.75 cent (0.625 cent on ciga-  
 6 rette papers removed during 1991 or 1992)” and in-  
 7 sserting “the amount determined in accordance with  
 8 the following table”, and

9 (2) by adding at the end the following:

<b>“In the case of cigarette papers removed—</b>	<b>The tax for each 50 papers is—</b>
After July 31, 1995 and before January 1, 1997 .....	1.22 cents
During 1997 .....	1.53 cents
During 1998 .....	1.84 cents
After December 31, 1998 .....	2.16 cents.”

10 (d) CIGARETTE TUBES.—Subsection (d) of section  
 11 5701 is amended—

12 (1) by striking “1.5 cents (1.25 cents on ciga-  
 13 rette tubes removed during 1991 or 1992)” and in-  
 14 sserting “the amount determined in accordance with  
 15 the following table”, and

16 (2) by adding at the end the following:

<b>“In the case of cigarette tubes removed—</b>	<b>The tax for each 50 tubes is—</b>
After July 31, 1995 and before January 1, 1997 .....	2.44 cents

<b>“In the case of cigarette tubes removed—</b>	<b>The tax for each 50 tubes is—</b>
During 1997 .....	3.06 cents
During 1998 .....	3.69 cents
After December 31, 1998 .....	4.31 cents.”

1 (e) SNUFF.—Paragraph (1) of section 5701(e) is  
 2 amended—

3 (1) by striking “36 cents (30 cents on snuff re-  
 4 moved during 1991 or 1992)” and inserting “the  
 5 amount determined in accordance with the following  
 6 table”, and

7 (2) by adding at the end the following:

<b>“In the case of snuff removed—</b>	<b>The tax per pound is—</b>
After July 31, 1995 and before January 1, 1997 .....	58.5 cents
During 1997 .....	73.5 cents
During 1998 .....	88.5 cents
After December 31, 1998 .....	\$1.03½.”

8 (f) CHEWING TOBACCO.—Paragraph (2) of section  
 9 5701(e) is amended—

10 (1) by striking “12 cents (10 cents on chewing  
 11 tobacco removed during 1991 or 1992)” and insert-  
 12 ing “the amount determined in accordance with the  
 13 following table”, and

14 (2) by adding at the end the following:

<b>“In the case of chewing tobacco removed—</b>	<b>The tax per pound is—</b>
After July 31, 1995 and before January 1, 1997 .....	19.5 cents
During 1997 .....	24.5 cents
During 1998 .....	29.5 cents
After December 31, 1998 .....	34.5 cents.”

15 (g) PIPE TOBACCO.—Subsection (f) of section 5701  
 16 is amended—

1 (1) by striking “67.5 cents (56.25 cents on pipe  
 2 tobacco removed during 1991 or 1992)” and insert-  
 3 ing “the amount determined in accordance with the  
 4 following table”, and

5 (2) by adding at the end the following:

<b>“In the case of pipe tobacco removed—</b>	<b>The tax per pound is—</b>
After July 31, 1995 and before January 1, 1997 .....	\$1.10
During 1997 .....	\$1.38
During 1998 .....	\$1.66
After December 31, 1998 .....	\$1.94.”

6 (h) APPLICATION OF TAX INCREASE TO PUERTO  
 7 RICO.—Section 5701 is amended by adding at the end the  
 8 following new subsection:

9 “(h) APPLICATION OF TAXES TO PUERTO RICO.—  
 10 Notwithstanding subsections (b) and (c) of section 7653  
 11 and any other provision of law—

12 “(1) IN GENERAL.—On tobacco products and  
 13 cigarette papers and tubes, manufactured in or im-  
 14 ported into the Commonwealth of Puerto Rico, there  
 15 is hereby imposed a tax at the rate equal to the ex-  
 16 cess of—

17 “(A) the rate of tax applicable under this  
 18 section to like articles manufactured in the  
 19 United States, over

20 “(B) the rate referred to in subparagraph  
 21 (A) as in effect on the day before the date of  
 22 the enactment of the Health Security Act.

1           “(2) SHIPMENTS TO PUERTO RICO FROM THE  
2           UNITED STATES.—Only the rates of tax in effect on  
3           the day before the date of the enactment of the  
4           Health Security Act shall be taken into account in  
5           determining the amount of any exemption from, or  
6           credit or drawback of, any tax imposed by this sec-  
7           tion on any article shipped to the Commonwealth of  
8           Puerto Rico from the United States.

9           “(3) SHIPMENTS FROM PUERTO RICO TO THE  
10           UNITED STATES.—The rates of tax taken into ac-  
11           count under section 7652(a) with respect to tobacco  
12           products and cigarette papers and tubes coming into  
13           the United States from the Commonwealth of Puer-  
14           to Rico shall be the rates of tax in effect on the day  
15           before the date of the enactment of the Health Secu-  
16           rity Act.

17           “(4) DISPOSITION OF REVENUES.—The provi-  
18           sions of section 7652(a)(3) shall not apply to any  
19           tax imposed by reason of this subsection.”

20           (i) EFFECTIVE DATE.—The amendments made by  
21           this section shall apply to articles removed (as defined in  
22           section 5702(k) of the Internal Revenue Code of 1986,  
23           as amended by this Act) after July 31, 1995.

24           (j) FLOOR STOCKS TAXES.—

1           (1) IMPOSITION OF TAX.—On tobacco products  
2           and cigarette papers and tubes manufactured in or  
3           imported into the United States or the Common-  
4           wealth of Puerto Rico which are removed before any  
5           tax-increase date and held on such date for sale by  
6           any person, there is hereby imposed a tax in an  
7           amount equal to the excess of—

8                   (A) the tax which would be imposed under  
9                   section 5701 of the Internal Revenue Code of  
10                  1986 on the article if the article had been re-  
11                  moved on such date, over

12                  (B) the prior tax (if any) imposed under  
13                  section 5701 or 7652 of such Code on such ar-  
14                  ticle.

15           (2) AUTHORITY TO EXEMPT CIGARETTES HELD  
16           IN VENDING MACHINES.—To the extent provided in  
17           regulations prescribed by the Secretary, no tax shall  
18           be imposed by paragraph (1) on cigarettes held for  
19           retail sale on any tax-increase date, by any person  
20           in any vending machine. If the Secretary provides  
21           such a benefit with respect to any person, the Sec-  
22           retary may reduce the \$500 amount in paragraph  
23           (3) with respect to such person.

24           (3) CREDIT AGAINST TAX.—Each person shall  
25           be allowed as a credit against the taxes imposed by

1 paragraph (1) on each tax-increase date an amount  
2 equal to \$500. Such credit shall not exceed the  
3 amount of taxes imposed by paragraph (1) on such  
4 date for which such person is liable.

5 (4) LIABILITY FOR TAX AND METHOD OF PAY-  
6 MENT.—

7 (A) LIABILITY FOR TAX.—A person hold-  
8 ing any article on any tax-increase date to  
9 which any tax imposed by paragraph (1) applies  
10 shall be liable for such tax.

11 (B) METHOD OF PAYMENT.—The tax im-  
12 posed by paragraph (1) shall be paid in such  
13 manner as the Secretary shall prescribe by reg-  
14 ulations.

15 (C) TIME FOR PAYMENT.—The tax im-  
16 posed by paragraph (1) on any tax-increase  
17 date shall be paid on or before the date which  
18 is 3 months after such tax-increase date.

19 (5) ARTICLES IN FOREIGN TRADE ZONES.—  
20 Notwithstanding the Act of June 18, 1934 (48 Stat.  
21 998, 19 U.S.C. 81a) and any other provision of law,  
22 any article which is located in a foreign trade zone  
23 on any tax-increase date shall be subject to the taxes  
24 imposed by paragraph (1) if—

1 (A) internal revenue taxes have been deter-  
2 mined, or customs duties liquidated, with re-  
3 spect to such article before such date pursuant  
4 to a request made under the 1st proviso of sec-  
5 tion 3(a) of such Act, or

6 (B) such article is held on such date under  
7 the supervision of a customs officer pursuant to  
8 the 2d proviso of such section 3(a).

9 (6) DEFINITIONS.—For purposes of this sub-  
10 section—

11 (A) TAX-INCREASE DATE.—The term “tax-  
12 increase date” means August 1, 1995, January  
13 1, 1997, January 1, 1998, and January 1,  
14 1999.

15 (B) OTHER DEFINITIONS.—Terms used in  
16 this subsection which are also used in section  
17 5702 of the Internal Revenue Code of 1986  
18 shall have the respective meanings such terms  
19 have in such section, as amended by this Act.

20 (C) SECRETARY.—The term “Secretary”  
21 means the Secretary of the Treasury or his del-  
22 egate.

23 (7) CONTROLLED GROUPS.—Rules similar to  
24 the rules of section 5061(e)(3) of such Code shall  
25 apply for purposes of this subsection.

1           (8) OTHER LAWS APPLICABLE.—All provisions  
2 of law, including penalties, applicable with respect to  
3 the taxes imposed by section 5701 of such Code  
4 shall, insofar as applicable and not inconsistent with  
5 the provisions of this subsection, apply to the floor  
6 stocks taxes imposed by paragraph (1), to the same  
7 extent as if such taxes were imposed by such section  
8 5701. The Secretary may treat any person who bore  
9 the ultimate burden of the tax imposed by para-  
10 graph (1) as the person to whom a credit or refund  
11 under such provisions may be allowed or made.

12 **SEC. 7102. MODIFICATIONS OF CERTAIN TOBACCO TAX**  
13 **PROVISIONS.**

14           (a) EXEMPTION FOR EXPORTED TOBACCO PROD-  
15 UCTS AND CIGARETTE PAPERS AND TUBES TO APPLY  
16 ONLY TO ARTICLES MARKED FOR EXPORT.—

17           (1) Subsection (b) of section 5704 is amended  
18 by adding at the end the following new sentence:  
19 “Tobacco products and cigarette papers and tubes  
20 may not be transferred or removed under this sub-  
21 section unless such products or papers and tubes  
22 bear such marks, labels, or notices as the Secretary  
23 shall by regulations prescribe.”

24           (2) Section 5761 is amended by redesignating  
25 subsections (c) and (d) as subsections (d) and (e),

1       respectively, and by inserting after subsection (b)  
2       the following new subsection:

3       “(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE  
4 PAPERS AND TUBES FOR EXPORT.—Except as provided  
5 in subsections (b) and (d) of section 5704—

6               “(1) every person who sells, relands, or receives  
7       within the jurisdiction of the United States any to-  
8       bacco products or cigarette papers or tubes which  
9       have been labeled or shipped for exportation under  
10      this chapter,

11              “(2) every person who sells or receives such re-  
12      landed tobacco products or cigarette papers or tubes,  
13      and

14              “(3) every person who aids or abets in such  
15      selling, relanding, or receiving,

16 shall, in addition to the tax and any other penalty provided  
17 in this title, be liable for a penalty equal to the greater  
18 of \$1,000 or 5 times the amount of the tax imposed by  
19 this chapter. All tobacco products and cigarette papers  
20 and tubes relanded within the jurisdiction of the United  
21 States, and all vessels, vehicles, and aircraft used in such  
22 relanding or in removing such products, papers, and tubes  
23 from the place where relanded, shall be forfeited to the  
24 United States.”

1           (3) Subsection (a) of section 5761 is amended  
2           by striking “subsection (b)” and inserting “sub-  
3           section (b) or (c)”.

4           (4) Subsection (d) of section 5761, as redesign-  
5           ated by paragraph (2), is amended by striking  
6           “The penalty imposed by subsection (b)” and insert-  
7           ing “The penalties imposed by subsections (b) and  
8           (c)”.

9           (5)(A) Subpart F of chapter 52 is amended by  
10          adding at the end the following new section:

11       **“SEC. 5754. RESTRICTION ON IMPORTATION OF PRE-**  
12       **VIOUSLY EXPORTED TOBACCO PRODUCTS.**

13       “(a) IN GENERAL.—Tobacco products and cigarette  
14       papers and tubes previously exported from the United  
15       States may be imported or brought into the United States  
16       only as provided in section 5704(d). For purposes of this  
17       section, section 5704(d), section 5761, and such other pro-  
18       visions as the Secretary may specify by regulations, ref-  
19       erences to exportation shall be treated as including a ref-  
20       erence to shipment to the Commonwealth of Puerto Rico.

21       “(b) CROSS REFERENCE.—

**“For penalty for the sale of tobacco products and  
cigarette papers and tubes in the United States  
which are labeled for export, see section 5761(c).”**

22       (B) The table of sections for subpart F of chap-  
23       ter 52 is amended by adding at the end the following  
24       new item:

“Sec. 5754. Restriction on importation of previously exported tobacco products.”

1 (b) IMPORTERS REQUIRED TO BE QUALIFIED.—

2 (1) Sections 5712, 5713(a), 5721, 5722,  
3 5762(a)(1), and 5763 (b) and (c) are each amended  
4 by inserting “or importer” after “manufacturer”.

5 (2) The heading of subsection (b) of section  
6 5763 is amended by inserting “QUALIFIED IMPORT-  
7 ERS,” after “MANUFACTURERS,”.

8 (3) The heading for subchapter B of chapter 52  
9 is amended by inserting “**and Importers**” after  
10 “**Manufacturers**”.

11 (4) The item relating to subchapter B in the  
12 table of subchapters for chapter 52 is amended by  
13 inserting “and importers” after “manufacturers”.

14 (c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES  
15 OF CIGARETTE MANUFACTURERS.—

16 (1) Subsection (a) of section 5704 is amend-  
17 ed—

18 (A) by striking “EMPLOYEE USE OR” in  
19 the heading, and

20 (B) by striking “for use or consumption by  
21 employees or” in the text.

22 (2) Subsection (e) of section 5723 is amended  
23 by striking “for use or consumption by their employ-

1       ees, or for experimental purposes” and inserting  
2       “for experimental purposes”.

3       (d) REPEAL OF TAX-EXEMPT SALES TO UNITED  
4 STATES.—Subsection (b) of section 5704 is amended by  
5 striking “and manufacturers may similarly remove such  
6 articles for use of the United States;”.

7       (e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS  
8 SUBJECT TO TAX.—Subsection (c) of section 5701 is  
9 amended by striking “On each book or set of cigarette  
10 papers containing more than 25 papers,” and inserting  
11 “On cigarette papers,”.

12       (f) STORAGE OF TOBACCO PRODUCTS.—Subsection  
13 (k) of section 5702 is amended by inserting “under section  
14 5704” after “internal revenue bond”.

15       (g) AUTHORITY TO PRESCRIBE MINIMUM MANUFAC-  
16 TURING ACTIVITY REQUIREMENTS.—Section 5712 is  
17 amended by striking “or” at the end of paragraph (1),  
18 by redesignating paragraph (2) as paragraph (3), and by  
19 inserting after paragraph (1) the following new paragraph:

20               “(2) the activity proposed to be carried out at  
21       such premises does not meet such minimum capacity  
22       or activity requirements as the Secretary may pre-  
23       scribe, or”.

1 (h) SPECIAL RULES RELATING TO PUERTO RICO  
 2 AND THE VIRGIN ISLANDS.—Section 7652 is amended by  
 3 adding at the end the following new subsection:

4 “(h) LIMITATION ON COVER OVER OF TAX ON TO-  
 5 BACCO PRODUCTS.—For purposes of this section, with re-  
 6 spect to taxes imposed under section 5701 or this section  
 7 on any tobacco product or cigarette paper or tube, the  
 8 amount covered into the treasuries of Puerto Rico and the  
 9 Virgin Islands shall not exceed the rate of tax under sec-  
 10 tion 5701 in effect on the article on the day before the  
 11 date of the enactment of the Health Security Act.”

12 (i) EFFECTIVE DATE.—The amendments made by  
 13 this section shall apply to articles removed (as defined in  
 14 section 5702(k) of the Internal Revenue Code of 1986,  
 15 as amended by this Act) after December 31, 1994.

16 **SEC. 7103. IMPOSITION OF EXCISE TAX ON MANUFACTURE**  
 17 **OR IMPORTATION OF ROLL-YOUR-OWN TO-**  
 18 **BACCO.**

19 (a) IN GENERAL.—Section 5701 (relating to rate of  
 20 tax), as amended by section 7101, is amended by redesi-  
 21 gnating subsections (g) and (h) as subsections (h) and (i)  
 22 and by inserting after subsection (f) the following new  
 23 subsection:

24 “(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own  
 25 tobacco, manufactured in or imported into the United

1 States, there shall be imposed a tax of the amount deter-  
 2 mined in accordance with the following table per pound  
 3 (and a proportionate tax at the like rate on all fractional  
 4 parts of a pound).

<b>“In the case of roll-your-own tobacco removed—</b>	<b>The tax per pound is—</b>
After July 31, 1995 and before January 1, 1997 .....	\$1.10
During 1997 .....	\$1.38
During 1998 .....	\$1.66
After December 31, 1998 .....	\$1.94.”

5 (b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (re-  
 6 lating to definitions) is amended by adding at the end the  
 7 following new subsection:

8 “(p) ROLL-YOUR-OWN TOBACCO.—The term ‘roll-  
 9 your-own tobacco’ means any tobacco which, because of  
 10 its appearance, type, packaging, or labeling, is suitable for  
 11 use and likely to be offered to, or purchased by, consumers  
 12 as tobacco for making cigarettes.”

13 (c) TECHNICAL AMENDMENTS.—

14 (1) Subsection (c) of section 5702 is amended  
 15 by striking “and pipe tobacco” and inserting “pipe  
 16 tobacco, and roll-your-own tobacco”.

17 (2) Subsection (d) of section 5702 is amend-  
 18 ed—

19 (A) in the material preceding paragraph  
 20 (1), by striking “or pipe tobacco” and inserting  
 21 “pipe tobacco, or roll-your-own tobacco”, and

1 (B) by striking paragraph (1) and insert-  
2 ing the following new paragraph:

3 “(1) a person who produces cigars, cigarettes,  
4 smokeless tobacco, pipe tobacco, or roll-your-own to-  
5 bacco solely for the person’s own personal consump-  
6 tion or use, and”.

7 (3) The chapter heading for chapter 52 is  
8 amended to read as follows:

9 **“CHAPTER 52—TOBACCO PRODUCTS AND**  
10 **CIGARETTE PAPERS AND TUBES”.**

11 (4) The table of chapters for subtitle E is  
12 amended by striking the item relating to chapter 52  
13 and inserting the following new item:

“CHAPTER 52. Tobacco products and cigarette papers and tubes.”

14 (d) EFFECTIVE DATE.—

15 (1) IN GENERAL.—The amendments made by  
16 this section shall apply to roll-your-own tobacco re-  
17 moved (as defined in section 5702(k) of the Internal  
18 Revenue Code of 1986, as amended by this Act)  
19 after July 31, 1995.

20 (2) TRANSITIONAL RULE.—Any person who—

21 (A) on the date of the enactment of this  
22 Act is engaged in business as a manufacturer of  
23 roll-your-own tobacco or as an importer of to-  
24 bacco products or cigarette papers and tubes,  
25 and

1 (B) before August 1, 1995, submits an ap-  
 2 plication under subchapter B of chapter 52 of  
 3 such Code to engage in such business,  
 4 may, notwithstanding such subchapter B, continue  
 5 to engage in such business pending final action on  
 6 such application. Pending such final action, all pro-  
 7 visions of such chapter 52 shall apply to such appli-  
 8 cant in the same manner and to the same extent as  
 9 if such applicant were a holder of a permit under  
 10 such chapter 52 to engage in such business.

11 **PART 2—HEALTH RELATED ASSESSMENTS**

12 **SEC. 7111. ASSESSMENTS ON INSURED AND SELF-INSURED**

13 **HEALTH PLANS.**

14 (a) GENERAL RULE.—Subtitle D (relating to mis-  
 15 cellaneous excise taxes) is amended by adding after chap-  
 16 ter 36 the following new chapter:

17 **“CHAPTER 37—HEALTH RELATED**  
 18 **ASSESSMENTS**

“SUBCHAPTER A. Insured and self-insured health plans.

19 **“Subchapter A—Insured and Self-Insured**  
 20 **Health Plans**

“Sec. 4501. Health insurance and health-related administrative services.

“Sec. 4502. Self-insured health plans.

“Sec. 4503. Definitions and special rules.

1 **“SEC. 4501. HEALTH INSURANCE AND HEALTH-RELATED**  
2 **ADMINISTRATIVE SERVICES.**

3 “(a) IMPOSITION OF TAX.—There is hereby im-  
4 posed—

5 “(1) on each taxable health insurance policy, a  
6 tax equal to 1.75 percent of the premiums received  
7 under such policy, and

8 “(2) on each amount received for health-related  
9 administrative services, a tax equal to 1.75 percent  
10 of the amount so received.

11 “(b) LIABILITY FOR TAX.—

12 “(1) HEALTH INSURANCE.—The tax imposed  
13 by subsection (a)(1) shall be paid by the issuer of  
14 the policy.

15 “(2) HEALTH-RELATED ADMINISTRATIVE SERV-  
16 ICES.—The tax imposed by subsection (a)(2) shall  
17 be paid by the person providing the health-related  
18 administrative services.

19 “(c) TAXABLE HEALTH INSURANCE POLICY.—For  
20 purposes of this section—

21 “(1) IN GENERAL.—Except as otherwise pro-  
22 vided in this section, the term ‘taxable health insur-  
23 ance policy’ means any insurance policy providing  
24 accident or health insurance with respect to individ-  
25 uals residing in the United States.

1           “(2) EXEMPTION OF CERTAIN POLICIES.—The  
2 term ‘taxable health insurance policy’ does not in-  
3 clude any insurance policy if substantially all of the  
4 coverage provided under such policy relates to—

5                   “(A) liabilities incurred under workers’  
6 compensation laws,

7                   “(B) tort liabilities,

8                   “(C) liabilities relating to ownership or use  
9 of property,

10                  “(D) credit insurance, or

11                  “(E) such other similar liabilities as the  
12 Secretary may specify by regulations.

13           “(3) SPECIAL RULE WHERE POLICY PROVIDES  
14 OTHER COVERAGE.—In the case of any taxable  
15 health insurance policy under which amounts are  
16 payable other than for accident or health coverage,  
17 in determining the amount of the tax imposed by  
18 subsection (a)(1) on any premium paid under such  
19 policy, there shall be excluded the amount of the  
20 charge for the nonaccident or health coverage if—

21                   “(A) the charge for such nonaccident or  
22 health coverage is either separately stated in  
23 the policy, or furnished to the policyholder in a  
24 separate statement, and

1           “(B) such charge is reasonable in relation  
2           to the total charges under the policy.

3           In any other case, the entire amount of the premium  
4           paid under such a policy shall be subject to tax  
5           under subsection (a)(1).

6           “(4) TREATMENT OF PREPAID HEALTH COV-  
7           ERAGE ARRANGEMENTS.—

8           “(A) IN GENERAL.—In the case of any ar-  
9           rangement described in subparagraph (B)—

10           “(i) such arrangement shall be treated  
11           as a taxable health insurance policy,

12           “(ii) the payments or premiums re-  
13           ferred to in subparagraph (B)(i) shall be  
14           treated as premiums received for a taxable  
15           health insurance policy, and

16           “(iii) the person referred to in sub-  
17           paragraph (B)(i) shall be treated as the  
18           issuer.

19           “(B) DESCRIPTION OF ARRANGEMENTS.—  
20           An arrangement is described in this subpara-  
21           graph if under such arrangement—

22           “(i) fixed payments or premiums are  
23           received as consideration for any person’s  
24           agreement to provide or arrange for the  
25           provision of accident or health coverage to

1 residents of the United States, regardless  
2 of how such coverage is provided or ar-  
3 ranged to be provided, and

4 “(ii) substantially all of the risks of  
5 the rates of utilization of services is as-  
6 sumed by such person or the provider of  
7 such services.

8 “(d) HEALTH-RELATED ADMINISTRATIVE SERV-  
9 ICES.—For purposes of this section, the term ‘health-re-  
10 lated administrative services’ means—

11 “(1) the processing of claims or performance of  
12 other administrative services in connection with acci-  
13 dent or health coverage under a taxable health in-  
14 surance policy if the charge for such services is not  
15 included in the premiums under such policy, and

16 “(2) processing claims, arranging for provision  
17 of accident or health coverage, or performing other  
18 administrative services in connection with an appli-  
19 cable self-insured health plan (as defined in section  
20 4502(e)) established or maintained by a person  
21 other than the person performing the services.

22 For purposes of paragraph (1), rules similar to the rules  
23 of subsection (c)(3) shall apply.

1 **“SEC. 4502. SELF-INSURED HEALTH PLANS.**

2 “(a) IMPOSITION OF TAX.—In the case of any appli-  
3 cable self-insured health plan, there is hereby imposed a  
4 tax for each month equal to 1.75 percent of the sum of—

5 “(1) the accident or health coverage expendi-  
6 tures for such month under such plan, and

7 “(2) the direct administrative expenditures for  
8 such month under such plan.

9 “(b) LIABILITY FOR TAX.—

10 “(1) IN GENERAL.—The tax imposed by sub-  
11 section (a) shall be paid by the plan sponsor.

12 “(2) PLAN SPONSOR.—For purposes of para-  
13 graph (1), the term ‘plan sponsor’ means—

14 “(A) the employer in the case of a plan es-  
15 tablished or maintained by a single employer,

16 “(B) the employee organization in the case  
17 of a plan established or maintained by an em-  
18 ployee organization, or

19 “(C) in the case of—

20 “(i) a plan established or maintained  
21 by 2 or more employers or jointly by 1 or  
22 more employers and 1 or more employee  
23 organizations,

24 “(ii) a voluntary employees’ bene-  
25 ficiary association under section 501(c)(9),  
26 or

1                   “(iii) a plan described in subsection  
2                   (c)(2)(F),  
3                   the association, committee, joint board of trust-  
4                   ees, cooperative, or other similar group of rep-  
5                   resentatives of the parties who establish or  
6                   maintain the plan.

7                   “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—  
8                   For purposes of this section, the term ‘applicable self-in-  
9                   sured health plan’ means any plan for providing accident  
10                  or health coverage if—

11                  “(1) any portion of such coverage is provided  
12                  other than through an insurance policy, and

13                  “(2) such plan is established or maintained—

14                         “(A) by one or more employers for the  
15                         benefit of their employees or former employees,

16                         “(B) by one or more employee organiza-  
17                         tions for the benefit of their members or former  
18                         members,

19                         “(C) jointly by 1 or more employers and 1  
20                         or more employee organizations for the benefit  
21                         of employees or former employees,

22                         “(D) by a voluntary employees’ beneficiary  
23                         association described in section 501(c)(9),

24                         “(E) by any organization described in sec-  
25                         tion 501(c)(6), or

1           “(F) in the case of a plan not described in  
2           the preceding subparagraphs, by a multiple em-  
3           ployer welfare arrangement, a rural electric co-  
4           operative, or a rural telephone cooperative asso-  
5           ciation, as such terms are defined in section  
6           3(40) of the Employee Retirement Income Se-  
7           curities Act of 1974.

8           “(d) ACCIDENT OR HEALTH COVERAGE EXPENDI-  
9           TURES.—For purposes of this section—

10           “(1) IN GENERAL.—The accident or health cov-  
11           erage expenditures of any applicable self-insured  
12           health plan for any month are the aggregate expend-  
13           itures paid in such month for accident or health cov-  
14           erage provided under such plan to the extent such  
15           expenditures are not subject to tax under section  
16           4501.

17           “(2) TREATMENT OF REIMBURSEMENTS.—In  
18           determining accident or health coverage expenditures  
19           during any month of any applicable self-insured  
20           health plan, reimbursements (by insurance or other-  
21           wise) received during such month shall be taken into  
22           account as a reduction in accident or health coverage  
23           expenditures.

24           “(3) CERTAIN EXPENDITURES DISREGARDED.—  
25           Paragraph (1) shall not apply to any expenditure for

1 the acquisition or improvement of land or for the ac-  
2 quisition or improvement of any property to be used  
3 in connection with the provision of accident or  
4 health coverage which is subject to the allowance  
5 under section 167, except that, for purposes of para-  
6 graph (1), allowances under section 167 shall be  
7 considered as expenditures.

8 “(e) DIRECT ADMINISTRATIVE EXPENDITURES.—  
9 For purposes of this section, the term ‘direct administra-  
10 tive expenditures’ means the administrative expenditures  
11 under the plan to the extent such expenditures are not  
12 subject to tax under section 4501. In determining the  
13 amount of such expenditures, rules similar to the rules of  
14 subsection (d)(3) shall apply.

15 **“SEC. 4503. DEFINITIONS AND SPECIAL RULES.**

16 “(a) DEFINITIONS.—For purposes of this sub-  
17 chapter—

18 “(1) ACCIDENT OR HEALTH COVERAGE.—The  
19 term ‘accident or health coverage’ means any cov-  
20 erage which, if provided by an insurance policy,  
21 would cause such policy to be a taxable health insur-  
22 ance policy (as defined in section 4501(c)).

23 “(2) INSURANCE POLICY.—The term ‘insurance  
24 policy’ means any policy or other instrument where-

1 by a contract of insurance is issued, renewed, or ex-  
2 tended.

3 “(3) PREMIUM.—The term ‘premium’ means  
4 the gross amount of premiums and other consider-  
5 ation (including advance premiums, deposits, fees,  
6 and assessments) arising from policies issued by a  
7 person acting as the primary insurer, adjusted for  
8 any return or additional premiums paid as a result  
9 of endorsements, cancellations, audits, or retrospec-  
10 tive rating. Amounts returned where the amount is  
11 not fixed in the contract but depends on the experi-  
12 ence of the insurer or the discretion of management  
13 shall not be included in return premiums.

14 “(4) UNITED STATES.—The term ‘United  
15 States’ includes any possession of the United States.

16 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

17 “(1) IN GENERAL.—For purposes of this sub-  
18 chapter—

19 “(A) the term ‘person’ includes any gov-  
20 ernmental entity, and

21 “(B) notwithstanding any other law or rule  
22 of law, governmental entities shall not be ex-  
23 empt from the taxes imposed by this subchapter  
24 except as provided in paragraph (2).

1           “(2) EXEMPT GOVERNMENTAL PROGRAMS.—In  
2 the case of an exempt governmental program—

3           “(A) no tax shall be imposed under section  
4 4501 on any premium received pursuant to  
5 such program or on any amount received for  
6 health-related administrative services pursuant  
7 to such program, and

8           “(B) no tax shall be imposed under section  
9 4502 on any expenditures pursuant to such  
10 program.

11           “(3) EXEMPT GOVERNMENTAL PROGRAM.—For  
12 purposes of this subchapter, the term ‘exempt gov-  
13 ernmental program’ means—

14           “(A) the insurance programs established  
15 by parts A and B of title XVIII of the Social  
16 Security Act,

17           “(B) the medical assistance program es-  
18 tablished by title XIX of the Social Security  
19 Act,

20           “(C) any program established by Federal  
21 law for providing medical care (other than  
22 through insurance policies) to individuals (or  
23 the spouses and dependents thereof) by reason  
24 of such individuals being—

1                   “(i) members of the Armed Forces of  
2                   the United States, or

3                   “(ii) veterans, and

4                   “(D) any program established by Federal  
5                   law for providing medical care (other than  
6                   through insurance policies) to members of In-  
7                   dian tribes (as defined in section 4(d) of the In-  
8                   dian Health Care Improvement Act).

9                   “(c) NO COVER OVER TO POSSESSIONS.—Notwith-  
10                  standing any other provision of law, no amount collected  
11                  under this subchapter shall be covered over to any posses-  
12                  sion of the United States.”

13                  (b) CLERICAL AMENDMENT.—The table of chapters  
14                  for subtitle D is amended by inserting after the item relat-  
15                  ing to chapter 36 the following new item:

                    “CHAPTER 37. Health related assessments.”

16                  (c) EFFECTIVE DATE.—The amendments made by  
17                  this section shall apply with respect to premiums received,  
18                  and expenses incurred, with respect to coverage for peri-  
19                  ods after December 31, 1995.

20                  **SEC. 7112. HIGH COST HEALTH PLAN ASSESSMENT.**

21                  (a) IN GENERAL.—Subchapter A of chapter 37 (re-  
22                  lating to assessments on insured and self-insured health  
23                  benefits), as added by section 7111, is amended by adding  
24                  at the end the following new part:

1           **“PART II—HIGH COST HEALTH PLANS**

          “Subpart A. Community-rated plans.

          “Subpart B. Experience-rated plans.

          “Subpart C. Definitions and special rules.

2           **“Subpart A—Community-Rated Plans**

          “Sec. 4511. Community-rated plans.

          “Sec. 4512. Reference premiums.

3   **“SEC. 4511. COMMUNITY-RATED PLANS.**

4           “(a) IMPOSITION OF TAX.—

5                   “(1) IN GENERAL.—If a community-rated cer-  
6           tified standard health plan is a high cost plan for  
7           any coverage period beginning after December 31,  
8           1996, there is hereby imposed a tax equal to 25 per-  
9           cent of the excess premiums of the plan for the pe-  
10          riod.

11                   “(2) LIABILITY FOR TAX.—The tax imposed by  
12          this section shall be paid by the issuer of the high  
13          cost plan.

14           “(b) HIGH COST PLAN.—For purposes of this sec-  
15          tion—

16                   “(1) IN GENERAL.—A plan is a high cost plan  
17          for any coverage period if—

18                           “(A) it is operating within a noncompeti-  
19                           tive community rating area, and

20                           “(B) it has excess premiums for the pe-  
21                           riod.

1           “(2) NONCOMPETITIVE COMMUNITY RATING  
2 AREA.—A community rating area is a noncompeti-  
3 tive community rating area for any coverage period  
4 if, for the preceding coverage period—

5                   “(A) the weighted average premium per  
6 primary insured in community-rated certified  
7 standard health plans in the area, exceeded

8                   “(B) the weighted average reference pre-  
9 mium for all such plans.

10 The determination under this paragraph shall be  
11 made on the basis of enrollment during the annual  
12 open enrollment period for such preceding coverage  
13 period.

14           “(c) EXCESS PREMIUMS.—For purposes of this sec-  
15 tion—

16                   “(1) IN GENERAL.—The term ‘excess pre-  
17 miums’ means, with respect to a certified standard  
18 health plan, the excess (if any) of—

19                           “(A) the premiums received under the plan  
20 during the coverage period, over

21                           “(B) the sum of the amounts determined  
22 under paragraph (2) with respect to each class  
23 of enrollment.

24           “(2) EXCESS PREMIUM BASELINE.—

1           “(A) IN GENERAL.—The amount deter-  
2           mined under this paragraph for any class of en-  
3           rollment for any coverage period is an amount  
4           equal to the product of the reference premium  
5           for such class and the number of primary in-  
6           sureds in such class for the period.

7           “(B) PROPORTIONATE REDUCTION OF  
8           REFERENCE PREMIUM.—The reference pre-  
9           mium applicable under subparagraph (A) to an  
10          individual who was a primary insured for only  
11          a portion of the coverage period shall be propor-  
12          tionately reduced to reflect the period the indi-  
13          vidual was not a primary insured.

14          “(3) DISREGARD OF AGE ADJUSTMENT.—The  
15          amount determined under paragraph (1)(A) shall be  
16          adjusted to reflect the premiums which would have  
17          been received if no age adjustment were permitted  
18          under section 1116 of the Health Security Act.

19          “(4) REDUCTION FOR TAXES.—The amount de-  
20          termined under paragraph (1)(A) shall be reduced  
21          by the amount of the tax imposed by this section in-  
22          cluded in determining the amount of the premiums.

23          “(d) COVERAGE PERIOD.—For purposes of this sub-  
24          part, the term ‘coverage period’ means, with respect to  
25          any community rating area, the 12-month period for which

1 an individual is covered under a standard health plan if  
2 the individual enrolls in the plan during the annual open  
3 enrollment period for the area under section 1503 of the  
4 Health Security Act.

5 “(e) PLANS COVERING MORE THAN ONE AREA.—  
6 For purposes of this subpart, if a community-rated plan  
7 covers individuals residing in more than 1 community rat-  
8 ing area, the plan shall be treated as a separate plan with  
9 respect to each such area.

10 **“SEC. 4512. REFERENCE PREMIUMS.**

11 “(a) ESTABLISHMENT OF REFERENCE PREMIUMS.—  
12 For purposes of this subpart—

13 “(1) IN GENERAL.—The Secretary shall, in con-  
14 sultation with the Secretary of Health and Human  
15 Services, establish for each coverage period a ref-  
16 erence premium for each class of enrollment for  
17 community-rated plans within a community rating  
18 area. The Secretary shall publish such reference pre-  
19 miums within a reasonable period of time before the  
20 annual open enrollment period for the coverage pe-  
21 riod.

22 “(2) METHOD OF DETERMINING REFERENCE  
23 PREMIUM.—Each reference premium for a class of  
24 enrollment for any coverage period shall be the ref-

1       erence premium in effect for such class for the pre-  
2       ceding coverage period—

3               “(A) increased by the target growth rate  
4               for the coverage period as provided under sub-  
5               section (b)(1), and

6               “(B) adjusted to reflect—

7                       “(i) material changes in the charac-  
8                       teristics of community-rated individuals as  
9                       provided under subsection (b)(2), and

10                      “(ii) changes in the actuarial value of  
11                      the standard benefits package as provided  
12                      under subsection (b)(3).

13       “(b) ANNUAL ADJUSTMENTS TO REFERENCE PRE-  
14 MIUMS.—For purposes of subsection (a)(2)—

15               “(1) TARGET GROWTH RATE.—The target  
16               growth rate for any coverage period is the percent-  
17               age increase in the Consumer Price Index (as de-  
18               fined in section 1(f)(4)) which the Secretary esti-  
19               mates will occur during the coverage period—

20                      “(A) increased by 2 percentage points (3  
21                      and 2.5 percentage points in the case of cov-  
22                      erage periods beginning in 1997 and 1998, re-  
23                      spectively), and

1           “(B) increased or decreased by the amount  
2           the estimate under this paragraph was incorrect  
3           for the preceding coverage period.

4           “(2) MATERIAL CHANGES.—

5           “(A) IN GENERAL.—The Secretary may, in  
6           consultation with the Secretary of Health and  
7           Human Services and pursuant to such method  
8           as the Secretary prescribes, adjust the reference  
9           premium to reflect changes in the demographic  
10          characteristics (including factors such as age,  
11          gender, and socioeconomic status) and health  
12          status of community-rated individuals in the  
13          community rating area which are materially dif-  
14          ferent when compared to the average changes in  
15          such characteristics and status in the United  
16          States.

17          “(B) EFFECT ON WEIGHTED AVERAGE.—  
18          Any adjustments under subparagraph (A) for  
19          any coverage period shall not result in a change  
20          in the weighted average of such factors for all  
21          community rating areas in the United States.

22          “(3) CHANGES IN BENEFIT PACKAGE.—If the  
23          actuarial value of the standard benefits package is  
24          changed pursuant to subtitle C of title I of the  
25          Health Security Act, the Secretary shall adjust the

1 reference premiums appropriately to reflect such  
2 change.

3 “(c) COMPUTATION OF REFERENCE PREMIUM FOR  
4 1996.—

5 “(1) IN GENERAL.—The Secretary, in consulta-  
6 tion with the Secretary of Health and Human Serv-  
7 ices, shall compute the reference premium for each  
8 class of enrollment for 1996. Each such reference  
9 premium shall be the reference premium which is  
10 adjusted under subsection (a)(2) in determining the  
11 reference premium for coverage periods beginning in  
12 1997.

13 “(2) METHOD OF DETERMINING REFERENCE  
14 PREMIUMS.—Each reference premium under para-  
15 graph (1) shall be equal to the national average per  
16 capita current coverage health expenditures for 1994  
17 (determined under subsection (d))—

18 “(A) increased as provided in paragraph  
19 (3),

20 “(B) adjusted to reflect the differences in  
21 the community rating area as provided in para-  
22 graph (4), and

23 “(C) modified to reflect the class of enroll-  
24 ment for which it is being determined in the

1 same manner as premiums are modified under  
2 section 1116 of the Health Security Act.

3 “(3) UPDATING FOR 1995 AND 1996.—The Sec-  
4 retary shall update the national average per capita  
5 current coverage health expenditures for 1994 to re-  
6 flect the annual percentage increases for calendar  
7 years 1995 and 1996 in private sector health care  
8 spending for items and services included in the  
9 standard benefits package. Such increase shall not  
10 exceed the current projected increase in per capita  
11 private health insurance premiums for such years  
12 contained in the estimate of national health insur-  
13 ance expenditures published by the Congressional  
14 Budget Office in the fall of 1993.

15 “(4) AREA ADJUSTMENTS.—

16 “(A) IN GENERAL.—The Secretary shall,  
17 using information of the type described in sub-  
18 paragraph (B), establish an adjustment for  
19 each community rating area which takes into  
20 account the differences among community rat-  
21 ing areas, including variations in health care ex-  
22 penditures, in rates of uninsurance and under-  
23 insurance, and in the proportion of expendi-  
24 tures for services provided by academic health  
25 centers.

