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104TH CONGRESS
1ST SESSION

S. 168

To ensure individual and family security through health insurance coverage for all Americans.

IN THE SENATE OF THE UNITED STATES

JANUARY 5, 1995

Mr. KENNEDY introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To ensure individual and family security through health insurance coverage for all Americans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Affordable Health Care for All Americans Act''.

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

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PART 1—UNIVERSAL COVERAGE

SEC. 1001. ENTITLEMENT TO HEALTH BENEFITS.

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

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

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

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

(B) a citizen of another country legally residing in the United States (as defined in section 1702(2)); or

(C) a long-term nonimmigrant (as defined in section 1702(6)); and

(2) not an exempt individual (as defined in section 1702(4)).

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

SEC. 1002. INDIVIDUAL RESPONSIBILITIES.

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

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

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

SEC. 1003. PROTECTION OF CONSUMER CHOICE.

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

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

(2) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care services not required to be included in the plan under subtitle B.

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

(4) Employers from providing coverage for benefits in addition to the those described in subtitle B (subject to section 1604).

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

SEC. 1004. APPLICABLE HEALTH PLAN PROVIDING COVERAGE.

Except as otherwise provided:

(1) GENERAL RULE: COMMUNITY-RATED HEALTH PLANS.—Except as provided for in regulations promulgated by the Secretary to further the purposes of this Act, the applicable health plan for a family is a community-rated health plan for the community-rating area in which the family resides.

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

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

SEC. 1005. TREATMENT OF OTHER NONIMMIGRANTS.

(a) CERTAIN ALIENS INELIGIBLE FOR BENEFITS.—An alien who is not an eligible individual or otherwise not

made eligible under this Act for benefits is not eligible to obtain the benefits required under subtitle B through enrollment in a health plan under this Act.

(b) RECIPROCAL TREATMENT OF OTHER NONIMMIGRANTS.—With respect to those classes of individuals who are lawful nonimmigrants but who are not long-term nonimmigrants (as defined in section 1702), such individuals may obtain such benefits through enrollment with community-rated health plans only in accordance with such reciprocal agreements between the United States and foreign states as may be entered into.

SEC. 1006. EFFECTIVE DATE OF ENTITLEMENT.

(a) IN GENERAL.—In the case of eligible individuals residing in a State, the entitlement under this part (and requirements under section 1002) shall not take effect until the State becomes a participating State (as defined in section 1200.

(b) GENERAL EFFECTIVE DATE DEFINED.—In this Act, the term ''general effective date'' means January 1, 1999.

PART 2—TREATMENT OF FAMILIES AND SPECIAL RULES

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

(a) IN GENERAL.—Except as provided in this part or otherwise in regulations promulgated by the Secretary to further the purposes of this Act, all members of the same family (as defined by the Secretary) shall be enrolled in the same applicable health plan.

(b) CHILD DEFINED.—

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

(A) is under 25 years of age, and

(B) is a dependent of an eligible individual.

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

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

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

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

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

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

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

(D) TREATMENT OF EMANCIPATED MINORS AND MARRIED INDIVIDUALS.—An emancipated minor or married individual shall not be treated as a child.

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

SEC. 1012. TREATMENT OF CERTAIN FAMILIES.

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

(1) IN GENERAL.—Except as specifically provided, in the case of an individual who is an individual described in paragraph (2) with respect to 2 consecutive months in a year (and it is anticipated would be in the following month and in such following month would be a medicare-eligible individual), the individual shall be treated as an eligible individual under this Act during such following month and the remainder of the year. Nothing in this section shall be construed to affect any entitlement under title XVII of the Social Security Act.

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

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

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

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

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

(1) AFDC recipients.

(2) Disabled SSI recipients.

(3) SSI recipients who are not disabled SSI recipients.

(d) QUALIFYING STUDENTS.—

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

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

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

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

SEC. 1013. MULTIPLE EMPLOYMENT SITUATIONS.

In the case of an individual who is eligible as a qualified employee, or a spouse of such an employee, for coverage under more than one health plan, the individual and the spouse of the individual shall elect the applicable health plan.

Subtitle B—Benefits

SEC. 1101. PROVISION OF COMPREHENSIVE BENEFITS BY PLANS.

(a) IN GENERAL.—A certified health plan shall provide benefits that are actuarially equivalent to the benefits provided under the Blue Cross/Blue Shield standard option plan which is provided under the Federal Employees Health Benefits Program on January 1, 1995.

(b) COVERAGE OF SERVICES.—A certified health plan shall provide coverage under subsection (a) for at least the following services:

(1) Hospital services.

(2) Services of health professionals.

(3) Emergency and ambulatory medical and surgical services.

(4) Clinical preventive services.

(5) Mental illness and substance abuse services.

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

(7) Hospice care, home health care, extended care services, outpatient rehabilitation services, and ambulance services.

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

(9) Outpatient prescription drugs and biologicals.

(10) Durable medical equipment, including hearing aids for children, and prosthetic and orthotic devices.

(11) Vision care and dental care for children.

(12) Patient care costs of qualified investigational treatments.

(c) MEDICAL NECESSITY.—

(1) IN GENERAL.—A certified health plan shall not be required to provide services that are not medically necessary or appropriate.

(2) SCOPE OR DURATION.—A certified health plan may not impose any limitations on the scope or

duration of any medically necessary or appropriate services described in paragraphs (1), (2), (3), (6), (8), (9), or (12). Such a plan may not apply a lifetime limit with respect to any such service and may not exclude people with congenital conditions from the same type of coverage as persons needing care as a result of illness or injury.

(3) LIMITATIONS.—The following services shall not be considered medically necessary or appropriate:

(A) In vitro fertilization services.

(B) Sex change surgery and related services.

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

(i) required to correct a congenital anomaly; or

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

(I) accidental injury;

(II) disease; or

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

(d) PREVENTIVE AND PRENATAL SERVICES.—

(1) IN GENERAL.—The clinical preventive services that are required under subsection (b)(4) are those services specified by the Secretary. Such specifications shall include the periodicity schedules for such services and special coverage or periodicity schedules for high risk populations, if appropriate. In developing such specifications the Secretary shall consult with—

(A) medical experts and insurers;

(B) the United States Preventive Service Task Force;

(C) the American Academy of Pediatrics, with respect to preventive services for children;

(D) the American College of Obstetricians and Gynecologists, with respect to preventive services for women.

(2) COST SHARING.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a certified health plan may not impose any cost-sharing requirements with respect to clinical preventive services and pre natal care services.

(B) NETWORK PLANS.—In the case of a certified health plan that is a network plan, the

requirement of subparagraph (A) shall not apply if the services described in such subparagraph are obtained from an out-of-network provider.

(e) MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.—The mental illness and substance abuse services that are required described under subsection (b)(5) are those services that meet the minimum standards for coverage of inpatient, residential, intensive nonresidential, and outpatient services as specified by the Secretary. Such standards shall ensure that effective beginning in 2001, there will be parity in the coverage of mental health services.

(f) HEALTH PROFESSIONAL SERVICES.—As used in subsection (b)(2), the term ''health professional services'' means professional services that are lawfully provided by a physician or professional services that could be lawfully provided by a physician but are provided by another health professional who is legally authorized to provide such services in the State in which the services are provided.

(g) ACTUARIAL EQUIVALENCY.—In calculating actuarial equivalency under subsection (a), a certified health plan shall exclude clinical preventive services and mental illness and substance abuse services that are provided under the plan or under the Blue Cross/Blue Shield stand-

ard option plan under the Federal Employees Health Benefits Program.

(h) MODEL PLANS.—The Secretary, in consultation with the NAIC, insurers, employers, consumers, and medical experts shall establish three model certified health plans for consideration by plan sponsors, of which—

(1) one plan shall have cost-sharing and scope and duration limits that are appropriate for fee-for-service plans that are actuarially equivalent to the Blue Cross/Blue Shield standard option plan;

(2) one plan shall have cost-sharing and scope and duration limits that are appropriate for preferred provider network plans that are actuarially equivalent to the Blue Cross/Blue Shield standard option plan; and

(3) one plan shall have cost-sharing and scope and duration limits that are appropriate for health maintenance organizations that are actuarially equivalent to the Blue Cross/Blue Shield standard option plan.

(i) QUALIFIED INVESTIGATIONAL TREATMENTS.—

(1) IN GENERAL.—As used in subsection (b)(13), the term ''qualified investigational treatment'' means an investigational treatment that is part of a peer-reviewed and approved research pro-

gram (as defined by the Secretary) or research trials approved by the Secretary. A certified health plan shall not be required to cover any patient care costs associated with such treatments if such cost would normally be covered by another party as determined under regulations promulgated by the Secretary.

(2) APPROVAL OF RESEARCH TRIALS.—A research trial is deemed to be approved for purposes of this subsection if such trial is approved by one or more of the following:

(A) The National Institutes of Health.

(B) The Food and Drug Administration (through an investigational new drug exemption pursuant to section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or an investigational device exemption pursuant to section 520(g) of such Act (21 U.S.C. 360j(g))).

(C) The Department of Veterans Affairs.

(D) The Department of Defense.

(E) A qualified nongovernmental research entity as defined in guidelines issued by one or more of the National Institutes of Health, including guidelines for cancer center support

grants designated by the National Cancer Institute.

(j) STUDY AND REPORT.—

(1) STUDY.—The Secretary shall conduct a study concerning the provision and enrollment patterns of certified health plans.

(2) REPORT.—Not later than 5 years after the date of enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the study conducted under paragraph (1). Such report shall include a determination by the Secretary of whether the standardization of certified health plan offerings would be appropriate to assist consumers in choosing among such plans based on cost and quality or to avoid plan design practices intended to attract better risks and resulting in poorer availability of reasonably priced coverage for individuals needing greater than average utilization of health care services.

SEC. 1102. PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

A health professional or a health facility may not be required to provide an item or service under a certified

health plan if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

SEC. 1103. BALANCE BILLING.

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

Subtitle C—State Role in Reform

SEC. 1200. PARTICIPATING STATE.

(a) IN GENERAL.—As used in this title, the term ''participating State'' means a State that meets the applicable requirements of this Act, including the requirement for the establishment of a market reform program described in this subtitle and the administration of subsidies as provided for in title V.

(b) REFORM PLAN.—To become a participating State under this section, a State shall submit to the Secretary a reform plan describing a health care system meeting the requirements of this Act that the State intends to establish (or has established), update such plan at time periods and in a manner specified by the Secretary, and implement such plan.

(c) DEADLINE FOR PARTICIPATION.—If a State is not a participating State by January 1, 1999, the provisions of section 1521 (relating to the Federal government's role in the case of default by a State) shall apply

to such State. A State may not be a participating State prior to January 1, 1997.