1           “(B) TYPE OF INFORMATION.—The type  
2 of information described in this subparagraph  
3 is—

4           “(i) information on variations in pre-  
5 miums across States and across commu-  
6 nity rating areas within a State (based on  
7 surveys and other data);

8           “(ii) information on variations in per  
9 capita health spending by State, as meas-  
10 ured by the Secretary;

11           “(iii) information on variations across  
12 States in per capita spending under the  
13 medicare program and in such spending  
14 among community rating areas within a  
15 State under such program; and

16           “(iv) area rating factors commonly  
17 used by actuaries.

18           “(C) CONSULTATION PROCESS.—The Sec-  
19 retary shall, in cooperation with the Secretary  
20 of Health and Human Services, consult with  
21 representatives of States and community rating  
22 areas before establishing the adjustment under  
23 this subsection.

24           “(d) DETERMINATION OF NATIONAL AVERAGE PER  
25 CAPITA CURRENT COVERAGE HEALTH EXPENDITURES.—

1           “(1) IN GENERAL.—The national average per  
2           capita current coverage health expenditures are  
3           equal to—

4                   “(A) the total amount of covered current  
5           health care expenditures described in paragraph  
6           (2), divided by

7                   “(B) the estimated population in the  
8           United States of community-rated individuals  
9           as of 1994 (as determined under paragraph  
10          (4)) for whom such expenditures were deter-  
11          mined.

12          The population under subparagraph (B) shall not in-  
13          clude SSI recipients.

14          “(2) COVERED CURRENT HEALTH CARE EX-  
15          PENDITURES.—

16                   “(A) IN GENERAL.—For purposes of para-  
17          graph (1), the term ‘covered current health care  
18          expenditures’ means the amount of total pay-  
19          ments made in the United States during 1994  
20          (other than amounts for cost sharing) for items  
21          and services included in the standard benefits  
22          package.

23                   “(B) REMOVAL OF CERTAIN EXPENDI-  
24          TURES NOT TO BE COVERED.—The amount de-  
25          termined under subparagraph (A) shall be de-

1           creased by the proportion of such amount that  
2           is attributable to any of the following:

3                   “(i) Medicare beneficiaries.

4                   “(ii) SSI recipients.

5                   “(iii) Expenditures which are paid for  
6                   through workers’ compensation or auto-  
7                   mobile or other liability insurance.

8                   “(iv) Any other expenditures by par-  
9                   ties (including the Federal Government)  
10                  that the Secretary estimates will not be  
11                  payable by community-rated plans for cov-  
12                  erage under the standard benefits package.

13                  “(C) ADDITION OF PROJECTED EXPENDI-  
14                  TURES FOR UNINSURED AND UNDERINSURED  
15                  INDIVIDUALS.—The amount determined under  
16                  subparagraph (A) (as adjusted under subpara-  
17                  graph (B)) shall be increased to take into ac-  
18                  count increased utilization of, and expenditures  
19                  for, items and services covered under the stand-  
20                  ard benefits package likely to occur, as a result  
21                  of coverage under a community-rated plan of  
22                  individuals who, as of 1994, were uninsured or  
23                  underinsured with respect to the standard bene-  
24                  fits package. In making such determination,  
25                  such expenditures shall be based on the esti-

1 mated average cost for such services in 1994  
2 (and not on private payment rates established  
3 for such services). In making such determina-  
4 tion, the estimated amount of uncompensated  
5 care in 1994 shall be reduced to reflect the  
6 number and characteristics of the currently un-  
7 insured who will become insured by reason of  
8 the Health Security Act and will not include ad-  
9 justments to offset payments below costs by  
10 public programs.

11 “(D) ADDITION OF HEALTH PLAN ADMIN-  
12 STRATION COSTS.—The amount determined  
13 under subparagraph (A) (as adjusted under the  
14 preceding subparagraphs) shall be increased by  
15 an estimated percentage (determined by the  
16 Secretary, but no more than 15 percent) that  
17 reflects the proportion of premiums that are re-  
18 quired for administration and for State pre-  
19 mium taxes (which taxes shall be limited to  
20 such amounts in 1994 as are attributable to the  
21 health benefits to be included in the standard  
22 benefits package).

23 “(E) DECREASE FOR COST SHARING.—The  
24 amount determined under subparagraph (A) (as  
25 adjusted under the preceding subparagraphs)

1 shall be decreased by a percentage that reflects  
2 (i) the estimated average percentage of total  
3 amounts payable for items and services covered  
4 under the standard benefits package that will  
5 be payments in the form of cost sharing under  
6 a certified standard benefit plan with a high  
7 cost-sharing option, and (ii) the percentage re-  
8 duction in utilization estimated to result from  
9 the application of such cost sharing.

10 “(3) SPECIAL RULES.—

11 “(A) BENEFITS USED.—The determina-  
12 tions under this subsection shall be based on  
13 the standard benefits package as in effect in  
14 1996.

15 “(B) ASSUMING NO CHANGE IN EXPENDI-  
16 TURE PATTERN.—The determination under  
17 paragraph (2) shall be made without regard to  
18 any change in the pattern of expenditures that  
19 may result from the enrollment of SSI recipi-  
20 ents in community-rated plans.

21 “(4) ELIGIBLE INDIVIDUALS.—The determina-  
22 tion of individuals who are community-rated individ-  
23 uals under this subsection shall be made as though  
24 the Health Security Act was fully in effect in each  
25 State as of 1994.

1       “(e) TREATMENT OF CERTAIN STATES.—For pur-  
2 poses of this section—

3           “(1) NONPARTICIPATING STATES.—In the case  
4 of a State that is not a participating State or other-  
5 wise has not established community rating areas, the  
6 entire State shall be treated as a single community  
7 rating area.

8           “(2) CHANGES IN BOUNDARIES.—In the case of  
9 a State that changes the boundaries of its commu-  
10 nity rating areas, the Secretary shall provide a  
11 method for computing reference premiums for each  
12 area affected by such change in a manner that—

13           “(A) reflects the factors taken into account  
14 in establishing the adjustment factors under  
15 this section, and

16           “(B) results in the weighted average of the  
17 newly computed reference premiums for the  
18 areas affected by the change being equal to the  
19 weighted average of the reference premiums for  
20 the areas as previously established.

21       **“Subpart B—Experience-Rated Plans**

      “Sec. 4515. Experience-rated plans.

22       **“SEC. 4515. EXPERIENCE-RATED PLANS.**

23       “(a) IMPOSITION OF TAX.—

1           “(1) IN GENERAL.—In the case of any calendar  
2 year beginning after December 31, 1999, there is  
3 hereby imposed a tax equal to 25 percent of the ex-  
4 cess premium equivalents of an experience-rated  
5 standard health plan.

6           “(2) LIABILITY FOR TAX.—The tax imposed by  
7 this section shall be paid by the plan sponsor.

8           “(b) EXCESS PREMIUM EQUIVALENTS.—For pur-  
9 poses of this section—

10           “(1) IN GENERAL.—The term ‘excess premium  
11 equivalents’ means the excess (if any) of—

12           “(A) the premium equivalents of the plan  
13 for the calendar year, over

14           “(B) the product of the reference premium  
15 and the number of primary insureds covered by  
16 the plan during the calendar year.

17           “(2) PROPORTIONATE REDUCTION IN REF-  
18 ERENCE PREMIUM.—The reference premium applica-  
19 ble under paragraph (1)(B) to a primary insured  
20 covered under the plan for only a portion of the cal-  
21 endar year shall be proportionately reduced to reflect  
22 the period the individual was not a primary insured.

23           “(c) REFERENCE PREMIUM.—For purposes of this  
24 section—

1           “(1) IN GENERAL.—The reference premium for  
2 any plan for any calendar year shall be the reference  
3 premium in effect for the preceding calendar year—

4           “(A) increased by the target growth rate  
5 for the calendar year as provided under para-  
6 graph (2), and

7           “(B) adjusted to reflect—

8           “(i) material changes in the charac-  
9 teristics of individuals covered by the plan  
10 as provided under paragraph (3), and

11           “(ii) changes in the actuarial value of  
12 the standard benefits package as provided  
13 under paragraph (4).

14           “(2) TARGET GROWTH RATE.—The target  
15 growth rate for any calendar year is the percentage  
16 increase in the Consumer Price Index (as defined in  
17 section 1(f)(4)) which the Secretary estimates will  
18 occur during the calendar year—

19           “(A) increased by 2 percentage points, and

20           “(B) increased or decreased by the amount  
21 the estimate under this paragraph was incorrect  
22 for the preceding calendar year.

23           “(3) MATERIAL CHANGES.—The Secretary may,  
24 in consultation with the Secretary of Health and  
25 Human Services, establish such method as the Sec-

1       retary determines appropriate for adjusting the ref-  
2       erence premium for any plan to reflect changes in  
3       the demographic characteristics (including factors  
4       such as age, gender, socioeconomic status, and class  
5       of enrollment) and health status of individuals in the  
6       plan which are materially different when compared  
7       to the average changes in such characteristics and  
8       status in the United States.

9               “(4) CHANGES IN BENEFIT PACKAGE.—If the  
10       actuarial value of the standard benefits package is  
11       changed pursuant to subtitle C of title I of the  
12       Health Security Act, the Secretary shall adjust the  
13       reference premiums appropriately to reflect such  
14       change.

15       “(d) REFERENCE PREMIUM FOR 1999.—

16               “(1) IN GENERAL.—The reference premium for  
17       calendar year 1999 shall be equal to the average of  
18       the per capita premium equivalents for calendar  
19       years 1997, 1998, and 1999. Such reference pre-  
20       mium shall be the reference premium which is ad-  
21       justed under subsection (c) for determining the ref-  
22       erence premium for calendar year 2000.

23               “(2) PER CAPITA PREMIUM EQUIVALENT.—

24                       “(A) IN GENERAL.—The per capita pre-  
25       mium equivalent for any calendar year shall be

1 equal to the premium equivalent for providing  
2 the standard benefits package to each primary  
3 insured, adjusted as provided under subpara-  
4 graph (B).

5 “(B) GROWTH FACTORS.—The amount de-  
6 termined under subparagraph (A)—

7 “(i) for calendar year 1997 shall be  
8 increased by the target growth rates for  
9 calendar years 1998 and 1999, and

10 “(ii) for calendar year 1998 shall be  
11 increased by the target growth rate for cal-  
12 endar year 1999.

13 For purposes of this subparagraph, the target  
14 growth rate shall be determined under sub-  
15 section (c)(2), except that subsection (c)(2)(A)  
16 shall be applied for calendar year 1998 by sub-  
17 stituting ‘2.5’ for ‘2’.

18 “(e) PREMIUM EQUIVALENTS.—For purposes of this  
19 section—

20 “(1) IN GENERAL.—The term ‘premium equiva-  
21 lents’ means, with respect to any calendar year, the  
22 sum of—

23 “(A) expenditures described in subsections  
24 (d) and (e) of section 4502 with respect to cov-  
25 erage under the plan, and

1           “(B) in the case of any coverage provided  
2           through an insurance policy, premiums paid for  
3           such coverage.

4           “(2) EXCLUSION OF NONSTANDARD COV-  
5           ERAGE.—The premium equivalents for any calendar  
6           year shall not include amounts with respect to—

7                   “(A) any coverage other than coverage for  
8                   the standard benefits package, or

9                   “(B) any cost-sharing coverage.

10           “(3) RISK ADJUSTMENT PAYMENTS.—The pre-  
11           mium equivalents for any calendar year shall include  
12           payments under any risk adjustment program estab-  
13           lished under title I of the Health Security Act.

14           “(4) TAXES DISREGARDED.—The premium  
15           equivalents for any calendar year shall not include  
16           the amount of any tax imposed by this section.

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

19                   “(1) AGGREGATION RULES.—

20                           “(A) PLANS.—All plans maintained by the  
21                           same plan sponsor shall be treated as 1 plan.

22                           “(B) SPONSORS.—All plan sponsors which  
23                           are treated as a single employer under sub-  
24                           section (b) or (c) of section 414 shall be treated  
25                           as 1 plan sponsor.

1           “(2) STARTUP PLANS.—If a plan sponsor first  
2 begins operation of an experience-rated plan after  
3 1997, the reference premium for the first calendar  
4 year for which the plan is in operation and to which  
5 this section applies shall, under regulations pre-  
6 scribed by the Secretary, be determined as if the ref-  
7 erence premium for the preceding calendar year  
8 were equal to the average of the reference premiums  
9 for all community-rated plans for the preceding cal-  
10 endar year in the areas in which the plan is oper-  
11 ating, adjusted to reflect the factors described in  
12 subsection (c)(3) under the plan which materially  
13 differ from such factors under the community-rated  
14 plans.

15           “(3) ACQUISITIONS AND DISPOSITIONS.—The  
16 reference premium after an acquisition or disposition  
17 described in section 41(f)(3) involving the plan spon-  
18 sor of an experience-rated plan shall be made pursu-  
19 ant to such regulations as the Secretary may pre-  
20 scribe.

21           “(4) INFORMATION.—The Secretary may re-  
22 quire a plan sponsor of an experience-rated plan to  
23 adopt such conventions as are necessary in its ac-  
24 counting practices and financial records to assure  
25 that only costs related to the standard benefits pack-

1 age are taken into account in determining the pre-  
 2 mium equivalents with respect to the plan.

3 **“Subpart C—Definitions and Special Rules**

“Sec. 4518. Right of recovery.

“Sec. 4519. Definitions and special rules.

4 **“SEC. 4518. RIGHT OF RECOVERY FROM PROVIDERS.**

5 “(a) GENERAL RULE.—Each issuer or plan sponsor  
 6 of a certified standard health plan shall be entitled to re-  
 7 cover from the providers of items or services covered by  
 8 the plan an amount equal to 50 percent of the amount  
 9 of any tax imposed by this part on the issuer or sponsor.

10 “(b) RECOVERY.—For purposes of subsection (a)—

11 “(1) any amount recovered from any provider  
 12 shall not exceed the provider’s proportionate share of  
 13 items or services provided under the plan for the pe-  
 14 riod the tax was imposed, and

15 “(2) an issuer or plan sponsor may recover an  
 16 amount from a provider through a reduction in pay-  
 17 ments under the plan, direct payments from the pro-  
 18 vider, or such other manner as may be provided  
 19 under State law adopted pursuant to section 1510 of  
 20 the Health Security Act.

21 “(c) BALANCE BILLING.—For prohibition of balance  
 22 billing of any amount recovered from a provider under this  
 23 section, see section 1128(h)(3) of the Health Security Act.

1 **“SEC. 4519. DEFINITIONS AND SPECIAL RULES.**

2 “(a) HEALTH PLANS.—For purposes of this part—

3 “(1) STANDARD HEALTH PLAN.—The term  
4 ‘standard health plan’ has the meaning given such  
5 term by section 1011(2)(B) of the Health Security  
6 Act, except that such term does not include a plan  
7 offering the alternative standard benefit package de-  
8 scribed in 1201(b) of such Act.

9 “(2) STANDARD BENEFITS PACKAGE.—The  
10 term ‘standard benefits package’ has the meaning  
11 given such term by section 1201(a) of such Act.

12 “(b) COMMUNITY RATING AREAS AND PLANS.—For  
13 purposes of this part—

14 “(1) COMMUNITY RATING AREA.—The term  
15 ‘community rating area’ means an area established  
16 under section 1502 of the Health Security Act.

17 “(2) COMMUNITY-RATED PLAN.—The term  
18 ‘community-rated plan’ means a plan which is com-  
19 munity-rated under section 1116 of such Act.

20 “(3) EXPERIENCE-RATED PLAN.—The term ‘ex-  
21 perience-rated plan’ means any plan which is not a  
22 community-rated plan.

23 “(c) PREMIUMS.—For purposes of this part—

24 “(1) IN GENERAL.—The term ‘premium’ has  
25 the meaning given such term by section 4503(a)(3).

1           “(2) ADMINISTRATIVE COSTS.—Amounts re-  
2           ceived for health-related administrative services (as  
3           defined in section 4501(d)) provided in connection  
4           with any standard health plan taken into account  
5           under section 4511(c)(3) shall be treated as pre-  
6           miums.

7           “(3) RISK ADJUSTMENT PAYMENTS.—Payments  
8           under a risk adjustment program established under  
9           title I of the Health Security Act shall be dis-  
10          regarded in computing the amount of any premiums.

11          “(d) INSURANCE POLICY AND PLAN SPONSOR.—For  
12          purposes of this part—

13                 “(1) INSURANCE POLICY.—The term ‘insurance  
14                 policy’ has the meaning given such term by section  
15                 4503(a)(2).

16                 “(2) PLAN SPONSOR.—The term ‘plan sponsor’  
17                 has the meaning given such term by section  
18                 4502(b)(2), except that in the case of a plan not de-  
19                 scribed in such section, such term means the person  
20                 or persons who establish or maintain the plan.

21          “(e) SPECIAL RULES.—For purposes of this part—

22                 “(1) DEPOSITS.—The Secretary may require  
23                 deposits of any taxes imposed by subpart A or B at  
24                 such times as the Secretary determines appropriate.

1           “(2) GOVERNMENTAL ENTITIES SUBJECT TO  
2 TAX.—The rules of section 4503(b) shall apply for  
3 purposes of this part.

4           “(3) NO COVER OVER TO POSSESSIONS.—Not-  
5 withstanding any other provision of law, no amount  
6 collected under this part shall be covered over to any  
7 possession of the United States.

8           “(f) REGULATIONS.—The Secretary shall issue such  
9 regulations as are necessary to carry out the provisions  
10 of this part, including regulations—

11           “(1) requiring the maintenance of such records,  
12 and the reporting of such information as the Sec-  
13 retary determines necessary, and

14           “(2) which provide that 2 or more plans of a  
15 person or any related persons must be aggregated,  
16 or a plan must be treated as 2 or more separate  
17 plans.”

18           (b) CONFORMING AMENDMENTS.—

19           (1) Subchapter A of chapter 37, as added by  
20 section 7111, is amended by inserting after the sub-  
21 chapter heading the following:

          “Part I. Premium and related assessments.

          “Part II. High cost health plans.

1           **“PART I—PREMIUM AND RELATED**  
2                                   **ASSESSMENTS”.**

3           (2) Section 4503, as so added, is amended by  
4           striking “subchapter” each place it appears and in-  
5           serting “part”.

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

8           **PART 3—RECAPTURE OF CERTAIN HEALTH CARE**  
9                                   **SUBSIDIES**

10          **SEC. 7121. RECAPTURE OF CERTAIN HEALTH CARE SUB-**  
11                                   **SIDIES RECEIVED BY HIGH-INCOME INDIVID-**  
12                                   **UALS.**

13          (a) IN GENERAL.—Subchapter A of chapter 1 is  
14          amended by adding at the end the following new part:

15          **“PART VIII—CERTAIN HEALTH CARE SUBSIDIES**  
16                                   **RECEIVED BY HIGH-INCOME INDIVIDUALS**

                                  “Sec. 59B. Recapture of certain health care subsidies.

17          **“SEC. 59B. RECAPTURE OF CERTAIN HEALTH CARE SUB-**  
18                                   **SIDIES.**

19          “(a) IMPOSITION OF RECAPTURE AMOUNT.—In the  
20          case of an individual, if the modified adjusted gross in-  
21          come of the taxpayer for the taxable year exceeds the  
22          threshold amount, such taxpayer shall pay (in addition to  
23          any other amount imposed by this subtitle) a recapture  
24          amount for such taxable year equal to the aggregate of  
25          the Medicare part B recapture amounts (if any) for

1 months during such year that a premium is paid under  
2 part B of title XVIII of the Social Security Act for the  
3 coverage of the individual under such part.

4 “(b) MEDICARE PART B PREMIUM RECAPTURE  
5 AMOUNT FOR MONTH.—For purposes of this section, the  
6 Medicare part B premium recapture amount for any  
7 month is the amount equal to the excess of—

8 “(1) 150 percent of the monthly actuarial rate  
9 for enrollees age 65 and over determined for that  
10 calendar year under section 1839(b) of the Social  
11 Security Act, over

12 “(2) the total monthly premium under section  
13 1839 of the Social Security Act (determined without  
14 regard to subsections (b) and (f) of section 1839 of  
15 such Act).

16 “(c) PHASE-IN OF RECAPTURE AMOUNT.—

17 “(1) IN GENERAL.—If the modified adjusted  
18 gross income of the taxpayer for any taxable year  
19 exceeds the threshold amount by less than \$15,000,  
20 the recapture amount imposed by this section for  
21 such taxable year shall be an amount which bears  
22 the same ratio to the recapture amount which would  
23 (but for this subsection) be imposed by this section  
24 for such taxable year as such excess bears to  
25 \$15,000.

1           “(2) JOINT RETURNS.—If a recapture amount  
2 is determined separately for each spouse filing a  
3 joint return, paragraph (1) shall be applied by sub-  
4 stituting ‘\$30,000’ for ‘\$15,000’ each place it ap-  
5 pears.

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

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

10           “(A) except as otherwise provided in this  
11 paragraph, \$90,000,

12           “(B) \$115,000 in the case of a joint re-  
13 turn, and

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

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

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

20           “(2) MODIFIED ADJUSTED GROSS INCOME.—

21 The term ‘modified adjusted gross income’ means  
22 adjusted gross income—

23           “(A) determined without regard to sections  
24 135, 911, 931, and 933, and

1           “(B) increased by the amount of interest  
2           received or accrued by the taxpayer during the  
3           taxable year which is exempt from tax.

4           “(3) JOINT RETURNS.—In the case of a joint  
5           return—

6           “(A) the recapture amount under sub-  
7           section (a) shall be the sum of the recapture  
8           amounts determined separately for each spouse,  
9           and

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

13           “(4) COORDINATION WITH OTHER PROVI-  
14           SIONS.—

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

19           “(B) NOT TREATED AS TAX FOR CERTAIN  
20           PURPOSES.—The recapture amount imposed by  
21           this section shall not be treated as a tax im-  
22           posed by this chapter for purposes of deter-  
23           mining—

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

1                   “(ii) the amount of the minimum tax  
2                   under section 55.

3                   “(C) TREATED AS PAYMENT FOR MEDICAL  
4                   INSURANCE.—The recapture amount imposed  
5                   by this section shall be treated as an amount  
6                   paid for insurance covering medical care, within  
7                   the meaning of section 213(d).

8                   “(5) TAXES IMPOSED BY POSSESSIONS.—The  
9                   tax imposed by this section shall not apply to a bona  
10                  fide resident of a possession with respect to which  
11                  the requirements of section 1509 of the Health Se-  
12                  curity Act are met.”

13                  (b) TRANSFERS TO FEDERAL SUPPLEMENTARY  
14                  MEDICAL INSURANCE TRUST FUND.—

15                  (1) IN GENERAL.—There are hereby appro-  
16                  priated to the Federal Supplementary Medical Insur-  
17                  ance Trust Fund amounts equivalent to the aggre-  
18                  gate increase in liabilities under chapter 1 of the In-  
19                  ternal Revenue Code of 1986 which is attributable  
20                  to the application of section 59B(a) of such Code, as  
21                  added by this section.

22                  (2) TRANSFERS.—The amounts appropriated  
23                  by paragraph (1) to the Federal Supplementary  
24                  Medical Insurance Trust Fund shall be transferred  
25                  from time to time (but not less frequently than

1 quarterly) from the general fund of the Treasury on  
2 the basis of estimates made by the Secretary of the  
3 Treasury of the amounts referred to in paragraph  
4 (1). Any quarterly payment shall be made on the  
5 first day of such quarter and shall take into account  
6 the recapture amounts referred to in such section  
7 59B(a) for such quarter. Proper adjustments shall  
8 be made in the amounts subsequently transferred to  
9 the extent prior estimates were in excess of or less  
10 than the amounts required to be transferred.

11 (c) REPORTING REQUIREMENTS.—

12 (1) Paragraph (1) of section 6050F(a) (relating  
13 to returns relating to social security benefits) is  
14 amended by striking “and” at the end of subpara-  
15 graph (B) and by inserting after subparagraph (C)  
16 the following new subparagraph:

17 “(D) the number of months during the cal-  
18 endar year for which a premium was paid under  
19 part B of title XVIII of the Social Security Act  
20 for the coverage of such individual under such  
21 part, and”.

22 (2) Paragraph (2) of section 6050F(b) is  
23 amended to read as follows:

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

1           (3) Subparagraph (A) of section 6050F(c)(1) is  
2           amended by inserting before the comma “and in the  
3           case of the information specified in subsection  
4           (a)(1)(D)”.

5           (4) The heading for section 6050F is amended  
6           by inserting “**AND MEDICARE PART B COV-**  
7           **ERAGE**” before the period.

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

12          (d) **WAIVER OF CERTAIN ESTIMATED TAX PEN-**  
13          **ALTIES.**—No addition to tax shall be imposed under sec-  
14          tion 6654 of the Internal Revenue Code of 1986 (relating  
15          to failure to pay estimated income tax) for any period be-  
16          fore April 16, 1997, with respect to any underpayment  
17          to the extent that such underpayment resulted from sec-  
18          tion 59B(a) of the Internal Revenue Code of 1986, as  
19          added by this section.

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

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

1 (f) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 1995.

4 **PART 4—OTHER PROVISIONS**

5 **SEC. 7131. INCREASE IN TAX ON CERTAIN HOLLOW POINT**  
6 **AND LARGE CALIBER HANDGUN AMMUNI-**  
7 **TION.**

8 (a) INCREASE IN MANUFACTURERS TAX.—

9 (1) IN GENERAL.—Section 4181 (relating to  
10 imposition of tax on firearms) is amended—

11 (A) by striking “Shells, and cartridges”  
12 and inserting “Shells and cartridges not taxable  
13 at 10,000 percent”, and

14 (B) by adding at the end the following:

15 “ARTICLES TAXABLE AT 10,000 PERCENT.—

16 “Any jacketed, hollow point projectile  
17 which may be used in a handgun and the jacket  
18 of which is designed to produce, upon impact,  
19 sharp-tipped, barb-like projections that extend  
20 beyond the diameter of the unfired projectile.

21 “Any cartridge with a projectile measuring  
22 .500 inch or greater in diameter which may be  
23 used in a handgun.”

24 (2) ADDITIONAL TAXES ADDED TO THE GEN-  
25 ERAL FUND.—Section 3(a) of the Act of September

1       2, 1937 (16 U.S.C. 669b(a)), commonly referred to  
2       as the “Pittman-Robertson Wildlife Restoration  
3       Act”, is amended by adding at the end the following  
4       new sentence: “There shall not be covered into the  
5       fund the portion of the tax imposed by such section  
6       4181 that is attributable to any increase in amounts  
7       received in the Treasury under such section by rea-  
8       son of the amendments made by section 7131(a)(1)  
9       of the Health Security Act, as estimated by the Sec-  
10      retary.”

11      (b) EFFECTIVE DATES.—

12           (1) IN GENERAL.—The amendments made by  
13      this section shall apply to sales after December 31,  
14      1994.

15           (2) FLOOR STOCKS TAX.—

16           (A) IN GENERAL.—In the case of any arti-  
17      cle held on January 1, 1995, which is taxable  
18      under section 4181 of the Internal Revenue  
19      Code of 1986 on and after such date at a tax  
20      rate of 10,000 percent, there is hereby imposed  
21      a tax equal to the excess of—

22           (i) the tax which would be imposed  
23      under section 4181 of such Code if the ar-  
24      ticle were sold on such date, over

1 (ii) the prior tax (if any) imposed  
2 under such section on such article.

3 (B) CREDIT.—Each person shall be al-  
4 lowed as a credit against the taxes imposed by  
5 subparagraph (A) an amount equal to the taxes  
6 imposed on articles which such person destroys  
7 (in such manner as the Secretary may pre-  
8 scribe) after December 31, 1994, and before  
9 April 1, 1995.

10 (C) PAYMENT.—The taxes imposed by sub-  
11 paragraph (A) on any article shall be paid by  
12 the person holding the article on January 1,  
13 1995. Such taxes shall be paid before April 1,  
14 1995, in such manner as the Secretary of the  
15 Treasury may prescribe.

16 (D) ARTICLES IN FOREIGN TRADE  
17 ZONES.—Notwithstanding the Act of June 18,  
18 1934 (48 Stat. 998, 19 U.S.C. 81a) and any  
19 other provision of law, any article which is lo-  
20 cated in a foreign trade zone on January 1,  
21 1995, shall be subject to the tax imposed by  
22 subparagraph (A) if—

23 (i) internal revenue taxes have been  
24 determined, or customs duties liquidated,  
25 with respect to such article before such

1 date pursuant to a request made under the  
2 1st proviso of section 3(a) of such Act, or  
3 (ii) such article is held on such date  
4 under the supervision of a customs officer  
5 pursuant to the 2d proviso of such section  
6 3(a).

7 (E) CONTROLLED GROUPS.—Rules similar  
8 to the rules of section 5061(e)(3) of such Code  
9 shall apply for purposes of this paragraph.

10 (F) OTHER LAWS APPLICABLE.—All provi-  
11 sions of law, including penalties, applicable with  
12 respect to the taxes imposed by section 4181 of  
13 such Code shall, insofar as applicable and not  
14 inconsistent with the provisions of this sub-  
15 section, apply to the floor stocks taxes imposed  
16 by subparagraph (A), to the same extent as if  
17 such taxes were imposed by such section 4181.  
18 The Secretary may treat any person who bore  
19 the ultimate burden of the tax imposed by sub-  
20 paragraph (A) as the person to whom a credit  
21 or refund under such provisions may be allowed  
22 or made.

1 **SEC. 7132. MODIFICATION TO SELF-EMPLOYMENT TAX**  
2 **TREATMENT OF CERTAIN S CORPORATION**  
3 **SHAREHOLDERS AND PARTNERS.**

4 (a) TREATMENT OF CERTAIN S CORPORATION  
5 SHAREHOLDERS.—

6 (1) AMENDMENT TO INTERNAL REVENUE  
7 CODE.—Section 1402 (relating to definitions) is  
8 amended by adding at the end the following new  
9 subsection:

10 “(k) TREATMENT OF CERTAIN S CORPORATION  
11 SHAREHOLDERS.—

12 “(1) IN GENERAL.—In the case of any indi-  
13 vidual—

14 “(A) who is a 2-percent shareholder (as  
15 defined in section 1372(b)) of an S corporation  
16 for any taxable year of such corporation, and

17 “(B) who provides significant services to or  
18 on behalf of such S corporation during such  
19 taxable year,

20 such shareholder’s net earnings from self-employ-  
21 ment shall include 80 percent of such shareholder’s  
22 pro rata share (as determined under section  
23 1366(a)) of the taxable income or loss of such cor-  
24 poration for such taxable year from service-related  
25 businesses carried on by such corporation, and to  
26 the extent provided in regulations, for any other tax-

1       able year to the extent such income or loss is attrib-  
2       utable to such services.

3           “(2) CERTAIN EXCEPTIONS TO APPLY.—In de-  
4       termining the amount to be taken into account  
5       under paragraph (1), the exceptions provided in sub-  
6       section (a) shall apply, except that, in the case of  
7       the exceptions provided in subsection (a)(5), rules  
8       similar to the rules of subparagraph (B) thereof  
9       shall apply to shareholders in S corporations.

10          “(3) SERVICE-RELATED BUSINESS.—For pur-  
11       poses of this subsection, the term ‘service-related  
12       business’ means—

13           “(A) any trade or business involving the  
14       performance of services in the fields of health  
15       (other than with respect to inpatient personal  
16       care facilities), law, engineering, architecture,  
17       accounting, actuarial services, performing arts,  
18       consulting, athletics, or financial services (other  
19       than lending or brokerage services), or

20           “(B) any other trade or business with re-  
21       spect to which the Secretary determines that  
22       capital is an insignificant income-producing fac-  
23       tor.

24          “(4) APPLICATION OF DEFERRED COMPENSA-  
25       TION RULES.—For purposes of subchapter D of

1 chapter 1 (and any other provision of this title relat-  
2 ing thereto), in the case of an individual who is  
3 treated as having net earnings from self-employment  
4 by reason of paragraph (1)—

5 “(A) such individual shall not be treated as  
6 a self-employed individual (within the meaning  
7 of section 401(c)(1)) with respect to services  
8 performed for the S corporation, and

9 “(B) such net earnings shall be treated as  
10 compensation received by the individual as an  
11 employee of the S corporation.”

12 (2) AMENDMENT TO SOCIAL SECURITY ACT.—

13 Section 211 of the Social Security Act is amended  
14 by adding at the end the following new subsection:

15 “Treatment of Certain S Corporation Shareholders

16 “(k)(1) In the case of any individual—

17 “(A) who is a 2-percent shareholder (as defined  
18 in section 1372(b) of the Internal Revenue Code of  
19 1986) of an S corporation for any taxable year of  
20 such corporation, and

21 “(B) who provides significant services to or on  
22 behalf of such S corporation during such taxable  
23 year,

24 such shareholder’s net earnings from self-employment  
25 shall include 80 percent of such shareholder’s pro rata

1 share (as determined under section 1366(a) of such Code)  
2 of the taxable income or loss of such corporation for such  
3 taxable year from service-related businesses (as defined in  
4 section 1402(k)(3) of such Code) carried on by such cor-  
5 poration, and to the extent provided in regulations, for any  
6 other taxable year to the extent such income or loss is  
7 attributable to such services.

8 “(2) In determining the amount to be taken into ac-  
9 count under paragraph (1), the exceptions provided in  
10 subsection (a) shall apply, except that, in the case of the  
11 exceptions provided in subsection (a)(5), rules similar to  
12 the rules of subparagraph (B) thereof shall apply to share-  
13 holders in S corporations.”

14 (b) TREATMENT OF CERTAIN LIMITED PARTNERS.—

15 (1) AMENDMENT OF THE INTERNAL REVENUE  
16 CODE.—Paragraph (13) of section 1402(a) is  
17 amended to read as follows:

18 “(13) there shall be excluded the distributive  
19 share of any item of income or loss of a limited part-  
20 ner, as such, other than—

21 “(A) guaranteed payments described in  
22 section 707(c) to that partner for services actu-  
23 ally rendered to or on behalf of the partnership  
24 to the extent that those payments are estab-

1 lished to be in the nature of remuneration for  
2 those services, or

3 “(B) in the case of a limited partner who  
4 provides significant services to or on behalf of  
5 the partnership for any taxable year of the  
6 partnership, 80 percent of the limited partner’s  
7 distributive share (determined without regard to  
8 payments described in subparagraph (A)) of the  
9 taxable income or loss of such partnership—

10 “(i) for such taxable year from serv-  
11 ice-related businesses (as defined in sub-  
12 section (k)(3)) of such partnership, and

13 “(ii) to the extent provided in regula-  
14 tions, for any other taxable year to the ex-  
15 tent attributable to such services;”.

16 (2) AMENDMENT OF THE SOCIAL SECURITY  
17 ACT.—Paragraph (12) of section 211(a) of the So-  
18 cial Security Act is amended to read as follows:

19 “(12) there shall be excluded the distributive  
20 share of any item of income or loss of a limited part-  
21 ner, as such, other than—

22 “(A) guaranteed payments described in  
23 section 707(e) of the Internal Revenue Code of  
24 1986 to that partner for services actually ren-  
25 dered to or on behalf of the partnership to the

1 extent that those payments are established to  
2 be in the nature of remuneration for those serv-  
3 ices, or

4 “(B) in the case of a limited partner who  
5 provides significant services to or on behalf of  
6 the partnership for any taxable year of the  
7 partnership, 80 percent of the limited partner’s  
8 distributive share (determined without regard to  
9 payments described in subparagraph (A)) of the  
10 taxable income or loss of such partnership—

11 “(i) for such taxable year from serv-  
12 ice-related businesses (as defined in section  
13 1402(k)(3) of such Code) of such partner-  
14 ship, and

15 “(ii) to the extent provided in regula-  
16 tions prescribed by the Secretary of the  
17 Treasury, for any other taxable year to the  
18 extent attributable to such services;”.

19 (c) INVENTORY INCOME.—Section 1402 (relating to  
20 definitions), as amended by subsection (a), is amended by  
21 adding at the end the following new subsection:

22 “(l) INVENTORY INCOME.—

23 “(1) IN GENERAL.—The net earnings from self-  
24 employment of any taxpayer for any taxable year  
25 under subsection (a) (determined without regard to

1 this subsection) shall be reduced by 40 percent of  
2 the lesser of—

3 “(A) the taxpayer’s allocable share of net  
4 inventory income, or

5 “(B) the amount of such net earnings in  
6 excess of the applicable amount for the taxable  
7 year.

8 “(2) NET INVENTORY INCOME.—

9 “(A) IN GENERAL.—For purposes of para-  
10 graph (1), the term ‘net inventory income’  
11 means net income from the sale of property de-  
12 scribed in section 1221(1).

13 “(B) DEALERS IN SECURITIES.—For pur-  
14 poses of subparagraph (A)—

15 “(i) any security described in section  
16 475(c)(2) (without regard to the last sen-  
17 tence thereof) which is held by a person as  
18 a dealer in securities (as defined in section  
19 475(c)(1)) shall be treated as property de-  
20 scribed in section 1221(1), and

21 “(ii) net income from any such secu-  
22 rity shall be taken into account to the ex-  
23 tent otherwise taken into account in com-  
24 puting net earnings from self-employment.

1           “(3) APPLICABLE AMOUNT.—For purposes of  
2 paragraph (1), the term ‘applicable amount’ means  
3 the excess of—

4                   “(A) \$135,000, adjusted, in the case of  
5 any taxable year beginning in any calendar year  
6 after 1996, in the same manner as is used in  
7 adjusting the contribution and benefit base for  
8 the calendar year under section 230(b) of the  
9 Social Security Act, over

10                   “(B) the amount of wages paid to the indi-  
11 vidual during the taxable year.”

12           (d) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to taxable years of individuals be-  
14 ginning after December 31, 1995, and to taxable years  
15 of S corporations and partnerships ending with or within  
16 such taxable years of individuals.

17 **SEC. 7133. EXTENDING MEDICARE COVERAGE OF, AND AP-**  
18 **PLICATION OF HOSPITAL INSURANCE TAX**  
19 **TO, ALL STATE AND LOCAL GOVERNMENT**  
20 **EMPLOYEES.**

21           (a) IN GENERAL.—

22                   (1) APPLICATION OF HOSPITAL INSURANCE  
23 TAX.—Section 3121(u)(2) is amended by striking  
24 subparagraphs (C) and (D).

1           (2) COVERAGE UNDER MEDICARE.—Section  
2           210(p) of the Social Security Act (42 U.S.C. 410(p))  
3           is amended by striking paragraphs (3) and (4).

4           (3) EFFECTIVE DATE.—The amendments made  
5           by this subsection shall apply to services performed  
6           after September 30, 1995.

7           (b) TRANSITION IN BENEFITS FOR STATE AND  
8           LOCAL GOVERNMENT EMPLOYEES AND FORMER EM-  
9           PLOYEES.—

10           (1) IN GENERAL.—

11           (A) EMPLOYEES NEWLY SUBJECT TO  
12           TAX.—For purposes of sections 226, 226A, and  
13           1811 of the Social Security Act, in the case of  
14           any individual who performs services during the  
15           calendar quarter beginning October 1, 1995,  
16           the wages for which are subject to the tax im-  
17           posed by section 3101(b) of the Internal Rev-  
18           enue Code of 1986 only because of the amend-  
19           ment made by subsection (a), the individual’s  
20           medicare qualified State or local government  
21           employment (as defined in subparagraph (B))  
22           performed before October 1, 1995, shall be con-  
23           sidered to be “employment” (as defined for pur-  
24           poses of title II of such Act), but only for pur-  
25           poses of providing the individual (or another

1 person) with entitlement to hospital insurance  
2 benefits under part A of title XVIII of such Act  
3 for months beginning with October 1995.

4 (B) MEDICARE QUALIFIED STATE OR  
5 LOCAL GOVERNMENT EMPLOYMENT DE-  
6 FINED.—In this paragraph, the term “medicare  
7 qualified State or local government employ-  
8 ment” means medicare qualified government  
9 employment described in section 210(p)(1)(B)  
10 of the Social Security Act (determined without  
11 regard to section 210(p)(3) of such Act, as in  
12 effect before its repeal under subsection (a)(2)).

13 (2) AUTHORIZATION OF APPROPRIATIONS.—

14 There are authorized to be appropriated to the Fed-  
15 eral Hospital Insurance Trust Fund from time to  
16 time such sums as the Secretary of Health and  
17 Human Services deems necessary for any fiscal year  
18 on account of—

19 (A) payments made or to be made during  
20 such fiscal year from such Trust Fund with re-  
21 spect to individuals who are entitled to benefits  
22 under title XVIII of the Social Security Act  
23 solely by reason of paragraph (1),

24 (B) the additional administrative expenses  
25 resulting or expected to result therefrom, and

1           (C) any loss in interest to such Trust  
2           Fund resulting from the payment of those  
3           amounts, in order to place such Trust Fund in  
4           the same position at the end of such fiscal year  
5           as it would have been in if this subsection had  
6           not been enacted.