PART 1—STATE MARKET REFORM

SEC. 1201. ESTABLISHMENT OF STATE MARKET REFORM PROGRAMS.

(a) IN GENERAL.—Each State shall establish a State market reform program that meets the requirements of this title.

(b) DEADLINE.—Each State shall establish and have in operation a State market reform program by not later than January 1, 1997, to carry out this title. Such program shall provide for the enrollment of individuals in certified health plans by not later than such date.

(c) PERIODIC SECRETARIAL REVIEW OF STATE PROGRAMS.—

(1) IN GENERAL.—The Secretary may periodically review State programs established under subsection (a) to determine if such programs meet the requirements of this subtitle.

(2) REPORTING REQUIREMENTS OF STATES.—For purposes of paragraph (1), each State shall submit to the Secretary, at intervals established by the Secretary, a report on the compliance of the State with the requirements of this subtitle.

SEC. 1202. CERTIFICATION OF INSURED HEALTH PLANS.

(a) IN GENERAL.—Each State market reform program shall provide for the certification of insured health plans as certified health plans if the appropriate certifying authority finds that the plan meets the applicable requirements for certification under this title.

(b) NONDISCRIMINATION AGAINST OUT-OF-STATE PLANS AND PROVIDERS.—A State—

(1) may not discriminate against any health plan because such plan is domiciled in another State; and

(2) may not limit the ability of any health plan to contract with a health care provider because such plan or such provider is located outside the boundaries of such State.

SEC. 1203. ESTABLISHMENT OF COMMUNITY RATING AREAS.

(a) ESTABLISHMENT.—Each State program shall provide, by not later than January 1, 1996, for the division of the State into 1 or more community rating areas. The program may revise the boundaries of such areas from time to time consistent with this section.

(b) MULTIPLE AREAS.—With respect to a community rating area—

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

(2) the number of individuals residing within a community rating area may not be less than 250,000 (and shall respect the existing referral patterns within market areas); and

(3) no area incorporated in a community rating area may be incorporated into another community rating area.

(c) INTERSTATE AREAS.—Two or more contiguous States are encouraged to provide for the establishment of a common community rating area that includes adjoining portions of the States if the market area extends across State lines, so long as all portions of any metropolitan statistical area within such States are within the same community rating area.

(d) SPECIAL OR UNDERSERVED POPULATIONS.—In establishing community rating areas, the State shall take into consideration the needs of special or underserved populations.

(e) DISCRIMINATION.—A State may not establish boundaries for community rating areas in a manner that has the effect of discriminating on the basis of any category described in section 1414.

SEC. 1204. PROCEDURES FOR CERTIFICATION OF PURCHASING COOPERATIVES.

Each State market reform program shall establish a process for the certification of purchasing cooperatives consistent with part 2 of subtitle D.

SEC. 1205. COORDINATION AMONG PURCHASING COOPERATIVES.

Each State shall establish rules consistent with part 2 of subtitle D for the coordination among purchasing cooperatives with respect to enrollment, payment of premiums, and provision of out-of-area benefits and services.

SEC. 1206. PREPARATION OF INFORMATION CONCERNING PLANS AND PURCHASING COOPERATIVES.

(a) IN GENERAL.—Each State market reform program shall prepare and make available to purchasing cooperatives, employers and to individuals located in the State information, in standardized comparative form as required under the program, concerning the health plans certified by such State and purchasing cooperatives operating in the State.

(b) ACCESS TO PLANS AND COOPERATIVES.—Each State shall provide information to employers and individuals describing how to access each community-rated health plan and purchasing cooperative in the area.

SEC. 1207. RISK ADJUSTMENT PROGRAM.

Each State market reform program shall provide for a risk adjustment program for community-rated and association health plans that meets the standards developed by the Secretary under section 1417.

SEC. 1208. SPECIFICATION OF ANNUAL GENERAL AND INITIAL ENROLLMENT PERIODS.

(a) ANNUAL GENERAL ENROLLMENT PERIOD.—Each State market reform program shall specify an annual period, of not less than 30 days, during which an eligible individual in the State may enroll in a certified health plan or change the certified health plan in which the individual is enrolled.

(b) INITIAL ENROLLMENT PERIOD.—Each State market reform program shall specify an initial enrollment period in 1996 of not less than 45 days, during which individuals in the State may enroll in certified health plans for coverage beginning as of January 1, 1997.

SEC. 1209. SPECIAL RULES REGARDING NETWORK PLANS.

A State market reform program may grant a network plan a certification to operate in a service area which is not identical to the borders of a community rating area if the network plan has demonstrated to the satisfaction of the State that the plan has met the requirements of section 1411(a)(4).

SEC. 1210. APPLICATION OF CERTAIN STATE LAWS.

Upon the application of a State, and the approval of such application by the Secretary, the State may—

(1) tighten premium rate bands beyond the variation permitted under section 1413;

(2) establish rules for association plans that are more restrictive than those provided for under part 3 of subtitle D if, in the judgement of the Secretary, such rules increase the viability of the community-rated market; and

(3) establish financial solvency requirements that exceed the requirements of section 1418.

SEC. 1211. CONSUMER ADVOCATE.

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

served populations. The Office in each State shall perform public outreach and provide education and assistance regarding consumer rights and responsibilities under this Act, and assist consumers in dealing with problems that arise with consumer purchasing cooperatives, experience-rated employers, health plans, and health care providers operating in such State.

(b) CONTRACTS.—

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

(2) CONTRACT PERIOD.—The contract period for the State Offices of Consumer Advocacy and the National Center of Consumer Advocacy under this

section shall be not less than 4 years and not more than 7 years.

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

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

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

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

(4) information to enrollees about existing grievance procedures and coordination with other entities to assist in identifying, investigating, and resolving enrollee grievances under this Act (including grievances before State medical boards);

(5) regular and timely access in the area to the services provided through the Office and its local of-

fices and timely responses from representatives of the Office to complaints;

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

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

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

(e) EVALUATION AND REPORT.—The Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract. The Office shall report to the Secretary and the State annually on the nature and patterns of consumer complaints received in the Office and its local offices during each year and any policy, regulatory, and legislative recommendations for needed improvements together with a record of the activities of the Office.

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

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

SEC. 1212. ELECTION PROCEDURE FOR COMMUNITY-RATED EMPLOYERS.

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

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

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

PART 2—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

SEC. 1221. SINGLE-PAYER SYSTEM DESCRIBED.

The Secretary may approve an application of a State to operate a single-payer system if the Secretary finds that the system meets the requirements of sections 1222 and 1223.

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

Each single-payer system shall meet the following requirements:

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

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

(3) ENROLLMENT OF INDIVIDUALS.—

(A) MANDATORY ENROLLMENT.—The system shall provide for the enrollment of all individuals residing in the State who are not medicare-eligible individuals, except that the Secretary may through regulation except appropriate individuals from the requirements of this subparagraph and such requirements shall not apply to the individuals described in subparagraph (B).

(B) EXCLUSION OF CERTAIN INDIVIDUALS.—A single-payer system may not require the enrollment of veterans, active duty military personnel, and American Indians.

(4) DIRECT PAYMENT TO PROVIDERS.—

(A) IN GENERAL.—With respect to providers who furnish items and services required under subtitle B to individuals enrolled in the system, the State shall make payments directly, or through fiscal intermediaries, to such providers and assume (subject to subparagraph (B))

all financial risk associated with making such payments.

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

(5) PROVISION OF BENEFITS.—

(A) IN GENERAL.—The system shall provide for coverage of items and services required under subtitle B, including the cost-sharing provided under the plan (subject to subparagraph (B)), to all individuals enrolled in the system.

(B) IMPOSITION OF REDUCED COST-SHARING.—The system may decrease the cost-sharing otherwise provided in under subtitle B with respect to any individuals enrolled in the system or any class of services included in the items and services under such subtitle, so long as the system does not increase the cost-sharing otherwise imposed with respect to any other individuals or services.

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

(A) the rate of growth in health care spending will not be higher than the National rate of growth;

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

(C) Federal payments to a single payer State shall be limited to the payments that would have been made in the absence of the implementation of the single payer system.

(7) REQUIREMENTS GENERALLY APPLICABLE TO CERTIFIED HEALTH PLANS.—The system shall meet the appropriate requirements applicable to a certified health plan, as determined by the Secretary.

SEC. 1223. ADDITIONAL RULES FOR SINGLE-PAYER SYSTEM.

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

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

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

(3) the State shall not use any funds collected pursuant to section 1221 and 1222 or any earnings on such funds for any reason other than to pay health care claims or provide health care benefits.

(b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR PARTICIPATING STATES.—In the case of a State operating a single-payer system, the State is not required to meet any requirements that the Secretary determines are not appropriate to apply to a State single-payer system.

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

Subtitle D—Expanded Access to Health Plans

PART 1—ACCESS THROUGH EMPLOYERS

SEC. 1301. EMPLOYER ACCESS AND ENROLLMENT REQUIREMENTS.

(a) IN GENERAL.—Each employer shall—

(1) make available to each employee of the employer the opportunity to enroll through the employer in one of at least three certified health plans,

if available, including either a fee-for-service plan or a health plan with a point-of-service option, and

(2) to provide payroll withholding of any required employee premiums.

If an employer desires to satisfy the requirement of paragraph (1) by offering a point-of-service plan, cost-sharing for out-of-network services shall not be substantially greater than those applied by fee-for-service plans.

(b) SPECIAL RULES.—

(1) PURCHASING COOPERATIVE.—A small employer may meet the requirements of subsection (a)(1) through a purchasing cooperative.

(2) LARGE EMPLOYER.—

(A) IN GENERAL.—A large employer shall meet the requirements of subsection (a)(1) only through offering experience-rated health plans.

(B) SINGLE INSURER.—Nothing in this section shall be construed as preventing or requiring a large employer from complying with subsection (a)(1) through the offering of plans by a single insurer.

SEC. 1302. SMALL EMPLOYER REQUIREMENTS.

(a) PAYROLL DEDUCTION.—Upon authorization from an employee, a small employer shall deduct from the employee's wages the employee's share of any premium

due to a certified health plan or purchasing cooperative. Except as provided in subsection (c), this subsection shall only apply to plans made available, either directly or through a purchasing cooperative, by the employer.

(b) NO REQUIREMENT TO ENROLL IN EMPLOYER-PROVIDED PLAN.—A community-rated individual who is an employee of a small employer may elect not to enroll in a certified health plan offered by such employer under this section. Such an employee may enroll in any certified health plan offered in the community rating area in which the employee works or in which the employee resides (including certified health plans offered through purchasing cooperatives serving such area).

(c) DEDUCTION AND CONTRIBUTION IN THE CASE OF FEHBP PLANS.—In the case of an election described in subsection (c) by an employee of a small employer to enroll in an FEHBP plan made available under section 1331, the small employer shall make the payroll deduction described in subsection (b) and shall forward the employer's contribution, if any, to such FEHBP plan. The employer may charge a reasonable adminstrative fee for such activities.

PART 2—ACCESS TO PURCHASING COOPERATIVES

SEC. 1311. ESTABLISHMENT OF COOPERATIVES.

A State may establish or charter purchasing cooperatives in accordance with this subtitle for the purpose of improving access to health plans, reducing the cost of health insurance, and improving the quality of care. Each purchasing cooperative established in a State shall be certified under State law.

SEC. 1312. CONFLICT OF INTEREST.

An insurer, agent, broker or any other individual or entity otherwise engaged in the sale of health insurance may not form or underwrite a purchasing cooperative or hold or control any right to vote with respect to a purchasing cooperative.

SEC. 1313. MEMBERSHIP.

A purchasing cooperative shall accept all small employers and individuals eligible for coverage in the community-rated market and residing within the area served by the cooperative if such employers or individuals request such membership. A purchasing cooperative shall conduct enrollment, outreach and marketing activities in a manner that provides individuals and employers with ready access and availability to cooperative health plans throughout the community-rating area served by the cooperative.

SEC. 1314. BOARD OF DIRECTORS.

A purchasing cooperative established under this part shall be governed by a board of directors or receive active input from an advisory board consisting of individuals and businesses participating in the cooperative.

SEC. 1315. CHOICE OF HEALTH PLANS.

A purchasing cooperative shall enter into agreements with at least three certified health plans (if available) providing the comprehensive benefits described in subtitle B, including (if available) at least one fee-for-service plan or point-of-service plan meeting the requirements described in section 1301.

SEC. 1316. LIMITATION ON ACTIVITIES.

A purchasing cooperative shall not—

(1) perform any activity involving approval or enforcement of payment rates for providers;

(2) perform any activity (other than the reporting of noncompliance) relating to compliance of certified health plans with the requirements of this Act;

(3) assume financial risk in relation to any such health plan; or

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

SEC. 1317. VOLUNTARY PARTICIPATION.

Nothing in this part shall be construed as requiring any individual or small employer to purchase a certified health plan exclusively through a purchasing cooperative.

PART 3—ACCESS THROUGH ASSOCIATION PLANS

Subpart A—Certified Association Plans

SEC. 1321. TREATMENT OF CERTIFIED ASSOCIATION PLANS.

For purposes of this Act, in the case of a certified association plan—

(1) except as otherwise provided in this subpart, the plan shall be required to meet all applicable requirements of this Act for certified health plans offered by large employers,

(2) if such plan is certified as meeting such requirements, such plan shall be treated as a health plan established and maintained by a large employer and individuals enrolled in such plan shall be treated as experience-rated individuals,

(3) any individual who is a member of the association not enrolling in the plan shall not be treated as an experience-rated individual solely by reason of membership in such association, and

(4) such plan shall cover at least 500 lives on and after the date of enactment of this Act.

SEC. 1322. MODIFICATIONS OF STANDARDS APPLICABLE TO CERTIFIED ASSOCIATION PLANS.

(a) CERTIFYING AUTHORITY.—

(1) MULTISTATE CERTIFIED ASSOCIATION SELF-INSURED PLANS.—For purposes of this Act, the Secretary of Labor shall be the appropriate certifying authority with respect to a certified association plan which is a multistate self-insured health plan.

(2) SINGLE STATE CERTIFIED ASSOCIATION SELF-INSURED PLANS.—For purposes of this Act, the State shall be the appropriate certifying authority with respect to a certified association plan which is a single State self-insured health plan.

(b) RISK ADJUSTMENT.—The requirements of section 1417 shall apply to a plan described in section 1321.

(c) CAPITAL REQUIREMENTS.—Not later than 9 months after the date of enactment of this Act, the Secretary of Labor, in consultation with the NAIC, shall establish solvency standards for health plans described in section 1321, and rules for monitoring and enforcing compliance with such standards. Such requirements shall be the applicable plan standards with respect to such plans in lieu of the requirements of section 1418.

(d) AVAILABILITY.—A certified association plan may only include in coverage any business or individual who

is a member of the association establishing or maintaining the plan, an employee of such member, or a spouse or dependent of either.

SEC. 1323. ASSOCIATION PLAN DEFINED.

(a) IN GENERAL.—The term ''association plan'' means a health plan which—

(1) is (or is a continuation of) an existing plan, and

(2) is established or maintained by a qualified association.

(b) EXISTING PLAN.—For purposes of this section—

(1) IN GENERAL.—A health plan is an existing plan if—

(A) on August 1, 1994, the plan was a self-insured health plan which—

(i) had been in existence and operating at all times during the 18-month period ending on such date as a multiple employer welfare arrangement,

(ii) had an application pending with, or approved by, the State insurance commissioner for a certificate of operation as a health plan, and

(iii) covered at least 1000 lives, or

(B) on and after the date of enactment of this Act, the plan was an experience-rated insured health plan covering at least 1000 lives.

(2) DISQUALIFICATION OF CERTAIN ARRANGEMENTS.—A health plan shall not be treated as meeting the requirements of paragraph (1)(A) if a State demonstrates that—

(A) fraudulent or material misrepresentations have been made by the sponsor in the application,

(B) the arrangement that is the subject of the application, on its face, fails to meet the requirements for a complete application, or

(C) a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operations.

(c) QUALIFIED ASSOCIATION.—For purposes of this section, the term ''qualified association'' means any organization (or wholly-owned subsidiary thereof) which—

(1) is organized and maintained in good faith by a trade association, an industry association, a professional association, a local chamber of commerce, or public entity association,

(2) is organized and maintained for substantial purposes other than to provide a health plan and a substantial share of whose revenues do not come from the sale of health plans,

(3) has a constitution, bylaws, or other similar governing document which specifically states its purpose,

(4) receives the active support of its members,

(5) does not have membership policies or practices which have the effect of screening members or prospective members (or their dependents), and does not otherwise limit access to any health plan maintained by it, on the basis of health status or evidence (or lack of evidence) of insurability of an individual, and

(6) has been in operation continuously during the 3-year period ending August 1, 1994 and has provided health coverage to its members over such period.

(d) COORDINATION WITH SUBPART B.—The term ''certified association plan'' shall not include a plan to which subpart B applies.

(e) DEFINITIONS.—For purposes of this part, the term ''multiple employer welfare arrangement'' has the meaning given such term by section 3(40) of the Employee

Retirement Income Security Act of 1974 (as in effect before the date of the enactment of the Health Reform Act).

SEC. 1324. REPEAL OF ERISA PROVISIONS.

(a) DEFINITION.—Paragraph (40) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)) is repealed.

(b) PREEMPTION.—Paragraph (6) of section 514(b) of such Act (29 U.S.C. 1144(b)(6)) is repealed.

Subpart B—Special Rule for Church and Multiemployer Plans

SEC. 1325. SPECIAL RULE FOR CHURCH AND MULTIEMPLOYER PLANS.

(a) GENERAL RULE.—For purposes of this Act, in the case of a health plan to which this section applies—

(1) except as otherwise provided in this part, the plan shall be required to meet all applicable requirements of this Act for certified health plans which are offered by large employers,

(2) if such plan is certified as meeting such requirements, such plan shall be treated as a health plan established and maintained by a large employer and individuals enrolled in such plan shall be treated as experience-rated individuals, and

(3) any individual eligible to enroll in the plan who does not enroll in the plan shall not be treated

as an experience-rated individual solely by reason of being eligible to enroll in the plan.

(b) MODIFIED STANDARDS.—

(1) CERTIFYING AUTHORITY.—For purposes of this Act, the Secretary of Labor shall be the appropriate certifying authority with respect to a plan to which this section applies.

(2) SOLVENCY, AND AVAILABILITY.—Rules similar to the rules of subsections (c) and (d) of section 1322 shall apply to a plan to which this section applies.

(3) ACCESS.—An employer which, pursuant to a collective bargaining agreement, offers an employee the opportunity to enroll in a plan described in subsection (c)(2) shall not be required to make any other plan available to the employee.

(c) PLANS TO WHICH SECTION APPLIES.—This section shall apply to a health plan which—

(1) is a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986) which covers 100 or more lives in the United States, or

(2) is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974) which is maintained by a health plan sponsor described in section 3(16)(B)(iii) of

such Act but only if such plan (or a predecessor plan) as of August 1, 1994—

(A) offered health benefits, and

(B) covered at least 500 lives in the United States.

Notwithstanding paragraph (2)(B), a multiemployer plan sponsored by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, may be combined to meet the threshold described in such subparagraph.

PART 4—ACCESS THROUGH FEHBP

SEC. 1331. ACCESS THROUGH FEHBP PLANS.

(a) IN GENERAL.—Any health plan participating in the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code (in this Act referred to as ''FEHBP''), shall offer such plan to community-rated individuals and small employers in community rating areas served by such plan at a premium established in accordance with section 1413. In the case of a plan described in section 8903(1) of title 5, United States Code, the requirement of this subsection shall be deemed to be a requirement on the local carriers providing coverage pursuant to an agreement with a national plan.

(b) LIMITATION.—A health plan may not be required to offer enrollment under subsection (a) if the Director of the Office of Personnel Management determines, based on a petition submitted by the health plan, that—

(1) the plan is unable to make such offering because of a limitation in the capacity of the plan to deliver services or assure financial solvency; or

(2) the plan is not sponsored by a carrier licensed under applicable State law.

The Director shall not make such a determination on the basis of any difference in the health status of Federal Government employees and the community-rated population.

Subtitle E—Standards for Reform

PART 1—ESTABLISHMENT AND APPLICATION OF STANDARDS

SEC. 1401. CERTIFIED HEALTH PLANS.

A certified health plan shall meet the applicable reform standards established under part 2 for insured health plans and part 3 for self-insured health plans.

SEC. 1402. GENERAL RULES.

(a) CONSTRUCTION.—Whenever in this subtitle a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or sponsor of the plan in relation to that plan.

(b) USE OF INTERIM, FINAL REGULATIONS.—In order to permit the timely implementation of the provisions of this title, the Secretary and the Secretary of Labor are each authorized to issue regulations under this title on an interim basis that become final on the date of publication, subject to change based on subsequent public comment.

(c) REFERENCE TO REFORM STANDARDS.—For purposes of this title, the term ''reform standards'' means the standards established and applied under this subtitle.

PART 2—STANDARDS APPLICABLE TO CERTIFIED INSURED HEALTH PLANS

SEC. 1411. GUARANTEED ISSUE AND RENEWAL.