7           (3) INFORMATION TO INDIVIDUALS WHO ARE  
8           PROSPECTIVE MEDICARE BENEFICIARIES BASED ON  
9           STATE AND LOCAL GOVERNMENT EMPLOYMENT.—  
10          Section 226(g) of the Social Security Act (42 U.S.C.  
11          426(g)) is amended—

12                 (A) by redesignating paragraphs (1)  
13                 through (3) as subparagraphs (A) through (C),  
14                 respectively,

15                 (B) by inserting “(1)” after “(g)”, and

16                 (C) by adding at the end the following new  
17                 paragraph:

18                 “(2) The Secretary, in consultation with State  
19                 and local governments, shall provide procedures de-  
20                 signed to assure that individuals who perform medi-  
21                 care qualified government employment by virtue of  
22                 service described in section 210(a)(7) are fully in-  
23                 formed with respect to (A) their eligibility or poten-  
24                 tial eligibility for hospital insurance benefits (based  
25                 on such employment) under part A of title XVIII,

1 (B) the requirements for, and conditions of, such eli-  
2 gibility, and (C) the necessity of timely application  
3 as a condition of becoming entitled under subsection  
4 (b)(2)(C), giving particular attention to individuals  
5 who apply for an annuity or retirement benefit and  
6 whose eligibility for such annuity or retirement ben-  
7 efit is based on a disability.”

8 (c) TECHNICAL AMENDMENTS.—

9 (1) Subparagraph (A) of section 3121(u)(2) is  
10 amended by striking “subparagraphs (B) and (C),”  
11 and inserting “subparagraph (B),”.

12 (2) Subparagraph (B) of section 210(p)(1) of  
13 the Social Security Act (42 U.S.C. 410(p)(1)) is  
14 amended by striking “paragraphs (2) and (3).” and  
15 inserting “paragraph (2).”

16 (3) Section 218 of the Social Security Act (42  
17 U.S.C. 418) is amended by striking subsection (n).

18 (4) The amendments made by this subsection  
19 shall apply after September 30, 1995.

1           **Subtitle B—Tax Treatment of**  
2           **Employer-Provided Health Care**

3           **PART 1—GENERAL PROVISIONS**

4           **SEC. 7201. LIMITATION ON EXCLUSION FOR EMPLOYER-**  
5           **PROVIDED HEALTH BENEFITS.**

6           (a) **GENERAL RULE.**—Section 106 (relating to con-  
7 tributions by employer to accident and health plans) is  
8 amended to read as follows:

9           **“SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT**  
10           **AND HEALTH PLANS.**

11           “(a) **GENERAL RULE.**—Except as otherwise provided  
12 in this section, gross income of an employee does not in-  
13 clude employer-provided coverage under an accident or  
14 health plan.

15           “(b) **INCLUSION OF CERTAIN BENEFITS NOT PART**  
16 **OF PERMITTED COVERAGE.**—

17           “(1) **IN GENERAL.**—Effective on and after Jan-  
18 uary 1, 2004, gross income of an employee shall in-  
19 clude employer-provided coverage under any accident  
20 or health plan which is not permitted coverage.

21           “(2) **PERMITTED COVERAGE.**—For purposes of  
22 this subsection, the term ‘permitted coverage’ means  
23 any—

1           “(A) coverage under a certified standard  
2 health plan (as defined in section 1011(2)(A) of  
3 the Health Security Act),

4           “(B) coverage under a certified supple-  
5 mental health benefit plan (as defined in section  
6 1011(3)(A) of the Health Security Act) which  
7 consists of the payment of cost sharing  
8 amounts under a certified standard health plan  
9 (as so defined) providing the standard benefits  
10 package described in part 1 of subtitle C of title  
11 I of such Act,

12           “(C) coverage under a qualified long-term  
13 care insurance policy (as defined in section  
14 7702B(b)),

15           “(D) coverage providing wages or pay-  
16 ments in lieu of wages for any period during  
17 which the employee is absent from work on ac-  
18 count of sickness or injury,

19           “(E) coverage only for accidental death or  
20 dismemberment,

21           “(F) coverage under a medicare supple-  
22 mental policy (as defined in section 1882(g)(1)  
23 of the Social Security Act),

1           “(G) coverage under an equivalent health  
2 care program (as defined in section 1013(3) of  
3 the Health Security Act), and

4           “(H) other coverage to the extent that the  
5 Secretary determines that the continuation of  
6 an exclusion for such coverage is not incon-  
7 sistent with the purposes of this subsection.

8           “(3) SPECIAL RULES FOR FLEXIBLE SPENDING  
9 ARRANGEMENTS.—

10           “(A) IN GENERAL.—To the extent that  
11 any employer-provided coverage is provided  
12 through a flexible spending or similar arrange-  
13 ment, paragraph (1) shall be applied by sub-  
14 stituting ‘January 1, 1996,’ for ‘January 1,  
15 2004’.

16           “(B) FLEXIBLE SPENDING ARRANGE-  
17 MENT.—For purposes of this paragraph, a  
18 flexible spending arrangement is a benefit pro-  
19 gram which provides employees with coverage  
20 under which—

21           “(i) specified incurred expenses may  
22 be reimbursed (subject to reimbursement  
23 maximums and other reasonable condi-  
24 tions), and

1                   “(ii) the maximum amount of reim-  
2                   bursement which is reasonably available to  
3                   a participant for such coverage is less than  
4                   500 percent of the value of such coverage.

5                   In the case of an insured plan, the maximum  
6                   amount reasonably available shall be deter-  
7                   mined on the basis of the underlying coverage.”

8                   (b) EMPLOYMENT TAX TREATMENT.—

9                   (1) SOCIAL SECURITY TAX.—

10                   (A) Subsection (a) of section 3121 is  
11                   amended by inserting after paragraph (21) the  
12                   following new sentence:

13                   “Nothing in paragraph (2) shall exclude from the term  
14                   ‘wages’ any amount which is required to be included in  
15                   gross income under section 106(b).”

16                   (B) Subsection (a) of section 209 of the  
17                   Social Security Act is amended by inserting  
18                   after paragraph (21) the following new sen-  
19                   tence:

20                   “Nothing in paragraph (2) shall exclude from the term  
21                   ‘wages’ any amount which is required to be included in  
22                   gross income under section 106(b) of the Internal Revenue  
23                   Code of 1986.”

24                   (2) RAILROAD RETIREMENT TAX.—Paragraph  
25                   (1) of section 3231(e) is amended by adding at the

1 end the following new sentence: “Nothing in clause  
2 (i) of the second sentence of this paragraph shall ex-  
3 clude from the term ‘compensation’ any amount  
4 which is required to be included in gross income  
5 under section 106(b).”

6 (3) UNEMPLOYMENT TAX.—Subsection (b) of  
7 section 3306 is amended by inserting after para-  
8 graph (16) the following new sentence:  
9 “Nothing in paragraph (2) shall exclude from the term  
10 ‘wages’ any amount which is required to be included in  
11 gross income under section 106(b).”

12 (4) WAGE WITHHOLDING.—Subsection (a) of  
13 section 3401 is amended by adding at the end the  
14 following new sentence:  
15 “Nothing in the preceding provisions of this subsection  
16 shall exclude from the term ‘wages’ any amount which is  
17 required to be included in gross income under section  
18 106(b).”

19 (c) EFFECTIVE DATES.—

20 (1) IN GENERAL.—The amendments made by  
21 this section shall take effect on January 1, 1996.

22 (2) BENEFITS PROVIDED PURSUANT TO COL-  
23 LECTIVE BARGAINING AGREEMENTS.—In the case of  
24 a flexible spending arrangement maintained pursu-  
25 ant to 1 or more collective bargaining agreements

1 between employee representatives and 1 or more em-  
2 ployers which was ratified before June 30, 1994, the  
3 amendments referred to in paragraph (1) shall not  
4 apply to benefits pursuant to any such agreement  
5 before the later of—

6 (A) January 1, 1996, or

7 (B) the earlier of—

8 (i) the date on which the last of such  
9 agreements terminate (determined without  
10 regard to any extension thereof on or after  
11 June 30, 1994), or

12 (ii) January 1, 1998.

13 **SEC. 7202. HEALTH BENEFITS MAY NOT BE PROVIDED**  
14 **UNDER CAFETERIA PLANS.**

15 (a) **GENERAL RULE.**—Subsection (f) of section 125  
16 (defining qualified benefits) is amended by adding at the  
17 end the following new sentence: “Such term shall not in-  
18 clude any benefits or coverage under an accident or health  
19 plan.”

20 (b) **CONFORMING AMENDMENT.**—Subsection (g) of  
21 section 125 is amended by striking paragraph (2) and re-  
22 designating paragraphs (3) and (4) as paragraphs (2) and  
23 (3), respectively.

24 (c) **EFFECTIVE DATES.**—

1           (1) IN GENERAL.—The amendments made by  
2 this section shall take effect on January 1, 1997.

3           (2) BENEFITS PROVIDED PURSUANT TO COL-  
4 LECTIVE BARGAINING AGREEMENTS.—In the case of  
5 a cafeteria plan maintained pursuant to 1 or more  
6 collective bargaining agreements between employee  
7 representatives and 1 or more employers which was  
8 ratified before June 30, 1994, the amendments re-  
9 ferred to in paragraph (1) shall not apply to benefits  
10 pursuant to any such agreement before the later  
11 of—

12                   (A) January 1, 1997, or

13                   (B) the earlier of—

14                           (i) the date on which the last of such  
15 agreements terminate (determined without  
16 regard to any extension thereof on or after  
17 June 30, 1994), or

18                           (ii) January 1, 1999.

19 **SEC. 7203. INCREASE IN DEDUCTION FOR HEALTH INSUR-**  
20 **ANCE COSTS OF SELF-EMPLOYED INDIVID-**  
21 **UALS.**

22 (a) PROVISION MADE PERMANENT.—

23           (1) IN GENERAL.—Subsection (l) of section 162  
24 (relating to special rules for health insurance costs

1 of self-employed individuals) is amended by striking  
2 paragraph (6).

3 (2) EFFECTIVE DATE.—The amendment made  
4 by paragraph (1) shall apply to taxable years begin-  
5 ning after December 31, 1993.

6 (b) AMOUNT OF DEDUCTION.—

7 (1) IN GENERAL.—Paragraphs (1) and (2) of  
8 section 162(l) are amended to read as follows:

9 “(1) IN GENERAL.—In the case of an individual  
10 who is an employee within the meaning of section  
11 401(c), there shall be allowed as a deduction under  
12 this section an amount equal to 50 percent of the  
13 amount paid during the taxable year for coverage  
14 under a certified standard health plan (as defined in  
15 section 1011(2)(A) of the Health Security Act).

16 “(2) LIMITATIONS.—

17 “(A) LOWER PERCENTAGE IN CERTAIN  
18 CASES.—

19 “(i) IN GENERAL.—If the taxpayer  
20 has 1 or more employees in a trade or  
21 business with respect to which such tax-  
22 payer is treated as an employee within the  
23 meaning of section 401(c), the deduction  
24 under paragraph (1) shall not exceed the  
25 portion of the amount paid which is equiv-

1           alent to the largest employer contribution  
2           made on behalf of any such employee for  
3           coverage under a certified standard health  
4           plan.

5           “(ii) EQUIVALENT CONTRIBUTION.—  
6           For purposes of clause (i), the amount  
7           paid is equivalent to a contribution if—

8                   “(I) it is the same dollar amount  
9                   as the contribution,

10                   “(II) it represents the same per-  
11                   centage of cost under the plan to  
12                   which it is made as does the contribu-  
13                   tion, or

14                   “(III) it represents the same per-  
15                   centage of the weighted average pre-  
16                   mium for the class of enrollment (as  
17                   defined in section 1113(c) of the  
18                   Health Security Act) for the commu-  
19                   nity rating area in which the employee  
20                   works as does the contribution.

21           For purposes of applying subclause (II) or  
22           (III), any dollar limitation applicable to all  
23           employer contributions (whether expressed  
24           as a dollar amount or a percentage de-

1           scribed in subclause (III)) shall be dis-  
2           regarded.

3           “(B) DEDUCTION LIMITED TO EARNED IN-  
4           COME.—No deduction shall be allowed under  
5           paragraph (1) to the extent that the amount of  
6           such deduction exceeds the taxpayer’s earned  
7           income (within the meaning of section 401(c)).

8           “(C) OTHER COVERAGE.—Paragraph (1)  
9           shall not apply to any taxpayer for any calendar  
10          month for which the taxpayer is eligible to par-  
11          ticipate in any subsidized health plan main-  
12          tained by any employer of the taxpayer or the  
13          taxpayer’s spouse.”

14          (2) CONFORMING AMENDMENT.—Subparagraph  
15          (A) of section 162(l)(5) is amended by striking  
16          “shall be treated as such individual’s earned in-  
17          come” and inserting “shall be included in such indi-  
18          vidual’s earned income”.

19          (3) EFFECTIVE DATE.—The amendments made  
20          by this subsection shall apply to taxable years begin-  
21          ning after December 31, 1995.

1 **SEC. 7204. LIMITATION ON PREPAYMENT OF MEDICAL IN-**  
2 **SURANCE PREMIUMS.**

3 (a) **GENERAL RULE.**—Subsection (d) of section 213  
4 is amended by adding at the end the following new para-  
5 graph:

6 “(10) **LIMITATION ON PREPAYMENTS.**—If—

7 “(A) the taxpayer pays a premium or other  
8 amount which constitutes medical care under  
9 paragraph (1), and

10 “(B) such premium or other amount is  
11 properly allocable to insurance coverage or care  
12 to be provided during periods more than 12  
13 months after the month in which such payment  
14 is made,

15 such premium or other amount shall be treated as  
16 paid ratably over the period during which such in-  
17 surance coverage or care is to be provided. The pre-  
18 ceding sentence shall not apply to any premium to  
19 which paragraph (7) applies.”

20 (b) **EFFECTIVE DATE.**—The amendment made by  
21 subsection (a) shall apply to amounts paid after December  
22 31, 1994.

1 **PART 2—VOLUNTARY EMPLOYER HEALTH CARE**  
2 **CONTRIBUTIONS**

3 **SEC. 7111. TAX TREATMENT OF VOLUNTARY EMPLOYER**  
4 **HEALTH CARE CONTRIBUTIONS.**

5 (a) IN GENERAL.—Chapter 37 (relating to health-re-  
6 lated taxes), as added by section 7111, is amended by add-  
7 ing at the end the following new subchapter:

8 **“Subchapter B—Voluntary Employer-**  
9 **Provided Health Benefits**

“Sec. 4521. Taxable employer-provided health benefits.

“Sec. 4522. Discriminatory employer practices.

“Sec. 4523. Exceptions.

“Sec. 4524. Definitions and special rules.

10 **“SEC. 4521. TAXABLE EMPLOYER-PROVIDED HEALTH BENE-**  
11 **FITS.**

12 “(a) IMPOSITION OF TAX.—There is hereby imposed  
13 a tax equal to the product of—

14 “(1) the sum of—

15 “(A) the taxable employer contributions for  
16 any taxable year, plus

17 “(B) the aggregate employer contributions  
18 for permitted coverage described in subpara-  
19 graph (A) or (B) of subsection (b)(2) during  
20 any portion of the taxable year during which  
21 there is discriminatory permitted coverage, and

22 “(2) the highest rate of tax imposed under sec-  
23 tion 11(b) for the taxable year.

1       “(b) TAXABLE EMPLOYER CONTRIBUTION.—For  
2 purposes of this section—

3           “(1) IN GENERAL.—The term ‘taxable employer  
4 contribution’ means any employer contribution under  
5 an accident or health plan for coverage of an em-  
6 ployee other than permitted coverage.

7           “(2) PERMITTED COVERAGE.—For purposes of  
8 this subsection, the term ‘permitted coverage’  
9 means—

10           “(A) coverage under a certified standard  
11 health plan (as defined in section 1011(2)(A) of  
12 the Health Security Act),

13           “(B) coverage under a certified supple-  
14 mental health benefit plan (as defined in section  
15 1011(3)(A) of such Act), except that this sub-  
16 paragraph shall not apply to coverage of any  
17 employee who is covered under a certified  
18 standard health plan which provides the alter-  
19 native standard benefits package described in  
20 subtitle C of title I of such Act,

21           “(C) coverage under a qualified long-term  
22 care insurance policy (as defined in section  
23 7702B(b)),

24           “(D) coverage providing wages or pay-  
25 ments in lieu of wages for any period during

1           which the employee is absent from work on ac-  
2           count of sickness or injury,

3           “(E) coverage only for accidental death or  
4           dismemberment,

5           “(F) coverage under a medicare supple-  
6           mental policy (as defined in section 1882(g)(1)  
7           of the Social Security Act), and

8           “(G) coverage under an equivalent health  
9           care program (as defined in section 1013(3) of  
10          the Health Security Act).

11          “(c) **DISCRIMINATORY PERMITTED COVERAGE.**—For  
12          purposes of this section, the term ‘discriminatory per-  
13          mitted coverage’ means, with respect to any period, cov-  
14          erage—

15                 “(1) which is permitted coverage described in  
16                 subparagraph (A) or (B) of subsection (b)(2), and

17                 “(2) with respect to which the requirements of  
18                 subsection (a) or (b) of section 4522 are not met  
19                 during such period.

20          **“SEC. 4522. DISCRIMINATORY EMPLOYER PRACTICES.**

21                 “(a) **HEALTH STATUS REQUIREMENTS.**—For pur-  
22          poses of section 4521(c), an employer meets the require-  
23          ments of this subsection if, with respect to coverage de-  
24          scribed in such section—

1           “(1) there is no waiting period or denial of cov-  
2           erage with respect to an employee, and

3           “(2) the amount of the employer contribution  
4           on behalf of an employee is not conditioned, and  
5           does not vary,

6 by reason of the employee’s health status, claims experi-  
7 ence, medical history, receipt of health care, or lack of evi-  
8 dence of insurability.

9           “(b) UNIFORM CONTRIBUTION REQUIREMENTS.—

10           “(1) IN GENERAL.—For purposes of section  
11           4521(e), an employer meets the requirements of this  
12           subsection if the employer contribution on behalf of  
13           an employee for coverage described in such section  
14           is equivalent to each employer contribution on behalf  
15           of all other employees who elect such coverage under  
16           plans offered by the employer.

17           “(2) EQUIVALENT CONTRIBUTION.—For pur-  
18           poses of paragraph (1), a contribution is equivalent  
19           to any other contribution if—

20                   “(A) it is the same dollar amount as the  
21                   other contribution,

22                   “(B) it represents the same percentage of  
23                   cost under the plan to which it is made as does  
24                   the other contribution, or

1           “(C) it represents the same percentage of  
2           the weighted average premium for the class of  
3           enrollment (as defined in section 1113(c) of the  
4           Health Security Act) for the community rating  
5           area in which the employee works as does the  
6           other contribution.

7           For purposes of applying subparagraph (B) or (C),  
8           any dollar limitation applicable to all employer con-  
9           tributions (whether expressed as a dollar amount or  
10          a percentage described in subparagraph (C)) shall be  
11          disregarded.

12          “(3) EXCLUDED EMPLOYEES.—

13                 “(A) IN GENERAL.—The following employ-  
14                 ees of an employer shall be excluded from con-  
15                 sideration under this subsection:

16                         “(i) Any employee before the employee  
17                         has completed 6 months of service with the  
18                         employer.

19                         “(ii) Any employee who normally  
20                         works less than 24 hours per week.

21                         “(iii) Any employee who normally  
22                         works during not more than 6 months of  
23                         any year.

24                         “(iv) Any employee who has not at-  
25                         tained age 18.

1           “(v) Any employee who is included in  
2           a unit of employees covered by an agree-  
3           ment which the Secretary finds to be a col-  
4           lective bargaining agreement between em-  
5           ployee representatives and 1 or more em-  
6           ployers if there is evidence that employer-  
7           provided benefits for standard health bene-  
8           fits coverage was the subject of good faith  
9           bargaining between the employee rep-  
10          resentatives and employer or employers.

11          “(vi) Any employee who is a non-  
12          resident alien and who receives no earned  
13          income (within the meaning of section  
14          911(d)(2)) from the employer which con-  
15          stitutes income from sources within the  
16          United States (within the meaning of sec-  
17          tion 861(a)(3)).

18          “(vii) Any former employee.

19          “(B) COVERAGE OF PART-TIME EMPLOY-  
20          EES.—

21          “(i) IN GENERAL.—If an employer  
22          makes an employer contribution for any  
23          period for coverage described in section  
24          4521(c) for any employee who normally  
25          works at least 10 hours but less than 24

1 hours per week, subparagraph (A)(ii) shall  
2 be applied by substituting ‘10 hours’ for  
3 ‘24 hours’.

4 “(ii) REQUIREMENTS MAY BE MET  
5 SEPARATELY.—If an employer elects the  
6 application of this clause—

7 “(I) the requirements of this sub-  
8 section shall be applied separately to  
9 employees to whom this subsection ap-  
10 plies by reason of clause (i), and

11 “(II) such employees shall be ex-  
12 cluded in determining whether such  
13 requirements are met with respect to  
14 any other employees.

15 “(iii) PRO RATA CONTRIBUTIONS PER-  
16 MISSIBLE.—For purposes of this sub-  
17 section, contributions on behalf of any em-  
18 ployee to which this subsection applies by  
19 reason of clause (i) shall not fail to be  
20 treated as equivalent solely because they  
21 are proportionate to the number of hours  
22 the employee works.

23 “(4) AGGREGATION RULES.—For purposes of  
24 this subsection—

1           “(A) IN GENERAL.—All employers treated  
2           as a single employer under subsection (b) or (c)  
3           of section 414 shall be treated as a single em-  
4           ployer.

5           “(B) AFFILIATED SERVICE GROUPS.—All  
6           employees of members of an affiliated service  
7           group (as defined in section 414(m)) shall be  
8           treated as employed by a single employer.

9           “(5) SEPARATE LINES OF BUSINESS.—If, under  
10          section 414(r), an employer is treated as operating  
11          separate lines of business for a year, the employer  
12          may apply this subsection separately to employees in  
13          each separate line of business.

14   **“SEC. 4523. EXCEPTIONS.**

15          “(a) EXCEPTION FOR REASONABLE DILIGENCE.—No  
16          tax shall be imposed by this subchapter during any period  
17          for which it is established to the satisfaction of the Sec-  
18          retary that the employer did not know, or exercising rea-  
19          sonable diligence would not have known, that the employer  
20          had taken any action subject to tax under this subchapter.

21          “(b) CORRECTIONS WITHIN 30 DAYS.—No tax shall  
22          be imposed by this subchapter with respect to any action  
23          subject to tax under this subchapter if—

24                  “(1) such action was due to reasonable cause  
25                  and not to willful neglect, and

1           “(2) such action is corrected during the 30-day  
2           period beginning on the 1st date the employer knew,  
3           or exercising reasonable diligence would have known,  
4           that such action was subject to such tax.

5           “(c) WAIVER BY SECRETARY.—In the case of any ac-  
6           tion subject to tax under this subchapter which is due to  
7           reasonable cause and not to willful neglect, the Secretary  
8           may waive part or all of any tax imposed by this sub-  
9           chapter to the extent that the payment of such tax would  
10          be excessive relative to the action involved.

11          **“SEC. 4524. DEFINITIONS AND SPECIAL RULES.**

12          “(a) DEFINITIONS.—For purposes of this sub-  
13          chapter—

14                  “(1) EMPLOYER.—

15                          “(A) IN GENERAL.—The term ‘employer’  
16                          means any person or governmental entity for  
17                          whom an individual performs services, of what-  
18                          ever nature, as an employee (as defined in sec-  
19                          tion 3401(c)).

20                          “(B) SPECIAL RULES.—

21                                  “(i) A partnership shall be treated as  
22                                  the employer of each partner who is an  
23                                  employee within the meaning of section  
24                                  401(c)(1).

1                   “(ii) An S corporation shall be treated  
2                   as the employer of each shareholder who is  
3                   an employee within the meaning of section  
4                   401(c)(1).

5                   “(2) EMPLOYER CONTRIBUTIONS.—The term  
6                   ‘employer contribution’ means, with respect to cov-  
7                   erage under a health plan, a reasonable estimate of  
8                   the portion of the cost of the coverage which is to  
9                   be provided by the employer.

10                  “(b) LIABILITY FOR TAX.—Any tax imposed by this  
11                  subchapter shall be paid by the employer.

12                  “(c) TAXES TO APPLY TO GOVERNMENTAL AND  
13                  OTHER TAX-EXEMPT ENTITIES.—Notwithstanding any  
14                  other provision of law or rule of law, none of the following  
15                  shall be exempt from the taxes imposed by this sub-  
16                  chapter:

17                         “(1) The United States, any State or political  
18                         subdivision thereof, the District of Columbia, and  
19                         any agency or instrumentality of any of the fore-  
20                         going.

21                         “(2) Any other entity otherwise exempt from  
22                         tax under chapter 1.

23                  “(d) NO COVER OVER TO POSSESSIONS.—Notwith-  
24                  standing any other provision of law, no amount collected

1 under this subchapter shall be covered over to any posses-  
2 sion of the United States.

3 “(e) REGULATIONS.—The Secretary shall prescribe  
4 such regulations as are necessary to carry out the provi-  
5 sions of this subchapter, including regulations providing  
6 for the determination of the amount of any employer con-  
7 tribution, the aggregation of governmental and tax-exempt  
8 entities, and the prevention of the avoidance of any tax  
9 imposed by this subchapter through the use of any ar-  
10 rangement described in section 414(o).”

11 (b) EMPLOYEE LEASING.—Paragraph (3) of section  
12 414(n) is amended by striking “and” at the end of sub-  
13 paragraph (B), by striking the period at the end of sub-  
14 paragraph (C) and inserting “, and”, and by adding at  
15 the end the following new subparagraph:

16 “(D) subchapter B of chapter 37.”

17 (c) TAX NOT DEDUCTIBLE.—Section 275(a) is  
18 amended by adding at the end the following new para-  
19 graph:

20 “(7) The taxes imposed by section 4521 (relat-  
21 ing to taxable employer-provided health benefits).”

22 (d) CONFORMING AMENDMENT.—The table of sub-  
23 chapters for chapter 37 is amended by adding at the end  
24 the following new item:

“SUBCHAPTER B. Voluntary employer-provided health benefits.”

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

3 **Subtitle C—Exempt Health Care**  
 4 **Organizations**

5 **PART 1—GENERAL PROVISIONS**

6 **SEC. 7301. QUALIFICATION AND DISCLOSURE REQUIRE-**  
 7 **MENTS FOR NONPROFIT HEALTH CARE OR-**  
 8 **GANIZATIONS.**

9 (a) TREATMENT OF HOSPITALS AND OTHER ENTI-  
 10 TIES PROVIDING HEALTH CARE SERVICES.—Section 501  
 11 (relating to exemption from tax on corporations, certain  
 12 trusts, etc.) is amended by redesignating subsection (n)  
 13 as subsection (o) and by inserting after subsection (m) the  
 14 following new subsection:

15 “(n) QUALIFICATION OF HEALTH CARE ORGANIZA-  
 16 TIONS AS EXEMPT ORGANIZATIONS.—

17 “(1) IN GENERAL.—An organization which is  
 18 described in paragraph (3) or (4) of subsection (c)  
 19 and the predominant activity of which is the provi-  
 20 sion of health care services shall be exempt from tax  
 21 under subsection (a) only if—

22 “(A) such organization, with the participa-  
 23 tion of community representatives, annually—

1           “(i) assesses its community’s needs  
2           for health care services and qualified out-  
3           reach services, and

4           “(ii) prepares a written plan to meet  
5           those needs,

6           “(B) pursuant to such plan, such organiza-  
7           tion provides (directly or indirectly) significant  
8           qualified outreach services,

9           “(C) such organization does not discrimi-  
10          nate against individuals in the provision of  
11          health care services on the basis of participation  
12          in a government-sponsored health plan, and

13          “(D) such organization does not discrimi-  
14          nate against individuals in the provision of  
15          emergency health care services on the basis of  
16          ability to pay.

17          “(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance or-  
18          ganization shall not be treated as described in sub-  
19          section (c)(3) unless substantially all of its primary  
20          care health services are provided as described in sub-  
21          section (m)(6)(A).

22          “(3) DEFINITIONS AND SPECIAL RULE.—For  
23          purposes of this subsection—  
24

1           “(A) QUALIFIED OUTREACH SERVICES.—

2           The term ‘qualified outreach services’ means  
3           health care services (or preventive care, edu-  
4           cational, or social services programs related  
5           thereto) which are provided—

6                   “(i) in 1 or more medically under-  
7                   served areas,

8                   “(ii) at below cost to individuals who  
9                   are otherwise unable to afford such serv-  
10                  ices, or

11                  “(iii) at emergency care facilities  
12                  which provide specialty services and which  
13                  normally operate at a loss.

14           Such term shall not include insurance described  
15           in subparagraph (B)(iii) unless such insurance  
16           is provided on a subsidized basis.

17           “(B) HEALTH CARE SERVICES.—The term  
18           ‘health care services’ means—

19                   “(i) any activity which consists of pro-  
20                   viding medical care (as defined in section  
21                   213(d)(1)(A)) to individuals,

22                   “(ii) in the case of an organization de-  
23                   scribed in subsection (c)(3), any activity  
24                   which is treated as accomplishing an ex-  
25                   empt purpose of the organization solely be-

1 cause it is carried on as part of an activity  
2 described in clause (i), and

3 “(iii) insurance (other than commer-  
4 cial-type insurance, as defined in sub-  
5 section (m)) for the activities described in  
6 clauses (i) and (ii).

7 “(C) MEDICALLY UNDERSERVED AREA.—  
8 The term ‘medically underserved area’ means,  
9 with respect to a health care service, any area  
10 reasonably determined by the organization (in a  
11 manner not inconsistent with regulations pre-  
12 scribed by the Secretary) to have—

13 “(i) a shortage (relative to the num-  
14 ber of individuals needing such service) of  
15 health professionals performing such serv-  
16 ice, or

17 “(ii) a population group experiencing  
18 such a shortage.

19 Such term includes a health professional short-  
20 age area (as defined in section 332 of the Pub-  
21 lic Health Service Act).

22 “(4) EXCEPTIONS.—This subsection shall not  
23 apply to any organization which—

24 “(A) demonstrates, in a manner not incon-  
25 sistent with regulations prescribed by the Sec-

1           retary, that one of its principal purposes is aca-  
2           demic training or medical research, or

3           “(B) provides health care services exclu-  
4           sively on an uncompensated basis, regardless of  
5           ability to pay.

6           “(5) DISALLOWANCE OF CHARITABLE DEDUC-  
7           TIONS.—No gift or bequest to an organization which  
8           is not exempt from tax by reason of this subsection  
9           shall be allowed as a deduction under section 170,  
10          545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or  
11          2522.

12          “(6) REQUIREMENTS SUPPLEMENT OTHER RE-  
13          QUIREMENTS.—The requirements of this subsection  
14          are in addition to, and not in lieu of, the require-  
15          ments otherwise applicable to an organization de-  
16          scribed in paragraph (3) or (4) of subsection (c).”

17          (b) REPORTING AND DISCLOSURE OF NEEDS AS-  
18          SESSMENT AND PLAN.—

19               (1) REPORTING.—

20                   (A) ORGANIZATIONS DESCRIBED IN SEC-  
21                   TION 501(C)(3).—Subsection (b) of section 6033  
22                   (relating to certain organizations described in  
23                   section 501(c)(3)) is amended by striking  
24                   “and” at the end of paragraph (9), by redesign-  
25                   nating paragraph (10) as paragraph (12), and

1 by inserting after paragraph (9) the following  
2 new paragraphs:

3 “(10) in the case of an organization which pre-  
4 pares a plan described in section 501(n)(1)(A) (re-  
5 lating to community needs)—

6 “(A) a copy of such plan for the year, and

7 “(B) information on the implementation of  
8 such plan for the year (including unrecovered  
9 costs and revenues foregone in furtherance of  
10 such plan),

11 “(11) such information as the Secretary may  
12 require with respect to any taxable inurement (as  
13 defined in section 4958(d)), and”.

14 (B) ORGANIZATIONS DESCRIBED IN SEC-  
15 TION 501(C)(4).—Section 6033 is amended by re-  
16 designating subsection (f) as subsection (g) and  
17 by inserting after subsection (e) the following  
18 new subsection:

19 “(f) CERTAIN ORGANIZATIONS DESCRIBED IN SEC-  
20 TION 501(c)(4).—Every organization described in section  
21 501(c)(4) which is subject to the requirements of sub-  
22 section (a) and which prepares a plan described in section  
23 501(n)(1)(A) (relating to community needs) for the  
24 year—

1           “(1) shall include a copy of such plan with the  
2 return required under subsection (a) for the year,  
3 and

4           “(2) shall include on such return the informa-  
5 tion referred to in paragraphs (10)(B) and (11) of  
6 subsection (b) with respect to such organization.”

7           (2) DISCLOSURE.—

8           (A) IN GENERAL.—Subsection (e) of sec-  
9 tion 6104 (relating to public inspection of cer-  
10 tain annual returns and applications for exemp-  
11 tion) is amended by adding at the end the fol-  
12 lowing new paragraph:

13           “(3) COMMUNITY HEALTH CARE NEEDS AS-  
14 SESSMENT AND PLAN.—

15           “(A) IN GENERAL.—Every organization  
16 which is required to prepare a plan described in  
17 section 501(n)(1)(A) (relating to community  
18 needs)—

19           “(i) shall make a copy of such plan  
20 (and the assessment on which such plan is  
21 based) available for inspection during reg-  
22 ular business hours by any individual at  
23 the principal office of such organization  
24 and, if such organization regularly main-  
25 tains 1 or more regional or district offices

1           having 3 or more employees, at each such  
2           regional or district office, and

3           “(ii) upon request of an individual  
4           made at such principal office or such a re-  
5           gional or district office, shall provide—

6                   “(I) a copy of such plan (and as-  
7                   sessment), and

8                   “(II) a copy of the annual return  
9                   filed under section 6033,

10           to such individual without charge other  
11           than a reasonable fee for any reproduction  
12           and mailing costs.

13           If the request under clause (ii) is made in per-  
14           son, such copies shall be provided immediately  
15           and, if made other than in person, shall be pro-  
16           vided within 30 days.

17           “(B) PERIOD OF AVAILABILITY.—Subpara-  
18           graph (A) shall apply—

19                   “(i) with respect to any plan (and as-  
20                   sessment) during the 3-year period after  
21                   the close of the year for which such plan  
22                   is prepared, and

23                   “(ii) with respect to any return, dur-  
24                   ing the 3-year period beginning on the fil-  
25                   ing date (as defined in paragraph (1)(D)).

1           “(C) LIMITATION.—Subparagraph (A)(ii)  
2 shall not apply to any request if the Secretary  
3 determines, upon application by an organiza-  
4 tion, that such request is part of a harassment  
5 campaign and that compliance with such re-  
6 quest is not in the public interest.”

7           (B) TECHNICAL AMENDMENT.—The head-  
8 ing for subsection (e) of section 6104 is amend-  
9 ed by striking “AND APPLICATIONS FOR EX-  
10 EMPTION” and inserting “, APPLICATIONS FOR  
11 EXEMPTION, AND COMMUNITY NEEDS ASSESS-  
12 MENT AND PLAN FOR HEALTH AND OUTREACH  
13 SERVICES”.

14       (c) EFFECTIVE DATES.—

15           (1) IN GENERAL.—Except as provided in para-  
16 graph (2), the amendments made by this section  
17 shall take effect on January 1, 1995.

18           (2) HMO SERVICE REQUIREMENT.—So much of  
19 the amendments made by this section as relates to  
20 section 501(n)(2) of the Internal Revenue Code of  
21 1986, as added by this section, shall take effect on  
22 the date of the enactment of this Act.

1 **SEC. 7302. EXCISE TAXES FOR PRIVATE INUREMENT BY**  
 2 **TAX-EXEMPT HEALTH CARE ORGANIZATIONS.**

3 (a) IN GENERAL.—Chapter 42 (relating to private  
 4 foundations and certain other tax-exempt organizations)  
 5 is amended by redesignating subchapter D as subchapter  
 6 E and by inserting after subchapter C the following new  
 7 subchapter:

8 **“Subchapter D—Private Inurement by Tax-**  
 9 **Exempt Health Care Organizations**

“Sec. 4958. Taxes on private inurement.

“Sec. 4959. Other definitions.

10 **“SEC. 4958. TAXES ON PRIVATE INUREMENT.**

11 “(a) INITIAL TAXES.—

12 “(1) ON THE BENEFICIARY.—There is hereby  
 13 imposed on any taxable inurement a tax equal to 25  
 14 percent of the amount thereof. The tax imposed by  
 15 this paragraph shall be paid by any beneficiary of  
 16 such inurement.

17 “(2) ON THE MANAGEMENT.—In any case in  
 18 which there is a tax imposed by paragraph (1), there  
 19 is hereby imposed on the participation of any organi-  
 20 zation manager of an organization in any taxable  
 21 inurement which occurs with respect to such organi-  
 22 zation, knowing that it is taxable inurement, a tax  
 23 equal to 2½ percent of the amount thereof, unless  
 24 such participation is not willful and is due to reason-

1       able cause. The tax imposed by this paragraph shall  
2       be paid by any organization manager who partici-  
3       pated in the taxable inurement.

4       “(b) ADDITIONAL TAXES.—

5             “(1) ON THE BENEFICIARY.—In any case in  
6       which an initial tax is imposed by subsection (a)(1)  
7       on any taxable inurement and such inurement is not  
8       corrected within the taxable period, there is hereby  
9       imposed a tax equal to 200 percent of the amount  
10      of the taxable inurement. The tax imposed by this  
11      paragraph shall be paid by any beneficiary of such  
12      inurement.

13            “(2) ON THE MANAGEMENT.—In any case in  
14      which an additional tax is imposed by paragraph (1),  
15      if an organization manager refused to agree to part  
16      or all of the correction, there is hereby imposed a  
17      tax equal to 50 percent of the amount of the taxable  
18      inurement. The tax imposed by this paragraph shall  
19      be paid by any organization manager who refused to  
20      agree to part or all of the correction.

21       “(c) SPECIAL RULES RELATING TO LIABILITY FOR  
22      TAX.—For purposes of this section—

23            “(1) JOINT AND SEVERAL LIABILITY.—If more  
24      than one person is liable under any paragraph of  
25      subsection (a) or (b) with respect to any one taxable

1 inurement, all such persons shall be jointly and sev-  
2 erally liable under such paragraph with respect to  
3 such inurement.

4 “(2) LIMIT FOR MANAGEMENT.—With respect  
5 to any 1 taxable inurement, the maximum amount  
6 of the tax imposed by subsection (a)(2) shall not ex-  
7 ceed \$10,000, and the maximum amount of the tax  
8 imposed by subsection (b)(2) shall not exceed  
9 \$10,000.

10 “(d) TAXABLE INUREMENT.—For purposes of this  
11 section, the term ‘taxable inurement’ means any  
12 inurement not permitted under paragraph (3) or (4) of  
13 section 501(c), as the case may be, in a transaction involv-  
14 ing an applicable tax-exempt health care organization in  
15 which—

16 “(1) the value of any economic benefit provided  
17 to or for the use of a disqualified person exceeds the  
18 value of the consideration (including the perform-  
19 ance of services) received by the organization for  
20 providing such benefit, or

21 “(2) the amount of any economic benefit pro-  
22 vided to or for the use of a disqualified person is de-  
23 termined in whole or in part by the gross or net rev-  
24 enues of 1 or more activities of the organization.

1 The amount of any taxable inurement with respect to any  
2 such transaction shall be the excess described in para-  
3 graph (1) or the amount described in paragraph (2). For  
4 purposes of paragraph (1), an economic benefit shall not  
5 be treated as provided as consideration for the perform-  
6 ance of services unless the organization clearly indicated  
7 its intent to so treat such benefit.

8 “(e) OTHER DEFINITIONS.—For purposes of this  
9 section—

10 “(1) DISQUALIFIED PERSON.—The term ‘dis-  
11 qualified person’ means, with respect to any trans-  
12 action—

13 “(A) any person who was, at any time dur-  
14 ing the 5-year period ending on the date of  
15 such transaction—

16 “(i) an organization manager, or

17 “(ii) an individual (other than an or-  
18 ganization manager)—

19 “(I) in a position to exercise sub-  
20 stantial influence over the affairs of  
21 the organization, or

22 “(II) performing substantial  
23 medical services as a physician pursu-  
24 ant to an employment or other con-

1                   tractual relationship with the organi-  
2                   zation or a related organization,

3                   “(B) a member of the family of an indi-  
4                   vidual described in subparagraph (A), and

5                   “(C) a 35-percent controlled entity.

6                   “(2) ORGANIZATION MANAGER.—The term ‘or-  
7                   ganization manager’ means, with respect to any ap-  
8                   plicable tax-exempt health care organization, any of-  
9                   ficer, director, or trustee of such organization (or  
10                  any individual having powers or responsibilities simi-  
11                  lar to those of officers, directors, or trustees of the  
12                  organization).

13                  “(3) 35-PERCENT CONTROLLED ENTITY.—

14                  “(A) IN GENERAL.—The term ‘35-percent  
15                  controlled entity’ means—

16                         “(i) a corporation in which persons  
17                         described in subparagraph (A) or (B) of  
18                         paragraph (1) own more than 35 percent  
19                         of the total combined voting power,

20                         “(ii) a partnership in which such per-  
21                         sons own more than 35 percent of the  
22                         profits interest, and

23                         “(iii) a trust or estate in which such  
24                         persons own more than 35 percent of the  
25                         beneficial interest.

1           “(B) CONSTRUCTIVE OWNERSHIP  
2           RULES.—Rules similar to the rules of para-  
3           graphs (3) and (4) of section 4946(a) shall  
4           apply for purposes of this subsection.

5           “(4) FAMILY MEMBERS.—The members of an  
6           individual’s family shall be determined under section  
7           4946(d); except that such members also shall in-  
8           clude the brothers and sisters (whether by the whole  
9           or halfblood) of the individual and their spouses.

10          “(f) TREATMENT OF PREVIOUSLY EXEMPT ORGANI-  
11          ZATIONS.—

12           “(1) IN GENERAL.—For purposes of this sec-  
13           tion, the status of any organization as an applicable  
14           tax-exempt health care organization shall be termi-  
15           nated only if—

16           “(A)(i) such organization notifies the Sec-  
17           retary (at such time and in such manner as the  
18           Secretary may by regulations prescribe) of its  
19           intent to accomplish such termination, or

20           “(ii) there is a final determination by the  
21           Secretary that such status has terminated, and

22           “(B)(i) such organization pays the tax im-  
23           posed by paragraph (2) (or any portion not  
24           abated pursuant to paragraph (3)), or

1           “(ii) the entire amount of such tax is  
2           abated pursuant to paragraph (3).

3           “(2) IMPOSITION OF TAX.—There is hereby im-  
4           posed on each organization referred to in paragraph  
5           (1) a tax equal to the lesser of—

6           “(A) the amount which the organization  
7           substantiates by adequate records or other cor-  
8           roborating evidence as the aggregate tax benefit  
9           resulting from its exemption from tax under  
10          section 501(a), or

11          “(B) the value of the net assets of such or-  
12          ganization.

13          “(3) ABATEMENT OF TAX.—The Secretary may  
14          abate the unpaid portion of the assessment of any  
15          tax imposed by paragraph (2), or any liability in re-  
16          spect thereof, if the applicable tax-exempt health  
17          care organization distributes all of its net assets to  
18          1 or more organizations each of which has been in  
19          existence, and described in section 501(c)(3), for a  
20          continuous period of at least 60 calendar months. If  
21          the distributing organization is described in section  
22          501(c)(4), the preceding sentence shall be applied by  
23          treating the reference to section 501(c)(3) as includ-  
24          ing a reference to section 501(c)(4).

1           “(4) CERTAIN RULES MADE APPLICABLE.—  
2           Rules similar to the rules of subsections (d), (e), and  
3           (f) of section 507 shall apply for purposes of this  
4           subsection.

5   **“SEC. 4959. OTHER DEFINITIONS.**

6           “(a) APPLICABLE TAX-EXEMPT HEALTH CARE OR-  
7           GANIZATION.—For purposes of this subchapter, the term  
8           ‘applicable tax-exempt health care organization’ means  
9           any organization—

10           “(1) the predominant activity of which is the  
11           provision of health care services (as defined in sec-  
12           tion 501(n)(3)), and

13           “(2) which (without regard to any taxable  
14           inurement) would be described in paragraph (3) or  
15           (4) of section 501(c) and exempt from tax under  
16           section 501(a).

17           Such term does not include a private foundation (as de-  
18           fined in section 509(a)).

19           “(b) TAXABLE PERIOD; CORRECTION.—For purposes  
20           of this subchapter—

21           “(1) TAXABLE PERIOD.—The term ‘taxable pe-  
22           riod’ means, with respect to any taxable inurement,  
23           the period beginning with the date on which the  
24           inurement occurs and ending on the earliest of—

1           “(A) the date of mailing a notice of defi-  
2           ciency under section 6212 with respect to the  
3           tax imposed by subsection (a)(1) of section  
4           4958, or

5           “(B) the date on which the tax imposed by  
6           such subsection (a)(1) is assessed.

7           “(2) CORRECTION.—The terms ‘correction’ and  
8           ‘correct’ mean, with respect to any taxable  
9           inurement, undoing the inurement to the extent pos-  
10          sible, establishing safeguards to prevent future such  
11          inurement, and where fully undoing the inurement is  
12          not possible, such additional corrective action as is  
13          prescribed by the Secretary by regulations.”

14          (b) APPLICATION OF PRIVATE INUREMENT RULE TO  
15          TAX-EXEMPT HEALTH CARE ORGANIZATIONS DE-  
16          SCRIBED IN SECTION 501(c)(4).—Paragraph (4) of sec-  
17          tion 501(c) is amended by inserting “(A)” after “(4)” and  
18          by adding at the end the following:

19               “(B) Subparagraph (A) shall not apply to an  
20               entity the predominant activity of which is the provi-  
21               sion of health care services (as defined in subsection  
22               (n)(3)) unless no part of the net earnings of such  
23               entity inures to the benefit of any private share-  
24               holder or individual.”

25          (c) TECHNICAL AND CONFORMING AMENDMENTS.—

1           (1) Subsection (e) of section 4955 is amend-  
2 ed—

3                   (A) by striking “SECTION 4945” in the  
4 heading and inserting “SECTIONS 4945 and  
5 4958”, and

6                   (B) by inserting before the period “or a  
7 taxable inurement for purposes of section  
8 4958”.

9           (2) Subsections (a), (b), and (c) of section 4963  
10 are each amended by inserting “4958,” after  
11 “4955,”.

12           (3) Subsection (e) of section 6213 is amended  
13 by inserting “4958 (relating to private inurement),”  
14 before “4971”.

15           (4) Paragraphs (2) and (3) of section 7422(g)  
16 are each amended by inserting “4958,” after  
17 “4955,”.

18           (5) Subsection (b) of section 7454 is amended  
19 by inserting “or whether an organization manager  
20 (as defined in section 4958(f)) has ‘knowingly’ par-  
21 ticipated in taxable inurement (as defined in section  
22 4958(d)),” after “section 4912(b),”.

23           (6) The table of subchapters for chapter 42 is  
24 amended by striking the last item and inserting the  
25 following:

“SUBCHAPTER D. Private inurement by tax-exempt health care organizations.

“SUBCHAPTER E. Abatement of first and second tier taxes in certain cases.”

1 (d) EFFECTIVE DATES.—

2 (1) IN GENERAL.—Except as provided in para-  
3 graph (2), the amendments made by this section  
4 shall apply to inurement occurring on or after June  
5 30, 1994.

6 (2) APPLICATION OF BINDING CONTRACT RULE  
7 TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DE-  
8 SCRIBED IN SECTION 501(C)(4).—The amendments  
9 made by this section shall not apply to any  
10 inurement involving an organization described in  
11 section 501(c)(4) of the Internal Revenue Code of  
12 1986 occurring before July 1, 1996, pursuant to a  
13 written contract which was binding on June 29,  
14 1994, and at all times thereafter before such  
15 inurement occurred.

16 **SEC. 7303. TREATMENT OF HEALTH MAINTENANCE ORGA-**  
17 **NIZATIONS, PARENT ORGANIZATIONS, AND**  
18 **HEALTH INSURANCE PURCHASING COOPERA-**  
19 **TIVES.**

20 (a) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.—  
21

22 (1) IN GENERAL.—Section 501(m) (relating to  
23 certain organizations providing commercial-type in-

1       surance not exempt from tax) is amended by adding  
2       at the end the following new paragraph:

3           “(6) CERTAIN ACTIVITIES PROVIDED BY  
4       HEALTH MAINTENANCE ORGANIZATIONS NOT TREAT-  
5       ED AS COMMERCIAL-TYPE INSURANCE.—For pur-  
6       poses of this subsection, the provision of (or the ar-  
7       ranging for the provision of) medical care on a pre-  
8       paid basis by a health maintenance organization  
9       shall not be treated as providing commercial-type in-  
10      surance if (and only if) such care is—

11           “(A) care provided by such organization to  
12      its members at its own facilities through health  
13      care professionals who do not provide substan-  
14      tial health care services other than on behalf of  
15      such organization,

16           “(B) care provided by a health care profes-  
17      sional to a member of such organization on a  
18      basis under which substantially all of the risks  
19      of the rates of utilization is assumed by the  
20      provider of such care,

21           “(C) care (other than primary care) pro-  
22      vided to a member of such organization pursu-  
23      ant to a referral by such organization, or

1           “(D) emergency care provided to a member  
2 of such organization at a location outside such  
3 member’s area of residence.”

4           (2) TECHNICAL AMENDMENTS.—

5           (A) Paragraph (3) of section 501(m) is  
6 amended by striking subparagraph (B) and by  
7 redesignating subparagraphs (C), (D), and (E)  
8 as subparagraphs (B), (C), and (D), respec-  
9 tively.

10           (B) Paragraph (5) of section 501(m) is  
11 amended by striking “paragraph (3)(E)” and  
12 inserting “paragraph (3)(D)”.

13           (b) TREATMENT OF PARENT ORGANIZATIONS OF  
14 HEALTH CARE PROVIDERS.—Section 509(a) (defining  
15 private foundation) is amended by striking “and” at the  
16 end of paragraph (3), by redesignating paragraph (4) as  
17 paragraph (5), and by inserting after paragraph (3) the  
18 following new paragraph:

19           “(4) an organization which is organized and op-  
20 erated for the benefit of, and which directly or indi-  
21 rectly controls, an organization described in section  
22 170(b)(1)(A)(iii), and”.

23           (c) PURCHASING COOPERATIVES EXEMPT FROM  
24 TAX.—

1           (1) IN GENERAL.—Subsection (c) of section  
2           501 (relating to exemption from tax on corporations,  
3           certain trusts, etc.) is amended by adding at the end  
4           the following new paragraph:

5           “(26)(A) Any health insurance purchasing co-  
6           operative described in section 1013(12) of the  
7           Health Security Act.

8           “(B) Such a cooperative shall not be exempt  
9           from tax pursuant to any provision other than this  
10          paragraph.

11          “(C) Such a cooperative shall not be exempt  
12          from tax unless—

13                 “(i) no part of the net earnings of such co-  
14                 operative inures to the benefit of any private  
15                 shareholder or individual,

16                 “(ii) no substantial part of the activities of  
17                 such cooperative is carrying on propaganda, or  
18                 otherwise attempting, to influence legislation  
19                 (except as otherwise provided in subsection (h)),  
20                 and

21                 “(iii) such cooperative does not participate  
22                 in, or intervene in (including the publishing or  
23                 distributing of statements), any political cam-  
24                 paign on behalf of (or in opposition to) any can-  
25                 didate for public office.”

1           (2) CERTAIN PROVISIONS APPLICABLE TO OR-  
2           GANIZATIONS DESCRIBED IN SECTION 501(C)(3) MADE  
3           APPLICABLE TO PURCHASING COOPERATIVES.—Sec-  
4           tion 501 is amended by redesignating subsection (o)  
5           as subsection (p) and by inserting after subsection  
6           (n) the following new subsection:

7           “(o) CERTAIN PROVISIONS MADE APPLICABLE TO  
8           HEALTH INSURANCE PURCHASING COOPERATIVES.—A  
9           health insurance purchasing cooperative described in sub-  
10          section (c)(26) shall be treated—

11           “(1) as described in subsection (e)(3) for pur-  
12          poses of applying subsection (h) (relating to expendi-  
13          tures by public charities to influence legislation),  
14          section 4955 (relating to taxes on political expendi-  
15          tures of section 501(c)(3) organizations), and sec-  
16          tion 4958 (relating to private inurement), and

17           “(2) as described in subsection (h)(4).”

18          (d) EFFECTIVE DATE.—The amendments made by  
19          this section shall take effect on the date of the enactment  
20          of this Act.

1 **SEC. 7304. TAX TREATMENT OF TAXABLE ORGANIZATIONS**  
2 **PROVIDING HEALTH INSURANCE AND OTHER**  
3 **PREPAID HEALTH CARE SERVICES.**

4 (a) GENERAL RULE.—Section 831 is amended by re-  
5 designating subsection (c) as subsection (d) and by insert-  
6 ing after subsection (b) the following new subsection:

7 “(c) TREATMENT OF ORGANIZATIONS PROVIDING  
8 HEALTH INSURANCE AND OTHER PREPAID HEALTH  
9 CARE SERVICES.—

10 “(1) GENERAL RULE.—Any organization to  
11 which this subsection applies shall be taxable under  
12 this part in the same manner as if it were an insur-  
13 ance company other than a life insurance company.

14 “(2) ORGANIZATIONS TO WHICH SUBSECTION  
15 APPLIES.—This subsection shall apply to any organi-  
16 zation—

17 “(A) which is not exempt from taxation  
18 under this subtitle,

19 “(B) which is not taxable as a life insur-  
20 ance company under part I of this subchapter,  
21 and

22 “(C) the primary and predominant busi-  
23 ness activity of which during the taxable year  
24 consists of 1 or more of the following:

25 “(i) Issuing accident and health insur-  
26 ance contracts or the reinsuring of risks

1           undertaken by other insurance companies  
2           under such contracts.

3           “(ii) Operating as a health mainte-  
4           nance organization.

5           “(iii) Entering into arrangements  
6           under which—

7                   “(I) fixed payments or premiums  
8                   are received as consideration for the  
9                   organization’s agreement to provide or  
10                  arrange for the provision of health  
11                  care services, regardless of how the  
12                  health care services are provided or  
13                  arranged to be provided, and

14                   “(II) substantially all of the risks  
15                   of the rates of utilization of such serv-  
16                   ices is assumed by such organization  
17                   or the provider of such services.

18           In the case of an organization which has as a mate-  
19           rial business activity the issuing of accident and  
20           health insurance contracts or the reinsuring of risks  
21           undertaken by other insurance companies under  
22           such contracts, the administering of accident and  
23           health insurance contracts by such organization shall  
24           be treated as part of such business activity for pur-  
25           poses of subparagraph (C)(i).”

1 (b) EFFECTIVE DATE.—

2 (1) IN GENERAL.—The amendment made by  
3 this section shall apply to taxable years beginning  
4 after December 31, 1994.

5 (2) TRANSITIONAL RULES.—

6 (A) ORGANIZATIONS TO WHICH PARA-  
7 GRAPH APPLIES.—This paragraph shall apply  
8 to any organization to which section 831(c) of  
9 the Internal Revenue Code of 1986 (as added  
10 by subsection (a)) applies for such organiza-  
11 tion's first taxable year beginning after Decem-  
12 ber 31, 1994; except that this paragraph shall  
13 not apply if such organization treated itself as  
14 an insurance company taxable under part II of  
15 subchapter L of chapter 1 of such Code on its  
16 original Federal income tax return for its tax-  
17 able year beginning in 1992 and for all of its  
18 taxable years thereafter beginning before Janu-  
19 ary 1, 1995.

20 (B) TREATMENT OF CURRENTLY TAXABLE  
21 COMPANIES.—Except as provided in regulations  
22 prescribed by the Secretary of the Treasury or  
23 his delegate, in the case of any organization to  
24 which this paragraph applies—

1 (i) the amendments made by this sec-  
2 tion shall be treated as a change in the  
3 method of accounting, and

4 (ii) all adjustments required to be  
5 taken into account under section 481 of  
6 the Internal Revenue Code of 1986 shall  
7 be taken into account for such company's  
8 first taxable year beginning after Decem-  
9 ber 31, 1994.

10 (C) TREATMENT OF CURRENTLY TAX-EX-  
11 EMPT COMPANIES.—Except as provided in regu-  
12 lations prescribed by the Secretary of the  
13 Treasury or his delegates, in the case of any or-  
14 ganization to which this paragraph applies and  
15 which was exempt from tax under chapter 1 of  
16 the Internal Revenue Code of 1986 for such or-  
17 ganization's last taxable year beginning before  
18 January 1, 1995—

19 (i) no adjustment shall be made under  
20 section 481 (or any other provision) of  
21 such Code on account of a change in its  
22 method of accounting required by this sec-  
23 tion for its first taxable year beginning  
24 after December 31, 1994, and

1 (ii) for purposes of determining gain  
2 or loss, the adjusted basis of any asset  
3 held by such organization on the first day  
4 of such taxable year shall be treated as  
5 equal to its fair market value as of such  
6 day.

7 **SEC. 7305. REPEAL OF SECTION 833.**

8 (a) REPEAL OF SECTION 833.—

9 (1) IN GENERAL.—Section 833 (relating to  
10 treatment of Blue Cross and Blue Shield and similar  
11 organizations) is hereby repealed.

12 (2) CONFORMING AMENDMENTS.—

13 (A) Section 56(c) is amended by striking  
14 paragraph (3).

15 (B) The table of sections for part II of  
16 subchapter L of chapter 1 is amended by strik-  
17 ing the item relating to section 833.

18 (b) APPLICATION OF SECTION 833 PRIOR TO RE-  
19 PEAL.—

20 (1) IN GENERAL.—Section 833(c) (relating to  
21 organization to which section applies) is amended by  
22 adding at the end the following new paragraph:

23 “(4) TREATMENT AS EXISTING BLUE CROSS OR  
24 BLUE SHIELD ORGANIZATION.—

1           “(A) IN GENERAL.—Paragraph (2) shall  
2           be applied to an organization described in sub-  
3           paragraph (B) as if it were a Blue Cross or  
4           Blue Shield organization.

5           “(B) APPLICABLE ORGANIZATION.—An or-  
6           ganization is described in this subparagraph if  
7           it—

8                   “(i) is organized and governed by  
9                   State laws which are specifically and exclu-  
10                  sively applicable to not-for-profit insurance  
11                  or health-service type organizations, and

12                   “(ii) is not a Blue Cross or Blue  
13                  Shield organization or health maintenance  
14                  organization.”

15           (2) EFFECTIVE DATE.—The amendment made  
16           by this section shall apply to taxable years beginning  
17           after December 31, 1986.

18           (c) EFFECTIVE DATE OF REPEAL.—

19                   (1) IN GENERAL.—Except as otherwise pro-  
20                  vided in this subsection, the amendments made by  
21                  subsection (a) shall apply to taxable years beginning  
22                  after December 31, 1996.

23                   (2) TRANSITION RULES FOR BLUE CROSS AND  
24                  BLUE SHIELD AND SIMILAR ORGANIZATIONS.—

1 (A) PRIOR FRESH START PRESERVED.—  
2 The adjusted basis of any asset determined  
3 under section 1012(c)(3)(A)(ii) of the Tax Re-  
4 form Act of 1986 shall not be affected by the  
5 amendments made by this section.

6 (B) RECOUPMENT OF PRIOR RESERVE  
7 BENEFIT.—In the case of any organization enti-  
8 tled to the benefits of section 833(a)(3) of the  
9 Internal Revenue Code of 1986 (as in effect  
10 after the amendment made by subsection (a))  
11 for such organization's last taxable year begin-  
12 ning before January 1, 1997, the amount deter-  
13 mined under paragraph (4) of section 832(b) of  
14 such Code for each of such organization's first  
15 6 taxable years beginning after December 31,  
16 1996, shall be increased by an amount equal to  
17  $3\frac{1}{3}$  percent of its unearned premiums on out-  
18 standing business as of the close of such organi-  
19 zation's last taxable year beginning before Jan-  
20 uary 1, 1997.

21 **SEC. 7306. TAX EXEMPTION FOR HIGH-RISK INSURANCE**  
22 **POOLS.**

23 Subsection (c) of section 501 (relating to list of ex-  
24 empt organizations) is amended by adding at the end the  
25 following new paragraph:

1 “(27)(A) In the case of taxable years beginning after  
2 December 31, 1989, and before January 1, 1997, a quali-  
3 fied high risk health insurance pool.

4 “(B) For purposes of subparagraph (A), the term  
5 ‘qualified high risk health insurance pool’ means an enti-  
6 ty—

7 “(i) which was established by a State or polit-  
8 ical subdivision thereof to provide health insurance  
9 on a nonprofit basis to persons unable to obtain  
10 health insurance because of health conditions,

11 “(ii) with respect to which the State or political  
12 subdivision—

13 “(I) participates in the ongoing governance  
14 of the entity, and

15 “(II) subsidizes the operation of the entity,  
16 and

17 “(iii) no part of the net earnings of which inure  
18 to the benefit of any private shareholder, member, or  
19 individual.”

20 **PART 2—TAX TREATMENT OF SECTION 501(c)(3)**

21 **BONDS**

22 **SEC. 748. TAX TREATMENT OF 501(c)(3) BONDS SIMILAR TO**  
23 **GOVERNMENTAL BONDS.**

24 (a) IN GENERAL.—Subsection (a) of section 150 (re-  
25 lating to definitions and special rules) is amended by strik-

1 ing paragraphs (2) and (4), by redesignating paragraphs  
2 (5) and (6) as paragraphs (4) and (5), respectively, and  
3 by inserting after paragraph (1) the following new para-  
4 graph:

5 “(2) EXEMPT PERSON.—

6 “(A) IN GENERAL.—The term ‘exempt per-  
7 son’ means—

8 “(i) a governmental unit, or

9 “(ii) a 501(c)(3) organization, but  
10 only with respect to its activities which do  
11 not constitute unrelated trades or busi-  
12 nesses as determined by applying section  
13 513(a).

14 “(B) GOVERNMENTAL UNIT NOT TO IN-  
15 CLUDE FEDERAL GOVERNMENT.—The term  
16 ‘governmental unit’ does not include the United  
17 States or any agency or instrumentality thereof.

18 “(C) 501(c)(3) ORGANIZATION.—The term  
19 ‘501(c)(3) organization’ means any organization  
20 described in section 501(c)(3) and exempt from  
21 tax under section 501(a).”

22 (b) REPEAL OF QUALIFIED 501(c)(3) BOND DES-  
23 IGNATION.—Section 145 (relating to qualified 501(c)(3)  
24 bonds) is repealed.

25 (c) CONFORMING AMENDMENTS.—

1           (1) Paragraph (3) of section 141(b) is amend-  
2 ed—

3           (A) by striking “government use” in sub-  
4 paragraph (A)(ii)(I) and subparagraph (B)(ii)  
5 and inserting “exempt person use”,

6           (B) by striking “a government use” in sub-  
7 paragraph (B) and inserting “an exempt person  
8 use”,

9           (C) by striking “related business use” in  
10 subparagraph (A)(ii)(II) and subparagraph (B)  
11 and inserting “related private business use”,

12           (D) by striking “RELATED BUSINESS USE”  
13 in the heading of subparagraph (B) and insert-  
14 ing “RELATED PRIVATE BUSINESS USE”, and

15           (E) by striking “GOVERNMENT USE” in the  
16 heading thereof and inserting “EXEMPT PERSON  
17 USE”.

18           (2) Subparagraph (A) of section 141(b)(6) is  
19 amended by striking “a governmental unit” and in-  
20 serting “an exempt person”.

21           (3) Paragraph (7) of section 141(b) is amend-  
22 ed—

23           (A) by striking “government use” and in-  
24 serting “exempt person use”, and

1 (B) by striking “GOVERNMENT USE” in  
2 the heading thereof and inserting “EXEMPT  
3 PERSON USE”.

4 (4) Section 141(b) is amended by striking para-  
5 graph (9).

6 (5) Paragraph (1) of section 141(c) is amended  
7 by striking “governmental units” and inserting “ex-  
8 empt persons”.

9 (6) Section 141 is amended by redesignating  
10 subsection (e) as subsection (f) and by inserting  
11 after subsection (d) the following new subsection:

12 “(e) CERTAIN ISSUES USED TO PROVIDE RESIDEN-  
13 TIAL RENTAL HOUSING FOR FAMILY UNITS.—

14 “(1) IN GENERAL.—Except as provided in para-  
15 graph (2), for purposes of this title, the term ‘pri-  
16 vate activity bond’ includes any bond issued as part  
17 of an issue if any portion of the net proceeds of the  
18 issue are to be used (directly or indirectly) by an ex-  
19 empt person described in section 150(a)(2)(A)(ii) to  
20 provide residential rental property for family units.  
21 This paragraph shall not apply if the bond would  
22 not be a private activity bond if the section  
23 501(c)(3) organization were not an exempt person.

24 “(2) EXCEPTION FOR BONDS USED TO PROVIDE  
25 QUALIFIED RESIDENTIAL RENTAL PROJECTS.—

1 Paragraph (1) shall not apply to any bond issued as  
2 part of an issue if the portion of such issue which  
3 is to be used as described in paragraph (1) is to be  
4 used to provide—

5 “(A) a residential rental property for fam-  
6 ily units if the first use of such property is pur-  
7 suant to such issue,

8 “(B) qualified residential rental projects  
9 (as defined in section 142(d)), or

10 “(C) property which is to be substantially  
11 rehabilitated in a rehabilitation beginning with-  
12 in the 2-year period ending 1 year after the  
13 date of the acquisition of such property.

14 “(3) SUBSTANTIAL REHABILITATION.—

15 “(A) IN GENERAL.—Except as provided in  
16 subparagraph (B), rules similar to the rules of  
17 section 47(e)(1)(C) shall apply in determining  
18 for purposes of paragraph (2)(C) whether prop-  
19 erty is substantially rehabilitated.

20 “(B) EXCEPTION.—For purposes of sub-  
21 subparagraph (A), clause (ii) of section 47(e)(1)(C)  
22 shall not apply, but the Secretary may extend  
23 the 24-month period in section 47(e)(1)(C)(i)  
24 where appropriate due to circumstances not  
25 within the control of the owner.

1           “(4) CERTAIN PROPERTY TREATED AS NEW  
2 PROPERTY.—Solely for purposes of determining  
3 under paragraph (2)(A) whether the 1st use of prop-  
4 erty is pursuant to tax-exempt financing—

5                   “(A) IN GENERAL.—If—

6                           “(i) the 1st use of property is pursu-  
7 ant to taxable financing,

8                           “(ii) there was a reasonable expecta-  
9 tion (at the time such taxable financing  
10 was provided) that such financing would be  
11 replaced by tax-exempt financing, and

12                           “(iii) the taxable financing is in fact  
13 so replaced within a reasonable period  
14 after the taxable financing was provided,

15 then the 1st use of such property shall be treat-  
16 ed as being pursuant to the tax-exempt financ-  
17 ing.

18                   “(B) SPECIAL RULE WHERE NO OPER-  
19 ATING STATE OR LOCAL PROGRAM FOR TAX-EX-  
20 EMPT FINANCING.—If, at the time of the 1st  
21 use of property, there was no operating State or  
22 local program for tax-exempt financing of the  
23 property, the 1st use of the property shall be  
24 treated as pursuant to the 1st tax-exempt fi-  
25 nancing of the property.

1           “(C) DEFINITIONS.—For purposes of this  
2 paragraph:

3           “(i) TAX-EXEMPT FINANCING.—The  
4 term ‘tax-exempt financing’ means financ-  
5 ing provided by tax-exempt bonds.

6           “(ii) TAXABLE FINANCING.—The  
7 term ‘taxable financing’ means financing  
8 which is not tax-exempt financing.”

9           (7) Section 141(f), as redesignated by para-  
10 graph (6), is amended—

11           (A) by adding “or” at the end of subpara-  
12 graph (E),

13           (B) by striking “, or” at the end of sub-  
14 paragraph (F), and inserting in lieu thereof a  
15 period, and

16           (C) by striking subparagraph (G).

17           (8) The last sentence of section 144(b)(1) is  
18 amended by striking “(determined” and all that fol-  
19 lows to the period.

20           (9) Clause (ii) of section 144(c)(2)(C) is  
21 amended by striking “a governmental unit” and in-  
22 serting “an exempt person”.

23           (10) Section 146(g) is amended—

24           (A) by striking paragraph (2), and

1           (B) by redesignating the remaining para-  
2           graphs after paragraph (1) as paragraphs (2)  
3           and (3), respectively.

4           (11) The heading of section 146(k)(3) is  
5           amended by striking “GOVERNMENTAL” and insert-  
6           ing “EXEMPT PERSON”.

7           (12) The heading of section 146(m) is amended  
8           by striking “GOVERNMENT” and inserting “EXEMPT  
9           PERSON”.

10          (13) Subsection (h) of section 147 is amended  
11          to read as follows:

12          “(h) CERTAIN RULES NOT TO APPLY TO MORTGAGE  
13 REVENUE BONDS AND QUALIFIED STUDENT LOAN  
14 BONDS.—Subsections (a), (b), (c), and (d) shall not apply  
15 to any qualified mortgage bond, qualified veterans’ mort-  
16 gage bond, or qualified student loan bond.”

17          (14) Section 147 is amended by striking para-  
18          graph (4) of subsection (b) and redesignating para-  
19          graph (5) of such subsection as paragraph (4).

20          (15) Subparagraph (F) of section 148(d)(3) is  
21          amended—

22                  (A) by striking “or which is a qualified  
23                  501(c)(3) bond”, and

1 (B) by striking “GOVERNMENTAL USE  
2 BONDS AND QUALIFIED 501(c)(3)” in the heading  
3 thereof and inserting “EXEMPT PERSON”.

4 (16) Subclause (II) of section 148(f)(4)(B)(ii)  
5 is amended by striking “(other than a qualified  
6 501(c)(3) bond)”.

7 (17) Clause (iv) of section 148(f)(4)(C) is  
8 amended—

9 (A) by striking “a governmental unit or a  
10 501(c)(3) organization” each place it appears  
11 and inserting “an exempt person”,

12 (B) by striking “qualified 501(c)(3)  
13 bonds,” and

14 (C) by striking the comma after “private  
15 activity bonds” the first place it appears.

16 (18) Subparagraph (A) of section 148(f)(7) is  
17 amended by striking “(other than a qualified  
18 501(c)(3) bond)”.

19 (19) Paragraph (2) of section 149(d) is amend-  
20 ed—

21 (A) by striking “(other than a qualified  
22 501(c)(3) bond)”, and

23 (B) by striking “CERTAIN PRIVATE” in the  
24 heading thereof and inserting “PRIVATE”.

25 (20) Section 149(e)(2) is amended—

1 (A) by striking “which is not a private ac-  
2 tivity bond” in the second sentence and insert-  
3 ing “which is a bond issued for an exempt per-  
4 son described in section 150(a)(2)(A)(i)”, and

5 (B) by adding at the end the following new  
6 sentence: “Subparagraph (D) shall not apply to  
7 any bond which is not a private activity bond  
8 but which would be such a bond if the  
9 501(c)(3) organization using the proceeds  
10 thereof were not an exempt person.”

11 (21) The heading of subsection (b) of section  
12 150 is amended by striking “TAX-EXEMPT PRIVATE  
13 ACTIVITY BONDS” and inserting “CERTAIN TAX-EX-  
14 EMPT BONDS”.

15 (22) Paragraph (3) of section 150(b) is  
16 amended—

17 (A) by inserting “owned by a 501(c)(3) or-  
18 ganization” after “any facility” in subpara-  
19 graph (A),

20 (B) by striking “any private activity bond  
21 which, when issued, purported to be a tax-ex-  
22 empt qualified 501(c)(3) bond” in subpara-  
23 graph (A) and inserting “any bond which, when  
24 issued, purported to be a tax-exempt bond, and  
25 which would be a private activity bond if the

1           501(c)(3) organization using the proceeds  
2           thereof were not an exempt person”, and

3           (C) by striking the heading thereof and in-  
4           serting “BONDS FOR EXEMPT PERSONS OTHER  
5           THAN GOVERNMENTAL UNITS.—”.

6           (23) Paragraph (5) of section 150(b) is  
7           amended—

8           (A) by striking “private activity” in sub-  
9           paragraph (A),

10          (B) by inserting “and which would be a  
11          private activity bond if the 501(c)(3) organiza-  
12          tion using the proceeds thereof were not an ex-  
13          empt person” after “tax-exempt bond” in sub-  
14          paragraph (A),

15          (C) by striking subparagraph (B) and in-  
16          serting the following new subparagraph:

17          “(B) such facility is required to be owned  
18          by an exempt person, and”, and

19          (D) by striking “GOVERNMENTAL UNITS  
20          OR 501(c)(3) ORGANIZATIONS” in the heading  
21          thereof and inserting “EXEMPT PERSONS”.

22          (24) Section 150 is amended by adding at the  
23          end the following new subsection:

24          “(f) CERTAIN RULES TO APPLY TO BONDS FOR EX-  
25          EMPT PERSONS OTHER THAN GOVERNMENTAL UNITS.—

1           “(1) IN GENERAL.—Nothing in section 103(a)  
2           or any other provision of law shall be construed to  
3           provide an exemption from Federal income tax for  
4           interest on any bond which would be a private activ-  
5           ity bond if the 501(c)(3) organization using the pro-  
6           ceeds thereof were not an exempt person unless such  
7           bond satisfies the requirements of subsections (b)  
8           and (f) of section 147.

9           “(2) SPECIAL RULE FOR POOLED FINANCING  
10          OF 501(c)(3) ORGANIZATION.—

11           “(A) IN GENERAL.—At the election of the  
12           issuer, a bond described in paragraph (1) shall  
13           be treated as meeting the requirements of sec-  
14           tion 147(b) if such bond meets the require-  
15           ments of subparagraph (B).

16           “(B) REQUIREMENTS.—A bond meets the  
17           requirements of this subparagraph if—

18           “(i) 95 percent or more of the net  
19           proceeds of the issue of which such bond is  
20           a part are to be used to make or finance  
21           loans to 2 or more 501(c)(3) organizations  
22           or governmental units for acquisition of  
23           property to be used by such organizations,

24           “(ii) each loan described in clause (i)  
25           satisfies the requirements of section 147(b)

1 (determined by treating each loan as a sep-  
2 arate issue),

3 “(iii) before such bond is issued, a de-  
4 mand survey was conducted which shows a  
5 demand for financing greater than an  
6 amount equal to 120 percent of the  
7 lendable proceeds of such issue, and

8 “(iv) 95 percent or more of the net  
9 proceeds of such issue are to be loaned to  
10 501(c)(3) organizations or governmental  
11 units within 1 year of issuance and, to the  
12 extent there are any unspent proceeds  
13 after such 1-year period, bonds issued as  
14 part of such issue are to be redeemed as  
15 soon as possible thereafter (and in no  
16 event later than 18 months after issuance).

17 A bond shall not meet the requirements of this  
18 subparagraph if the maturity date of any bond  
19 issued as part of such issue is more than 30  
20 years after the date on which the bond was  
21 issued (or, in the case of a refunding or series  
22 of refundings, the date on which the original  
23 bond was issued).”

24 (25) Section 1302 of the Tax Reform Act of  
25 1986 is repealed.

1           (26) Subparagraph (C) of section 57(a)(5) is  
2 amended by striking clause (ii) and redesignating  
3 clauses (iii) and (iv) as clauses (ii) and (iii), respec-  
4 tively.

5           (27) Paragraph (3) of section 103(b) is amend-  
6 ed by inserting “and section 150(f)” after “section  
7 149”.

8           (28) Paragraph (3) of section 265(b) is amend-  
9 ed—

10                   (A) by striking clause (ii) of subparagraph  
11 (B) and inserting the following:

12                           “(ii) CERTAIN BONDS NOT TREATED  
13 AS PRIVATE ACTIVITY BONDS.—For pur-  
14 poses of clause (i)(II), there shall not be  
15 treated as a private activity bond any obli-  
16 gation issued to refund (or which is part of  
17 a series of obligations issued to refund) an  
18 obligation issued before August 8, 1986,  
19 which was not an industrial development  
20 bond (as defined in section 103(b)(2) as in  
21 effect on the day before the date of the en-  
22 actment of the Tax Reform Act of 1986)  
23 or a private loan bond (as defined in sec-  
24 tion 103(o)(2)(A), as so in effect, but with-  
25 out regard to any exemption from such

1 definition other than section  
 2 103(o)(2)(A).”; and  
 3 (B) by striking “(other than a qualified  
 4 501(c)(3) bond, as defined in section 145)” in  
 5 subparagraph (C)(ii)(I).

6 (d) EFFECTIVE DATE.—The amendments made by  
 7 this section shall apply to bonds (including refunding  
 8 bonds) issued after December 31, 1994.

9 **Subtitle D—Tax Treatment of**  
 10 **Long-Term Care Insurance and**  
 11 **Services**

12 **SEC. 7401. QUALIFIED LONG-TERM CARE SERVICES TREAT-**  
 13 **ED AS MEDICAL CARE.**

14 (a) GENERAL RULE.—Paragraph (1) of section  
 15 213(d) (defining medical care) is amended by striking  
 16 “or” at the end of subparagraph (B), by redesignating  
 17 subparagraph (C) as subparagraph (D), and by inserting  
 18 after subparagraph (B) the following new subparagraph:

19 “(C) for qualified long-term care services  
 20 (as defined in subsection (g)), or”.

21 (b) QUALIFIED LONG-TERM CARE SERVICES DE-  
 22 FINED.—Section 213 (relating to the deduction for med-  
 23 ical, dental, etc., expenses) is amended by adding at the  
 24 end the following new subsection:

1       “(g) QUALIFIED LONG-TERM CARE SERVICES.—For  
2 purposes of this section—

3           “(1) IN GENERAL.—The term ‘qualified long-  
4 term care services’ means necessary diagnostic, cur-  
5 ing, mitigating, treating, preventive, therapeutic, and  
6 rehabilitative services, and maintenance and per-  
7 sonal care services (whether performed in a residen-  
8 tial or nonresidential setting) which—

9           “(A) are required by an individual during  
10 any period the individual is an incapacitated in-  
11 dividual (as defined in paragraph (2)),

12           “(B) have as their primary purpose—

13           “(i) the provision of needed assistance  
14 with 1 or more activities of daily living (as  
15 defined in paragraph (3)), or

16           “(ii) protection from threats to health  
17 and safety due to severe cognitive impair-  
18 ment, and

19           “(C) are provided pursuant to a continuing  
20 plan of care prescribed by a licensed profes-  
21 sional (as defined in paragraph (4)).

22           “(2) INCAPACITATED INDIVIDUAL.—The term  
23 ‘incapacitated individual’ means any individual  
24 who—

1           “(A) is unable to perform, without sub-  
2           stantial assistance from another individual (in-  
3           cluding assistance involving cueing or substan-  
4           tial supervision), at least 2 activities of daily  
5           living as defined in paragraph (3), or

6           “(B) has severe cognitive impairment as  
7           defined by the Secretary in consultation with  
8           the Secretary of Health and Human Services.

9           Such term shall not include any individual otherwise  
10          meeting the requirements of the preceding sentence  
11          unless a licensed professional within the preceding  
12          12-month period has certified that such individual  
13          meets such requirements.

14          “(3) ACTIVITIES OF DAILY LIVING.—Each of  
15          the following is an activity of daily living:

16                 “(A) Eating.

17                 “(B) Toileting.

18                 “(C) Transferring.

19                 “(D) Bathing.

20                 “(E) Dressing.

21          “(4) LICENSED PROFESSIONAL.—The term ‘li-  
22          censed professional’ means—

23                 “(A) a physician or registered professional  
24                 nurse, or

1           “(B) any other individual who meets such  
2 requirements as may be prescribed by the Sec-  
3 retary after consultation with the Secretary of  
4 Health and Human Services.

5           “(5) CERTAIN SERVICES NOT INCLUDED.—The  
6 term ‘qualified long-term care services’ shall not in-  
7 clude any services provided to an individual—

8           “(A) by a relative (directly or through a  
9 partnership, corporation, or other entity) unless  
10 the relative is a licensed professional with re-  
11 spect to such services, or

12           “(B) by a corporation or partnership which  
13 is related (within the meaning of section 267(b)  
14 or 707(b)) to the individual.

15 For purposes of this paragraph, the term ‘relative’  
16 means an individual bearing a relationship to the in-  
17 dividual which is described in paragraphs (1)  
18 through (8) of section 152(a).”

19 (c) TECHNICAL AMENDMENTS.—

20           (1) Subparagraph (D) of section 213(d)(1) (as  
21 redesignated by subsection (a)) is amended to read  
22 as follows:

23           “(D) for insurance (including amounts  
24 paid as premiums under part B of title XVIII  
25 of the Social Security Act, relating to supple-

1           mentary medical insurance for the aged) cov-  
 2           ering medical care referred to in—

3                   “(i) subparagraphs (A) and (B), or

4                   “(ii) subparagraph (C), but only if  
 5                   such insurance is provided under a quali-  
 6                   fied long-term care insurance policy (as de-  
 7                   fined in section 7702B(b)) and the amount  
 8                   paid for such insurance is not disallowed  
 9                   under section 7702B(d)(4).”