(a) ISSUE.—

(1) IN GENERAL.—Except as otherwise provided in this section, a certified health plan sponsor—

(A) offering—

(i) a community-rated certified health plan, shall offer such plan to any community-rated individual applying for coverage, and

(ii) an experience-rated certified health plan, shall offer such plan to any

experience-rated individual eligible for coverage under the plan; and

(B) shall offer such plan for each class of enrollment described in section 1413(b)(2)(B)(ii).

(2) AVAILABILITY.—Except as provided in paragraph (4), a community-rated certified health plan shall be made available throughout the entire community rating area in which such plan is offered, including through any purchasing cooperative choosing to offer such plan.

(3) APPLICATION OF CAPACITY LIMITS.—

(A) IN GENERAL.—Subject to subparagraph (B), a certified health plan may cease enrolling individuals under the plan if—

(i) the plan ceases to enroll any new individuals; and

(ii) the applicable certifying authority determines that the plan's financial or provider capacity to serve previously covered groups or individuals (and additional individuals who will be expected to enroll because of affiliation with such previously covered groups or individuals) will be im-

paired if such plan is required to enroll other individuals.

(B) FAIR ENROLLMENT.—A certified health plan may exercise the limitations provided for in subparagraph (A) only if such plan provides individuals with a fair opportunity to enroll in the plan, regardless of the method by which such individuals seek enrollment or the time during the open enrollment period at which enrollment is sought.

(4) NETWORK PLANS.—A network plan may be made available only in a service area not identical to the borders of a community rating area if the State determines that—

(A)(i) the plan has not established its service area in a manner that has the effect of discriminating against an individual or groups of individuals on the basis of categories described in section 1414; and

(ii) the service area is not smaller than a county, or 3-digit zip code area;

(B) the service area has been approved pursuant to title XIII of the Public Health Service Act; and

(C) the network plan shall participate in any risk adjustment program established for each community rating area involved.

(b) RENEWAL.—

(1) IN GENERAL.—Except as provided in paragraph (2), a certified health plan that is issued to an individual shall be renewed at the option of the individual.

(2) GROUNDS FOR REFUSAL TO RENEW.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a certified health plan sponsor may under no circumstances refuse to renew, or for any reason terminate, a certified health plan with respect to any individual, family, or employer under this title.

(B) EXCEPTION.—Subparagraph (A) shall not apply in the case of—

(i) nonpayment of premiums;

(ii) fraud on the part of the individual involved;

(iii) misrepresentation of material facts on the part of the individual relating to an application for coverage or claim for benefits; or

(iv) exit of the insurer from the market if pursuant to rules established by the Secretary.

(c) CERTAIN EXCLUDED PLANS.—The provisions of this section (other than subsection (b)) and section 1451 (other than subsections (b)(1)(B), (b)(2), and (b)(3)), shall not apply to any religious fraternal benefit society in existence as of September 1993, which bears the risk of providing insurance to its members, and which is an organization described in section 501(c)(8) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code.

SEC. 1412. ENROLLMENT.

(a) IN GENERAL.—A certified health plan shall establish an enrollment process consistent rules established by the Secretary.

(b) ENROLLMENT REQUIREMENTS.—The rules established under subsection (a) shall provide for—

(1) general enrollment periods;

(2) special enrollment periods for individuals who experience a change in their employment of family situation or in their residence; and

(3) disenrollment for cause.

SEC. 1413. RATING LIMITATIONS FOR COMMUNITY-RATED MARKET.

(a) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED ELIGIBLE INDIVIDUALS.—Each certified health plan which covers community-rated individuals shall establish within each community rating area in which the plan is to be offered, a standard premium for individual enrollment.

(b) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the standard premium for each certified health plan shall be the same, and shall not include the administrative costs described in paragraph (3).

(2) APPLICATION TO ENROLLEES.—

(A) IN GENERAL.—The premium charged for coverage in a certified health plan which covers community-rated individuals shall be the product of—

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

(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

(iii) the age adjustment factor (specified under subparagraph (C)).

(B) FAMILY ADJUSTMENT FACTOR.—

(i) IN GENERAL.—The reform standards shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

(ii) CLASSES OF ENROLLMENT.—

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

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

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

(cc) Coverage of an unmarried individual and one or more children (referred to in this Act

as the ''single parent'' enrollment or class of enrollment).

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

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

(aa) FAMILY.—The terms ''family enrollment'' and ''family class of enrollment'', refer to enrollment in a class of enrollment described in item (bb), (cc), or (dd) of subclause (I).

(bb) COUPLE.—The term ''couple class of enrollment'' refers to enrollment in a class of enrollment described in item (bb) or (dd) of subclause (I).

(III) SPOUSE; MARRIED; COUPLE.—

(aa) IN GENERAL.—In this Act, the terms ''spouse'' and

''married'' mean, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

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

(C) AGE ADJUSTMENT FACTOR.—

(i) IN GENERAL.—The Secretary, in consultation with the NAIC, shall specify uniform age categories and maximum rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed twice the lowest age adjustment factor.

(ii) PHASE-IN PERIOD.—The Secretary, in consultation with the NAIC, shall establish a schedule for the phase-in of age-adjusted community rates so as to

minimize disruption of the insurance market.

(3) ADMINISTRATIVE SAVINGS.—Nothing in this section shall be construed as preventing a purchasing cooperative from negotiating a unique premium with a certified health plan that reflects administrative and other sources of savings.

SEC. 1414. NONDISCRIMINATION BASED ON HEALTH STATUS.

Except as otherwise provided in this Act, a certified health plan may not deny, limit, or condition the coverage under (or benefits of) the plan for any reason, including but not limited to, health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care, disability, or lack of evidence of insurability, of an individual.

SEC. 1415. BENEFITS OFFERED.

A certified health plan shall offer to all enrollees in the plan the comprehensive benefits established under subtitle B.

SEC. 1416. REQUIREMENTS OF SUPPLEMENTALS.

A certified health plan sponsor may only offer benefits that are not covered benefits, or a reduction in cost sharing below the cost sharing specified under section 1101(h), if—

(1) such additional coverage is offered and priced separately from the comprehensive benefits package offered by such plan;

(2) the purchase of the certified health plan is not conditioned upon the purchase of such additional coverage;

(3) coverage of such additional benefits is also offered to individuals who are not enrolled in the certified health plan; and

(4) the cost sharing reduction is offered only to individuals enrolled in the certified health plan by such plan for a price which includes any expected increase in utilization resulting from the purchase of such cost sharing reduction.

SEC. 1417. RISK ADJUSTMENT.

(a) IN GENERAL.—Each community-rated certified health plan shall participate in a risk adjustment program of the State in accordance with subsection (b).

(b) ESTABLISHMENT OF STANDARDS FOR RISK ADJUSTMENT PROGRAMS.—

(1) IN GENERAL.—The Secretary shall develop standards under paragraph (2) for participating States to provide risk adjustment programs under section 1207 for participation by certified health plans.

(2) RISK ADJUSTMENT PROGRAM.—The standards developed by the Secretary under this paragraph shall include a risk adjustment program which—

(A) assures that payments to community-rated certified health plans reflect the expected relative utilization and expenditures for health care services by each plan's enrollees compared to the average utilization and expenditures for community-rated individuals; and

(B) protects plans that enroll a disproportionate share of such individuals with respect to whom expected utilization of health care services and expected health care expenditures for such services are greater than the average utilization and expenditures for such eligible individuals.

SEC. 1418. FINANCIAL REQUIREMENTS.

Each sponsor offering a community-rated certified health plan shall meet financial solvency requirements to assure protection of enrollees with respect to potential insolvency. The Secretary, in consultation with the NAIC, shall establish such standards by regulation.

SEC. 1419. COLLECTION AND PROVISION OF STANDARDIZED INFORMATION.

Each certified health plan that provides coverage for individuals residing in a State shall submit to the State and, upon request, to community-rated individuals, information regarding—

(1) certification status of the plan;

(2) benefits offered under the plan;

(3) premiums, cost-sharing, and administrative charges under the plan;

(4) risk and referral arrangements under the plan;

(5) the number, distribution, and variety of health care providers used under the plan and the availability of such providers;

(6) the enrollee complaint and appeals process used under the plan;

(7) the rights and responsibilities of plan enrollees; and

(8) other information determined appropriate by the Secretary or the State.

SEC. 1420. QUALITY IMPROVEMENT AND ASSURANCE.

(a) IN GENERAL.—Each certified health plan shall establish procedures, including ongoing quality improvement procedures, to ensure that the health care services provided to enrollees under the plan will be provided under

reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice.

(b) INTERNAL QUALITY ASSURANCE PROGRAM.—Each certified health plan shall establish, and communicate to its enrollees and its providers, an ongoing internal program, including periodic reporting, to monitor and evaluate the quality and cost effectiveness of its health care services, pursuant to standards established by the Secretary.

(c) UTILIZATION MANAGEMENT PROTOCOLS.—The utilization review and management activities of each certified health plan, provided either directly or through contract, shall meet the following standards as defined by the Secretary:

(1) PERSONNEL.—All review determinations shall be made by licensed, certified, or otherwise credentialed health professionals who are qualified to review utilization of the treatment being sought.

(2) REVIEW PROCESS.—Each certified health plan shall base utilization management on current scientific knowledge, stress the efficient delivery of health care and outcomes, rely primarily on evaluating and comparing practice patterns rather than routine case-by-case review, be consistent and timely

in application, and have a process for making review determinations for urgent and emergency care 24 hours a day.

(3) NO FINANCIAL INCENTIVES.—Utilization management by each certified health plan may not create financial incentives for reviewers to reduce or limit medically necessary or appropriate services.

(4) CONSUMER DISCLOSURE.—Each certified health plan shall disclose, upon request, to enrollees (and prospective enrollees) and to participating providers (and prospective providers) the utilization review protocols and the type of financial arrangements, if any, used by the plan for controlling utilization and costs, while protecting proprietary business information to the extent specified by the Secretary.

(d) PHYSICIAN INCENTIVE PLANS.—A certified health plan may not operate a physician incentive plan unless such incentive plan meets the requirements of section 1876(i)(8)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(8)(A)).

(e) CREDENTIALING.—Each certified health plan shall—

(1) verify the credentials of participating physicians and practitioners; and

(2) ensure that participating providers and facilities are appropriately accredited, certified, and licensed.

SEC. 1421. PATIENT PROTECTIONS AND PROVIDER SELECTION.

(a) INFORMATION REGARDING A PATIENT'S RIGHT TO SELF-DETERMINATION IN HEALTH CARE SERVICES.—Each certified health plan shall be considered to be an eligible organization under title XVIII of the Social Security Act for purposes of applying the rules under section 1866(f) of such Act (42 U.S.C. 1395cc(f)).