10           (2) Paragraph (6) of section 213(d) is amend-  
 11           ed—

12                   (A) by striking “subparagraphs (A) and  
 13                   (B)” and inserting “subparagraph (A), (B),  
 14                   and (C)”, and

15                   (B) by striking “paragraph (1)(C)” in sub-  
 16                   paragraph (A) and inserting “paragraph  
 17                   (1)(D)”.

18           (d) EFFECTIVE DATE.—The amendments made by  
 19           this section shall apply to taxable years beginning after  
 20           December 31, 1995.

21           **SEC. 7402. TREATMENT OF LONG-TERM CARE INSURANCE.**

22           (a) GENERAL RULE.—Chapter 79 (relating to defini-  
 23           tions) is amended by inserting after section 7702A the fol-  
 24           lowing new section:

1 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSUR-**  
2 **ANCE.**

3 “(a) IN GENERAL.—For purposes of this title—

4 “(1) a qualified long-term care insurance policy  
5 (as defined in subsection (b)) shall be treated as an  
6 accident or health insurance contract,

7 “(2) amounts (other than policyholder dividends  
8 (as defined in section 808) or premium refunds) re-  
9 ceived under a qualified long-term care insurance  
10 policy shall be treated as amounts received for per-  
11 sonal injuries and sickness and shall be treated as  
12 reimbursement for expenses actually incurred for  
13 medical care (as defined in section 213(d)),

14 “(3) any plan of an employer providing cov-  
15 erage under a qualified long-term care insurance pol-  
16 icy shall be treated as an accident or health plan  
17 with respect to such coverage,

18 “(4) except as provided in subsection (d)(4),  
19 amounts paid for a qualified long-term care insur-  
20 ance policy providing the benefits described in sub-  
21 section (b)(6)(B) shall be treated as payments made  
22 for insurance for purposes of section 213(d)(1)(D),  
23 and

24 “(5) a qualified long-term care insurance policy  
25 shall be treated as a guaranteed renewable contract  
26 subject to the rules of section 816(e).

1       “(b) QUALIFIED LONG-TERM CARE INSURANCE POL-  
2 ICY.—For purposes of this title:

3           “(1) IN GENERAL.—The term ‘qualified long-  
4 term care insurance policy’ means any certified long-  
5 term care policy (as defined in section 1011(4)(A))  
6 of the Health Security Act) that—

7           “(A) limits benefits under such policy to  
8 individuals who are certified by a licensed pro-  
9 fessional (as defined in section 213(g)(4)) with-  
10 in the preceding 12-month period—

11           “(i) as being unable to perform, with-  
12 out substantial assistance from another in-  
13 dividual (including assistance involving  
14 cueing or substantial supervision), 2 or  
15 more activities of daily living (as defined in  
16 section 213(g)(3)), or

17           “(ii) having a severe cognitive impair-  
18 ment (as defined in section 213(g)(2)(B)),  
19 and

20           “(B) satisfies the requirements of para-  
21 graphs (2), (3), (4), (5), and (6).

22           “(2) PREMIUM REQUIREMENTS.—The require-  
23 ments of this paragraph are met with respect to a  
24 policy if such policy provides that premium pay-  
25 ments may not be made earlier than the date such

1 payments would have been made if the contract pro-  
2 vided for level annual payments over the life expect-  
3 ancy of the insured or 20 years, whichever is short-  
4 er. A policy shall not be treated as failing to meet  
5 the requirements of the preceding sentence solely by  
6 reason of a provision in the policy providing for a  
7 waiver of premiums if the insured becomes an indi-  
8 vidual certified in accordance with paragraph (1)(A).

9 “(3) PROHIBITION OF CASH VALUE.—The re-  
10 quirements of this paragraph are met if the policy  
11 does not provide for a cash value or other money  
12 that can be paid, assigned, pledged as collateral for  
13 a loan, or borrowed, other than as provided in para-  
14 graph (4).

15 “(4) REFUNDS OF PREMIUMS AND DIVI-  
16 DENDS.—The requirements of this paragraph are  
17 met with respect to a policy if such policy provides  
18 that—

19 “(A) policyholder dividends are required to  
20 be applied as a reduction in future premiums  
21 or, to the extent permitted under paragraph  
22 (6), to increase benefits described in subsection  
23 (a)(2),

24 “(B) refunds of premiums upon a partial  
25 surrender or a partial cancellation are required

1 to be applied as a reduction in future pre-  
2 miums, and

3 “(C) any refund on the death of the in-  
4 sured, or on a complete surrender or cancella-  
5 tion of the policy, cannot exceed the aggregate  
6 premiums paid under the contract.

7 Any refund on a complete surrender or cancellation  
8 of the policy shall be includible in gross income to  
9 the extent that any deduction or exclusion was allow-  
10 able with respect to the premiums.

11 “(5) COORDINATION WITH OTHER ENTITLED-  
12 MENTS.—The requirements of this paragraph are  
13 met with respect to a policy if such policy does not  
14 pay, or provide reimbursement for, expenses in-  
15 curred to the extent that such expenses are also paid  
16 or reimbursed under title XVIII of the Social Secu-  
17 rity Act or are paid or reimbursed under a certified  
18 standard health plan (as defined in section  
19 1011(2)(A)) of the Health Security Act).

20 “(6) MAXIMUM BENEFIT.—

21 “(A) IN GENERAL.—The requirements of  
22 this paragraph are met if the benefits payable  
23 under the policy for any period (whether on a  
24 periodic basis or otherwise) may not exceed the  
25 dollar amount in effect for such period.

1           “(B) NONREIMBURSEMENT PAYMENTS  
2 PERMITTED.—Benefits shall include all pay-  
3 ments described in subsection (a)(2) to or on  
4 behalf of an insured individual without regard  
5 to the expenses incurred during the period to  
6 which the payments relate. For purposes of sec-  
7 tion 213(a), such payments shall be treated as  
8 compensation for expenses paid for medical  
9 care.

10           “(C) DOLLAR AMOUNT.—The dollar  
11 amount in effect under this paragraph shall be  
12 \$150 per day (or the equivalent amount within  
13 the calendar year in the case of payments on  
14 other than a per diem basis).

15           “(D) ADJUSTMENTS FOR INCREASED  
16 COSTS.—

17           “(i) IN GENERAL.—In the case of any  
18 calendar year after 1996, the dollar  
19 amount in effect under subparagraph (C)  
20 for any period or portion thereof occurring  
21 during such calendar year shall be equal to  
22 the sum of—

23                   “(I) the amount in effect under  
24                   subparagraph (C) for the preceding

1 calendar year (after application of this  
2 subparagraph), plus

3 “(II) the product of the amount  
4 referred to in subclause (I) multiplied  
5 by the cost-of-living adjustment for  
6 the calendar year.

7 “(ii) COST-OF-LIVING ADJUSTMENT.—  
8 For purposes of clause (i), the cost-of-liv-  
9 ing adjustment for any calendar year is the  
10 percentage (if any) by which the cost index  
11 under clause (iii) for the preceding cal-  
12 endar year exceeds such index for the sec-  
13 ond preceding calendar year.

14 “(iii) COST INDEX.—The Secretary, in  
15 consultation with the Secretary of Health  
16 and Human Services, shall before January  
17 1, 1997, establish a cost index to measure  
18 increases in costs of nursing home and  
19 similar facilities. The Secretary may from  
20 time to time revise such index to the extent  
21 necessary to accurately measure increases  
22 or decreases in such costs.

23 “(iv) SPECIAL RULE FOR CALENDAR  
24 YEAR 1997.—Notwithstanding clause (ii),  
25 for purposes of clause (i), the cost-of-living

1 adjustment for calendar year 1997 is the  
2 sum of 1.5 percent plus the percentage by  
3 which the CPI for calendar year 1996 (as  
4 defined in section 1(f)(4)) exceeds the CPI  
5 for calendar year 1995 (as so defined).

6 “(E) PERIOD.—For purposes of this para-  
7 graph, a period begins on the date that an indi-  
8 vidual has a condition which would qualify for  
9 certification under subsection (b)(1)(A) and  
10 ends on the earlier of the date upon which—

11 “(i) such individual has not been so  
12 certified within the preceding 12-months,  
13 or

14 “(ii) the individual’s condition ceases  
15 to be such as to qualify for certification  
16 under subsection (b)(1)(A).

17 “(F) AGGREGATION RULE.—For purposes  
18 of this paragraph, all policies issued with re-  
19 spect to the same insured shall be treated as  
20 one policy.

21 “(c) TREATMENT OF LONG-TERM CARE INSURANCE  
22 POLICIES.—For purposes of this title, any amount re-  
23 ceived or coverage provided under a long-term care insur-  
24 ance policy that is not a qualified long-term care insurance  
25 policy shall not be treated as an amount received for per-

1 sonal injuries or sickness or provided under an accident  
2 or health plan and shall not be treated as excludible from  
3 gross income under any provision of this title.

4 “(d) TREATMENT OF COVERAGE PROVIDED AS PART  
5 OF A LIFE INSURANCE CONTRACT.—Except as otherwise  
6 provided in regulations prescribed by the Secretary, in the  
7 case of any long-term care insurance coverage (whether  
8 or not qualified) provided by rider on a life insurance con-  
9 tract—

10 “(1) IN GENERAL.—This section shall apply as  
11 if the portion of the contract providing such cov-  
12 erage is a separate contract or policy.

13 “(2) PREMIUMS AND CHARGES FOR LONG-TERM  
14 CARE COVERAGE.—Premium payments for coverage  
15 under a long-term care insurance policy and charges  
16 against the life insurance contract’s cash surrender  
17 value (within the meaning of section 7702(f)(2)(A))  
18 for such coverage shall be treated as premiums for  
19 purposes of subsection (b)(2).

20 “(3) APPLICATION OF SECTION 7702.—Section  
21 7702(c)(2) (relating to the guideline premium limi-  
22 tation) shall be applied by increasing the guideline  
23 premium limitation with respect to a life insurance  
24 contract, as of any date—

1           “(A) by the sum of any charges (but not  
2 premium payments) described in paragraph (2)  
3 made to that date under the contract, less

4           “(B) any such charges the imposition of  
5 which reduces the premiums paid for the con-  
6 tract (within the meaning of section  
7 7702(f)(1)).

8           “(4) APPLICATION OF SECTION 213.—No deduc-  
9 tion shall be allowed under section 213(a) for  
10 charges against the life insurance contract’s cash  
11 surrender value described in paragraph (2), unless  
12 such charges are includible in income as a result of  
13 the application of section 72(e)(10) and the coverage  
14 provided by the rider is a qualified long-term care  
15 insurance policy under subsection (b).

16           “(5) AMOUNT OF DISTRIBUTION UNDER  
17 RIDER.—This subsection shall not apply to any rider  
18 on a life insurance contract unless the percentage re-  
19 duction in the cash surrender value of the contract  
20 by reason of any payment under the rider does not  
21 exceed the percentage reduction in the death benefit  
22 payable under the contract by reason of the pay-  
23 ment.

24 For purposes of this subsection, the term ‘portion’ means  
25 only the terms and benefits under a life insurance contract

1 that are in addition to the terms and benefits under the  
2 contract without regard to the coverage under a long-term  
3 care insurance policy, except that the coverage under a  
4 rider described in this subsection shall not fail to be treat-  
5 ed as such an addition by reason of a reduction in the  
6 contract's death benefit or cash surrender value resulting  
7 from any payment under the rider.

8       “(e) REGULATIONS.—The Secretary shall prescribe  
9 such regulations as may be necessary to carry out the re-  
10 quirements of this section, including regulations to prevent  
11 the avoidance of this section by providing long-term care  
12 insurance coverage under a life insurance contract and to  
13 provide for the proper allocation of amounts between the  
14 long-term care and life insurance portions of a contract.”

15       (b) CAFETERIA PLANS.—Section 125(f) is amended  
16 by adding at the end the following new sentence: “Such  
17 term does not include any coverage or benefits under a  
18 qualified long-term care policy (as defined in section  
19 7702B).”

20       (c) RESERVES.—Clause (iii) of section 807(d)(3)(A)  
21 is amended by inserting “(other than a qualified long-term  
22 care insurance policy within the meaning of section  
23 7702(B))” after “contract”.

1 (d) CLERICAL AMENDMENT.—The table of sections  
2 for chapter 79 is amended by inserting after the item re-  
3 lating to section 7702A the following new item:

“Sec. 7702B. Treatment of long-term care insurance.”

4 (e) EFFECTIVE DATE.—

5 (1) IN GENERAL.—The amendments made by  
6 this section shall apply to policies issued after De-  
7 cember 31, 1995, except that a policy issued before  
8 January 1, 1996, which, on January 1, 1996, satis-  
9 fies the requirements of a qualified long-term care  
10 insurance policy as set forth in section 7702B(b) of  
11 the Internal Revenue Code of 1986 shall be treated  
12 as having been issued on January 1, 1996.

13 (2) TRANSITION RULE.—If, after the date of  
14 enactment of this Act and before January 1, 1996,  
15 a policy providing for long-term care insurance cov-  
16 erage is exchanged solely for a qualified long-term  
17 care insurance policy (as defined in section  
18 7702B(b) of such code), no gain or loss shall be rec-  
19 ognized on the exchange, except that gain (if any)  
20 shall be recognized to the extent of the sum of the  
21 money and the fair market value of the other prop-  
22 erty received. For purposes of this paragraph, the  
23 cancellation of a policy providing for long-term care  
24 insurance coverage and reinvestment of the cancella-  
25 tion proceeds in a qualified long-term care insurance

1 policy within 60 days thereafter shall be treated as  
2 an exchange.

3 (3) ISSUANCE OF RIDER NOT TREATED AS MA-  
4 TERIAL CHANGE.—For purposes of applying section  
5 101(f), 7702, or 7702A of such Code to any con-  
6 tract, the issuance of a rider on a life insurance con-  
7 tract providing long-term care insurance coverage  
8 shall not be treated as a modification or material  
9 change of such contract.

10 **SEC. 7403. TAX TREATMENT OF ACCELERATED DEATH BEN-**  
11 **EFITS UNDER LIFE INSURANCE CONTRACTS.**

12 (a) GENERAL RULE.—Section 101 (relating to cer-  
13 tain death benefits) is amended by adding at the end the  
14 following new subsection:

15 “(g) TREATMENT OF CERTAIN ACCELERATED  
16 DEATH BENEFITS.—

17 “(1) IN GENERAL.—For purposes of this sec-  
18 tion, any amount received under a life insurance  
19 contract on the life of an insured who is a terminally  
20 ill individual shall be treated as an amount paid by  
21 reason of the death of such insured.

22 “(2) NECESSARY CONDITIONS.—

23 “(A) IN GENERAL.—Paragraph (1) shall  
24 not apply to any amount received unless—

1           “(i) the total amount received is not  
2           less than the present value (determined  
3           under subparagraph (B)) of the reduction  
4           in the death benefit otherwise payable in  
5           the event of the death of the insured, and

6           “(ii) the percentage reduction in the  
7           cash surrender value of the contract by  
8           reason of the distribution does not exceed  
9           the percentage reduction in the death ben-  
10          efit payable under the contract by reason  
11          of such distribution.

12          “(B) PRESENT VALUE.—The present value  
13          of the reduction in the death benefit shall be  
14          determined by—

15                 “(i) using a discount rate which is  
16                 based on an interest rate which does not  
17                 exceed the highest interest rate set forth in  
18                 subparagraph (C), and

19                 “(ii) assuming that the death benefit  
20                 (or the portion thereof) would have been  
21                 paid on the date which is 12 months after  
22                 the date of the certification referred to in  
23                 paragraph (3).

24          “(C) RATES.—The interest rates set forth  
25          in this subparagraph are the following:

1 “(i) the 90-day Treasury bill yield,

2 “(ii) the rate described as Moody’s  
3 Corporate Bond Yield Average-Monthly  
4 Average Corporates as published by  
5 Moody’s Investors Service, Inc., or any  
6 successor thereto, for the calendar month  
7 ending 2 months before the date on which  
8 the rate is determined, and

9 “(iii) the rate used to compute the  
10 cash surrender values under the contract  
11 during the applicable period plus 1 percent  
12 per annum.

13 “(D) SPECIAL RULES RELATING TO  
14 LIENS.—If a lien is imposed against a life in-  
15 surance contract with respect to any amount re-  
16 ferred to in paragraph (1)—

17 “(i) for purposes of subparagraph (A),  
18 the amount of such lien shall be treated as  
19 a reduction (at the time of receipt) in the  
20 death benefit or cash surrender value to  
21 the extent that such benefit or value, as  
22 the case may be, is (or may become) sub-  
23 ject to the lien, and

24 “(ii) paragraph (1) shall not apply to  
25 the amount received unless any rate of in-

1           terest with respect to any amount in con-  
2           nection with which such lien is imposed  
3           does not exceed the highest rate set forth  
4           in subparagraph (C).

5           “(3) TERMINALLY ILL INDIVIDUAL.—For pur-  
6           poses of this subsection, the term ‘terminally ill indi-  
7           vidual’ means an individual who the insurer has de-  
8           termined, after receipt of an acceptable certification  
9           by a licensed physician, has an illness or physical  
10          condition which can reasonably be expected to result  
11          in death within 12 months after the date of certifi-  
12          cation.

13          “(4) EXCEPTION FOR BUSINESS-RELATED POLI-  
14          CIES.—This subsection shall not apply in the case of  
15          any amount paid to any taxpayer other than the in-  
16          sured if such taxpayer has an insurable interest with  
17          respect to the life of the insured by reason of the in-  
18          sured being a director, officer, or employee of the  
19          taxpayer or by reason of the insured having a finan-  
20          cial interest in any trade or business carried on by  
21          the taxpayer.”

22          (b) EFFECTIVE DATES.—

23                 (1) IN GENERAL.—Except as provided in para-  
24          graph (2), the amendment made by this section shall

1 apply to amounts received after the date of the en-  
2 actment of this Act.

3 (2) DELAY IN APPLICATION OF DISCOUNT  
4 RULES.—Clause (i) of section 101(g)(2)(A) of the  
5 Internal Revenue Code of 1986 shall not apply to  
6 any amount received before January 1, 1995.

7 (3) ISSUANCE OF RIDER NOT TREATED AS MA-  
8 TERIAL CHANGE.—For purposes of applying section  
9 101(f), 7702, or 7702A of the Internal Revenue  
10 Code of 1986 to any contract, the issuance of a  
11 qualified accelerated death benefit rider (as defined  
12 in section 818(g) of such Code (as added by this  
13 Act)) shall not be treated as a modification or mate-  
14 rial change of such contract.

15 **SEC. 7404. TAX TREATMENT OF COMPANIES ISSUING**  
16 **QUALIFIED ACCELERATED DEATH BENEFIT**  
17 **RIDERS.**

18 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-  
19 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-  
20 ing to other definitions and special rules) is amended by  
21 adding at the end the following new subsection:

22 “(g) QUALIFIED ACCELERATED DEATH BENEFIT  
23 RIDERS TREATED AS LIFE INSURANCE.—For purposes of  
24 this part—

1           “(1) IN GENERAL.—Any reference to a life in-  
2           surance contract shall be treated as including a ref-  
3           erence to a qualified accelerated death benefit rider  
4           on such contract.

5           “(2) QUALIFIED ACCELERATED DEATH BEN-  
6           EFIT RIDERS.—For purposes of this subsection, the  
7           term ‘qualified accelerated death benefit rider’  
8           means any rider on a life insurance contract which  
9           provides for a distribution to an individual upon the  
10          insured becoming a terminally ill individual (as de-  
11          fined in section 101(g)(3)).”

12          (b) EFFECTIVE DATE.—The amendments made by  
13          this section shall take effect on January 1, 1995.

## 14                   **Subtitle E—Other Revenue** 15                   **Provisions**

### 16           **PART 1—EMPLOYMENT STATUS PROVISIONS**

#### 17   **SEC. 7501. EMPLOYMENT STATUS PROPOSAL REQUIRED** 18                   **FROM DEPARTMENT OF THE TREASURY.**

19           Not later than January 1, 1996, the Secretary of the  
20          Treasury shall submit to the Committee on Ways and  
21          Means of the House of Representatives and the Committee  
22          on Finance of the Senate a legislative proposal providing  
23          statutory standards for the classification of workers as  
24          employees or independent contractors.

1 **SEC. 7502. INCREASE IN SERVICES REPORTING PENALTIES.**

2 (a) INCREASE IN PENALTY.—Section 6721(a) (relat-  
3 ing to imposition of penalty) is amended by adding at the  
4 end the following new paragraph:

5 “(3) INCREASED PENALTY FOR RETURNS IN-  
6 VOLVING PAYMENTS FOR SERVICES.—

7 “(A) IN GENERAL.—Subject to the overall  
8 limitation of paragraph (1), the amount of the  
9 penalty under paragraph (1) for any failure  
10 with respect to any applicable return shall be  
11 equal to the greater of \$50 or 5 percent of the  
12 amount required to be reported correctly but  
13 not so reported.

14 “(B) EXCEPTION WHERE SUBSTANTIAL  
15 COMPLIANCE.—Subparagraph (A) shall not  
16 apply to failures with respect to applicable re-  
17 turns required to be filed by a person during  
18 any calendar year if the aggregate amount  
19 which is timely and correctly reported on appli-  
20 cable returns filed by the person for the cal-  
21 endar year is at least 97 percent of the aggre-  
22 gate amount which is required to be reported  
23 on applicable returns by the person for the cal-  
24 endar year.

25 “(C) APPLICABLE RETURN.—For purposes  
26 of this paragraph, the term ‘applicable return’

1 means any information return required to be  
2 filed under—

3 “(i) section 6041(a) but only if such  
4 return relates to payments to any person  
5 for services performed by such person  
6 (other than as an employee), or

7 “(ii) section 6041A(a).”

8 (b) CONFORMING AMENDMENT.—Section 6721(a)(1)  
9 is amended by striking “In” and inserting “Except as pro-  
10 vided in paragraph (3), in”.

11 (c) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to returns the due date for which  
13 (without regard to extensions) is more than 30 days after  
14 the date of the enactment of this Act.

## 15 **PART 2—TAX INCENTIVES FOR HEALTH**

### 16 **SERVICES PROVIDERS**

#### 17 **SEC. 7511. NONREFUNDABLE CREDIT FOR CERTAIN PRI-** 18 **MARY HEALTH SERVICES PROVIDERS.**

19 (a) IN GENERAL.—Subpart A of part IV of sub-  
20 chapter A of chapter 1 (relating to nonrefundable personal  
21 credits) is amended by inserting after section 22 the fol-  
22 lowing new section:

1 **“SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

2 “(a) ALLOWANCE OF CREDIT.—There shall be al-  
3 lowed as a credit against the tax imposed by this chapter  
4 for the taxable year an amount equal to the product of—

5 “(1) the number of months during such taxable  
6 year—

7 “(A) during which the taxpayer is a quali-  
8 fied primary health services provider, and

9 “(B) which are within the taxpayer’s eligi-  
10 ble service period, and

11 “(2) \$1,000 (\$500 in the case of a qualified  
12 practitioner who is not a physician).

13 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-  
14 VIDER.—For purposes of this section—

15 “(1) IN GENERAL.—The term ‘qualified pri-  
16 mary health services provider’ means, with respect to  
17 any month, any qualified practitioner who—

18 “(A) has in effect a certification by the  
19 Bureau as a provider of primary health services  
20 and such certification is, when issued, for a  
21 health professional shortage area in which the  
22 qualified practitioner is providing primary  
23 health services,

24 “(B) is providing primary health services  
25 full time in the health professional shortage  
26 area identified in such certification, and

1           “(C) has not received a scholarship under  
2           the National Health Service Corps Scholarship  
3           Program or any loan repayments under the  
4           National Health Service Corps Loan Repay-  
5           ment Program.

6           “(2) SPECIAL RULES RELATING TO SHORTAGE  
7           AREAS.—

8           “(A) AREAS CEASING TO BE SHORTAGE  
9           AREAS.—For purposes of paragraph (1)(B) and  
10          subsection (e)(2), a provider shall be treated as  
11          providing services in a health professional  
12          shortage area when such area ceases to be such  
13          an area if it was such an area on the first day  
14          of the provider’s eligible service period.

15          “(B) AREAS WITHIN METROPOLITAN  
16          AREAS.—A qualified practitioner who is pro-  
17          viding services within a metropolitan statistical  
18          area (as defined in section 143(k)(2)) shall not  
19          be treated as meeting the requirements of para-  
20          graph (1)(B) unless such services are provided  
21          for, or on behalf of, a governmental or non-  
22          profit entity.

23          “(3) QUALIFIED PRACTITIONER.—The term  
24          ‘qualified practitioner’ means a physician, a physi-

1       cian assistant, a nurse practitioner, or a certified  
2       nurse-midwife.

3       “(c) ELIGIBLE SERVICE PERIOD.—For purposes of  
4 this section, the term ‘eligible service period’ means the  
5 period of 36 consecutive calendar months beginning with  
6 the first month the taxpayer is a qualified primary health  
7 services provider (as specified in the certification under  
8 subsection (b)(1)(A)). A taxpayer shall not have more  
9 than 1 eligible service period.

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

12               “(1) BUREAU.—The term ‘Bureau’ means the  
13 Bureau of Primary Health Care, Health Resources  
14 and Services Administration of the United States  
15 Public Health Service.

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

19               “(3) PHYSICIAN ASSISTANT; NURSE PRACTI-  
20 TIONER.—The terms ‘physician assistant’ and ‘nurse  
21 practitioner’ have the meanings given to such terms  
22 by section 1861(aa)(5) of the Social Security Act.

23               “(4) CERTIFIED NURSE-MIDWIFE.—The term  
24 ‘certified nurse-midwife’ has the meaning given to

1 such term by section 1861(gg)(2) of the Social Secu-  
2 rity Act.

3 “(5) PRIMARY HEALTH SERVICES.—The term  
4 ‘primary health services’ has the meaning given such  
5 term by section 330(b)(1) of the Public Health Serv-  
6 ice Act.

7 “(6) HEALTH PROFESSIONAL SHORTAGE  
8 AREA.—The term ‘health professional shortage area’  
9 has the meaning given such term by section  
10 332(a)(1)(A) of the Public Health Service Act.

11 “(7) PRACTITIONER CURRENTLY PRACTICING IN  
12 SHORTAGE AREAS.—In the case of a qualified practi-  
13 tioner who, on December 31, 1994, was providing  
14 primary health services in any health professional  
15 shortage area—

16 “(A) the practitioner’s eligible service pe-  
17 riod shall begin on January 1, 1995, and

18 “(B) if such practitioner is a physician,  
19 subsection (a)(2) shall be applied by sub-  
20 stituting ‘\$500’ for ‘\$1,000’.

21 “(e) RECAPTURE OF CREDIT.—

22 “(1) IN GENERAL.—If there is a recapture  
23 event during any taxable year, then—

1           “(A) no credit shall be allowed under sub-  
2           section (a) for such taxable year and any suc-  
3           ceeding taxable year, and

4           “(B) the tax of the taxpayer under this  
5           chapter for such taxable year shall be increased  
6           by an amount equal to the aggregate credits al-  
7           lowed to such taxpayer under this section for all  
8           prior taxable years.

9           “(2) RECAPTURE EVENT DEFINED.—

10           “(A) IN GENERAL.—For purposes of this  
11           subsection, the term ‘recapture event’ means  
12           the failure of the taxpayer to be a qualified pri-  
13           mary health services provider during any of the  
14           first 24 months during the taxpayer’s eligible  
15           service period.

16           “(B) SECRETARIAL WAIVER.—The Sec-  
17           retary, in consultation with the Secretary of  
18           Health and Human Services, may waive any re-  
19           capture event caused by extraordinary cir-  
20           cumstances.

21           “(3) NO CREDITS AGAINST TAX; MINIMUM  
22           TAX.—Any increase in tax under this subsection  
23           shall not be treated as a tax imposed by this chapter  
24           for purposes of determining the amount of any cred-

1       it under subpart A, B, or D of this part or for pur-  
2       poses of section 55.”

3       (b) CLERICAL AMENDMENT.—The table of sections  
4 for subpart A of part IV of subchapter A of chapter 1  
5 is amended by inserting after the item relating to section  
6 22 the following new item:

      “Sec. 23. Primary health services providers.”

7       (c) EFFECTIVE DATE.—The amendments made by  
8 this section shall apply to taxable years beginning after  
9 December 31, 1994.

10 **SEC. 7512. EXPENSING OF MEDICAL EQUIPMENT.**

11       (a) IN GENERAL.—Paragraph (1) of section 179(b)  
12 (relating to dollar limitation on expensing of certain depre-  
13 ciable business assets) is amended to read as follows:

14               “(1) DOLLAR LIMITATION.—

15                       “(A) GENERAL RULE.—The aggregate cost  
16 which may be taken into account under sub-  
17 section (a) for any taxable year shall not exceed  
18 \$17,500.

19                       “(B) HEALTH CARE PROPERTY.—The ag-  
20 gregate cost which may be taken into account  
21 under subsection (a) shall be increased by the  
22 lesser of—

23                               “(i) the cost of section 179 property  
24 which is health care property placed in  
25 service during the taxable year, or

1 “(ii) \$10,000.”

2 (b) DEFINITION.—Section 179(d) (relating to defini-  
3 tions) is amended by adding at the end the following new  
4 paragraph:

5 “(11) HEALTH CARE PROPERTY.—

6 “(A) IN GENERAL.—For purposes of this  
7 section, the term ‘health care property’ means  
8 section 179 property—

9 “(i) which is medical equipment used  
10 in the screening, monitoring, observation,  
11 diagnosis, or treatment of patients in a  
12 laboratory, medical, or hospital environ-  
13 ment,

14 “(ii) which is owned (directly or indi-  
15 rectly) and used by 1 or more physicians  
16 (as defined in section 1861(r) of the Social  
17 Security Act) in the active conduct of the  
18 full-time trade or business of all such phy-  
19 sicians of providing primary health services  
20 (as defined in section 330(b)(1) of the  
21 Public Health Service Act) in a health pro-  
22 fessional shortage area (as defined in sec-  
23 tion 332(a)(1)(A) of the Public Health  
24 Service Act), and

1                   “(iii) substantially all the use of which  
2                   is in such area.

3                   “(B) SPECIAL RULE FOR METROPOLITAN  
4                   STATISTICAL AREAS.—A physician who is pro-  
5                   viding services within a metropolitan statistical  
6                   area (as defined in section 143(k)(2)) shall not  
7                   be treated as meeting the requirements of sub-  
8                   paragraph (A)(ii) unless such services are pro-  
9                   vided for, or on behalf of, a governmental or  
10                  nonprofit entity.”

11               (c) RECAPTURE.—Paragraph (10) of section 179(d)  
12 is amended by inserting “and with respect to any health  
13 care property which ceases (other than by an area failing  
14 to be treated as a health professional shortage area) to  
15 be health care property at any time” before the period.

16               (d) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to property placed in service in  
18 taxable years beginning after December 31, 1994.

### 19               **PART 3—MISCELLANEOUS PROVISIONS**

#### 20               **SEC. 7521. POST-RETIREMENT MEDICAL AND LIFE INSUR-** 21               **ANCE RESERVES.**

22               (a) MINIMUM PERIOD FOR WORKING LIVES.—Sec-  
23 tion 419A(c)(2) (relating to additional reserves for post-  
24 retirement medical and life insurance benefits) is amended

1 by inserting “(but not less than 10 years)” after “working  
2 lives of the covered employees”.

3 (b) SEPARATE ACCOUNTING.—

4 (1) REQUIREMENT.—Section 419A(c)(2) is  
5 amended by adding at the end the following new  
6 flush sentence:

7 “Such reserve shall be maintained as a separate account.”

8 (2) USE OF RESERVE FOR OTHER PURPOSES.—

9 Paragraph (1) of section 4976(b) (defining disquali-  
10 fied benefit) is amended by striking “and” at the  
11 end of subparagraph (B), by striking the period at  
12 the end of subparagraph (C) and inserting “, and”,  
13 and by adding after subparagraph (C) the following  
14 new subparagraph:

15 “(D) any payment to which subparagraph  
16 (C) does not apply which is out of an account  
17 described in section 419A(c)(2) and which is  
18 not used to provide a post-retirement medical  
19 benefit or life insurance benefit.”

20 (c) EFFECTIVE DATES.—

21 (1) IN GENERAL.—Except as provided in para-  
22 graph (2), the amendments made by this section  
23 shall apply to contributions paid or accrued after  
24 December 31, 1994, in taxable years ending after  
25 such date.

1           (2) SEPARATE ACCOUNTING.—The amendments  
2           made by subsection (b) shall apply to contributions  
3           paid or accrued after the date of the enactment of  
4           this Act, in taxable years ending after such date.

5 **SEC. 7522. CREDIT FOR COST OF PERSONAL ASSISTANCE**  
6                           **SERVICES REQUIRED BY EMPLOYED INDIVID-**  
7                           **UALS.**

8           (a) IN GENERAL.—Subpart A of part IV of sub-  
9           chapter A of chapter 1 (relating to nonrefundable personal  
10          credits), as amended by section 7511, is amended by in-  
11          serting after section 23 the following new section:

12 **“SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES RE-**  
13                           **QUIRED BY EMPLOYED INDIVIDUALS.**

14          “(a) ALLOWANCE OF CREDIT.—

15                 “(1) IN GENERAL.—In the case of an eligible  
16                 individual, there shall be allowed as a credit against  
17                 the tax imposed by this chapter for the taxable year  
18                 an amount equal to the applicable percentage of the  
19                 personal assistance expenses paid or incurred by the  
20                 taxpayer during such taxable year.

21                 “(2) APPLICABLE PERCENTAGE.—For purposes  
22                 of paragraph (1), the term ‘applicable percentage’  
23                 means 50 percent reduced (but not below zero) by  
24                 10 percentage points for each \$5,000 by which the  
25                 modified adjusted gross income (as defined in sec-

1       tion 59B(d)(2)) of the taxpayer for the taxable year  
2       exceeds \$45,000. In the case of a married individual  
3       filing a separate return, the preceding sentence shall  
4       be applied by substituting ‘\$2,500’ for ‘\$5,000’ and  
5       ‘\$22,500’ for ‘\$45,000’.

6       “(b) LIMITATION.—The amount of personal assist-  
7       ance expenses for the benefit of an individual which may  
8       be taken into account under subsection (a) for the taxable  
9       year shall not exceed the lesser of—

10               “(1) \$15,000, or

11               “(2) such individual’s earned income (as de-  
12       fined in section 32(c)(2)) for the taxable year.

13       In the case of a joint return, the amount under the pre-  
14       ceding sentence shall be determined separately for each  
15       spouse.

16       “(c) ELIGIBLE INDIVIDUAL.—For purposes of this  
17       section, the term ‘eligible individual’ means any individual  
18       (other than a nonresident alien) who, by reason of any  
19       medically determinable physical impairment which can be  
20       expected to result in death or which has lasted or can be  
21       expected to last for a continuous period of not less than  
22       12 months, is unable to engage in any substantial gainful  
23       activity without personal assistance services appropriate to  
24       carry out activities of daily living. An individual shall not  
25       be treated as an eligible individual unless such individual

1 furnishes such proof thereof (in such form and manner,  
2 and at such times) as the Secretary may require.

3 “(d) OTHER DEFINITIONS.—For purposes of this  
4 section—

5 “(1) PERSONAL ASSISTANCE EXPENSES.—The  
6 term ‘personal assistance expenses’ means expenses  
7 for—

8 “(A) personal assistance services appro-  
9 priate to carry out activities of daily living in or  
10 outside the home,

11 “(B) homemaker/chore services incidental  
12 to the provision of such personal assistance  
13 services,

14 “(C) in the case of an individual with a  
15 cognitive impairment, assistance with life skills,

16 “(D) communication services,

17 “(E) work-related support services,

18 “(F) coordination of services described in  
19 this paragraph,

20 “(G) assistive technology and devices, in-  
21 cluding assessment of the need for particular  
22 technology and devices and training of family  
23 members, and

24 “(H) modifications to the principal place of  
25 abode of the individual to the extent the ex-

1           penses for such modifications would (but for  
2           subsection (e)(2)) be expenses for medical care  
3           (as defined by section 213) of such individual.

4           “(2) ACTIVITIES OF DAILY LIVING.—The term  
5           ‘activities of daily living’ means eating, toileting,  
6           transferring, bathing, and dressing.

7           “(e) SPECIAL RULES.—

8           “(1) PAYMENTS TO RELATED PERSONS.—No  
9           credit shall be allowed under this section for any  
10          amount paid by the taxpayer to any person who is  
11          related (within the meaning of section 267 or  
12          707(b)) to the taxpayer.

13          “(2) COORDINATION WITH MEDICAL EXPENSE  
14          DEDUCTION.—Any amount taken into account in de-  
15          termining the credit under this section shall not be  
16          taken into account in determining the amount of the  
17          deduction under section 213.

18          “(3) BASIS REDUCTION.—For purposes of this  
19          subtitle, if a credit is allowed under this section for  
20          any expense with respect to any property, the in-  
21          crease in the basis of such property which would  
22          (but for this paragraph) result from such expense  
23          shall be reduced by the amount of the credit so al-  
24          lowed.

1       “(f) COST-OF-LIVING ADJUSTMENT.—In the case of  
2 any taxable year beginning after 1996, the \$45,000 and  
3 \$22,500 amounts in subsection (a)(2) and the \$15,000  
4 amount in subsection (b) shall be increased by an amount  
5 equal to—

6               “(1) such dollar amount, multiplied by

7               “(2) the cost-of-living adjustment determined  
8 under section 1(f)(3) for the calendar year in which  
9 the taxable year begins by substituting ‘calendar  
10 year 1995’ for ‘calendar year 1992’ in subparagraph  
11 (B) thereof.

12 If any increase determined under the preceding sentence  
13 is not a multiple of \$1,000, such increase shall be rounded  
14 to the nearest multiple of \$1,000.”

15       (b) TECHNICAL AMENDMENT.—Subsection (a) of  
16 section 1016 is amended by striking “and” at the end of  
17 paragraph (24), by striking the period at the end of para-  
18 graph (25) and inserting “, and”, and by adding at the  
19 end thereof the following new paragraph:

20               “(26) in the case of any property with respect  
21 to which a credit has been allowed under section 24,  
22 to the extent provided in section 24(e)(3).”

23       (c) CLERICAL AMENDMENT.—The table of sections  
24 for subpart A of part IV of subchapter A of chapter 1

1 is amended by inserting after the item relating to section  
2 23 the following new item:

“Sec. 24. Cost of personal assistance services required by em-  
ployed individuals.”

3 (d) **EFFECTIVE DATE.**—The amendments made by  
4 this section shall apply to taxable years beginning after  
5 December 31, 1995.

6 **SEC. 7523. DISCLOSURE OF RETURN INFORMATION FOR AD-**  
7 **MINISTRATION OF CERTAIN PROGRAMS**  
8 **UNDER THE HEALTH SECURITY ACT.**

9 (a) **IN GENERAL.**—Section 6103(l) (relating to dis-  
10 closure of returns and return information for purposes  
11 other than tax administration) is amended by adding at  
12 the end the following new paragraph:

13 “(15) **DISCLOSURE OF RETURN INFORMATION**  
14 **FOR PURPOSES OF HEALTH SECURITY ACT.**—

15 “(A) **IN GENERAL.**—The Secretary shall,  
16 upon written request, disclose current return in-  
17 formation described in subparagraph (B) to any  
18 Federal, State, or local agency administering an  
19 assistance program under the Health Security  
20 Act.

21 “(B) **INFORMATION.**—The information de-  
22 scribed in this subparagraph is information  
23 which consists only of adjusted gross income,  
24 the untaxed portion of social security benefits,

1 tax-exempt interest income, marital status, and  
2 dependents.

3 “(C) RESTRICTION ON DISCLOSURE.—The  
4 Secretary shall disclose return information  
5 under subparagraph (A) only for purposes of,  
6 and to the extent necessary in, determining eli-  
7 gibility for, or the correct amount of, assistance  
8 provided under the Health Security Act.

9 “(D) EXCLUSION FROM MATCHING PRO-  
10 GRAM.—Any matches of information under this  
11 paragraph shall not be treated as a matching  
12 program for purposes of section 552a of title 5,  
13 United States Code.”

14 (b) CONFORMING AMENDMENTS.—

15 (1) Section 6103(9)(2) is amended by inserting  
16 “or (15)” after “subsection (l)(7)(D)”.

17 (2) Section 6103(p)(3)(A) is amended by strik-  
18 ing “or (14)” and inserting “(14), or (15)”.

19 (3) Section 6103(p)(4) is amended—

20 (A) by striking “or (12)” in the matter  
21 preceding subparagraph (A) and inserting  
22 “(12), or (15)”, and

23 (B) by striking “or (14)” in subparagraph  
24 (F)(ii) and inserting “(14), or (15)”.

1 (4) Section 7213(a)(2) is amended by striking  
 2 “or (12)” and inserting “(12), or (15)”.

3 **Subtitle F—Graduate Medical Edu-**  
 4 **cation and Academic Health**  
 5 **Centers Trust Fund**

6 **SEC. 7601. ESTABLISHMENT OF GRADUATE MEDICAL EDU-**  
 7 **CATION AND ACADEMIC HEALTH CENTERS**  
 8 **TRUST FUND.**

9 (a) IN GENERAL.—Subchapter A of chapter 98 (re-  
 10 lating to establishment of trust funds) is amended by add-  
 11 ing at the end the following new part:

12 **“PART II—HEALTH CARE TRUST FUNDS**

“Sec. 9551. Graduate Medical Education and Academic Health  
 Centers Trust Fund

13 **“SEC. 9551. GRADUATE MEDICAL EDUCATION AND ACA-**  
 14 **DEMIC HEALTH CENTERS TRUST FUND.**

15 **“(a) CREATION OF TRUST FUND.—**

16 **“(1) IN GENERAL.—**There is established in the  
 17 Treasury of the United States a trust fund to be  
 18 known as the ‘Graduate Medical Education and Aca-  
 19 demic Health Centers Trust Fund’, consisting of  
 20 such amounts as may be appropriated or credited to  
 21 the Academic Health Centers Trust Fund as pro-  
 22 vided in this section or section 9602(b).

23 **“(2) ACCOUNTS IN THE TRUST FUND.—**The  
 24 Graduate Medical Education and Academic Health

1 Centers Trust Fund shall consist of the following 2  
2 accounts:

3 “(A) The Graduate Medical Education Ac-  
4 count.

5 “(B) The Academic Health Centers Ac-  
6 count.

7 Each such account shall consist of such amounts as  
8 are allocated to it under this section.

9 “(b) TRANSFERS TO THE TRUST FUND.—

10 “(1) TAXES.—There are hereby appropriated to  
11 the Graduate Medical Education and Academic  
12 Health Centers Trust Fund amounts received in the  
13 Treasury under sections 4501 and 4502 (relating to  
14 assessments on insured and self-insured health  
15 plans) to the extent attributable to the rates of such  
16 taxes not in excess of 1.5 percent.

17 “(2) TRANSFERS FROM OTHER TRUST  
18 FUNDS.—The Secretary of Health and Human Serv-  
19 ices shall transfer each fiscal year to the Graduate  
20 Medical Education and Academic Health Centers  
21 Trust Fund from the Federal Hospital Insurance  
22 Trust Fund and the Federal Supplementary Medical  
23 Insurance Trust Fund established under the Social  
24 Security Act the sum of—

1           “(A) the amount that would have been  
2           paid from the Federal Hospital Insurance Trust  
3           Fund in such fiscal year under section  
4           1886(d)(5)(B) of such Act (as in effect before  
5           the date of the enactment of the Health Secu-  
6           rity Act), plus

7           “(B) the amount that would have been  
8           paid from such trust funds in such fiscal year  
9           under section 1886(h) of such Act (as so in ef-  
10          fect).

11          “(c) GRADUATE MEDICAL EDUCATION ACCOUNT.—

12           “(1) TRANSFERS.—There is allocated to the  
13          Graduate Medical Education Account each fiscal  
14          year an amount equal to the sum of—

15           “(A) amounts described in subsection  
16          (b)(2)(B), plus

17           “(B) the excess of—

18           “(i) the amounts made available  
19          under section 3033 of the Health Security  
20          Act, over

21           “(ii) the amount described in subpara-  
22          graph (A).

23          “(2) EXPENDITURES.—Amounts in the Grad-  
24          uate Medical Education Account are appropriated to  
25          make the payments described in sections 3031 and

1 3055 of the Health Security Act, and to the extent  
2 any such amount is not expended during any fiscal  
3 year, such amount shall be available for such pur-  
4 pose for subsequent fiscal years.

5 “(d) ACADEMIC HEALTH CENTERS ACCOUNT.—

6 “(1) TRANSFERS.—There is allocated to the  
7 Academic Health Centers Account each fiscal year  
8 an amount equal to the sum of—

9 “(A) amounts described in subsection  
10 (b)(2)(A), plus

11 “(B) the excess of—

12 “(i) the amounts made available  
13 under section 3053 of the Health Security  
14 Act, over

15 “(ii) the amount described in subpara-  
16 graph (A).

17 “(2) EXPENDITURES.—Amounts in the Aca-  
18 demic Health Centers Account are appropriated to  
19 make the payments described in section 3051 of the  
20 Health Security Act, and to the extent any such  
21 amount is not expended during any fiscal year, such  
22 amount shall be available for such purpose for sub-  
23 sequent fiscal years.

24 “(e) RULES RELATING TO ACCOUNTS.—

1           “(1) INSUFFICIENT FUNDS.—If, for any fiscal  
2 year, the sum of the amounts required to be allo-  
3 cated under subsections (c) and (d) exceeds the  
4 amounts received in the Graduate Medical Edu-  
5 cation and Academic Health Centers Trust Fund,  
6 then each of such amounts required to be so allo-  
7 cated shall be reduced to an amount which bears the  
8 same ratio to such amount as the amounts received  
9 in the trust fund bear to the amounts required to be  
10 so allocated (without regard to this paragraph).

11           “(2) ALLOCATION OF EXCESS FUNDS AND IN-  
12 TEREST.—Amounts received in the Graduate Med-  
13 ical Education and Academic Health Centers Trust  
14 Fund in excess of the amounts required to be allo-  
15 cated under subsections (c) and (d), and amounts  
16 credited to such trust fund under section 9602(b),  
17 for any fiscal year shall be allocated to each account  
18 ratably on the basis of the amounts allocated to the  
19 account for the fiscal year (without regard to this  
20 paragraph).”.

21           (b) CONFORMING AMENDMENT.—Subchapter A of  
22 chapter 98 is amended by inserting after the subchapter  
23 heading the following new items:

“Part I. General trust funds.

“Part II. Health care trust funds.

1           **“PART I—GENERAL TRUST FUNDS”.**  
2           **TITLE VIII—OTHER FEDERAL**  
3           **PROGRAMS**  
4           **Subtitle A—Indian Health Service**

5   **SEC. 8101. PURPOSES.**

6           The purposes of this subtitle are as follows:

7           (1) To ensure the delivery of health care serv-  
8           ices to American Indians and Alaska Natives in a  
9           culturally appropriate manner in fulfillment of the  
10          unique trust responsibility of the Federal Govern-  
11          ment and legal obligation to American Indian and  
12          Alaska Native people—

13                   (A) derived from the province of inter-  
14                   national law; and

15                   (B) founded in the treaties, Constitution,  
16                   statutes, and court decisions of the United  
17                   States.

18          (2) To provide sufficient funding for the provi-  
19          sion of the standard benefit package as it applies to  
20          all eligible beneficiaries under this subtitle.

21          (3) To ensure that funding levels for services  
22          and benefits that are not part of the standard bene-  
23          fits package described in this subtitle are not diluted  
24          or diminished.

25          (4) To raise the health status of American Indi-  
26          ans and Alaska Natives to the highest possible level.

1           (5) To raise the quality of health care delivery  
2 to American Indians and Alaska Natives to the high-  
3 est possible level.

4           (6) To ensure that health care services provided  
5 to American Indians and Alaska Natives are pro-  
6 vided in a manner consistent with, and carries out,  
7 the recognized Indian self-determination and tribal  
8 self-governance policy of the United States.

9 **SEC. 8102. DEFINITIONS.**

10 For the purposes of this subtitle—

11           (1) the term “American Indian” has the mean-  
12 ing provided the term “Indian” under paragraph  
13 (6);

14           (2) the term “Alaska Native” has the meaning  
15 provided the term “Native” under section 3(b) of  
16 the Alaska Native Claims Settlement Act (43 U.S.C.  
17 1602(b));

18           (3) the term “health program of the Indian  
19 Health Service” means a program which provides or  
20 is responsible for obtaining health services under  
21 this Act or any other applicable law through pro-  
22 grams operated by the Indian Health Service, Indian  
23 tribes, or tribal organizations, including Indian  
24 tribes or tribal organizations operating under the au-

1       thority of the Indian Self-Determination and Edu-  
2       cation Assistance Act (25 U.S.C. 450 et seq.);

3           (4) the term “reservation” means the reserva-  
4       tion of any federally recognized Indian tribe, former  
5       Indian reservations in Oklahoma, and lands held by  
6       incorporated Native groups, regional corporations,  
7       and village corporations under the provisions of the  
8       Alaska Native Claims Settlement Act (43 U.S.C.  
9       1601 et seq.);

10          (5) the term “urban Indian program” means  
11       any program operated pursuant to title V of the In-  
12       dian Health Care Improvement Act; and

13          (6) the terms “Indian”, “Indian tribe”, “tribal  
14       organization”, “urban Indian”, “urban Indian orga-  
15       nization”, and “service unit” have the same meaning  
16       as given such terms under the Indian Health Care  
17       Improvement Act (25 U.S.C. 1601 et seq.).

18 **SEC. 8103. ELIGIBILITY AND HEALTH SERVICE COVERAGE**

19                   **OF INDIANS.**

20          (a) **COVERAGE.**—The programs of the Indian Health  
21       Service shall remain as the principal provider of health  
22       care for Indians, except that nothing in this subtitle shall  
23       limit the ability of Indians to seek care from providers out-  
24       side the programs of the Indian Health Service.

1 (b) ELIGIBILITY.—An Indian is eligible for services  
2 under a program of the Indian Health Service if the indi-  
3 vidual is—

4 (1) eligible to receive services pursuant to sec-  
5 tions 36.1 through 36.14 of title 42, Code of Federal  
6 Regulations (as in effect on the day before the date  
7 of enactment of this Act);

8 (2) an urban Indian residing in an area served  
9 by an urban Indian program; or

10 (3) an Indian described in section 809(b) of the  
11 Indian Health Care Improvement Act (25 U.S.C.  
12 1679(b)).

13 (c) LIMITATION ON CHARGES.—An eligible Indian  
14 (as defined in subsection (b)) receiving services from or  
15 being referred by a health program of the Indian Health  
16 Service shall not be subject to any charge for deductibles,  
17 copayments, coinsurance, or any other cost for health serv-  
18 ices provided under such program.

19 **SEC. 8104. SUPPLEMENTAL INDIAN HEALTH CARE BENE-**  
20 **FITS.**

21 (a) IN GENERAL.—All individuals described in sec-  
22 tion 8103(b) shall remain eligible for such benefits under  
23 the laws administered by the Indian Health Service as  
24 supplement the standard benefit package. The individual

1 shall not be subject to any charge or any other cost for  
2 such benefits.

3 (b) MAINTENANCE OF EFFORT.—The Secretary shall  
4 ensure that the requirements of this subtitle do not result  
5 in a reduction of the level of supplemental benefits pro-  
6 vided by or through the Indian Health Service.

7 **SEC. 8105. PROVISION OF HEALTH SERVICES TO NON-INDI-**  
8 **ANS.**

9 (a) CONTRACTS WITH HEALTH PLANS.—A health  
10 program of the Indian Health Service may enter into a  
11 contract with a health plan for the provision of health care  
12 services to individuals enrolled in such health plan if—

13 (1) the appropriate official of the program de-  
14 termines that the provision of such health services  
15 will not result in a denial or diminishment of health  
16 services to any individual described in section  
17 8103(b); and

18 (2) each tribe or urban Indian organization  
19 served by the program authorizes or has authorized  
20 the provision of services to such individuals.

21 (b) FAMILY TREATMENT.—A health program of the  
22 Indian Health Service may provide health care services to  
23 insured non-Indian family members of individuals de-  
24 scribed in section 8103(b) under the same restrictions as  
25 those described in subsection (a).

1 (c) APPLICABLE INDIVIDUAL CHARGES.—Non-Indi-  
2 ans receiving services in a program under subsection (b)  
3 shall be subject to any applicable deductibles, copayments,  
4 coinsurance, or any other cost for health services provided.

5 **SEC. 8106. ESSENTIAL COMMUNITY PROVIDERS.**

6 A health program of the Indian Health Service auto-  
7 matically certified as an essential community provider  
8 under section 1462 may elect to accept certification—

9 (1) only for eligible individuals described in sec-  
10 tion 8103(b);

11 (2) for non-Indian individuals if each tribe or  
12 tribal organization served by the program authorizes  
13 or has authorized serving non-Indians; or

14 (3) for eligible individuals described in section  
15 8103(b) and family members of such individuals de-  
16 scribed in section 8505(b) who are enrolled in a plan  
17 other than a health program of the Indian Health  
18 Service, if each tribe or urban Indian organization  
19 served by the program authorizes or has authorized  
20 serving such family members.

21 **SEC. 8107. PAYMENT BY OTHER PROVIDERS.**

22 (a) PAYMENT FOR SERVICES PROVIDED BY INDIAN  
23 HEALTH SERVICE PROGRAMS.—Nothing in this subtitle  
24 shall be construed as amending section 206, 401, or 402  
25 of the Indian Health Care Improvement Act (25 U.S.C.

1 1621e, 1641, or 1642) or any other provision of law relat-  
2 ing to payments on behalf of Indians for health services  
3 from other Federal programs or from other third party  
4 payers.

5 (b) PAYMENT FOR SERVICES PROVIDED BY CON-  
6 TRACTORS.—Nothing in this subtitle shall be construed as  
7 affecting any other provision of law, regulation, or judicial  
8 or administrative interpretation of law or policy con-  
9 cerning the status of the Indian Health Service as the  
10 payer of last resort for Indians eligible for contract health  
11 services under a health program of the Indian Health  
12 Service.

13 (c) PAYMENT FOR SERVICES BY MEDICARE.—Pro-  
14 grams of the Indian Health Service shall be eligible for  
15 payments for services provided to Medicare beneficiaries.

16 (d) RETENTION OF RECEIPTS.—Notwithstanding  
17 any other provision of law, the collections made by a  
18 health program of the Indian Health Service shall remain  
19 with the health program if the receipts are used to—

20 (1) expand or improve its services;

21 (2) increase the number of persons it is able to  
22 serve;

23 (3) construct, expand or modernize its health  
24 care facilities;

1           (4) improve the administration of its health  
2           service programs; or

3           (5) develop or improve linkages with other  
4           health care providers.

5           (e) COLLECTION.—Each health program of the In-  
6           dian Health Service shall make every reasonable effort to  
7           collect appropriate reimbursement for its costs in pro-  
8           viding health services to persons who are covered by public  
9           or private health insurance programs.

10 **SEC. 8108. CONTRACTING AUTHORITY.**

11           Section 601(d)(1)(B) of the Indian Health Care Im-  
12           provement Act (25 U.S.C. 1661(d)(1)(B)) is amended by  
13           inserting “(including personal services for the provision of  
14           direct health care services)” after “goods and services”.

15 **SEC. 8109. CONSULTATION.**

16           (a) OMB AND SECRETARY.—The Director of the Of-  
17           fice of Management and Budget and the Secretary shall  
18           consult, on an annual basis, with representatives of Indian  
19           tribes, tribal organizations, and urban Indian organiza-  
20           tions concerning health care reform initiatives that affect  
21           Indian communities, and policy, funding, and administra-  
22           tion of health programs of the Indian Health Service. The  
23           Secretary shall solicit and consider the views and rec-  
24           ommendations provided by Indian tribes, tribal organiza-  
25           tions, and representatives of urban Indian organizations

1 in making determinations that affect Indians and Indian  
2 tribes and shall resolve any differences in favor of Indians  
3 and Indian tribes.

4 (b) FEDERAL ADVISORY GROUP.—

5 (1) ESTABLISHMENT.—The Secretary shall es-  
6 tablish an advisory group to assess all aspects of the  
7 development and administration of the budget for  
8 programs of the Indian Health Service and advise  
9 the Office of Management and Budget, the Sec-  
10 retary and Congress with respect to such aspects.

11 (2) COMPOSITION.—The advisory group shall be  
12 comprised of—

13 (A) not less than one representative from  
14 each area of the Indian Health Service to be  
15 appointed by the Secretary from nominees of  
16 tribes and tribal organizations in the respective  
17 areas;

18 (B) not less than one urban Indian rep-  
19 resentative from each area the Indian Health  
20 Service with an urban Indian (as defined in sec-  
21 tion 4(f) of the Indian Health Care Improve-  
22 ment Act (25 U.S.C. 1603(f)) program to be  
23 appointed by the Secretary; and

24 (C) such other appointees as the Secretary  
25 determines appropriate, on the condition that a

1 majority of the members are selected from  
2 nominations submitted to the Secretary by a  
3 tribe or tribal organization.

4 **SEC. 8110. TRANSITIONAL STUDIES.**

5 (a) IN GENERAL.—The Secretary shall conduct plan-  
6 ning, feasibility, or similar health services studies related  
7 to the transition of the health programs of the Indian  
8 Health Service under health care reform. Such studies  
9 shall take into account the measurements and the means  
10 to accomplish the Healthy People 2000 objectives as re-  
11 quired under sections 3 and 214 of the Indian Health Care  
12 Improvement Act. Such studies shall include an assess-  
13 ment of—

14 (1) the feasibility of developing an Indian  
15 health plan or plans;

16 (2) the financing necessary to provide the same  
17 level of standard benefits to American Indians and  
18 Alaska Natives as will be available to all other  
19 Americans;

20 (3) the staffing, program and infrastructure en-  
21 hancements required to deliver the standard benefits  
22 package;

23 (4) the facility and capital construction needs  
24 necessary to provide the standard benefit package;  
25 and

1           (5) the administrative improvements necessary  
2 to network, share and access patient data, quality  
3 management and improvement data, and financial  
4 information.

5 (b) ADVISORY GROUP.—

6           (1) ESTABLISHMENT.—The Secretary shall es-  
7 tablish an advisory group to provide the Secretary  
8 with advise concerning the focus, content and con-  
9 duct of studies under subsection (a).

10           (2) COMPOSITION.—The advisory group shall be  
11 comprised of—

12           (A) not less than one representative from  
13 each area of the Indian Health Service to be  
14 appointed by the Secretary from among nomi-  
15 nees of tribes and tribal organizations in the re-  
16 spective areas;

17           (B) not less than one urban Indian rep-  
18 resentative from each area of the Indian Health  
19 Service which an urban Indian (as defined in  
20 section 4(f) of the Indian Health Care Improve-  
21 ment Act (25 U.S.C. 1603(f)) program to ap-  
22 pointed by the Secretary; and

23           (C) other appointees as the Secretary de-  
24 termines appropriate, except that the Secretary  
25 shall ensure that a majority of the members so

1 appointed are selected from nominations sub-  
2 mitted to the Secretary by tribes or tribal orga-  
3 nizations.

4 (c) RECOMMENDATIONS.—Not later than June 30,  
5 1997, the Secretary shall submit to Congress rec-  
6 ommendations based on the studies conducted under this  
7 section, including recommendations for changes in the  
8 structure of Indian Health Services. A time-table for im-  
9 plementing health care reform activities shall be included  
10 in such final recommendations.

11 **SEC. 8111. LOANS AND LOAN GUARANTEES.**

12 The Secretary may make loans, and guarantee the  
13 payment of principal and interest, to Federal and non-  
14 Federal lenders on behalf of health programs of the Indian  
15 Health Service for the purpose of improving and expand-  
16 ing such facilities. Loans and loan guarantees under this  
17 section shall be provided under such terms and conditions  
18 as the Secretary may prescribe.

19 **SEC. 8112. SIMPLIFICATION OF BILLING.**

20 The Secretary shall take such action as may be nec-  
21 essary to ensure that health programs of the Indian  
22 Health Service may submit all claims for benefits or pay-  
23 ment for services entitled to reimbursement in a manner  
24 consistent with that of all other health care providers.

1 **SEC. 8113. LONG-TERM CARE DEMONSTRATIONS.**

2 Subject to the availability of appropriations under  
3 subtitle B of title II (for home and community-based long-  
4 term care services), the Secretary shall establish a dem-  
5 onstration program to provide five grants to health pro-  
6 grams of the Indian Health Service to enable such Pro-  
7 grams to plan and implement innovative methods of pro-  
8 viding enhanced home and community-based long-term  
9 care services.

10 **SEC. 8114. TECHNICAL ASSISTANCE.**

11 Indian tribes shall be eligible for funds made avail-  
12 able under this Act for technical assistance or transitional  
13 support.

14 **SEC. 8115. PUBLIC HEALTH PROGRAMS.**

15 Health programs of the Indian Health Service shall  
16 be eligible to apply for funding under public health pro-  
17 grams authorized under title III of this Act (including  
18 those under section 3695(b)(14)), as deemed appropriate  
19 by the Secretary.

20 **SEC. 8116. SURVEY OF HEALTH SERVICES AVAILABLE TO**  
21 **INDIAN VETERANS.**

22 (a) IN GENERAL.—The Secretary, in consultation  
23 with the Secretary of Veterans Affairs, Indian tribes and  
24 tribal organizations, shall conduct a survey to assess the  
25 availability and accessibility of health care services for In-  
26 dian veterans residing on Indian reservations.

1 (b) REPORT.—Not later than 180 days after the date  
2 of enactment of this Act, the Secretary shall submit a re-  
3 port to Congress that shall include recommendations con-  
4 cerning the survey conducted under subsection (a).

5 **SEC. 8117. RULE OF CONSTRUCTION.**

6 Unless otherwise provided in this Act, no part of this  
7 Act shall be construed to rescind or otherwise modify any  
8 obligations, findings, or purposes contained in the Indian  
9 Health Care Improvement Act (25 U.S.C. 1601 et seq.)  
10 and in the Indian Self-Determination and Education As-  
11 sistance Act (25 U.S.C. 450 et seq).

12 **SEC. 8118. AUTHORIZATION OF APPROPRIATIONS.**

13 (a) AUTHORIZATION.—

14 (1) IN GENERAL.—For the purpose of carrying  
15 out this subtitle, including transitional costs and the  
16 purchase of additional contract health care services  
17 for individual eligible Indians, there are authorized  
18 to be appropriated \$515,000,000 for fiscal year  
19 1995, \$930,000,000 for fiscal year 1996, and  
20 \$1,150,000,000 for each of the fiscal years 1997  
21 through 2004.

22 (2) SUPPLEMENTAL INDIAN HEALTH CARE  
23 BENEFITS.—In addition to amounts otherwise au-  
24 thorized to be appropriated (including the amounts  
25 authorized to be appropriated under paragraph (1)),

1 for the purpose of carrying out section 8104, there  
2 are authorized to be appropriated \$360,000,000 for  
3 fiscal year 1995, \$400,000,000 for each of the fiscal  
4 years 1996 through 1999, and such sums as may be  
5 necessary for fiscal year 2000 and each fiscal year  
6 thereafter.

7 (3) LOANS AND LOAN GUARANTEES.—In addi-  
8 tion to amounts otherwise authorized to be appro-  
9 priated (including the amounts authorized to be ap-  
10 propriated under paragraph (1)), for the purpose of  
11 carrying out section 8111, there are authorized to be  
12 appropriated \$500,000,000 for the principal of the  
13 loan. The authority of the Secretary to make loans  
14 and to guarantee loans under such section shall be  
15 subject to such amounts as may be provided for in  
16 each fiscal year in advance in an appropriations Act.

17 (b) RELATION TO OTHER FUNDS.—The authoriza-  
18 tions of appropriations established under this subtitle are  
19 in addition to any other authorizations of appropriations  
20 that are available for the purposes of carrying out this  
21 subtitle.

22 **SEC. 8119. FUNDING METHODOLOGY.**

23 The Secretary shall establish new methodologies, con-  
24 sistent with the Indian Health Care Improvement Act, for  
25 the distribution to Indian tribes of all new funds that be-

1 come available for health care initiatives under this sub-  
 2 title. New distribution methodologies should consider dif-  
 3 ferences in local resources, status of health (as declared  
 4 under section 3 of such Act), socioeconomic status of trib-  
 5 al people, and facilities, equipment and staff available in  
 6 concert with the establishment of Indian epidemiological  
 7 centers under such Act.

8 **Subtitle B—Department of**  
 9 **Veterans Affairs**

10 **SEC. 8101. SHORT TITLE.**

11 This Act may be cited as the “Veterans Health Care  
 12 Reform Act of 1994”.

13 **SEC. 8102. BENEFITS AND ELIGIBILITY THROUGH DEPART-**  
 14 **MENT OF VETERANS AFFAIRS MEDICAL SYS-**  
 15 **TEM.**

16 (a) DEPARTMENT OF VETERANS AFFAIRS AS A PAR-  
 17 TICIPANT IN HEALTH CARE REFORM.—

18 (1) IN GENERAL.—Title 38, United States  
 19 Code, is amended by inserting after chapter 17 the  
 20 following new chapter:

21 **“CHAPTER 18—ELIGIBILITY AND BENEFITS**  
 22 **UNDER HEALTH SECURITY ACT**

“SUBCHAPTER I—GENERAL

“1801. Definitions.

“SUBCHAPTER II—ENROLLMENT

“1811. Enrollment: veterans.

“1812. Enrollment: CHAMPVA eligibles.

“1813. Enrollment: family members.

“SUBCHAPTER III—BENEFITS

“1821. Benefits for VA enrollees.

“1822. Chapter 17 benefits.

“1823. Supplemental health benefits plans.

“1824. Limitation regarding veterans enrolled with health plans outside Department.

“SUBCHAPTER IV—FINANCIAL MATTERS

“1831. Premiums, copayments, and other charges.

“1832. Medicare coverage and reimbursement.

“1833. Recovery of cost of certain care and services.

“1834. Health Plan Fund.

1 “SUBCHAPTER I—GENERAL

2 **“§ 1801. Definitions**

3 “For purposes of this chapter:

4 “(1) The term ‘health plan’ means an entity  
5 that has been certified under the Health Security  
6 Act as a health plan.

7 “(2) The term ‘VA health plan’ means a health  
8 plan that is operated by the Secretary under section  
9 7341 of this title.

10 “(3) The term ‘VA enrollee’ means an indi-  
11 vidual enrolled under the Health Security Act in a  
12 VA health plan.

13 “(4) The term ‘standard benefit package’  
14 means the package of benefits required to be pro-  
15 vided by a health plan under the Health Security  
16 Act.

## 1           “SUBCHAPTER II—ENROLLMENT

2   **“§ 1811. Enrollment: veterans**

3           “Each veteran may enroll with a VA health plan. A  
4 veteran who wants to receive the standard benefit package  
5 through the Department shall enroll with a VA health  
6 plan.

7   **“§ 1812. Enrollment: CHAMPVA eligibles**

8           “An individual who is eligible for benefits under sec-  
9 tion 1713 of this title may enroll with a VA health plan  
10 in the same manner as a veteran.

11   **“§ 1813. Enrollment: family members**

12           “(a) The Secretary may authorize a VA health plan  
13 to enroll members of the family of an enrollee under sec-  
14 tion 1811 or 1812 of this title, subject to payment of pre-  
15 miums, deductibles, copayments, and coinsurance as re-  
16 quired under the Health Security Act.

17           “(b) For purposes of subsection (a), an enrollee’s  
18 family is those individuals (other than the enrollee) in-  
19 cluded within the term ‘family’ as defined in section  
20 1113(b) of the Health Security Act.

## 21           “SUBCHAPTER III—BENEFITS

22   **“§ 1821. Benefits for VA enrollees**

23           “‘The Secretary shall ensure that each VA health plan  
24 provides to each individual enrolled with it the items and  
25 services in the standard benefit package under the Health

1 Security Act, to the extent that such items and services  
2 can be provided consistent with appropriations for that  
3 purpose. In the event that appropriations are insufficient  
4 the Secretary may revise the standard benefit package  
5 available to enrolled individuals.

6 **“§ 1822. Chapter 17 benefits**

7 “The Secretary shall provide to a veteran the care  
8 and services not included in the standard benefit package  
9 that are authorized to be provided under chapter 17 of  
10 this title in accordance with the terms and conditions ap-  
11 plicable to that veteran and that care under such chapter,  
12 to the extent that such items and services can be provided  
13 consistent with appropriations for that purpose. In the  
14 event that appropriations are insufficient the Secretary  
15 may revise the standard benefit package available to en-  
16 rolled individuals.

17 **“§ 1823. Supplemental health benefits plans**

18 “(a) As part of a VA health plan, the Secretary may  
19 offer to veterans—

20 “(1) supplemental health benefits plans (as that  
21 term is defined in section 1011(3)(B) of the Health  
22 Security Act) for the care and services described in  
23 subsection (b); and

1           “(2) cost-sharing plans consistent with the re-  
2           quirements of part 4 of subtitle B of title I of the  
3           Health Security Act.

4           “(b) The care and services referred to in subsection  
5 (a) are care and services that—

6           “(1) are not available under the standard ben-  
7           efit package; and

8           “(2) can be provided by the Secretary at rea-  
9           sonable cost.

10 **“§ 1824. Limitation regarding veterans enrolled with**  
11 **health plans outside Department**

12           “A veteran who is residing in a community-rated area  
13 in which the Department operates a health plan and who  
14 is enrolled in a health plan that is not operated by the  
15 Department may be provided the items and services in the  
16 standard benefit package by a VA health plan only if the  
17 plan is reimbursed for the care provided.

18           “SUBCHAPTER IV—FINANCIAL MATTERS

19 **“§ 1831. Premiums, copayments, and other charges**

20           “(a) Except as provided in paragraph (2), the Sec-  
21 retary may not impose on or collect from a veteran de-  
22 scribed in subsection (b) who is a VA enrollee a cost-share  
23 charge of any kind (whether a premium, copayment, de-  
24 ductible, coinsurance charge, or other charge) for items

1 and services in the standard benefit package that a VA  
2 health plan provides.

3 “(b) The veterans referred to in subsection (a) are  
4 the following:

5 “(1) Any veteran with a compensable service-  
6 connected disability.

7 “(2) Any veteran whose discharge or release  
8 from the active military, naval or air service was for  
9 a disability incurred or aggravated in the line of  
10 duty.

11 “(3) Any veteran who is in receipt of, or who,  
12 but for a suspension pursuant to section 1151 of  
13 this title (or both such a suspension and the receipt  
14 of retired pay), would be entitled to disability com-  
15 pensation, but only to the extent that such a vet-  
16 eran’s continuing eligibility for such care is provided  
17 for in the judgment or settlement provided for in  
18 such section.

19 “(4) Any veteran who is a former prisoner of  
20 war.

21 “(5) Any veteran of the Mexican border period  
22 or World War I.

23 “(6) Any veteran who is unable to defray the  
24 expenses of necessary care as determined under sec-  
25 tion 1722(a) of this title.

1           “(7) Any veteran referred to in subparagraph  
2           (A), (B), or (C) of section 1710(e) of this title.

3           “(c)(1) Except as provided in paragraph (2), in the  
4 case of a VA enrollee who is not described in subsection  
5 (b), the Secretary shall charge premiums and establish co-  
6 payments, deductibles, and coinsurance amounts for care  
7 and services provided under this chapter. The premium  
8 rate, and the rates for deductibles and copayments, for  
9 each VA health plan shall be established by that health  
10 plan based on rules established under the Health Security  
11 Act.

12           “(2) The Secretary may not charge a veteran referred  
13 to in paragraph (1) a premium for any care or service  
14 that the Secretary provides the veteran under a supple-  
15 mental health benefits plan offered under section 1823 of  
16 this title if the Secretary is required to provide such care  
17 or service under chapter 17 of this title.

18           **“§ 1832. Medicare coverage and reimbursement**

19           “(a) For purposes of any program administered by  
20 the Secretary of Health and Human Services under title  
21 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.),  
22 a Department facility shall be deemed to be a Medicare  
23 provider.

24           “(b)(1) A VA health plan shall be considered to be  
25 a Medicare HMO.

1           “(2) For purposes of this section, the term ‘Medicare  
2 HMO’ means an eligible organization under section 1876  
3 of the Social Security Act.

4           “(c) In the case of care provided under this chapter  
5 to a veteran (other than a veteran described in section  
6 1831(b) of this title), or to a family member of a veteran,  
7 who is eligible for benefits under the Medicare program  
8 under title XVIII of the Social Security Act, the Secretary  
9 of Health and Human Services shall reimburse a VA  
10 health plan or Department health-care facility providing  
11 services as a Medicare provider or Medicare HMO in the  
12 same amounts and under the same terms and conditions  
13 as that Secretary reimburses other Medicare providers or  
14 Medicare HMOs, respectively. The Secretary of Health  
15 and Human Services shall include with each such reim-  
16 bursement a Medicare explanation of benefits.

17           “(d) When the Secretary provides care to a veteran,  
18 or a family member of a veteran, for which the Secretary  
19 receives reimbursement under this section, the Secretary  
20 shall require the veteran to pay to the Department any  
21 applicable deductible or copayment that is not covered by  
22 Medicare.

23 **“§ 1833. Recovery of cost of certain care and services**

24           “(a) In the case of an individual provided care or  
25 services through a VA health plan who has coverage under

1 a supplemental health benefits plan pursuant to part 4  
2 of subtitle B of title I of the Health Security Act, a Medi-  
3 care supplemental health insurance plan, or any other pro-  
4 vision of law, the Secretary has the right to recover or  
5 collect charges for care or services (as determined by the  
6 Secretary, but not including care or services for a service-  
7 connected disability) from the party providing that cov-  
8 erage to the extent that the individual (or the provider  
9 of the care or services) would be eligible to receive pay-  
10 ment for such care or services from such party if the care  
11 or services had not been furnished by a department or  
12 agency of the United States.

13 “(b) In the case of a veteran referred to in section  
14 1831(b) of this title who is enrolled in a health plan other  
15 than a VA health plan and who is provided care or services  
16 for a service-connected disability by a VA health plan, the  
17 Secretary has the right to recover or collect charges for  
18 such care and services from the party operating the health  
19 plan to the extent that the veteran (or the provider of the  
20 care or services) would be eligible to receive payment for  
21 such care or services from such party if the care or serv-  
22 ices had not been furnished by a department or agency  
23 of the United States.

24 “(c) The provisions of subsections (b) through (f) of  
25 section 1729 of this title shall apply with respect to claims

1 by the United States under subsection (a) or (b) in the  
2 same manner as they apply to claims under subsection (a)  
3 of that section.

4 **“§ 1834. Health Plan Fund**

5 “(a) There is hereby established in the Treasury a  
6 revolving fund to be known as the ‘Department of Vet-  
7 erans Affairs Health Plan Fund’.

8 “(b)(1) Subject to paragraphs (2) and (3), amounts  
9 collected or recovered by the Department under this sub-  
10 chapter by reason of the furnishing of care and services  
11 to an individual by a VA health plan or the enrollment  
12 of an individual with a VA health plan (including amounts  
13 received as premiums, premium discount payments, copay-  
14 ments or coinsurance, and deductibles, amounts received  
15 as third-party reimbursements or reimbursements from  
16 Medicare, and amounts received as reimbursements from  
17 another health plan for care furnished to one of its enroll-  
18 ees) shall be credited to the revolving fund.

19 “(2) Premiums collected by the Department under  
20 this subchapter during fiscal year 1996 or 1997 by reason  
21 of the furnishing of care and services under a VA health  
22 plan to a veteran referred to in section 1831(b) of this  
23 title shall be credited to the revolving fund established  
24 under subsection (a) only if the amount of funds appro-  
25 priated to the Veterans Health Care Investment Fund es-

1 tablished under subsection (a)(1) of section 7346 of this  
2 title for the fiscal year concerned is less than the amount  
3 specified to be credited to that fund for that fiscal year  
4 under subsection (c) of such section 7346.

5       “(3) Premiums received by the Department under  
6 this subchapter in any fiscal year after fiscal year 1997  
7 by reason of the furnishing of care and services under a  
8 VA health plan to a veteran referred to in paragraph (2)  
9 shall be credited to the revolving fund established under  
10 subsection (a) only if the cost of providing such care and  
11 services is not covered by appropriations. The amount so  
12 credited shall be the amount of such premiums received  
13 that is necessary to cover the difference between the cost  
14 of such care and services and such appropriations.

15       “(c) The Secretary shall establish in the revolving  
16 fund a separate account for each VA health plan. The Sec-  
17 retary shall credit any amount received under subsection  
18 (b) by reason of the furnishing of care and services in or  
19 through a VA health plan or the enrollment of an indi-  
20 vidual with a VA health plan.

21       “(d) Amounts credited to the account of the revolving  
22 fund for a VA health plan under subsection (b) are hereby  
23 made available to the VA health plan for the expenses of  
24 the delivery by the VA health plan of the items and serv-

1 ices in the standard benefit package and any supplemental  
 2 health benefits plan offered by the VA health plan.”.

3 (2) The table of chapters at the beginning of  
 4 title 38, United States Code, and at the beginning  
 5 of part II of such title, is amended by inserting after  
 6 the item relating to chapter 17 the following new  
 7 item:

“18. Benefits and Eligibility Under Health Security Act ..... 1801.”.

8 (b) PRESERVATION OF EXISTING BENEFITS FOR FA-  
 9 CILITIES NOT OPERATING AS HEALTH PLANS.—(1)  
 10 Chapter 17 of title 38, United States Code, is amended  
 11 by inserting after section 1704 the following new section:

12 **“§ 1705. Facilities not operating within health plans**

13 “The provisions of this chapter shall apply with re-  
 14 spect to the furnishing of care and services by any facility  
 15 of the Department when it is not operating as or within  
 16 a health plan certified as a health plan under the Health  
 17 Security Act.”.

18 (2) The table of sections at the beginning of such  
 19 chapter is amended by inserting after the item relating  
 20 to section 1704 the following new item:

“1705. Facilities not operating within health plans.”.

21 **SEC. 8103. ORGANIZATION OF DEPARTMENT OF VETERANS**  
 22 **AFFAIRS FACILITIES AS HEALTH PLANS.**

23 (a) IN GENERAL.—Chapter 73 of title 38, United  
 24 States Code, is amended—

1 (1) by redesignating subchapter IV as sub-  
2 chapter V; and

3 (2) by inserting after subchapter III the fol-  
4 lowing new subchapter IV:

5 “SUBCHAPTER IV—PARTICIPATION AS PART OF  
6 NATIONAL HEALTH CARE REFORM

7 “§ 7341. **Organization of health care facilities as**  
8 **health plans**

9 “(a)(1) The Secretary may, subject to the availability  
10 of appropriations, organize health plans and operate De-  
11 partment facilities as or within health plans under the  
12 Health Security Act.

13 “(2)(A) The Secretary may prescribe regulations es-  
14 tablishing standards for the operation of Department  
15 health care facilities as or within health plans under that  
16 Act. In prescribing such standards, the Secretary shall en-  
17 sure that they conform, to the extent possible under the  
18 requirements of section 1821, to the requirements for  
19 health plans generally set forth in part 1 of subtitle B  
20 of title I of the Health Security Act.

21 “(B) Not later than 30 days after prescribing such  
22 standards, the Secretary shall submit to the Committees  
23 on Veterans’ Affairs of the Senate and the House of Rep-  
24 resentatives a report describing the differences, if any, be-

1 tween such standards and the requirements for health  
2 plans generally referred to in subparagraph (A).

3 “(b) Health care facilities of the Department located  
4 within an area or region may be organized to operate as  
5 a single health plan encompassing all Department facili-  
6 ties within that area or region or may be organized to op-  
7 erate as several health plans.

8 “(c) In carrying out responsibilities under the Health  
9 Security Act, a State (or a State-established entity)—

10 “(1) may not impose any standard or require-  
11 ment on a VA health plan that is inconsistent with  
12 this chapter or any regulation prescribed under this  
13 chapter or other Federal laws regarding the oper-  
14 ation of this chapter; and

15 “(2) may not deny certification of a VA health  
16 plan under the Health Security Act on the basis of  
17 a conflict between a rule of a State and this chapter  
18 or regulations prescribed under this chapter or other  
19 Federal laws regarding the operation of this chapter.

20 **“§ 7342. Contract authority for facilities operating as**  
21 **or within health plans**

22 “(a) The Secretary shall designate a health plan di-  
23 rector for each VA health plan organized and operated  
24 under this subchapter.

1       “(b) The health plan director of a VA health plan  
2 may enter into contracts and agreements for the provision  
3 of care and services to be provided under the VA health  
4 plan and contracts and agreements for other services (in-  
5 cluding procurement of equipment, maintenance and re-  
6 pair services, and other services related to the provision  
7 of health care services) consistent with section 1821 of  
8 this title.

9       “(c) Contracts and agreements (including leases)  
10 under subsection (a) shall not be subject to the following  
11 provisions of law:

12               “(1) Section 8110(c) of this title, relating to  
13 the contracting of services at Department health-  
14 care facilities.

15               “(2) Section 8122(a)(1) of this title, relating to  
16 the lease of Department property.

17               “(3) Section 8125 of this title, relating to local  
18 contracts for the procurement of health-care items.