(b) GATEKEEPER.—With respect to each network plan that utilizes a gatekeeper or similar process to approve network items and services, such plan shall ensure that such gatekeeper or process does not create an undue burden for enrollees with complex or chronic health conditions and shall ensure access to relevant specialists for the continued care of such enrollees when medically indicated. In cases of a patient with a severe, complex, or chronic health condition, such plan shall determine, in conjunction with the enrollee and the enrollee's primary care provider, whether it is medically necessary or appropriate to use a specialist or a care coordinator from an interdisciplinary team as the gatekeeper or in the health care approval process.

(c) CONFIDENTIALITY OF PATIENT RECORDS.—Each certified health plan shall have explicit procedures to protect the confidentiality of individual patient information.

(d) MARKETING.—A sponsor of a certified health plan may not engage in selective marketing that would have the effect of avoiding high-risk subscribers within a community-rating area. Marketing materials may not contain false or materially misleading information.

(e) NO PATIENT LIABILITY FOR UNPAID PLAN OBLIGATIONS.—An individual enrolled in a certified health plan shall not be liable to any health care provider or practitioner with respect to the provision of health services covered by the plan in excess of the amount for which the individual would have been liable had the health plan made payments to providers in a timely manner.

(f) REMEDIES AND ENFORCEMENT.—

(1) IN GENERAL.—Each certified health plan shall comply with the applicable remedies and enforcement requirements.

(2) GRIEVANCE PROCESS.—Each certified health plan shall establish a grievance process for enrollees dissatisfied with matters other than the denial of payment or provision of benefits by the plan.

(g) ENROLLMENT.—A certified health plan may not knowingly accept the enrollment of an individual who is enrolled in another certified health plan.

(h) PROVIDER SELECTION.—

(1) IN GENERAL.—In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a certified health plan may not engage in any practice that discriminates against a provider based on the actual or anticipated health status of the patients of the provider.

(2) ADDITIONAL REQUIREMENTS.—No health plan may discriminate on the basis of the provider's status as a member of a health care profession for the purposes of selecting among providers of health services for participation in a provider network, provided that the State authorizes members of that profession to render the services in question and that such services are covered in the comprehensive benefits package described in subtitle B.

(3) NUMBER AND TYPE.—Nothing in this subsection shall—

(A) prevent a certified health plan sponsor from matching the number and type of health

care providers to the needs of the plan members; or

(B) establish any other measure designed to maintain quality or to control costs.

(i) PHYSICIAN PARTICIPATION.—Each certified health plan shall establish mechanisms through which physicians have input into matters affecting patient care and through which patients have the ability to choose any primary care physician from among participating providers.

SEC. 1422. ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

(a) CERTIFICATION.—The Secretary shall certify as an essential community provider the following providers and organizations:

(1) Covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), and comparable nonprofit hospitals, except that subsections (a)(4)(L)(iii) and (a)(7) of such section shall not apply.

(2) A Medicare dependent small rural hospital under section 1886(d)(8)(iii) of the Social Security Act.

(3) Children's hospitals meeting comparable criteria determined appropriate by the Secretary.

(4) Public and private, nonprofit mental health and substance abuse providers receiving funds under title V or XIX of the Public Health Service Act.

(5) Runaway homeless youth centers or transitional living programs for homeless youth providing health services under the Runaway Homeless Youth Act of 1974 (42 U.S.C. 5701 et seq.).

(6) Public or nonprofit maternal and child health providers that receive funding under title V of the Social Security Act.

(7) Rural health clinics as defined under section 1861(aa)(2) of the Social Security Act.

(8) School health services centers under title III of this Act.

(9) Nonprofit hospitals with a minimum of 200 beds, located in urban areas where—

(A) the cumulative total of its services provided to individuals who are entitled to benefits under title XVIII of the Social Security Act or under a State plan under title XIX of such Act equals a minimum of 65 percent; and

(B) a minimum of 20 percent of its services are provided to individuals eligible for assistance under such title XIX.

(b) REQUIREMENTS RELATING TO ESSENTIAL COMMUNITY PROVIDERS.—

(1) IN GENERAL.—Each health plan shall, with respect to each electing essential community provider (as defined in paragraph (5), other than a provider of school health services) located within the plan's service area, either—

(A) enter into a written provider participation agreement (described in paragraph (3)) with the provider; or

(B) enter into a written agreement under which the plan shall make payment to the provider in accordance with paragraph (4).

The requirements of this paragraph shall not apply to a health plan with respect to any essential community provider for which a demonstration is made pursuant to paragraph (2).

(2) WAIVERS.—Effective one year after the date on which a State becomes a participating State, the Secretary shall grant a waiver of the requirements of paragraph (1) to any health plan that demonstrates that it has the capacity to provide services to plan enrollees residing in the area served by an essential community provider that are reasonably equivalent to the services provided by the essential

community provider in terms of the scope of services and convenience. Any such waiver shall not become effective until the plan year following the succeeding open enrollment period. Any health plan receiving such a waiver shall notify the essential community provider with respect to which such a waiver has been granted and enrollees of the plan not less than 60 days prior to the commencement of such enrollment period.

(3) PARTICIPATION AGREEMENT.—A participation agreement between a health plan and an electing essential community provider under this paragraph shall provide that the health plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers participating in the health plan with respect to each of the following:

(A) The scope of services for which payment is made by the plan to the provider.

(B) The rate of payment for covered care and services.

(C) The availability of financial incentives to participating providers.

(D) Limitations on financial risk provided to other participating providers.

(E) Assignment of enrollees to participating providers.

(F) Access by the provider's patients to providers in medical specialties or subspecialties participating in the plan.

(4) PAYMENTS FOR PROVIDERS WITHOUT PARTICIPATION AGREEMENTS.—

(A) IN GENERAL.—Payment in accordance with this paragraph is payment based on payment methodologies and rates used under the applicable Medicare payment methodology and rates (or the most closely applicable methodology under such program as the Secretary of Health and Human Services specifies in regulations).

(B) NO APPLICATION OF GATE-KEEPER LIMITATIONS.—Payment in accordance with this paragraph may be subject to utilization review, but may not be subject to otherwise applicable gate-keeper requirements under the plan.

(5) ELECTION.—

(A) IN GENERAL.—In this section, the term ''electing essential community provider'' means, with respect to a health plan, an essen-

tial community provider that elects this section to apply to the health plan.

(B) FORM OF ELECTION.—An election under this paragraph shall be made in a form and manner specified by the Secretary, and shall include notice to the health plan involved. Such an election may be made annually with respect to a health plan, except that the plan and provider may agree to make such an election on a more frequent basis.

(c) RECOMMENDATION ON CONTINUATION OF REQUIREMENT.—

(1) STUDIES.—In order to prepare recommendations under paragraph (2), the Secretary shall conduct studies regarding essential community providers, including studies that assess—

(A) the definition of essential community provider,

(B) the sufficiency of the funding levels for providers, including rules for federally qualified health centers, for both covered and uncovered benefits under this Act,

(C) the effects of contracting requirements relating to such providers on such providers, health plans, and enrollees,

(D) the impact of the payment rules for such providers, and

(E) the impact of national health reform on such providers.

(2) RECOMMENDATIONS TO CONGRESS.—The Secretary shall submit to Congress, by not later than March 1, 2001, specific recommendations respecting whether, and to what extent, subsection (b) should continue to apply to some or all essential community providers. Such recommendations may include a description of the particular types of such providers and circumstances under which such section should continue to apply.

SEC. 1423. ACCESS TO SPECIALIZED SERVICES.

(a) IN GENERAL.—Each certified health plan shall have within the plan's network, or have such other arrangements with, a sufficient number, distribution, and variety of providers of specialized services to assure that such services are available and accessible to adults, infants, children, and persons with disabilities. With respect to children such specialized care shall be in pediatrics.

(b) ELIGIBLE CENTERS OF SPECIALIZED TREATMENT EXPERTISE.—

(1) IN GENERAL.—Each network plan shall demonstrate that adults, children, and individuals

with disabilities have access to specialized treatment expertise when medically indicated by meeting evaluation criteria established by the Secretary. In establishing such criteria, the Secretary may consider a process by which a network plan could be deemed to meet such evaluation criteria if such plan demonstrates referrals to designated centers of specialized care when medically necessary or appropriate and informs enrollees of the availability of referral care.

(2) ELIGIBLE CENTERS.—The Secretary shall establish criteria for designating centers of specialized care and shall designate eligible centers based on such criteria. The criteria shall include requirements for staff credentials and experience, and requirements for measured outcomes in the diagnosis and treatment of patients. The Secretary shall develop additional criteria for outcomes of specialized treatment as research findings become available. To be designated as a center of specialized care, a center shall—

(A) attract patients from outside the center's local geographic region, from across the State or the United States; and

(B) either sponsor, participate in, or have medical staff who participate in peer-reviewed research.

(3) LIMITATION.—A State may not establish rules or policies that require or encourage network plans to give preference to centers of specialized treatment expertise within the State or within the community rating area. A health plan shall not prohibit an academic health center, teaching hospital, or other center for specialized care with which it contracts from contracting with one or more other plans.

(4) SPECIALIZED TREATMENT EXPERTISE.—For purposes of this subsection, the term ''specialized treatment expertise'', with respect to the treatment of a health condition by an eligible center, means expertise in diagnosing and treating unusual diseases or conditions, diagnosing and treating diseases or conditions which are unusually difficult to diagnose or treat, and providing other specialized health care.

(c) EVALUATION CRITERIA FOR SPECIALIZED SERVICES STANDARDS.—A certified health plan may choose to provide specialized services within a provider network if such provision meets the requirements of this section.

SEC. 1424. COMMUNITY RATING AREA CAPACITY.

Each certified health plan shall have the capacity within the plan's network, or through arrangements with a sufficient number, distribution, and variety of providers, to deliver the comprehensive benefits required under subtitle B throughout the community rating area (designated under section 1203) in which such plan is offered. Services shall be provided with reasonable promptness and accessibility, in a manner which assures continuity, and in a manner which appropriately serves the diverse needs of the population.

SEC. 1425. OUT-OF-AREA COVERAGE.

Each certified health plan shall provide emergency out-of-area and out-of-plan coverage for enrollees of the plan and urgent out-of-area coverage.

PART 3—STANDARDS APPLICABLE TO CERTIFIED SELF-INSURED HEALTH PLANS

SEC. 1431. STANDARDS APPLICABLE TO CERTIFIED SELF-INSURED HEALTH PLANS.

(a) IN GENERAL.—Subject to subsection (b), the requirements applicable to certified self-insured health plans are the requirements specified in the following provisions (as modified in regulations promulgated by the Secretary of Labor to make such provisions applicable to self-insured plans):

(1) Section 1411, except that such subsections (a) and (b) shall be applied (for purposes of this subsection) only with respect to employees of the employer sponsor or members of the family of such employees.