19               “(4) Section 702 of title 5, relating to the right  
20 of review of agency wrongs by courts of the United  
21 States.

22               “(5) Sections 1346(a)(2) and 1491 of title 28,  
23 relating to the jurisdiction of the district courts of  
24 the United States and the United States Court of

1 Federal Claims, respectively, for the actions enumer-  
2 ated in such sections.

3 “(6) Subchapter V of chapter 35 of title 31, re-  
4 lating to adjudication of protests of violations of pro-  
5 curement statutes and regulations.

6 “(7) Sections 3526 and 3702 of such title, re-  
7 lating to the settlement of accounts and claims, re-  
8 spectively, of the United States.

9 “(8) Subsections (b)(7), (e), (f), (g), and (h) of  
10 section 8 of the Small Business Act (15 U.S.C.  
11 637(b)(7), (e), (f), (g), and (h)), relating to require-  
12 ments with respect to small businesses for contracts  
13 for property and services.

14 “(9) The provisions of law assembled for pur-  
15 poses of codification of the United States Code as  
16 section 471 through 544 of title 40 that relate to the  
17 authority of the Administrator of General Services  
18 over the lease and disposal of Federal Government  
19 property.

20 “(10) The provisions of the Office of Federal  
21 Procurement Policy Act (41 U.S.C. 401 et seq.), re-  
22 lating to the procurement of property and services  
23 by the Federal Government.

24 “(11) Chapter 3 of the Federal Property and  
25 Administrative Services Act of 1949 (41 U.S.C. 251

1 et seq.), relating to the procurement of property and  
2 services by the Federal Government.

3 “(12) Office of Management and Budget Cir-  
4 cular A-76.

5 “(c)(1) Contracts and agreements for the provision  
6 of care and services under subsection (a) may include any  
7 contract or other agreement that the health plan director  
8 of a VA health plan determines is consistent with section  
9 1821 of this title and appropriate in order to provide care  
10 and services under the VA health plan.

11 “(2) Contracts and agreements under this subsection  
12 may be entered into without prior review by the Central  
13 Office of the Department.

14 “(d)(1) The entry into a contract or agreement under  
15 this section for services other than the services referred  
16 to in subsection (c) (including contracts and agreements  
17 for procurement of equipment, maintenance and repair  
18 services, and other services related to the provision of  
19 health care services) shall not be subject to prior review  
20 by the Central Office if the contract is consistent with sec-  
21 tion 1821 of this title and the amount of the contract or  
22 agreement is less than \$250,000.

23 “(2) The Central Office may conduct a prior review  
24 of a contract or agreement referred to in paragraph (1)

1 if the amount of the contract or agreement is \$250,000  
2 or greater.

3 **“§ 7343. Resource sharing authority**

4 “(a) The Secretary may, consistent with section 1821  
5 of this title, enter into agreements under section 8153 of  
6 this title with other health care plans, with health care  
7 providers, and with other health industry organizations,  
8 and with individuals, for the sharing of resources of the  
9 Department under a VA health plan.

10 “(b) The Secretary may, consistent with section 1821  
11 of this title, enter into agreements with other departments  
12 and agencies of the Federal Government for the sharing  
13 of resources of the Department and such departments and  
14 agencies in order to provide care and services under a VA  
15 health plan.

16 **“§ 7344. Administrative and personnel flexibility**

17 “(a) Notwithstanding any other provision of law, the  
18 Secretary may—

19 “(1) appoint health care personnel to positions  
20 in any facility of the Department operating as or  
21 within a VA health plan in accordance with such  
22 qualifications for such positions as the Secretary  
23 may establish; and

1           “(2) promote and advance personnel serving in  
2           such positions in accordance with such qualifications  
3           as the Secretary may establish.

4           “(b) Subject to the provisions of section 1125 of the  
5           Health Security Act, the Secretary may carry out appro-  
6           priate promotional, advertising, and marketing activities  
7           to inform individuals of the availability of VA health plans.

8           **“§ 7345. Expenditure authority**

9           “(a)(1) To the extent that appropriations are avail-  
10          able, the director of a VA health plan may expend funds  
11          available to a VA health plan (including funds available  
12          under section 1834(c) of this title, funds available under  
13          section 7346(d)(2)(B) of this title, and funds otherwise  
14          made available to the VA health plan by the Secretary)  
15          for any purpose, and in any amount, that the director de-  
16          termines appropriate in order to ensure that the VA health  
17          plan meets the requirements and the requirements of fur-  
18          nishing care and services to veterans under chapter 17 of  
19          this title.

20          “(2) Funds may be expended under this subsection  
21          in order to cover the following costs:

22                  “(A) The costs of marketing and advertising  
23          under a VA health plan.

1           “(B) The costs of legal services provided to a  
2           VA health plan by the General Counsel of the De-  
3           partment.

4           “(C) The costs of acquisition (including acquisi-  
5           tion of land), construction, repair, or renovation of  
6           facilities.

7           “(3) The exercise by a health plan director of the au-  
8           thority provided in paragraph (1) shall not be subject to  
9           prior review by the Central Office of the Department.

10          “(b) Subsection (a) shall not apply to expenditures  
11          of funds provided to a facility by the Central Office of  
12          the Department exclusively for the purpose of the provi-  
13          sion of the following services:

14                 “(1) Services relating to post-traumatic stress  
15                 disorder.

16                 “(2) Services relating to spinal-cord dysfunc-  
17                 tion.

18                 “(3) Services relating to substance abuse.

19                 “(4) Services relating to the rehabilitation of  
20                 blind veterans.

21          **“§ 7346. Veterans Health Care Investment Fund**

22                 “(a) There is hereby established in the Treasury of  
23          the United States a fund to be known as the Veterans  
24          Health Care Investment Fund (in this section referred to  
25          as the ‘Fund’).

1       “(b) There is hereby authorized to be appropriated  
2 to the Department, in addition to amounts otherwise au-  
3 thorized to be appropriated to the Department for VA  
4 health plans, such amounts as are necessary for the Sec-  
5 retary of the Treasury to fulfill the requirement of sub-  
6 section (c).

7       “(c) For each of fiscal years 1995, 1996, and 1997,  
8 the Secretary of the Treasury shall, subject to the avail-  
9 ability of appropriated funds, credit to the Fund an  
10 amount in that fiscal year as follows:

11               “(1) For fiscal year 1995, \$1,225,000,000.

12               “(2) For fiscal year 1996, \$600,000,000.

13               “(3) For fiscal year 1997, \$1,700,000,000.

14       “(d)(1) Subject to paragraph (2), amounts in the  
15 Fund shall be available to the Secretary only for the VA  
16 health plans organized and operated under this sub-  
17 chapter.

18       “(2)(A) For each of fiscal years 1996 and 1997, the  
19 Secretary shall estimate the total amount to be collected  
20 or recovered under sections 1831, 1832, and 1833 of this  
21 title by reason of the provision of care and services  
22 through VA health plans under chapter 18 of this title  
23 or the enrollment of individuals in such plans under that  
24 chapter. The Secretary shall estimate the amount to be

1 so collected or recovered with respect to each VA health  
2 plan and with respect to all VA health plans.

3 “(B) For each such fiscal year, the Secretary shall  
4 make available to each VA health plan an amount that  
5 bears the same relationship to the total amount available  
6 in the Fund for the fiscal year as the amount estimated  
7 to be collected or recovered by the VA health plan during  
8 the fiscal year bears to the total amount estimated to be  
9 collected or recovered by all VA health plans during that  
10 fiscal year.

11 “(e) Not later than March 1, 1997, the Secretary  
12 shall submit to Congress a report concerning the operation  
13 of the Department of Veterans Affairs health care system  
14 in preparing for, and operating under, national health care  
15 reform under the Health Security Act during fiscal years  
16 1995 and 1996. The report shall include a discussion of—

17 “(1) the adequacy of amounts in the Fund for  
18 the operation of VA health plans;

19 “(2) the quality of care provided by such plans;  
20 and

21 “(3) the ability of such plans to attract pa-  
22 tients.

1 **“§ 7347. Funding provisions: grants and other sources**  
 2 **of assistance**

3 “The Secretary may apply for and accept, if awarded,  
 4 any grant or other source of funding that is intended to  
 5 meet the needs of special populations and that but for this  
 6 section is unavailable to facilities of the Department or  
 7 to health plans operated by the Government if funds ob-  
 8 tained through the grant or other source of funding will  
 9 be used through a facility of the Department operating  
 10 as or within a health plan.”.

11 (b) CLERICAL AMENDMENT.—The table of sections  
 12 at the beginning of chapter 73 is amended by striking out  
 13 the item relating to the heading for subchapter IV and  
 14 inserting in lieu thereof the following:

“SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE  
 REFORM

- “7341. Organization of health care facilities as health plans.
- “7342. Contract authority for facilities operating as or within health plans.
- “7343. Resource sharing authority.
- “7344. Administrative and personnel flexibility.
- “7345. Expenditure authority.
- “7346. Veterans Health Care Investment Fund.
- “7347. Funding provisions: grants and other sources of assistance.

“SUBCHAPTER V—RESEARCH CORPORATIONS”.

1 **TITLE IX—WORKERS COMPENSA-**  
2 **TION MEDICAL SERVICES**

3 **SEC. 9000. APPLICATION OF INFORMATION REQUIRE-**  
4 **MENTS.**

5 (a) IN GENERAL.—The provisions of subtitle B of  
6 title V shall apply to the provision of workers compensa-  
7 tion medical services provided by a health plan or health  
8 care provider in the same manner as such provisions apply  
9 with respect to the provision of services included in the  
10 standard benefit package.

11 (b) INFORMATION.—Subject to the provisions of sub-  
12 title C of title V, health plans and health care providers  
13 that render workers compensation medical services shall  
14 provide to the worker and to the workers compensation  
15 carrier, the employer or both, as appropriate, relevant  
16 health care information necessary to assist the worker in  
17 the safe and timely return to work.

18 (c) COMPLIANCE WITH DUTIES AND REQUIRE-  
19 MENTS.—A health plan to which this section applies and  
20 its providers shall comply with legal duties and reporting  
21 requirements under State workers compensation laws, and  
22 other Federal and State laws, including laws regarding the  
23 reporting of occupational injuries and diseases.

24 (d) RULES.—The Secretary of Labor shall promul-  
25 gate rules to clarify the responsibilities of health plans and

1 health care providers in carrying out the provisions re-  
2 ferred to in subsection (a).

3 **SEC. 9001. PROVISION OF CARE IN DISPUTED CASES.**

4 (a) IN GENERAL.—In cases in which a workers com-  
5 pensation claim is challenged by the employer, the workers  
6 compensation carrier, or both, a health plan shall provide  
7 or pay for all medical care included in the standard benefit  
8 package according to the applicable workers compensation  
9 fee schedule, if any, until such time as a determination  
10 is made through the adjudication process that the claim  
11 is compensable as a workers compensation claim. If such  
12 a determination is made, the workers compensation carrier  
13 (or the employer, if self-insured) shall reimburse the  
14 health plan (for the cost of services delivered to the mem-  
15 ber for the work-related illness or injury) and the worker  
16 (for any copayments, deductibles or coinsurance costs in-  
17 curred for such services).

18 (b) APPLICABILITY.—Subsection (a) shall not apply  
19 in a case where compensation has been accepted by the  
20 insurer or the employer, or paid without prejudice.

21 **SEC. 9002. DEMONSTRATION PROJECTS.**

22 (a) AUTHORIZATION.—The Secretary of Health and  
23 Human Services and the Secretary of Labor are author-  
24 ized to conduct demonstration projects under this section

1 in one or more States with respect to treatment of work-  
2 related injuries and illnesses.

3 (b) DEVELOPMENT OF WORK-RELATED PROTO-  
4 COLS.—

5 (1) IN GENERAL.—The Secretary of Health and  
6 Human Services and the Secretary of Labor, in con-  
7 sultation with the States and such experts on work-  
8 related injuries and illnesses as each such Secretary  
9 finds appropriate, shall develop protocols for the ap-  
10 propriate treatment of work-related conditions.

11 (2) TESTING OF PROTOCOLS.—The Secretary of  
12 Health and Human Services and the Secretary of  
13 Labor shall enter into contracts with one or more  
14 community-rated health plans to test the validity of  
15 the protocols developed under subsection (a).

16 (c) DEVELOPMENT OF CAPITATION PAYMENT MOD-  
17 ELS.—The Secretary of Health and Human Services and  
18 the Secretary of Labor shall develop, using protocols devel-  
19 oped under subsection (b) if possible, methods of providing  
20 for payment by workers compensation carriers to health  
21 plans on a per case basis, capitated payment for the treat-  
22 ment of specified work-related injuries and illnesses.

1 **SEC. 9003. COMMISSION ON WORKERS COMPENSATION**  
2 **MEDICAL SERVICES.**

3 (a) ESTABLISHMENT.—There is hereby established a  
4 Commission on Workers Compensation Medical Services  
5 (hereafter in this section referred to as the “Commis-  
6 sion”).

7 (b) COMPOSITION.—

8 (1) IN GENERAL.—The Commission shall con-  
9 sist of 15 members appointed in accordance with  
10 paragraph (2). Members of the Commission shall in-  
11 clude—

12 (A) one or more individuals representing  
13 State workers compensation commissioners;

14 (B) one or more individuals representing  
15 State workers compensation funds;

16 (C) one or more individuals representing  
17 labor organizations;

18 (D) one or more individuals representing  
19 employers (other than workers compensation in-  
20 surance carriers);

21 (E) one or more individuals representing  
22 workers compensation insurance carriers;

23 (F) one or more members of the medical  
24 profession having expertise in occupational  
25 health; and

1 (G) one or more educators or researchers  
2 having expertise in the field of occupational  
3 health.

4 Eight members of the Commission shall constitute a  
5 quorum.

6 (2) APPOINTMENTS.—Members of the Commis-  
7 sion shall be appointed by the President and shall  
8 include—

9 (A) three members appointed from among  
10 individuals recommended by the Speaker of the  
11 House of Representatives;

12 (B) three members appointed from among  
13 individuals recommended by the Minority Lead-  
14 er of the House of Representatives;

15 (C) three members appointed from among  
16 individuals recommended by the Majority Lead-  
17 er of the Senate; and

18 (D) three members appointed from among  
19 individuals recommended by the Minority Lead-  
20 er of the Senate.

21 (3) NO COMPENSATION EXCEPT TRAVEL EX-  
22 PENSES.—Members of the Commission shall serve  
23 without compensation, but each member shall receive  
24 travel expenses, including per diem in lieu of subsist-

1       ence, in accordance with sections 5702 and 5703 of  
2       title 5, United States Code.

3       (c) DUTIES.—

4           (1) IN GENERAL.—The Commission shall study  
5       the relationship of workers compensation medical  
6       services to the new health system under this Act in  
7       terms of impact on the cost of workers compensation  
8       medical services, access to appropriate care for in-  
9       jured workers, and quality of medical care and its  
10      impact on functional and vocational outcomes for in-  
11      jured workers.

12          (2) EVALUATION ISSUES TO BE ADDRESSED.—

13      In its deliberations under paragraph (1), the Com-  
14      mission shall consider the following issues in exam-  
15      ining the relationship between health plans and  
16      workers compensation medical services:

17           (A) The impact of health reform on work-  
18      ers compensation medical costs and premium  
19      rates charged to employers for workers com-  
20      pensation insurance.

21           (B) The extent and impact of cost-shifting  
22      and price discrimination between the workers  
23      compensation medical system and traditional  
24      health insurers.

1 (C) The impact of experience rating ad-  
2 justments resulting from workers compensation  
3 medical services on workplace safety.

4 (D) The advantages and disadvantages of  
5 maintaining separate financing, payment and  
6 delivery systems for workers compensation med-  
7 ical services, including the impact on—

8 (i) the quality of medical care deliv-  
9 ered to workers injured or made ill on the  
10 job;

11 (ii) the incentives for employers to  
12 maintain safe work-places; and

13 (iii) workers compensation indemnity  
14 benefit costs, medical costs and the overall  
15 costs of the workers compensation system.

16 (E) The advisability and appropriateness  
17 of transferring financial responsibility for some  
18 or all workers compensation medical benefits to  
19 health plans.

20 (F) The impact of State-to-State variations  
21 in medical and rehabilitation benefits on costs,  
22 access and quality of care.

23 (G) The options that are available to ac-  
24 complish the delivery of workers compensation

1 benefits not included in the standard benefit  
2 package in integrated systems

3 (H) Whether capitated rates can be devel-  
4 oped for workers compensation medical bene-  
5 fits, and the impact of using such rates on med-  
6 ical and indemnity costs, access, and quality of  
7 care.

8 (I) The impact of provider choice, with re-  
9 spect to an injured worker, on workers com-  
10 pensation medical costs, wage-loss benefits  
11 costs, and quality of care.

12 (d) STAFF SUPPORT.—The Secretary of Health and  
13 Human Services and the Secretary of Labor shall provide  
14 staff support for the Commission.

15 (e) REPORTS.—Not later than October 1, 2000, the  
16 Commission shall submit a final report on its work to the  
17 President, the Committee on Labor and Human Resources  
18 of the Senate and the Committee on Education and Labor  
19 of the House of Representatives. Such report shall include  
20 a recommendation as to whether a transfer of financial  
21 responsibility for some or all medical benefits to health  
22 plans should be effected, and a detailed implementation  
23 plan should such a transfer be recommended. Prior to the  
24 submission of the final report, the Commission shall sub-  
25 mit such interim reports on issues addressed by the Com-

1 mission as the members of the Commission determine to  
2 be appropriate.

3 **TITLE X—PREMIUM FINANCING**  
4 **Subtitle A—National Health Care**  
5 **Cost and Coverage Commission**

6 **SEC. 10001. NATIONAL HEALTH CARE COST AND COVERAGE**  
7 **COMMISSION.**

8 There is established a commission to be known as the  
9 National Health Care Cost and Coverage Commission  
10 (hereafter in this title referred to as the “Commission”).

11 **SEC. 10002. COMPOSITION.**

12 (a) COMPOSITION.—The Commission shall be com-  
13 posed of 7 members appointed by the President and con-  
14 firmed by the Senate. Members shall be appointed not  
15 later than 9 months after the date of the enactment of  
16 this Act based on their expertise and national recognition  
17 in the fields of health economics including insurance prac-  
18 tices, health care benefit design, health care provider orga-  
19 nization and reimbursement, and labor markets. In ap-  
20 pointing members of the Commission, the President shall  
21 ensure that no more than 4 members of the Commission  
22 are affiliated with the same political party.

23 (b) CHAIRPERSON.—The President shall designate 1  
24 individual described in subsection (a) who shall serve as  
25 Chairperson of the Commission.

1 (c) TERMS.—

2 (1) IN GENERAL.—The terms of members of  
3 the Commission shall be for 6 years to commence on  
4 January 1, 1996, except that of the members first  
5 appointed, 3 shall be appointed for an initial term  
6 of 4 years, 3 shall be appointed for an initial term  
7 of 5 years and the chairperson shall be appoint for  
8 an initial term of 6 years.

9 (2) CONTINUATION IN OFFICE.—Upon the expi-  
10 ration of a term of office, a member shall continue  
11 to serve until a successor is appointed and qualified.

12 (d) VACANCIES.—

13 (1) IN GENERAL.—A vacancy in the Commis-  
14 sion shall be filled in the same manner as the origi-  
15 nal appointment, but the individual appointed to fill  
16 the vacancy shall serve only for the unexpired por-  
17 tion of the term for which the individual's prede-  
18 cessor was appointed.

19 (2) NO IMPAIRMENT OF FUNCTION.—A vacancy  
20 in the membership of the Commission does not im-  
21 pair the authority of the remaining members to exer-  
22 cise all of the powers of the Commission.

23 (3) ACTING CHAIRPERSON.—The Commission  
24 may designate a member to act as Chairperson dur-

1       ing any period in which there is no Chairperson des-  
2       ignated by the President.

3 **SEC. 10003. DUTIES OF COMMISSION.**

4       (a) IN GENERAL.—The general duties of the Com-  
5       mission are to monitor and respond to—

6             (1) trends in health care coverage; and

7             (2) changes in per-capita premiums and other  
8       indicators of health care inflation.

9       The Commission may be advised by individuals with exper-  
10      tise concerning the economic, demographic, and insurance  
11      market factors that affect the cost and coverage of health  
12      insurance.

13      (b) ANNUAL REPORTS.—

14             (1) IN GENERAL.—The Commission shall report  
15      to Congress annually on January 1 (beginning in  
16      1997) concerning trends in health care coverage and  
17      costs. Such reports shall categorize such information  
18      on a national basis, a State by State basis, and a  
19      community rating area basis.

20             (2) HEALTH CARE COVERAGE.—For purposes  
21      of this title, the term “health care coverage” means  
22      coverage under—

23                 (A) a certified standard health plan pro-  
24                 viding a standard benefits package or an alter-  
25                 native standard benefits package;

1 (B) the medicare program under title  
2 XVIII of the Social Security Act;

3 (C) the medicaid program under title XIX  
4 of the Social Security Act;

5 (D) the health care program for active  
6 military personnel under title 10, United States  
7 Code;

8 (E) the veterans health care program  
9 under chapter 17 of title 38, United States  
10 Code;

11 (F) the Civilian Health and Medical Pro-  
12 gram of the Uniformed Services (CHAMPUS),  
13 as defined in section 1073(4) of title 10, United  
14 States Code;

15 (G) the Indian health service program  
16 under the Indian Health Care Improvement Act  
17 (25 U.S.C. 1601 et seq.);

18 (H) a State single-payer system approved  
19 under subpart B of part 3 of subtitle F of title  
20 I; or

21 (I) any governmental health care program  
22 for institutionalized individuals.

23 (3) CONTENTS OF REPORT.—Each report under  
24 paragraph (1) shall include the findings of the Com-  
25 mission with respect to the following:

1 (A) Demographics and employment status  
2 of the uninsured individuals, and findings on  
3 why such individuals are uninsured.

4 (B) Structure of delivery systems.

5 (C) Status of insurance reforms.

6 (D) Development and operation of pur-  
7 chasing cooperatives and other buyer reforms.

8 (E) Success of market and other mecha-  
9 nisms in expanding coverage and controlling  
10 health expenditures and premium costs among  
11 employers and families.

12 (F) Success of the tax imposed under sec-  
13 tion 4521 of the Internal Revenue Code of  
14 1986.

15 (G) Success and adequacy of the individual  
16 and employer subsidy programs under title VI  
17 in expanding coverage through employers and  
18 families.

19 (H) Per capita cost of health care, includ-  
20 ing—

21 (i) the rate of growth in health care  
22 costs categorized by type of health care  
23 provider and type of payor in States and  
24 community rating areas;

- 1 (ii) the expected rate of growth in per  
2 capita health care costs;  
3 (iii) the causes of such growth; and  
4 (iv) proposed strategies for controlling  
5 such growth.

6 (I) The percentage of the resident popu-  
7 lation in the United States, and each State,  
8 that has health care coverage.

9 (4) BENEFITS ISSUES.—The Commission shall  
10 consult with the National Health Benefits Board in  
11 gathering data and in making recommendations con-  
12 cerning issues that effect the standard benefit pack-  
13 age.

14 (c) AFFORDABILITY REPORTS.—

15 (1) IN GENERAL.—As part of each annual re-  
16 port under subsection (b), beginning with the report  
17 for 1999, the Commission shall include information  
18 on—

19 (A) the affordability of health care cov-  
20 erage for families and employers; and

21 (B) the success of market incentives and  
22 other provisions of this Act in achieving health  
23 care cost containment.

24 (2) DETERMINATION AND RECOMMENDA-  
25 TIONS.—If the Commission determines for any year

1 that health care coverage is unaffordable (as de-  
2 scribed in paragraph (3)) or that cost containment  
3 efforts under this Act are unsuccessful, the Commis-  
4 sion shall submit recommendations in the annual re-  
5 port for systematic improvements as provided for in  
6 paragraph (4).

7 (3) COST OF COVERAGE.—The Commission  
8 shall make a determination of unaffordability under  
9 paragraph (2) if the Commission finds that, with re-  
10 spect to the year for which the report is submitted,  
11 fewer than 35 percent of those eligible to enroll in  
12 community-rated health plans were able to enroll in  
13 plans with a premium that was at or below the ref-  
14 erence premium for the community rating area in-  
15 volved.

16 (4) RECOMMENDATIONS.—If the Commission  
17 makes a finding under paragraph (3) with respect to  
18 any year, the Commission shall recommend to Con-  
19 gress a means of controlling health care costs in  
20 order to ensure that the growth in the per capita  
21 premium for community-rated plans is at or below  
22 the growth in the target per capita premium for the  
23 community rating area involved. The Commission  
24 may recommend alternative target per capita pre-

1 mium growth if the Commission determines that  
2 such alternative would be more appropriate.

3 (5) CONGRESSIONAL CONSIDERATION.—The  
4 recommendations of the Commission under para-  
5 graph (4) shall be submitted to Congress in the form  
6 of an implementing bill which contains such statu-  
7 tory provisions as the Commission determines are  
8 necessary or appropriate to implement such rec-  
9 ommendations. Such bill shall be considered under  
10 the procedures established under section 10004.

11 (d) COVERAGE TRIGGER.—

12 (1) COMMISSION DETERMINATION.—By Janu-  
13 ary 1, 2000, the Commission shall make a deter-  
14 mination as to the percentage of the resident popu-  
15 lation in the United States, and each State, that has  
16 health care coverage.

17 (2) ATTAINMENT OF COVERAGE GOAL.—

18 (A) IN GENERAL.—If, under paragraph  
19 (1), the Commission determines that health  
20 care coverage of at least 95 percent of the resi-  
21 dent population in the United States has been  
22 attained, the Commission shall submit rec-  
23 ommendations (under subparagraph (B)) in its  
24 annual report to Congress on January 1, 2000.

1 (B) RECOMMENDATION REQUIREMENT.—

2 The recommendations of the Commission under  
3 subparagraph (A) shall include methods to ex-  
4 pand health care coverage to those who are not  
5 covered. Such recommendations shall address  
6 all relevant parties, including States, employers,  
7 employees, unemployed and low-income individ-  
8 uals, and public program participants.

9 (3) COVERAGE GOAL NOT ATTAINED.—

10 (A) IN GENERAL.—If, under paragraph  
11 (1), the Commission determines that health  
12 care coverage of at least 95 percent of the resi-  
13 dent population in the United States has not  
14 been attained by January 1, 2000, the Commis-  
15 sion shall submit recommendations (under sub-  
16 paragraph (B)) in its annual report to Congress  
17 not later than May 15, 2000.

18 (B) RECOMMENDATION REQUIREMENTS.—

19 The recommendations of the Commission under  
20 paragraph (1) shall include one or more legisla-  
21 tive proposals for expanding health care cov-  
22 erage to cover the remaining uninsured popu-  
23 lation. Such recommendations shall address all  
24 relevant parties, including States, employers,

1 employees, unemployed and low-income individ-  
2 uals, and public program participants.

3 (C) CONGRESSIONAL CONSIDERATION.—

4 The recommendations of the Commission under  
5 subparagraph (A) shall be submitted to Con-  
6 gress in the form of one or more implementing  
7 bills which contains such statutory provisions as  
8 the Commission determines are necessary or ap-  
9 propriate to implement such recommendations.  
10 Such bill shall be considered under the proce-  
11 dures established under section 10004.

12 **SEC. 10004. CONGRESSIONAL CONSIDERATION OF COMMIS-**  
13 **SION RECOMMENDATIONS.**

14 (a) IMPLEMENTING BILLS.—

15 (1) IN GENERAL.—Except as provided in para-  
16 graph (2), an implementing bill described in section  
17 10003(c)(5) or section 10003(d)(3)(C) shall be con-  
18 sidered by Congress under the procedures for consid-  
19 eration described in subsection (b), except that with  
20 respect to an implementing bill described in section  
21 10003(c)(5), the date described in subsection (b)(3)  
22 shall not apply.

23 (2) GAO CONSIDERATION.—With respect to an  
24 implementing bill described in section  
25 10003(d)(3)(C), to be eligible for Congressional con-

1       sideration under subsection (b), the General Ac-  
2       counting Office must certify that, if implemented,  
3       the legislative proposals in such bill would expand  
4       health care coverage to cover the remaining unin-  
5       sured population.

6       (b) CONGRESSIONAL CONSIDERATION.—

7           (1) RULES OF HOUSE OF REPRESENTATIVES  
8       AND SENATE.—This subsection is enacted by Con-  
9       gress—

10           (A) as an exercise of the rulemaking power  
11       of the House of Representatives and the Sen-  
12       ate, respectively, and as such is deemed a part  
13       of the rules of each House, respectively, but ap-  
14       plicable only with respect to the procedure to be  
15       followed in that House in the case of an imple-  
16       menting bill described in subsection (a), and su-  
17       persedes other rules only to the extent that  
18       such rules are inconsistent therewith; and

19           (B) with full recognition of the constitu-  
20       tional right of either House to change the rules  
21       (so far as relating to the procedure of that  
22       House) at any time, in the same manner and  
23       to the same extent as in the case of any other  
24       rule of that House.

1           (2) INTRODUCTION AND REFERRAL.—On the  
2 day on which the implementing bill described in sub-  
3 section (a) is transmitted to the House of Represent-  
4 atives and the Senate, such bill shall be introduced  
5 (by request) in the House of Representatives by the  
6 Majority Leader of the House, for himself or herself  
7 and the Minority Leader of the House, or by Mem-  
8 bers of the House designated by the Majority Leader  
9 and Minority Leader of the House and shall be in-  
10 troduced (by request) in the Senate by the Majority  
11 Leader of the Senate, for himself or herself and the  
12 Minority Leader of the Senate, or by Members of  
13 the Senate designated by the Majority Leader and  
14 Minority Leader of the Senate. If either House is  
15 not in session on the day on which the implementing  
16 bill is transmitted, the bill shall be introduced in  
17 that House, as provided in the preceding sentence,  
18 on the first day thereafter on which that House is  
19 in session. If the implementing bill is not introduced  
20 within 5 days of its transmission, any Member of the  
21 House and of the Senate may introduce such bill.  
22 The implementing bill introduced in the House of  
23 Representatives and the Senate shall be referred to  
24 the appropriate committees of each House.

1           (3) PERIOD FOR COMMITTEE CONSIDER-  
2           ATION.—If the committee or committees of either  
3           House to which an implementing bill has been re-  
4           ferred have not reported the bill at the close of July  
5           1, 2000 (or if such House is not in session, the next  
6           day such House is in session), such committee or  
7           committees shall be automatically discharged from  
8           further consideration of the implementing bill and it  
9           shall be placed on the appropriate calendar.

10           (4) FLOOR CONSIDERATION IN THE SENATE.—

11           (A) IN GENERAL.—Within 5 days after the  
12           implementing bill is placed on the calendar, the  
13           Majority Leader, at a time to be determined by  
14           the Majority Leader in consultation with the  
15           Minority Leader, shall proceed to the consider-  
16           ation of the bill. If on the sixth day after the  
17           bill is placed on the calendar, the Senate has  
18           not proceeded to consideration of the bill, then  
19           the presiding officer shall automatically place  
20           the bill before the Senate for consideration. A  
21           motion in the Senate to proceed to the consider-  
22           ation of an implementing bill shall be privileged  
23           and not debatable. An amendment to the mo-  
24           tion shall not be in order, nor shall it be in

1 order to move to reconsider the vote by which  
2 the motion is agreed to or disagreed to.

3 (B) TIME LIMITATION ON CONSIDERATION  
4 OF BILL.—

5 (i) IN GENERAL.—Debate in the Sen-  
6 ate on an implementing bill, and all  
7 amendments and debatable motions and  
8 appeals in connection therewith, shall be  
9 limited to not more than 30 hours. The  
10 time shall be equally divided between, and  
11 controlled by, the Majority Leader and the  
12 Minority Leader or their designees.

13 (ii) DEBATE OF AMENDMENTS, MO-  
14 TIONS, POINTS OF ORDER, AND AP-  
15 PEALS.—In the Senate, no amendment  
16 which is not relevant to the bill shall be in  
17 order. Debate in the Senate on any amend-  
18 ment, debatable motion or appeal, or point  
19 of order in connection with an imple-  
20 menting bill shall be limited to—

21 (I) not more than 2 hours for  
22 each first degree relevant amendment,

23 (II) one hour for each second de-  
24 gree relevant amendment, and

1 (III) 30 minutes for each debat-  
2 able motion or appeal, or point of  
3 order submitted to the Senate,  
4 to be equally divided between, and con-  
5 trolled by, the mover and the manager of  
6 the implementing bill, except that in the  
7 event the manager of the implementing bill  
8 is in favor of any such amendment, mo-  
9 tion, appeal, or point of order, the time in  
10 opposition thereto, shall be controlled by  
11 the Minority Leader or designee of the Mi-  
12 nority Leader. The Majority Leader and  
13 Minority Leader, or either of them, may,  
14 from time under their control on the pas-  
15 sage of an implementing bill, allot addi-  
16 tional time to any Senator during the con-  
17 sideration of any amendment, debatable  
18 motion or appeal, or point of order.

19 (C) OTHER MOTIONS.—A motion to recom-  
20 mit an implementing bill is not in order.

21 (D) FINAL PASSAGE.—Upon the expiration  
22 of the 30 hours available for consideration of  
23 the implementing bill, it shall not be in order to  
24 offer or vote on any amendment to, or motion  
25 with respect to, such bill. Immediately following

1 the conclusion of debate in the Senate on an  
2 implementing bill that was introduced in the  
3 Senate, such bill shall be deemed to have been  
4 read a third time and the vote on final passage  
5 of such bill shall occur without any intervening  
6 action or debate.

7 (E) DEBATE ON DIFFERENCES BETWEEN  
8 THE HOUSES.—Debate in the Senate on mo-  
9 tions and amendments appropriate to resolve  
10 the differences between the Houses, at any par-  
11 ticular stage of the proceedings, shall be limited  
12 to not more than 5 hours.

13 (F) DEBATE ON CONFERENCE REPORT.—  
14 Debate in the Senate on the conference report  
15 shall be limited to not more than 10 hours.

16 (5) FLOOR CONSIDERATION IN THE HOUSE OF  
17 REPRESENTATIVES.—

18 (A) PROCEED TO CONSIDERATION.—On  
19 the sixth day after the implementing bill is  
20 placed on the calendar, it shall be privileged for  
21 any Member to move without debate that the  
22 House resolve itself into the Committee of the  
23 Whole House on the State of the Union, for the  
24 consideration of the bill, and the first reading  
25 of the bill shall be dispensed with.

1           (B) GENERAL DEBATE.—After general de-  
2           bate, which shall be confined to the imple-  
3           menting bill and which shall not exceed 4  
4           hours, to be equally divided and controlled by  
5           the Chairman and Ranking Minority Member of  
6           the Committee or Committees to which the bill  
7           had been referred, the bill shall be considered  
8           for amendment by title under the 5-minute rule  
9           and each title shall be considered as having  
10          been read. The total time for considering all  
11          amendments shall be limited to 26 hours of  
12          which the total time for debating each amend-  
13          ment under the 5-minute rule shall not exceed  
14          one hour.

15          (C) RISE AND REPORT.—At the conclusion  
16          of the consideration of the implementing bill for  
17          amendment, the Committee of the Whole on the  
18          State of the Union shall rise and report the bill  
19          to the House with such amendments as may  
20          have been adopted, and the previous question  
21          shall be considered as ordered on the bill and  
22          the amendments thereto, and the House shall  
23          proceed to vote on final passage without inter-  
24          vening motion except one motion to recommit.

1           (6) COMPUTATION OF DAYS.—For purposes of  
2 this subsection, in computing a number of days in  
3 either House, there shall be excluded—

4           (A) the days on which either House is not  
5 in session because of an adjournment of more  
6 than 3 days to a day certain, or an adjourn-  
7 ment of the Congress sine die, and

8           (B) any Saturday and Sunday not ex-  
9 cluded under subparagraph (A) when either  
10 House is not in session.

11           (7) POINTS OF ORDER BASED ON EXPANDING  
12 COVERAGE.—

13           (A) IN GENERAL.—It shall not be in order  
14 in the Senate to consider—

15                   (i) any bill;

16                   (ii) any bill prior to third reading; or

17                   (iii) any conference report;

18 under the procedures described in this sub-  
19 section if such bill or conference report has not  
20 been certified by the General Accounting Office  
21 under subsection (a)(2) as expanding coverage  
22 to cover the remaining uninsured.

23           (B) WAIVER OR SUSPENSION.—Subpara-  
24 graph (A) may be waived or suspended in the  
25 Senate only by the affirmative vote of  $\frac{3}{5}$  of the

1 members duly chosen and sworn. An affirmative  
2 vote of  $\frac{3}{5}$  of the members of the Senate duly  
3 chosen and sworn shall be required in the Sen-  
4 ate to sustain an appeal of the ruling of the  
5 chair on a point of order raised under this  
6 paragraph.

7 (c) **FAILURE TO ENACT LEGISLATION.**—If Congress  
8 fails to enact legislation with respect to an implementing  
9 bill under section 10003(d)(3)(C) by December 31, 2000,  
10 the employer and individual premium financing provisions  
11 of subtitle B shall become effective on January 1, 2002  
12 with respect to those States determined by the Commis-  
13 sion under 10003(d)(3)(A) to have health care coverage  
14 for less than 95 percent of the resident populations of  
15 each such State.

16 **SEC. 10005. OPERATION OF THE COMMISSION.**

17 (a) **MEETINGS; QUORUM.**—

18 (1) **MEETINGS.**—The Chairperson shall preside  
19 at meetings of the Commission, and in the absence  
20 of the Chairperson, the Commission shall elect a  
21 member to act as Chairperson pro tempore.

22 (2) **QUORUM.**—Four members of the Commis-  
23 sion shall constitute a quorum thereof.

24 (b) **ADMINISTRATIVE PROVISIONS.**—

1           (1) FACA NOT APPLICABLE.—The Federal Ad-  
2       visory Committee Act (5 U.S.C. App.) shall not  
3       apply to the Commission.

4           (2) PAY AND TRAVEL EXPENSES.—

5           (A) PAY.—Each member of the Commis-  
6       sion shall be paid at a rate equal to the daily  
7       equivalent of the minimum annual rate of basic  
8       pay payable for level IV of the Executive Sched-  
9       ule under section 5315 of title 5, United States  
10      Code, for each day (including travel time) dur-  
11      ing which the member is engaged in the actual  
12      performance of duties vested in the Commis-  
13      sion.

14          (B) TRAVEL EXPENSES.—Members of the  
15      Commission shall receive travel expenses, in-  
16      cluding per diem in lieu of subsistence, in ac-  
17      cordance with sections 5702 and 5703 of title  
18      5, United States Code.

19          (3) EXECUTIVE DIRECTOR.—

20          (A) IN GENERAL.—The Commission shall,  
21      without regard to section 5311(b) of title 5,  
22      United States Code, appoint an Executive Di-  
23      rector.

1           (B) PAY.—The Executive Director shall be  
2 paid at a rate equivalent to a rate for the Sen-  
3 ior Executive Service.

4           (4) STAFF.—

5           (A) IN GENERAL.—Subject to subpara-  
6 graphs (B) and (C), the Executive Director,  
7 with the approval of the Commission, may ap-  
8 point and fix the pay of additional personnel.

9           (B) PAY.—The Executive Director may  
10 make such appointments without regard to the  
11 provisions of title 5, United States Code, gov-  
12 erning appointments in the competitive service,  
13 and any personnel so appointed may be paid  
14 without regard to the provisions of chapter 51  
15 and subchapter III of chapter 53 of such title,  
16 relating to classification and General Schedule  
17 pay rates, except that an individual so ap-  
18 pointed may not receive pay in excess of 120  
19 percent of the annual rate of basic pay payable  
20 for GS-15 of the General Schedule.

21           (C) DETAILED PERSONNEL.—Upon re-  
22 quest of the Executive Director, the head of any  
23 Federal department or agency may detail any  
24 of the personnel of that department or agency

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

3 (5) OTHER AUTHORITY.—

4 (A) CONTRACT SERVICES.—The Commis-  
5 sion may procure by contract, to the extent  
6 funds are available, the temporary or intermit-  
7 tent services of experts or consultants pursuant  
8 to section 3109 of title 5, United States Code.

9 (B) LEASES AND PROPERTY.—The Com-  
10 mission may lease space and acquire personal  
11 property to the extent funds are available.

12 (c) AUTHORIZATION OF APPROPRIATIONS.—There  
13 are authorized to be appropriated such sums as are nec-  
14 essary for the operation of the Commission.

15 **Subtitle B—Employer and Indi-**  
16 **vidual Premium Requirements**  
17 **and Assistance**

18 **SEC. 10101. APPLICATION OF SUBTITLE.**

19 (a) IN GENERAL.—The provisions of the subtitle  
20 shall apply as provided in section 10003(c).