(2) Sections 1412 through 1425, except that sections 1413(a), 1416, 1417, and 1418 shall not apply.

(b) COLLECTIVE BARGAINING EXCEPTION.—Paragraph (1) of subsection (a) shall not apply to a certified self-insured health plan sponsor that is providing benefits pursuant to a collective bargaining agreement.

(c) FINANCIAL SOLVENCY.—Each certified self-insured health plan shall meet the solvency, reserve, and stop-loss requirements established by the Secretary of Labor under section 1501.

(d) MANAGEMENT OF FUNDS.—

(1) MANAGEMENT OF FUNDS.—A certified self-insured health plan sponsor shall, in the management of the plan's funds, be subject to the applicable fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, together with the applicable enforcement provisions of part 5 of subtitle B of title I of such Act.

(2) MANAGEMENT OF FINANCES AND RECORDS; ACCOUNTING SYSTEM.—A certified self-insured health plan sponsor shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

(e) ADDITIONAL STANDARDS.—In addition to the requirements applicable to certified self-insured health plans under subsection (a), the Secretary of Labor shall establish standards to ensure that such health plans and insured, experience-rated health plans—

(1) do not vary premiums for any reason described in section 1414(a);

(2) do not discriminate on a basis described in section 1203(e) (relating to geographic discrimination); and

(3) provide information to employees of the employer sponsor of the plans offered.

PART 4—PREEMPTION OF CERTAIN STATE LAWS

SEC. 1441. PREEMPTION FROM STATE BENEFIT MANDATES.

Effective as of January 1, 1997, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of a certified health plan, of any services, category of care, or services of any class or type of provider that is dif-

ferent from the benefit categories specified under this Act; or

(2) requires a right of conversion from a group health plan that is a certified health plan to an individual certified health plan.

SEC. 1442. PREEMPTION OF STATE LAW RESTRICTIONS ON CERTIFIED HEALTH PLANS.

Effective as of January 1, 1997—

(1) a State may not prohibit or limit a certified health plan from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit or limit such plans from limiting coverage of services to those provided by a participating provider;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers under such plans;

(4) a State may not prohibit or limit such plans from limiting the number of participating providers;

(5) a State may not prohibit or limit such plans from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers;

(6) a State may not prohibit or limit the corporate practice of medicine;

(7) a State may not regulate utilization management and review programs of any health plan to the extent not provided by this title;

(8) a State may not prohibit or limit a health plan from using single source suppliers for pharmacy services, non-serviced medical equipment, and other supplies and services; and

(9) a State may not prohibit a certified health plan, including a Federally qualified health maintenance organization, from offering a point of service option.

PART 5—INTERIM STANDARDS

SEC. 1451. APPLICATION OF INTERIM STANDARDS.

(a) IN GENERAL.—During the interim standards application period, a health plan sponsor may only offer a health plan in a State if such plan meets the standards specified in subsections (b) and (c).

(b) SPECIFIED STANDARDS.—

(1) GUARANTEED ISSUE AND NONDISCRIMINATION.—The standards specified in—

(A) section 1411(a), and

(B) section 1414.

(2) RENEWAL.—The standards specified in section 1411(b).

(3) COVERAGE.—A self-insured health plan may not reduce or limit coverage of any condition or course of treatment that is expected to cost not less than $5,000 during any 12-month period.

(c) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS PRIOR TO UNIVERSAL COVERAGE.—

(1) IN GENERAL.—Notwithstanding section 1414, prior to the achievement of universal coverage, a certified health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual only if—

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

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

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

(D) the limitation or exclusion does not apply to pregnancy.

(2) CREDITING OF PREVIOUS COVERAGE.—A certified health plan shall provide that if an individual under such plan is in a period of continuous coverage as of the date of enrollment under such plan, any period of exclusion of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in the period of continuous coverage.

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

(A) PERIOD OF CONTINUOUS COVERAGE.—The term ''period of continuous coverage'' means the period beginning on the date an individual is enrolled under a health plan or health care program which provides benefits similar to those provided by the certified health plan in which the individual is seeking to enroll with respect to coverage of a preexisting condition and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(B) PREEXISTING CONDITION.—The term ''preexisting condition'' means, with respect to coverage under a certified health plan, a condition which was diagnosed, or which was treated, within the 3-month period ending on the day

before the date of enrollment (without regard to any waiting period).

(d) INTERIM STANDARDS APPLICATION PERIODS.—The interim standards application period is—

(1) in the case of the standard specified in subsection (b) and (c), on or after January 1, 1996, and before the State becomes a participating State; and

(2) in the case of the standard specified in subsection (b)(3), on or after the date of the enactment of this Act, and before January 1, 1997.

(d) PREEMPTION.—The requirements of this section do not preempt any State law unless State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with such requirements. The Secretary may issue letter determinations with respect to whether this section preempts a provision of State law.

(e) CONSTRUCTION.—The provisions of this section shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health plans in effect on the effective date of this Act.

(f) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations regarding the application of this section in the case of health plans (or

groups of such plans) which are transferred from one health plan sponsor to another sponsor through assumption, acquisition, or otherwise.

Subtitle F—Federal Responsibilities

PART 1—ESTABLISHMENT OF FEDERAL STANDARDS FOR CERTIFIED INSURED HEALTH PLANS

SEC. 1500. ESTABLISHMENT.

The Secretary, in consultation with the NAIC and other qualified experts, shall develop and publish the standards specified in part 2 of subtitle E by not later than June 1, 1996.

PART 2—CERTIFICATION OF SELF-INSURED HEALTH PLANS

SEC. 1501. ESTABLISHMENT AND CERTIFICATION OF STANDARDS APPLICABLE TO SELF-INSURED CERTIFIED HEALTH PLANS.

(a) ESTABLISHMENT OF STANDARDS BY SECRETARY OF LABOR.—The Secretary of Labor, in consultation with the Secretary, shall develop and publish standards applicable to certified self-insured health plans relating to the requirements specified in part 3 of subtitle E. The Secretary shall develop and publish such standards by not later than June 1, 1996.

(b) CERTIFICATION OF HEALTH PLANS.—In the case of self-insured health plans, the Secretary of Labor shall provide for the certification of self-insured health plans as certified health plans.

(c) FINANCIAL STANDARDS.—The Secretary of Labor shall develop, by not later than January 1, 1996, standards for the solvency, reserve, and stop-loss requirements for certified self-insured health plans and for qualified association plans.

SEC. 1502. CORRECTIVE ACTIONS FOR SELF-INSURED HEALTH PLANS.

(a) IN GENERAL.—The Secretary of Labor shall by regulation establish procedures for the filing and implementation of corrective action plans in any case in which such Secretary or a self-insured plan sponsor determines that a self-insured plan has failed to meet the requirements of this Act, or expects such a failure.

(b) DISQUALIFIED OR TERMINATION OF PLAN.—

(1) IN GENERAL.—In any case in which the plan sponsor of a self-insured health plan determines that there is reason to believe that the plan will cease to be a certified self-insured health plan or will terminate, the plan sponsor shall so inform the Secretary of Labor, shall develop a plan for winding up the affairs of the plan in connection with such dis-

qualification or termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and shall submit such plan in writing to such Secretary. Actions required under this subparagraph shall be taken in such form and manner as may be prescribed in regulations by such Secretary.

(2) ACTIONS REQUIRED IN CONNECTION WITH DISQUALIFICATION OR TERMINATION.—

(A) ACTIONS BY PLAN SPONSOR.—Upon a determination by the Secretary of Labor that a corrective action plan has not been implemented or that such a plan cannot reasonably be expected to bring the health plan into compliance with this Act, the plan sponsor shall, at the direction of such Secretary, terminate the plan and, in the course of the termination, take such actions as such Secretary may require as necessary to ensure timely payment of all benefits for which the plan is obligated.

(B) ACTIONS BY LARGE EMPLOYER.—Upon a determination by the Secretary of Labor under subparagraph (A), the large employer shall provide for such contingency coverage for all employees of the employer in ac-

cordance with regulations which shall be prescribed in regulations of such Secretary.

SEC. 1503. ERISA APPLICABILITY TO SELF-INSURED HEALTH PLANS.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) in the heading for section 110, by adding ''BY PENSION PLANS'' at the end;

(2) by redesignating section 111 as section 112; and

(3) by inserting after section 110 the following new section:

''SPECIAL RULES FOR GROUP HEALTH PLANS

''SEC. 111. (a) IN GENERAL.—The Secretary may by regulation provide special rules for the application of this part to group health plans which are consistent with the purposes of the Affordable Health Care for All Americans Act and which take into account the special needs of participants, beneficiaries, and health care providers under such plans.

''(b) ADDITIONAL REQUIREMENTS.—Such special rules may include rules providing for reporting and disclosure to the Secretary and to participants and beneficiaries of additional information or at additional times with respect to group health plans to which this part applies

under section 4(c)(2), if such reporting and disclosure would be comparable to and consistent with similar requirements applicable under the Health Reform Act with respect to community-rated health plans and applicable regulations of the Secretary of Health and Human Services prescribed thereunder.''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the items relating to sections 110 and 111 and inserting the following new items:

''Sec. 110. Alternative methods of compliance by pension plans.
''Sec. 111. Special rules for group health plans.
''Sec. 112. Repeal and effective date.''.

PART 3—OTHER RESPONSIBILITIES

SEC. 1521. FEDERAL ROLE IN THE CASE OF A DEFAULT BY A STATE.

If a State fails to become a participating State under section 1200 or, having become a participating State, the State fails to continue to meet the requirements of such section, the Secretary shall, after notice and opportunity for correction, impose intermediate sanctions, order corrective actions, and may, if necessary to fulfill the purposes of this Act, carry out activities under this Act in the same manner as a participating State would carry out such activities.

SEC. 1522. RULES DETERMINING SEPARATE EMPLOYER STATUS.

Under rules of the Secretary, employers that are related (as defined under such rules) shall be treated under this Act as a single employer if a reason for their separation relates to the health risk characteristics of eligible employees of such employers.

SEC. 1523. WORKPLACE WELLNESS PROGRAM.

(a) IN GENERAL.—The Secretary shall develop certification criteria for workplace wellness programs.

(b) APPLICATION OF SECTION.—Any health plan may offer a uniform premium discount, not to exceed 10 percent, to employers maintaining certified workplace wellness programs.

PART 4—COLLECTIVE BARGAINING DISPUTE RESOLUTION

SEC. 1531. FINDINGS AND PURPOSE.

(a) FINDING.—Congress finds that—

(1) consistent with the intention of this Act to eliminate waste and inefficiency in the health care industry, it is important to avoid costly and disruptive labor disputes; and

(2) such disputes are particularly likely to take place during the period of transition to a restructured health care delivery system because of disrup-

tions to established employment relationships resulting from that restructuring.

(b) PURPOSE.—It is the purpose of this part to expand the role of the Federal Mediation and Conciliation Service, acting through the Boards of Inquiry provided for in limited terms under section 8(g) of the National Labor Relations Act (29 U.S.C. 158(g)) and section 213 of the Labor Management Relations Act of 1947 (29 U.S.C. 183), to avoid labor disputes by providing for public fact finding in contract negotiations.

SEC. 1532. APPLICATION LIMITED TO TRANSITION PERIOD.

The provisions of this part are intended to avoid costly and disruptive labor disputes during the period of transition to a restructured health care delivery system, and shall be repealed effective upon the end of calendar year 2000.

SEC. 1533. REQUEST FOR APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—A health care entity (as defined in section 3082(a)) or a labor organization that has been lawfully certified or recognized as the representative of the employees of a health care entity for the purpose of engaging in collective bargaining concerning wages, hours and other terms and conditions of employment, may request that the Director of the Federal Mediation and Concilia-

tion Service (hereafter referred to in this part as the ''Director'') appoint an impartial Health Care Board of Inquiry to investigate the issues involved in a collective bargaining dispute between the entity and the labor organization.

(b) TIME FOR REQUEST.—Such request may be made no earlier than 60 days after notice of the existence of a contract dispute has been provided to—

(1) the Federal Mediation and Conciliation Service in accordance with clause (A) or (B) of the last sentence of section 8(d) of the Labor Management Relations Act (29 U.S.C. 158(d)); or

(2) where the health care entity is otherwise exempt from coverage under such Act, any comparable State or territorial agency established to mediate and conciliate disputes to which notice is required to be given under applicable State law.

SEC. 1534. APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—Except as provided in subsection (b), the Director shall appoint a Health Care Board of Inquiry not later than 10 days after receipt of a request under section 1532. Each such Board shall be composed of such number of individuals as the Director may deem desirable. No member appointed under this section shall have any interest or involvement in the health care institu-

tions or the employee organizations involved in the dispute.

(b) LIMITATION.—With respect to the appointment of a Health Care Board of Inquiry under paragraph (1), if the Director determines that—

(1) the health care entity is—

(A) otherwise exempt from coverage under the Labor Management Relations Act, as amended (29 U.S.C. 141 et seq.); and

(B) subject to State laws containing procedures for the resolution of impasses in collective bargaining that are comparable to those that would be followed by a Board of Inquiry under this section; or

(2) the parties involved have agreed to procedures for the resolution of the impasse in collective bargaining that are comparable to those that would be followed by a Board of Inquiry;

the Director may refuse the request for the appointment of such a Board.

SEC. 1535. PUBLIC FACTFINDING.

A Health Care Board of Inquiry appointed under this part shall investigate the issues involved in the dispute and make a written report thereon to the parties and to the Director within 30 days after the establishment of such

a Board. The written report shall contain the findings of fact together with the Board's recommendations for settling the dispute, with the objective of achieving a prompt, peaceful and just settlement of the dispute. The Board shall arrange for publication of such report within the community served by the health care entity involved.

SEC. 1535A. COMPENSATION OF MEMBERS OF BOARDS OF INQUIRY.

(a) EMPLOYEES IF FEDERAL GOVERNMENT.—Members of any board established under this part who are otherwise employed by the Federal Government shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by such members in carrying out its duties under this section.

(b) OTHER MEMBERS.—Members of any board established under this section who are not subject to subsection (a) shall receive compensation at a rate prescribed by the Director but not to exceed the daily rate prescribed for GS–12 of the General Schedule under section 5332 of title 5, United States Code, including travel for each day they are engaged in the performance of their duties under this section and shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by them in carrying out their duties under this part.

SEC. 1535B. MAINTENANCE OF STATUS QUO.

After the establishment of a board under section 1533, and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time the parties began their bargaining in the case of an initial beginning negotiation, except by agreement, shall be made by the parties to the controversy.

Subtitle G—Miscellaneous Employer Requirements

SEC. 1601. AUDITING OF RECORDS.

Each community-rated employer shall maintain such records, and provide the State for the area in which the employer maintains the principal place of employment (as specified by the Secretary of Labor) with access to such records, as may be necessary to verify and audit the information reported under this Act.

SEC. 1602. PROHIBITION OF CERTAIN EMPLOYER DISCRIMINATION.

No employer may discriminate with respect to an employee on the basis of the family status of the employee or on the basis of the class of family enrollment selected with respect to the employee.

SEC. 1603. EVASION OF OBLIGATIONS.

It shall be unlawful for any employer or other person to discharge, fine, suspend, expel, discipline, discriminate or otherwise take adverse action against any employee if a purpose of such action is to interfere with the employee's attainment of status as a qualifying employee, as a full time employee, or as a part-time employee, or if a purpose of such action is to evade or avoid any obligation under this Act.

SEC. 1604. PROHIBITION ON SELF-FUNDING OF COST SHARING BENEFITS.

(a) PROHIBITION.—A community-rated employer (and an experience-rated employer with respect to employees who are community rated eligible individuals) may provide benefits to employees that consist of the benefits included in a cost sharing policy only through a contribution toward the purchase of a cost sharing policy which is funded primarily through insurance.

(b) INDIVIDUAL AND EMPLOYER RESPONSIBILITIES.—In the case of an individual who resides in a single-payer State and an employer with respect to employees who reside in such a State, the responsibilities of such individual and employer under such system shall supersede the obligations of the individual and employer under this subtitle.

SEC. 1605. ENFORCEMENT.

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

Subtitle H—General Definitions; Miscellaneous Provisions

PART 1—GENERAL DEFINITIONS

SEC. 1700. DEFINITIONS AND SPECIAL RULES RELATING TO HEALTH PLANS.

For purposes of this Act—

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term ''health plan'' means an insured health plan or a self-insured health plan which provides, or pays the cost of, health benefits. Such term does not include the following, or any combination thereof:

(i) Coverage only for accidental death or dismemberment.

(ii) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

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

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

(v) General liability insurance.

(vi) Worker's compensation or similar insurance.

(vii) Automobile or automobile medical-payment insurance.

(viii) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy provides sufficiently comprehensive coverage of a benefit so that it should be treated as a health plan).

(ix) A specified disease or illness insurance policy.

(x) A hospital or fixed indemnity income-protection policy.

(xi) A disability income policy.

(xii) Insurance with respect to accidents.

(xiii) An equivalent health care program.

(xiv) Such other plan or arrangement as the Secretary determines is not a health plan.

(B) INSURED HEALTH PLAN.—

(i) IN GENERAL.—The term ''insured health plan'' means any health plan which is a hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization or preferred provider organization group contract offered by an insurer.

(ii) INSURER.—The term ''insurer'' means—

(I) a licensed insurance company,

(II) a prepaid hospital or medical service plan,

(III) a preferred provider organization,

(IV) a health maintenance organization, or

(V) any similar entity (other than an entity described in subparagraph (C)),

which is engaged in the business of providing a plan of health insurance or health benefits.

(C) SELF-INSURED HEALTH PLAN.—The term ''self-insured health plan'' means a health plan—

(i) which is established and maintained by a large employer, and

(ii) under which the large employer retains a substantial risk for the providing of health benefits under the plan.

(D) NETWORK PLAN.—The term ''network plan'' means a health plan with which providers have entered into an agreement that obligates such providers to provide items and services to individuals enrolled in the plan, or an agreement to provide items and services on a fee-for-service basis.

(E) POINT-OF-SERVICE PLAN.—The term ''point-of-service plan'' means a network plan that provides reimbursement for items and services provided out-of-network at increased cost-sharing levels.

(F) FEE-FOR-SERVICE PLAN.—The term ''fee-for-service plan'' means a health plan that—

(i) provides coverage for all items and services included in the comprehensive ben-

efit package that are furnished by any lawful health care provider of the enrollee's choice, subject to reasonable restrictions, as determined by the Secretary, and

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

(2) CERTIFIED HEALTH PLAN.—The term ''certified health plan'' means a health plan which is certified by the appropriate certifying authority as meeting the applicable requirements of this Act, including the offering of the comprehensive benefits described in subtitle B. A health plan shall not fail to be treated as a certified health plan if such plan offers a medicare-eligible benefits package to medicare beneficiaries under—

(A) a contract entered into with the Secretary under section 1876 of the Social Security Act, or

(B) a plan of an organization providing benefits pursuant to an agreement under section 1833(a)(1)(A) of such Act.

(3) TERMS AND RULES RELATING TO COMMUNITY AND EXPERIENCE RATING.—

(A) COMMUNITY-RATED HEALTH PLAN.—The term ''community-rated health plan'' means a health plan which meets the requirements of section 1013.

(B) COMMUNITY-RATED INDIVIDUAL.—The term ''community-rated individual'' means an individual—

(i) who is not an experience-rated individual, or

(ii) who is an experience-rated individual (determined without regard to this subparagraph) who is not a full-time employee of a large employer and who does not enroll in a certified health plan offered by the employer.

(C) SMALL EMPLOYER.—The term ''small employer'' means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed less than 100 full-time employees for the day.

(D) EXPERIENCE-RATED HEALTH PLAN.—The term ''experience-rated health plan'' means

an insured or self-insured health plan covering only experience-rated individuals.

(E) EXPERIENCE-RATED INDIVIDUAL.—The term ''experience-rated individual'' means an individual who is—

(i) an employee (or the dependent of an employee) of a large employer,

(ii) a member (or the dependent of a member) of a qualified association plan (as defined in section 1323), or

(iii) an individual enrolled in a plan to which section 1325 applies.

(F) LARGE EMPLOYER.—

(i) IN GENERAL.—The term ''large employer'' means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed 100 or more full-time employees for the day.

(ii) ELECTION NOT TO AGGREGATE.—Any employer may elect not to aggregate its employees across community rating areas. Upon such election, the employer

shall be treated as a small employer in any community rating area in which it employs less than 100 full-time employees and as a large employer in any community rating area in which it employs 100 or more full-time employees. Such election shall remain in effect for a period of not less than 5 years. An employer may revoke such election after a 5-year period by notifying the Secretary of Labor under rules prescribed by the Secretary.

(G) SPECIAL RULE FOR SPOUSES AND DEPENDENTS.—If any individual is offered coverage under a health plan as the spouse or a dependent of a primary enrollee of such plan, such individual shall have the status of such enrollee unless such individual is eligible to elect other coverage and so elects.

SEC. 1701. DEFINITIONS RELATING TO EMPLOYMENT AND INCOME.