21 (b) APPLICATION WITH RESPECT TO INDIVID-  
22 UALS.—

23 (1) LAWFUL RESIDENTS.—

1 (A) IN GENERAL.—This subtitle shall only  
2 apply with respect to an individual who is resid-  
3 ing in a State involved and who is—

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

6 (ii) an alien permanently residing in  
7 the United States under color of law (as  
8 defined in subparagraph (B)).

9 (B) ALIEN PERMANENTLY RESIDING IN  
10 THE UNITED STATES UNDER COLOR OF LAW.—

11 The term “alien permanently residing in the  
12 United States under color of law” means an  
13 alien lawfully admitted for permanent residence  
14 (within the meaning of section 101(a)(20) of  
15 the Immigration and Nationality Act), and in-  
16 cludes any of the following:

17 (i) An alien who is admitted as a ref-  
18 ugee under section 207 of the Immigration  
19 and Nationality Act.

20 (ii) An alien who is granted asylum  
21 under section 208 of such Act.

22 (iii) An alien whose deportation is  
23 withheld under section 243(h) of such Act.

1 (iv) An alien who is admitted for tem-  
2 porary residence under section 210, 210A,  
3 or 245A of such Act.

4 (v) An alien who has been paroled  
5 into the United States under section  
6 212(d)(5) of such Act for an indefinite pe-  
7 riod or who has been granted extended vol-  
8 untary departure as a member of a nation-  
9 ality group.

10 (vi) An alien who is the spouse or un-  
11 married child under 21 years of age of a  
12 citizen of the United States, or the parent  
13 of such a citizen if the citizen is over 21  
14 years of age, and with respect to whom an  
15 application for adjustment to lawful per-  
16 manent residence is pending.

17 (2) INDIVIDUAL RESPONSIBILITIES.—With re-  
18 spect to a State to which this subtitle applies, each  
19 individual described in paragraph (1)(A)—

20 (A) must enroll in (or be covered under) a  
21 health plan for the individual, and

22 (B) must pay any premium required, con-  
23 sistent with this Act, with respect to such en-  
24 rollment.

1           (3) INDIVIDUALS COVERED UNDER EQUIVALENT  
2 HEALTH CARE PROGRAMS.—This subtitle shall not  
3 apply with respect to an individual covered under an  
4 equivalent health care program.

5           (4) EQUIVALENT HEALTH CARE PROGRAM.—As  
6 used in paragraph (1), the term “equivalent health  
7 care program” means—

8                   (A) part A or part B of the medicare pro-  
9 gram under title XVIII of the Social Security  
10 Act,

11                   (B) the medicaid program under title XIX  
12 of the Social Security Act,

13                   (C) the health care program for active  
14 military personnel under title 10, United States  
15 Code,

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

19                   (E) the Civilian Health and Medical Pro-  
20 gram of the Uniformed Services (CHAMPUS),  
21 as defined in section 1073(4) of title 10, United  
22 States Code,

23                   (F) the Indian health service program  
24 under the Indian Health Care Improvement Act  
25 (25 U.S.C. 1601 et seq.), and

1 (G) a State single-payer system approved  
2 by the Secretary under subpart B of part 3 of  
3 subtitle F.

4 (5) INMATES.—This subtitle shall not apply  
5 with respect to an individual who is an inmate of a  
6 public institution (except as a patient of a medical  
7 institution).

8 (6) EXEMPTION.—

9 (A) IN GENERAL.—The requirements of  
10 this subtitle shall not apply with respect to an  
11 individual granted a qualified religious exemp-  
12 tion.

13 (B) QUALIFIED RELIGIOUS EXEMPTION.—

14 (i) IN GENERAL.—The term ‘qualified  
15 religious exemption’ means an exemption  
16 granted by the Secretary to an indi-  
17 vidual—

18 (I) who is a member of a recog-  
19 nized religious sect or division thereof  
20 with respect to which such Secretary  
21 makes the findings referred to in sub-  
22 paragraphs (C), (D), and (E) of sec-  
23 tion 1402(g)(1) of the Internal Rev-  
24 enue Code of 1986,

1 (II) who is an adherent of estab-  
 2 lished tenets or teachings of such sect  
 3 or division as described in such sec-  
 4 tion, and

5 (III) who submits an application  
 6 for such exemption which contains or  
 7 is accompanied by the evidence de-  
 8 scribed in section 1402(g)(1)(A) of  
 9 such Act and a waiver described in  
 10 section 1402(g)(1)(B) of such Act.

11 (C) LIMITATION.—An exemption granted  
 12 under this paragraph shall cease to apply begin-  
 13 ning on the date such Secretary determines  
 14 that the individual, or the sect or division,  
 15 ceased to meet the requirements of subpara-  
 16 graph (B).

17 **SEC. 10102. DEFINITIONS.**

18 For purposes of this title:

19 (1) FULL-TIME EQUIVALENT EMPLOYEES;  
 20 PART-TIME EMPLOYEES.—

21 (A) IN GENERAL.—A qualifying employee  
 22 who is employed by an employer—

23 (i) for at least 120 hours in a month,  
 24 is counted as 1 full-time equivalent em-

1            ployee for the month and shall be deemed  
2            to be employed on a full-time basis, or

3            (ii) for at least 40 hours, but less  
4            than 120 hours, in a month, is counted as  
5            a fraction of a full-time equivalent em-  
6            ployee in the month equal to the full-time  
7            employment ratio (as defined in subpara-  
8            graph (B)) for the employee and shall be  
9            deemed to be employed on a part-time  
10           basis.

11           (B) FULL-TIME EMPLOYMENT RATIO DE-  
12           FINED.—The term “full-time employment  
13           ratio” means, with respect to a qualifying em-  
14           ployee of an employer in a month, the lesser of  
15           1 or the ratio of—

16           (i) the number of hours of employ-  
17           ment such employee is employed by such  
18           employer for the month, to

19           (ii) 120 hours.

20           (C) FULL-TIME EMPLOYEE.—The term  
21           “full-time employee” means, with respect to an  
22           employer, an employee who is employed on a  
23           full-time basis (as specified in subparagraph  
24           (A)) by the employer.

1           (D) PART-TIME EMPLOYEE.—The term  
2 “part-time employee” means, with respect to an  
3 employer, an employee who is employed on a  
4 part-time basis (as specified in subparagraph  
5 (A)) by the employer.

6           (E) CONSIDERATION OF INDUSTRY PRAC-  
7 TICE.—As provided under rules established by  
8 the Secretary of Labor, an employee who is not  
9 described in subparagraph (C) or (D) shall be  
10 considered to be employed on a full-time or  
11 part-time basis by an employer (and to be a  
12 full-time or part-time employee of an employer)  
13 for a month (or for all months in a 12-month  
14 period) if the employee is employed by that em-  
15 ployer on a continuing basis that, taking into  
16 account the structure or nature of employment  
17 in the industry, represents full or part-time em-  
18 ployment in that industry.

19           (F) QUALIFYING EMPLOYEE.—

20           (i) The term “qualifying employee”  
21 means, with respect to an employer for a  
22 month, an employee who is employed by  
23 the employer for at least 40 hours in the  
24 month, subject to the limitation set forth  
25 in clause (ii).

1 (i) The term qualifying employee shall  
2 not include, with respect to an employer  
3 for a month, an employee of a nonelecting  
4 employer.

5 (2) FAMILY ADJUSTED INCOME.—

6 (A) IN GENERAL.—Except as otherwise  
7 provided, the term “family adjusted income”  
8 means, with respect to a family, the sum of the  
9 adjusted incomes (as defined in subparagraph  
10 (B)) for all members of the family.

11 (B) ADJUSTED INCOME.—In subparagraph  
12 (A), the term “adjusted income” means, with  
13 respect to an individual, adjusted gross income  
14 (as defined in section 62(a) of the Internal Rev-  
15 enue Code of 1986)—

16 (i) determined without regard to sec-  
17 tions 135, 162(l), 911, 931, and 933 of  
18 such Code, and

19 (ii) increased by the amount of inter-  
20 est received or accrued by the individual  
21 which is exempt from tax.

22 (C) PRESENCE OF ADDITIONAL DEPEND-  
23 ENTS.—At the option of an individual, a family  
24 may include (and not be required to separate  
25 out) the income of other individuals who are

1           claimed as dependents of the family for income  
2           tax purposes, but such individuals shall not be  
3           counted as part of the family for purposes of  
4           determining the size of the family.

5           (3) NONENROLLING EMPLOYEE.—The term  
6           “nonenrolling employee” means an employee of an  
7           employer who does not enroll in a health plan of-  
8           fered by the employer.

9           (4) REFERENCE PREMIUM.—The term “ref-  
10          erence premium” means the reference premium es-  
11          tablished under section 4512 of the Internal Rev-  
12          enue Code of 1986.

13          (5) SECRETARY.—The term “Secretary” means  
14          the Secretary of Labor.

15          (6) SELF-EMPLOYED INDIVIDUAL.—The term  
16          “self-employed individual” means, for a year, an in-  
17          dividual who has net earnings (as defined in section  
18          1402(a) of the Internal Revenue Code of 1986) from  
19          self-employment for the year.

20          (7) WEIGHTED AVERAGE PREMIUM.—The term  
21          “weighted average premium” has the same meaning  
22          given such term in section 6002(b)(1)(C).

1       **PART 1—EMPLOYER PREMIUM PAYMENTS**

2       **SEC. 10111. OBLIGATION.**

3       (a) **IN GENERAL.**—Except as otherwise provided in  
4 this subtitle, a contributing employer (as defined in sub-  
5 section (b)) shall make health care coverage premium pay-  
6 ments on behalf of the qualifying employees of the em-  
7 ployer in accordance with this subtitle.

8       (b) **CONTRIBUTING EMPLOYER.**—As used in sub-  
9 section (a), the term “contributing employer” means an  
10 employer that—

11           (1) employs, on average, 25 or more employees;

12           or

13           (2) employs less than 25 employees that elects  
14 under subsection (c) to be a contributing employee.

15       (c) **ELECTION.**—

16           (1) **IN GENERAL.**—An employer that does not  
17 meet the requirements of subsection (b) may elect to  
18 be treated as a community-rated employer under the  
19 procedures to be developed by the Secretary.

20           (2) **COMMUNITY-RATED EMPLOYER.**—An ex-  
21 empt employer shall be treated as a community-  
22 rated employer as of the first date of the first year  
23 following an election made under paragraph (1).

24           (3) **SELF-EMPLOYED.**—A self-employed indi-  
25 vidual that does not employ at least one full-time

1 employee may not make an election under paragraph  
2 (1).

3 **SEC. 10112. COMMUNITY-RATED EMPLOYERS.**

4 (a) REQUIREMENT.—

5 (1) IN GENERAL.—Each community-rated con-  
6 tributing employer for a month shall pay at least an  
7 amount equal to the sum across all qualifying em-  
8 ployees of the amount specified in subsection (b) for  
9 each such qualifying employee of the employer. Such  
10 payments shall be made in accordance with stand-  
11 ards established by the Secretary.

12 (2) TREATMENT OF CERTAIN EMPLOYMENT BY  
13 EXPERIENCE-RATED EMPLOYERS.—An experience-  
14 rated employer shall be deemed, for purposes of this  
15 subtitle, to be a community-rated employer with re-  
16 spect to qualifying employees who are not experience  
17 rate eligible individuals.

18 (b) PREMIUM PAYMENT AMOUNT.—

19 (1) GENERAL RULE.—The amount of the em-  
20 ployer premium payment under subsection (a) for a  
21 month for each qualifying employee of the employer  
22 who is residing in a community rating area, shall be  
23 equal to the sum of—

24 (A) 50 percent of the weighted average  
25 premium of the purchasing cooperative through

1           which the employer offered health plan coverage  
2           with respect to each such employee in such  
3           area; and

4                   (B) the employer collection shortfall add-  
5           on described in paragraph (2).

6           (2) EMPLOYER COLLECTION SHORTFALL ADD-  
7           ON.—The employer collection shortfall add-on for a  
8           month for each qualifying employee of the employer  
9           residing in a community rating area shall be equal  
10          to 50 percent of the amount described in section  
11          10134 with respect to each such employee.

12          (3) PART-TIME EMPLOYEES.—With respect to a  
13          part-time employee, the payment required under  
14          paragraph (1) (and the add-on described in para-  
15          graph (2)) shall be based on a pro-rated share (to  
16          be established by the Secretary) of the weighted av-  
17          erage premium of the purchasing cooperative in-  
18          volved (or, with respect to the shortfall add-on, the  
19          amount described in paragraph (2)).

20 **SEC. 10113. EXPERIENCE RATED EMPLOYERS.**

21          (a) REQUIREMENT.—Each experience-rated employer  
22          that in a month employs a qualifying employee who is—

23                  (1) enrolled in an experienced-rated health plan  
24          sponsored by the employer, shall provide for a pay-  
25          ment toward the premium for the plan for such em-

1        ployee in an amount specified under subsection (b);  
2        or

3            (2) is not so enrolled, shall make employer pre-  
4        mium payments with respect to such employee in an  
5        amount that is equal to 50 percent of the weighted  
6        average premium (for the applicable class of family  
7        enrollment) of the community rating area in which  
8        the employee resides.

9        (b) PREMIUM PAYMENT AMOUNT.—

10            (1) GENERAL RULE.—The amount of the expe-  
11        rience rated employer premium payment under sub-  
12        section (a)(1) for a month for each qualifying em-  
13        ployee of the employer, shall be equal to 50 percent  
14        of the weighted average premium of the health plans  
15        offered by the employer.

16            (2) SELF-INSURED PLANS.—In the case of a  
17        self-insured health plan, the amount of the premium  
18        payment under subsection (a) shall be equal to the  
19        premium equivalent of the self-insured health plan.

20            (3) PART-TIME EMPLOYEES.—With respect to a  
21        part-time employee, the payment required under  
22        paragraph (1) shall be a pro-rated share (to be es-  
23        tablished by the Secretary) of the amount described  
24        in subsection (a)(2).

1           (4) PREMIUM AREAS.—An experience-rated  
 2 plan sponsor employer may, based on regulations  
 3 promulgated by the Secretary, establish premium  
 4 areas. Experience rated employers may base their  
 5 payments under this section on the weighted average  
 6 premium of the health plans offered in such pre-  
 7 mium areas.

8           **PART 2—FAMILY PAYMENT RESPONSIBILITIES**

9                           **Subpart A—Family Share**

10          **SEC. 10131. ENROLLMENT AND PREMIUM PAYMENTS.**

11           (a) REQUIREMENT.—Each family enrolled in a com-  
 12 munity-rated health plan or in a experienced-rated health  
 13 plan in a class of family enrollment is responsible for pay-  
 14 ment of the family share of premium payable respecting  
 15 such enrollment. Such premium may be paid by an em-  
 16 ployer or other person on behalf of such a family.

17           (b) FAMILY SHARE OF PREMIUM DEFINED.—In this  
 18 part, the term “family share of premium” means, with re-  
 19 spect to enrollment of a family—

20                   (1) in a community-rated health plan, the  
 21 amount specified in section 10132(a) for the class;  
 22 or

23                   (2) in an experienced-rated health plan, the  
 24 amount specified in section 10132(b) for the class.

1 **SEC. 10132. FAMILY SHARE OF PREMIUMS.**

2 (a) COMMUNITY-RATED HEALTH PLANS.—

3 (1) IN GENERAL.—The family share of pre-  
4 miums for a family enrolled in a community-rated  
5 health plan based on a class of family enrollment  
6 shall equal the sum of the base amounts described  
7 in paragraph (2) reduced (but not below zero) by the  
8 sum of the amounts described in paragraph (3).

9 (2) BASE.—The base amounts described in this  
10 paragraph (for a plan for a class of enrollment)  
11 are—

12 (A) the applicable premium specified in  
13 section 10133(a) with respect to such class of  
14 enrollment;

15 (B) 50 percent of the applicable collection  
16 shortfall add-on (computed under section 10134  
17 for such class); and

18 (C) any applicable marketing fee as de-  
19 scribed in section 1112(f).

20 (3) CREDITS AND DISCOUNTS.—The amounts  
21 described in this paragraph (for a plan for a class  
22 of enrollment) are—

23 (A) the amount of the family credit under  
24 section 10135(a); and

25 (B) the amount of any premium discount  
26 provided under section 10136(a)(1).

1 (b) EXPERIENCE-RATED HEALTH PLANS.—

2 (1) IN GENERAL.—The family share of pre-  
3 miums for a family enrolled in an experience-rated  
4 health plan based on a class of family enrollment  
5 shall equal the premium described in paragraph (2)  
6 reduced (but not below zero) by the sum of the  
7 amounts described in paragraph (3).

8 (2) PREMIUM.—The premium described in this  
9 paragraph (for a plan for a class of enrollment) is  
10 the applicable plan premium specified in section  
11 10133(b) with respect to the plan and class of en-  
12 rollment involved.

13 (3) CREDITS AND DISCOUNTS.—The amounts  
14 described in this paragraph (for a plan for a class  
15 of enrollment) are—

16 (A) the amount of the family credit under  
17 section 10135(a); and

18 (B) the amount of any premium discount  
19 provided under section 10136(a).

20 (4) MULTISTATE EMPLOYERS.—For purposes  
21 of this subsection, the Secretary shall establish alter-  
22 native contribution rules for multistate self-insured  
23 employers.

1 **SEC. 10133. AMOUNT OF PREMIUM.**

2 (a) **COMMUNITY-RATED PLANS.**—The amount of the  
3 applicable premium charged by a community-rated health  
4 plan for all families in a class of family enrollment under  
5 a community-rated health plan offered in the health care  
6 coverage area is equal to the product of—

7 (1) the final community rate for the plan; and

8 (2) the premium class factor established by the  
9 Secretary of Health and Human Service for that  
10 class under subpart D of part 1 of subtitle E of title  
11 I;

12 increased for any applicable plan marketing fees (de-  
13 scribed in section 1112(f)) and purchasing cooperative  
14 membership fees (described in section 1324).

15 (b) **REFERENCE TO OTHER PREMIUMS.**—The  
16 amount of the premium charged by an experience-rated  
17 employer for all families in a class of family enrollment  
18 under an experience-rated health plan is specified under  
19 section 10113.

20 **SEC. 10134. COLLECTION SHORTFALL ADD-ON.**

21 (a) **IN GENERAL.**—The collection shortfall add-on for  
22 a community rating area for a class of enrollment for a  
23 year, is a per enrollee amount (determined under rules de-  
24 veloped by the Secretary of Health and Human Services),  
25 adjusted proportionately by the premium class factors de-  
26 scribed in section 10133(a)(2), such that the total of the

1 adjusted per enrollee amounts in the community rating  
2 area equals the aggregate collection shortfall as deter-  
3 mined under subsection (b).

4 (b) AGGREGATE COLLECTION SHORTFALL.—

5 (1) IN GENERAL.—Each State shall estimate,  
6 for each community rating area for each year (be-  
7 ginning with the first year for which this section ap-  
8 plies) the total amount of payments which the State  
9 can reasonably identify as owed to community-rated  
10 health plans under this Act for the year and not  
11 likely to be collected during a period specified by the  
12 Secretary beginning on the first day of the year.

13 (2) EXCLUSION OF GOVERNMENT DEBTS.—The  
14 amount under paragraph (1) shall not include any  
15 payments owed to a community-rated health plan by  
16 the Federal, State, or local governments.

17 (3) ADJUSTMENT FOR PREVIOUS SHORTFALL  
18 ESTIMATION DISCREPANCY.—The amount estimated  
19 under this subsection for a year shall be adjusted to  
20 reflect over (or under) estimations in the amounts so  
21 computed under this subsection for previous years  
22 (based on actual collections), taking into account in-  
23 terest payable based upon borrowings (or savings)  
24 attributable to such over or under estimations.

1 **SEC. 10135. FAMILY CREDIT.**

2 (a) IN GENERAL.—The credit provided under this  
3 section for a family enrolled through an employer in a  
4 community-rated or experience-rated plan for a class of  
5 family enrollment is equal to the amount of the minimum  
6 employer premium payment required under part 1 with  
7 respect to the family.

8 (b) FAMILY NOT ENROLLED THROUGH EM-  
9 PLOYER.—The credit provided under this section for a  
10 family that is not enrolled in a community-rated or experi-  
11 ence-rated plan through an employer for a class of family  
12 enrollment is equal to 50 percent of the premium of the  
13 plan in which the family is enrolled. In no case shall such  
14 amount exceed the weighted average premium in the com-  
15 munity rating area involved.

16 **SEC. 10136. PREMIUM SUBSIDY.**

17 (a) IN GENERAL.—Except as otherwise provided in  
18 this section, each family enrolled with a community-rated  
19 or experience-rated plan is entitled to a premium discount  
20 under this section, in the amount specified in subsection  
21 (b)(1).

22 (b) AMOUNT OF PREMIUM DISCOUNT.—

23 (1) IN GENERAL.—Subject to the succeeding  
24 paragraphs of this subsection, the amount of the  
25 premium discount under this subsection for a family  
26 under a class of family enrollment is equal to—

1 (A) 50 percent of the lesser of—

2 (i) the weighted average premium for  
3 community-rated plans offered in the com-  
4 munity-rating area involved, increased by  
5 any amount provided under paragraph (2);  
6 or

7 (ii)(I) in the case of a family enrolled  
8 through a community-rated employer, the  
9 weighted average premium for the pur-  
10 chasing cooperative through which the  
11 family obtains coverage; or

12 (II) in the case of a family enrolled  
13 through an experience-rated employer, the  
14 weighted average premium for the pre-  
15 mium area of the health plans offered by  
16 the employer; less

17 (B) the sum of—

18 (i) the family obligation amount de-  
19 scribed in subsection (c); and

20 (ii) the amount of any voluntary em-  
21 ployer payment (not required under part  
22 1) towards the family share of premiums  
23 for covered members of the family.

24 (2) INCREASE FOR COMMUNITY-RATED FAMI-  
25 LIES TO ASSURE ENROLLMENT IN AT-OR-BELOW-AV-

1       ERAGE-COST PLAN.—In the case of a family enrolled  
2       in a community-rated plan, if a State determines  
3       that a family eligible for a discount under this sec-  
4       tion is unable to enroll in an at-or-below-average-  
5       cost plan (as defined in paragraph (3)) that serves  
6       the area in which the family resides, the amount of  
7       the premium discount under this subsection is in-  
8       creased to the extent that such amount will permit  
9       the family to enroll in a community-rated plan with-  
10      out the need to pay a family share of premium  
11      under this part in excess of the sum described in  
12      paragraph (1)(B).

13           (3) AT-OR-BELOW-AVERAGE-COST PLAN DE-  
14      FINED.—In this section, the term “at-or-below-aver-  
15      age-cost plan” means a community-rated plan the  
16      premium for which does not exceed, for the class of  
17      family enrollment involved, the weighted average  
18      premium for the community-rating area.

19      (c) FAMILY OBLIGATION AMOUNT.—

20           (1) DETERMINATION.—Subject to paragraphs  
21      (2) and (3), the family obligation amount under this  
22      subsection is determined as follows:

23           (A) NO OBLIGATION IF INCOME BELOW IN-  
24      COME THRESHOLD AMOUNT.—If the family ad-  
25      justed income of the family is less than the in-

1           come threshold amount (specified in paragraph  
2           (4)), the family obligation amount is zero.

3           (B) INCOME ABOVE INCOME THRESHOLD  
4           AMOUNT.—If such income is at least such in-  
5           come threshold amount, the family obligation  
6           amount is the sum of the following:

7                   (i) FOR INCOME (ABOVE INCOME  
8                   THRESHOLD AMOUNT) UP TO THE POV-  
9                   ERTY LEVEL.—The product of the initial  
10                  marginal rate for the applicable class of  
11                  family enrollment (specified in paragraph  
12                  (2)) and the amount by which—

13                           (I) the family adjusted income  
14                           (not including any portion that ex-  
15                           ceeds the applicable poverty level for  
16                           the class of family involved), exceeds;

17                           (II) such income threshold  
18                           amount.

19                   (ii) GRADUATED PHASE OUT OF DIS-  
20                   COUNT UP TO 200 PERCENT OF POVERTY  
21                   LEVEL.—The product of the final marginal  
22                   rate for the applicable class of family en-  
23                   rollment (specified in paragraph (2)) and  
24                   the amount by which the family adjusted  
25                   income exceeds 100 percent (but is less

1                   than 200 percent) of the applicable poverty  
2                   level.

3                   (2) MARGINAL RATES.—In paragraph (1), for a  
4                   year:

5                   (A) INITIAL MARGINAL RATE.—The initial  
6                   marginal rate is the ratio of—

7                   (i) 4 percent of the applicable poverty  
8                   level for the class of enrollment involved  
9                   for the year; to

10                   (ii) the amount by which such poverty  
11                   level exceeds such income threshold  
12                   amount.

13                   (B) FINAL MARGINAL RATE.—The final  
14                   marginal rate is 12 percent.

15                   (3) LIMITATION TO 8 PERCENT FOR ALL FAMI-  
16                   LIES.—

17                   (A) IN GENERAL.—In no case shall the  
18                   family obligation amount under this subsection  
19                   for the year exceed 8 percent of the adjusted in-  
20                   come of the family.

21                   (B) FAMILIES ABOVE 200 percent of pov-  
22                   erty.—With respect to a family with a family  
23                   adjusted income that exceeds 200 percent of the  
24                   applicable poverty level, the family obligation

1 amount shall be equal to 8 percent of such fam-  
2 ily adjusted income.

3 (4) INCOME THRESHOLD AMOUNT.—

4 (A) IN GENERAL.—For purposes of this  
5 subtitle, the income threshold amount specified  
6 in this paragraph is \$1,000 (adjusted under  
7 subparagraph (B)).

8 (B) INDEXING.—For the 1-year period be-  
9 ginning on January 1, 1995, the income thresh-  
10 old amount specified in subparagraph (A) shall  
11 be increased or decreased by the same percent-  
12 age as the percentage increase or decrease by  
13 which the average CPI for the 12-month-period  
14 ending with August 31 of the preceding year  
15 exceeds such average for the 12-month period  
16 ending with August 31, 1993.

17 (C) ROUNDING.—Any increase or decrease  
18 under subparagraph (B) for a year shall be  
19 rounded to the nearest multiple of \$10.

20 **SEC. 10137. NO LOSS OF COVERAGE.**

21 In no case shall the failure to pay amounts owed  
22 under this Act result in an individual's or family's loss  
23 of coverage.

1     **Subpart B—Payment of Family Credit by Certain**  
2                                   **Families**

3     **SEC. 10141. PAYMENT OF FAMILY CREDIT BY NONWORKING**  
4                                   **AND PART-TIME CERTAIN FAMILIES.**

5           Subject to the limitations described in section 10142,  
6 a family with an employer contribution for a month that  
7 is less than the family credit amount described in section  
8 10135, shall be liable for payment of an amount equal to  
9 the family credit amount less any employer contributions  
10 for the family for the month.

11   **SEC. 10142. LIMITATION OF LIABILITY BASED ON INCOME.**

12           (a) IN GENERAL.—In the case of an eligible family  
13 described in subsection (b), the repayment amount re-  
14 quired under section 10141 with respect to a year shall  
15 not exceed the amount of liability described in subsection  
16 (c) for the year.

17           (b) ELIGIBLE FAMILY DESCRIBED.—An eligible fam-  
18 ily described in this subsection is a family which is deter-  
19 mined by the State for the community rating area in which  
20 the family resides, to have wage-adjusted income (as de-  
21 fined in subsection (d)) below 200 percent of the applica-  
22 ble poverty level.

23           (c) AMOUNT OF LIABILITY.—

24                   (1) DETERMINATION.—Subject to subsection  
25 (f), in the case of a family enrolled in a class of en-  
26 rollment with wage-adjusted income (as defined in

1 subsection (d)), the amount of liability under this  
2 subsection is determined as follows:

3 (A) NO OBLIGATION IF INCOME BELOW IN-  
4 COME THRESHOLD AMOUNT.—If such income is  
5 less than the income threshold amount (speci-  
6 fied in section 10136(c)(4)), the amount of li-  
7 ability is zero.

8 (B) INCOME ABOVE INCOME THRESHOLD  
9 AMOUNT.—If such income is at least such in-  
10 come threshold amount, the amount of liability  
11 is the sum of the following:

12 (i) INITIAL MARGINAL RATE.—The  
13 initial marginal rate (specified in para-  
14 graph (2)(A)) of the amount by which—

15 (I) the wage-adjusted income  
16 (not including any portion that ex-  
17 ceeds the applicable poverty level for  
18 the class of family involved), exceeds

19 (II) such income threshold  
20 amount.

21 (ii) FINAL MARGINAL RATE.—Where  
22 wage-adjusted income exceeds 100 percent  
23 of the applicable poverty level, the final  
24 marginal rate (specified in paragraph  
25 (2)(B)) of the amount by which the wage-

1 adjusted income exceeds 100 percent of the  
2 applicable poverty level.

3 (2) MARGINAL RATES.—In paragraph (1)—

4 (A) INITIAL MARGINAL RATE.—The initial  
5 marginal rate, for a year for a class of enroll-  
6 ment, is the ratio of—

7 (i) 4 percent of the applicable poverty  
8 level for the class of enrollment for the  
9 year, to

10 (ii) the amount by which such poverty  
11 level exceeds such income threshold  
12 amount.

13 (B) FINAL MARGINAL RATE.—The final  
14 marginal rate, for a year for a class of enroll-  
15 ment, is the ratio of—

16 (i) the amount by which (I) 50 per-  
17 cent of the weighted average premium in  
18 the community rating area (for the class  
19 and year) exceeds (II) 4 percent of applica-  
20 ble poverty level (for the class and year);  
21 to

22 (ii) 100 percent of such poverty level.

23 (d) WAGE-ADJUSTED INCOME DEFINED.—In this  
24 subtitle, the term “wage-adjusted income” means, for a

1 family, family adjusted income of the family, reduced by  
2 the sum of the following:

3 (1)(A) Subject to subparagraph (B), the  
4 amount of any wages included in such family's in-  
5 come that is received for employment which is taken  
6 into account in the computation of the amount of  
7 employer premiums under part 1.

8 (B) The reduction under subparagraph (A)  
9 shall not exceed for a year \$5,000 (adjusted under  
10 section 10136(c)(3)(B)) multiplied by the number of  
11 months (including portions of months) of employ-  
12 ment with respect to which employer premiums were  
13 payable under part 1.

14 (2) The amount of unemployment compensation  
15 included in income under section 85 of the Internal  
16 Revenue Code of 1986.

17 (e) DETERMINATIONS.—A family's wage-adjusted in-  
18 come and the amount of liability under subsection (c) shall  
19 be determined by the State upon application by a family.

## 20 **TITLE XI—ENSURING HEALTH** 21 **CARE REFORM FINANCING**

### 22 **SEC. 11001. ENSURING HEALTH CARE REFORM FINANCING.**

23 (a) PURPOSE.—The purpose of this section is to en-  
24 sure that the enactment of this Act does not result in un-  
25 anticipated increases in the Federal deficit.

1 (b) LEGAL ENTITLEMENTS CONTINGENT.—Any enti-  
2 tlement provided by this Act, including those to premium  
3 assistance, shall be subject to the operation of this section.

4 (c) DETERMINATION OF UNFINANCED HEALTH  
5 SPENDING.—

6 (1) INITIAL HEALTH CARE BASELINE.—Not  
7 later than the date that is 60 days after the date of  
8 enactment of this Act, the President shall, using up-  
9 to-date estimates, issue an order setting forth the  
10 initial health care baseline for fiscal year 1995 and  
11 for each subsequent fiscal year through 2004, which  
12 shall consist of estimates (for each year) projecting  
13 the following:

14 (A) total direct spending outlays resulting  
15 from this Act and under the Medicare and Med-  
16 icaid programs; and

17 (B) total revenues resulting from this Act.

18 (2) PRESIDENT'S BUDGET TO INCLUDE A CUR-  
19 RENT HEALTH CARE BASELINE.—When the Presi-  
20 dent submits the budget for fiscal year 1997 (as re-  
21 quired by section 1105 of title 31), and for each fis-  
22 cal year through 2004, the President shall include—

23 (A) a current health care baseline (as spec-  
24 ified in paragraph (3)) with respect to the cur-

1           rent fiscal year, the budget year, and the 4 fol-  
2           lowing fiscal years; and

3           (B) an estimate of the difference between  
4           the current health care baseline and the initial  
5           health care baseline for the current fiscal year,  
6           the budget year, and the 4 following fiscal  
7           years.

8           (3) CURRENT HEALTH CARE BASELINE.—The  
9           current health care baseline shall, for the applicable  
10          fiscal year, consist of—

11          (A) updated spending and revenue  
12          amounts contained in the initial projection (as  
13          set forth in paragraph (1)); plus or minus

14          (B) other outlays or revenue changes con-  
15          tained in legislation enacted after the date of  
16          enactment of this Act offsetting outlays or reve-  
17          nues resulting from this Act.

18          (4) COMPARING INITIAL AND CURRENT HEALTH  
19          CARE BASELINES.—Once OMB has determined the  
20          difference between the initial and current health care  
21          baselines, OMB shall remove from that difference  
22          any health care variable not attributable either to  
23          this Act or to any legislation described in paragraph  
24          (3)(B).

1 (d) OFFSETTING UNFINANCED HEALTH SPEND-  
2 ING.—

3 (1) REQUIREMENT FOR SEQUESTRATION TO  
4 FULLY OFFSET UNFINANCED HEALTH SPENDING.—  
5 If the President's budget includes a determination  
6 that the current health care baseline exceeds the ini-  
7 tial health care baseline pursuant to subsection  
8 (c)(2)(B) for the budget year and the current fiscal  
9 year by more than \$10,000,000,000 in total, such  
10 determination shall be accompanied by a proposed  
11 order to become effective on October 1 of that cal-  
12 endar year which fully offsets in the budget year and  
13 the following fiscal year the sum of such excess (for  
14 the budget year and the current fiscal year) in the  
15 manner provided in this subsection. Such proposed  
16 order shall be accompanied by such proposed regula-  
17 tions as the President deems necessary to carry out  
18 the sequester.

19 (2) OFFSETS.—

20 (A) IN GENERAL.—The offsets required by  
21 this subsection shall be accomplished through a  
22 combination of—

23 (i) subject to the provisions of sub-  
24 paragraph (B), in the case of the premium  
25 assistance program, reducing the percent-

1           ages otherwise in effect for the fiscal year  
2           under subparagraphs (A), (B), and (C) of  
3           section 6002(a)(2);

4           (ii) adjusting the deductible for Medi-  
5           care drugs as provided in section  
6           1834(d)(1)(B)(i) of the Social Security  
7           Act; and

8           (iii) reducing each direct spending  
9           program provided in the Act by a uniform  
10          percentage,

11         to the extent (subject to paragraph (3)) nec-  
12         essary to accomplish all of the sequestrations  
13         necessary to fully offset the amounts required  
14         for that fiscal year.

15         (B) ELIGIBILITY PERCENTAGE FOR PREG-  
16         NANT WOMEN AND CHILDREN REDUCED  
17         LAST.—Any reduction under subparagraph  
18         (A)(i)—

19           (i) shall be made first by reducing the  
20           percentages under section 6002(a)(2)(A);  
21           and

22           (ii) to the extent sufficient offsets may  
23           not be made under subparagraph (A), shall  
24           then be made by reducing the percentages  
25           under section 6002(a)(2) (B) and (C).

1           (3) PROPORTIONALITY.—The President shall  
2       apply the offset mechanisms provided in paragraph  
3       (2)(A) (i), (ii), and (iii) proportionally (based on the  
4       ratio of the outlays caused by each program to the  
5       total outlays of all sequesterable programs under  
6       paragraph (2)(A)), to the extent possible, in the  
7       budget year and the following fiscal year, but in no  
8       case shall the total amount of offsets be less than  
9       the amount required by paragraph (1).

10           (4) EFFECTIVE PERIOD.—For purposes of a fis-  
11       cal year not subject to an order under this section  
12       following a fiscal year subject to an order under this  
13       section, this Act and the amendments made by this  
14       Act shall be assumed to continue as if the order had  
15       not been issued.

16           (5) CONSULTATION.—The President shall con-  
17       fer with the National Health Benefits Board and the  
18       National Health Care Cost and Coverage Commis-  
19       sion in carrying out this subsection.

20           (e) FINAL SEQUESTER DETERMINATION.—Using the  
21       same economic and technical assumptions as used in mak-  
22       ing the preliminary determination under subsection (c),  
23       the President shall reestimate the current health care  
24       baselines on September 15 based on legislation in effect  
25       as of September 10. If the aggregate difference between

1 the initial and updated baseline is more than  
2 \$10,000,000,000 in the current fiscal year and budget  
3 year combined, the President shall issue a final order (and  
4 accompanying final regulations) following the procedure  
5 set forth in subsection (d).

6 (f) SUSPENSION IN THE EVENT OF WAR OR LOW  
7 GROWTH.—

8 (1) LOW GROWTH.—The President shall not  
9 issue either a proposed or final order under this sec-  
10 tion if the Office of Management and Budget noti-  
11 fies the Congress that—

12 (A) during the period consisting of the  
13 quarter during which such notification is given,  
14 the quarter preceding such notification, and the  
15 4 quarters following such notification, the Of-  
16 fice of Management and Budget has determined  
17 that real economic growth is projected or esti-  
18 mated to be less than zero with respect to each  
19 of any 2 consecutive quarters within such pe-  
20 riod; or

21 (B) the most recent of the Department of  
22 Commerce's advance preliminary or final re-  
23 ports of actual real economic growth indicate  
24 that the rate of real economic growth for each  
25 of the most recently reported quarter and the

1 immediately preceding quarter is less than 1  
2 percent.

3 (2) WAR.—The President shall not issue either  
4 a proposed or final order under this section if a dec-  
5 laration of war is in effect.

6 (g) RECOMMENDATIONS FOR ALTERNATIVE REDUC-  
7 TIONS.—If the President's budget for a fiscal year is ac-  
8 companied by an order under subsection (d)(1), the Na-  
9 tional Health Benefits Board shall, within a reasonable  
10 time, transmit to the President, the Speaker of the House  
11 of Representatives, and the President of the Senate a re-  
12 port including alternative proposals to offset the projected  
13 excess set forth in subsection (c)(4).

14 (h) GAO AUDIT OF REDUCTIONS.—If the President  
15 has issued an order under subsection (d)(1), the General  
16 Accounting Office shall report to Congress, as soon there-  
17 after as possible following the date of transmittal of the  
18 President's budget, an analysis of whether the order has  
19 fully complied with the requirements of this section.

20 (i) ADDITIONAL OMB REPORTING REQUIREMENTS  
21 TO BE INCLUDED IN PRESIDENT'S BUDGET.—

22 (1) ADJUSTED ESTIMATE OF TOTAL FEDERAL  
23 HEALTH CARE COSTS.—

24 (A) IN GENERAL.—When the President  
25 submits the budget for fiscal year 1997, and

1 each fiscal thereafter through 2004, the Presi-  
2 dent shall include an estimate of total Federal  
3 health care costs as described in subparagraph  
4 (B).

5 (B) TOTAL FEDERAL HEALTH CARE  
6 COSTS.—Total Federal health care costs are—

7 (i) Federal spending in the current  
8 health care baseline (as determined under  
9 subsection (c)(3)); plus

10 (ii) discretionary health care spending  
11 on—

12 (I) the health care program for  
13 active military personnel under title  
14 10, United States Code;

15 (II) the veterans health care pro-  
16 gram under chapter 17 of title 38,  
17 United States Code;

18 (III) the Civilian Health and  
19 Medical Program of the Uniformed  
20 Services (CHAMPUS), as defined in  
21 section 1073(4) of title 10, United  
22 States Code;

23 (IV) the Federal Employee  
24 Health Benefit Plan under chapter 89

1 of title 5, United States Code  
2 (FEHB); and

3 (V) the Indian health service pro-  
4 gram under the Indian Health Care  
5 Improvement Act (25 U.S.C. 1601 et  
6 seq.).

7 (2) COST AS A PERCENT OF TOTAL REVE-  
8 NUES.—The President shall include with the esti-  
9 mate required by this subsection a calculation by  
10 OMB of the percentage of personal and corporate  
11 income taxes needed to pay for total Federal health  
12 care costs, as adjusted by this subsection, in excess  
13 of dedicated health revenues. OMB shall assume  
14 that all dedicated health revenues resulting from  
15 amendments made by this Act will be allocated for  
16 total Federal health care costs, as adjusted by this  
17 subsection.

18 (j) ADDITIONAL COMMISSION REPORTING REQUIRE-  
19 MENTS.—Effective beginning in 1997, the National  
20 Health Care Commission shall report annually on how  
21 health care expenses are being financed. Among other  
22 things, this report shall include—

23 (1) how much is spent annually in premiums,  
24 out-of-pocket expenses, and third party expenses;  
25 and

1           (2) the number of businesses that provide  
2 health insurance and a profile of businesses that do  
3 not provide health insurance, including the earnings  
4 of such businesses.

○