(a) IN GENERAL.—Except as otherwise specifically provided, in this Act the following definitions and rules apply:

(1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND WAGES DEFINED.—Except as provided in this section—

(A) the terms ''wages'' and ''employment'' have the meanings given such terms under section 3121 of the Internal Revenue Code of 1986,

(B) the term ''employee'' has the meaning given such term under section 3121 of such Code, subject to the provisions of chapter 25 of such Code, and

(C) the term ''employer'' has the same meaning as the term ''employer'' as used in such section 3121.

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

(A) EMPLOYMENT.—

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

(ii) EXCLUSION OF INMATES AS EMPLOYEES.—Employment shall not include services performed in a penal institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(B) WAGES.—

(i) IN GENERAL.—Paragraph (1) of section 3121(a) of the Internal Revenue Code of 1986 shall not apply.

(ii) TIPS NOT INCLUDED.—The term ''wages'' does not include cash tips.

(C) EXCLUSION OF CERTAIN FOREIGN EMPLOYMENT.—The term ''employee'' does not include an individual with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States.

(3) AGGREGATION RULES FOR EMPLOYERS.—For purposes of this Act—

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) under regulations of the Secretary of Labor, all employees of organizations which are

under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under subparagraph (B) shall be based on principles similar to the principles which apply to taxable organizations under subparagraph (A).

(4) EMPLOYER PREMIUM.—The term ''employer premium'' refers to the premium established and imposed under part 2 of subtitle B of title V.

(b) QUALIFYING EMPLOYEE; FULL-TIME EMPLOYMENT.—

(1) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—In this Act, the term ''qualifying employee'' means, with respect to an employer for a month, an employee (other than a covered child, as defined in subparagraph (C)) who is employed by the employer for at least 40 hours (as determined under paragraph (3)) in the month, subject to the limitation set forth in subparagraph (D).

(B) NO SPECIAL TREATMENT OF MEDICARE BENEFICIARIES, SSI RECIPIENTS, AFDC

RECIPIENTS, AND OTHERS.—Subparagraph (A) shall apply regardless of whether or not the employee is a medicare-eligible individual, an SSI recipient, an AFDC recipient, an eligible individual or is authorized to be so employed.

(C) COVERED CHILD DEFINED.—In subparagraph (A), the term ''covered child'' means an eligible individual who is a child and is enrolled under a health plan as a family member described in section 1011(b).

(D) QUALIFYING EMPLOYEES.—As used in this Act—

(i) the term qualifying employee shall not include, with respect to an employer for a month, an employee of a nonelecting small employer (as defined in section 6120); and

(ii) the term ''qualifying employee'' shall include, with respect to an employer for a month, a part-time employee beginning with the second month of such employee's employment.

(2) FULL-TIME EQUIVALENT EMPLOYEES; PART-TIME EMPLOYEES.—

(A) IN GENERAL.—For purposes of this Act, a qualifying employee who is employed by an employer—

(i) for at least 120 hours in a month, is counted as 1 full-time equivalent employee for the month and shall be deemed to be employed on a full-time basis, or

(ii) for at least 40 hours, but less than 120 hours, in a month, is counted as a fraction of a full-time equivalent employee in the month equal to the full-time employment ratio for the employee and shall be deemed to be employed on a part-time basis.

(B) FULL-TIME EMPLOYEE.—For purposes of this Act, the term ''full-time employee'' means, with respect to an employer, an employee who is employed on a full-time basis (as specified in subparagraph (A)) by the employer.

(C) PART-TIME EMPLOYEE.—For purposes of this Act, the term ''part-time employee'' means, with respect to an employer, an employee who is employed on a part-time basis (as specified in subparagraph (A)) by the employer.

(D) CONSIDERATION OF INDUSTRY PRACTICE.—As provided under rules established by the Secretary, an employee who is not described in subparagraph (B) or (C) shall be considered to be employed on a full-time or part-time basis by an employer (and to be a full-time or part-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into account the structure or nature of employment in the industry, represents full or part-time employment in that industry.

(E) INSTITUTIONS OF HIGHER EDUCATION.—Notwithstanding any other provision in this section—

(i)(I) employees of an Institution of higher education (as defined in section 1201(a) of the Higher Education Act of 1965), or of an elementary or secondary school (as defined in section 1471 of the Elementary and Secondary Education Act of 1965), who are exempt under section 13 of the Fair Labor Standards Act, shall be deemed to be full-time employees if they

work the hours that constitute full-time employment as defined at such institution;

(II) part-time employment shall be considered proportional to such hours for full-time employees; and

(III) part-time employees who work at least one-third of the hours that constitute full-time employment as defined at such institution shall be eligible for proportional employer premium contributions; and

(ii) regular employees of institutions of higher education or elementary and secondary schools who are not paid during the summer months or other periods of the year, but are assured employment at the end of such periods, shall be eligible for year-round employer premium contributions if such individuals are not eligible to collect unemployment compensation for the periods for which they would receive health care premium contributions from the employer covered by this subsection.

(3) TREATMENT OF SALARIED EMPLOYEES AND EMPLOYEES PAID ON CONTINGENT OR BONUS ARRANGEMENTS.—In the case of an employee who re-

ceives compensation on a salaried basis or on the basis of a commission (or other contingent or bonus basis), rather than an hourly wage, the Secretary shall establish rules for the conversion of the compensation to hours of employment.

(c) DEFINITIONS RELATING TO SELF-EMPLOYMENT.—In this Act:

(1) NET EARNINGS FROM SELF-EMPLOYMENT.—The term ''net earnings from self-employment'' has the meaning given such term under section 1402(a) of the Internal Revenue Code of 1986.

(2) SELF-EMPLOYED INDIVIDUAL.—The term ''self-employed individual'' means, for a year, an individual who has net earnings from self-employment for the year.

(d) CONSUMER PRICE INDEX; CPI.—The terms ''consumer price index'' and ''CPI'' mean the Consumer Price Index for all urban consumers (U.S. city average), as published by the Bureau of Labor Statistics.

SEC. 1702. OTHER GENERAL DEFINITIONS.

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

(1) APPLICABLE HEALTH PLAN.—The term ''applicable health plan'' means, with respect to an

eligible individual, the health plan specified pursuant to section 1004 and part 2 of subtitle A.

(2) CITIZEN OF ANOTHER COUNTRY LEGALLY RESIDING IN THE UNITED STATES.—The term ''citizen of another country legally residing in the United States'' means an alien lawfully admitted for permanent residence, or otherwise permanentlty residing, in the United States under color of law as included in regulations in effect under title XIX of the Social Security Act as of December 1, 1994.

(3) COVERED WAGES DEFINED.—In this section, the term ''covered wages'' means wages paid an employee of an employer during a month in which the employee was a qualifying employee of the employer.

(4) EXEMPT INDIVIDUAL.—The term ''exempt individual'' means an individual that has been granted an exemption from paying Social Security Taxes under section 1402(g) of the Internal Revenue Code of 1986, or an individual who would be eligible for an exemption under such section if the individual were self-employed.

(5) HEALTH PLAN SPONSOR.—The term ''health plan sponsor'' means—

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

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

(C) with respect to a self-funded experience-rated plan, the employer providing the plan.

(6) LONG-TERM NONIMMIGRANT.—The term ''long-term nonimmigrant'' means a nonimmigrant described in subparagraph (E), (H), (I), (J), (K), (L), (M), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act or an alien within such other classification of nonimmigrant as the Secretary may establish by regulation.

(7) POVERTY LEVEL.—The term ''applicable poverty level'' means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved for 1994.

(8) SECRETARY.—The term ''Secretary'' unless expressly provided otherwise, means the Secretary of Health and Human Services.

PART 2—MISCELLANEOUS PROVISIONS

SEC. 1711. REGULATORY AUTHORITY.

The Secretary of Health and Human Services and the Secretary of Labor are each authorized to issue regulations as are necessary to implement this Act. In order to permit the timely implementation of the provisions of this Act, such regulations may be issued on an interim basis. Such regulations shall become final on the date of publication, subject to change based on subsequent public comment.

SEC. 1712. NEUTRALITY CONCERNING UNION ORGANIZING.

Amounts appropriated to carry out this Act may not be utilized to assist, promote or deter union organizing.

SEC. 1713. SOCIAL SECURITY ACT REFERENCES.

Except as may otherwise be provided, any reference in this title, or in title V, to a provision of the Social Security Act shall be to that provision of the Social Security Act as in effect on the date of the enactment of this Act.

SEC. 1714. COVERAGE OF BENEFITS UNDER AFFORDABLE HEALTH CARE FOR ALL AMERICANS ACT.

(a) DAVIS-BACON ACT.—Subsection (b)(2) of the first section of the Davis Bacon Act (40 U.S.C. 276a(b)(2)) is amended in the matter following subparagraph (B) by inserting after ''local law'' the following: ''(other than benefits provided pursuant to the Affordable Health Care For all Americans Act)''.

(b) SERVICE CONTRACT ACT OF 1965.—The second sentence of section 2(a)(2) of the Service Contract Act of 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after ''local law'' the following: ''(other than benefits provided pursuant to the Affordable Health Care for All Americans Act)''.

SEC. 1715. SENSE OF THE COMMITTEE CONCERNING FUNDING SOURCES.

It is the sense of the Committee on Labor and Human Resources of the Senate that when the Affordable Health Care for All Americans Act is enacted it should include the following sources of financing not within the jurisdiction of the Committee:

(1) The net savings and revenues included in S.1757, the Health Security Act (as introduced in the 103d Congress) which are outside the jurisdiction of the Committee.

(2) An increase in the cigarette tax of 75 cents per pack in excess of the amount specified in S.1757, the Health Security Act.

(3) A phased-in premium assessment, not to exceed 1 percent, equal to the additional amount provided for biomedical research under title III of this Act.

(4) Such other savings or revenues as are necessary, if any, to provide budget neutrality based on estimates of the Congressional Budget Office.

(5) A one percent payroll assessment on exempt employers with five or fewer workers and a two percent payroll assessment on exempt employers with six to 10 workers payable to the State to defray a portion of the additional subsidy costs for employees of such employers.

TITLE II—NEW BENEFITS

Subtitle A—Home and Community-Based Services

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

SEC. 2101. STATE PLANS.

(a) PLAN REQUIREMENTS.—In order to be approved under subsection (b), a State plan for home and community-based services for individuals with disabilities must meet the following requirements:

(1) STATE MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—A State plan under this subtitle shall provide that the State will, during any fiscal year that the State is furnishing services under this subtitle, make expenditures of State funds in an amount equal to the State

maintenance of effort amount for the year determined under subparagraph (B) for furnishing the services described in subparagraph (C) under the State plan under this subtitle and the State plan under title XIX of the Social Security Act.

(B) STATE MAINTENANCE OF EFFORT AMOUNT.—

(i) IN GENERAL.—The maintenance of effort amount for a State for a fiscal year is an amount equal to—

(I) for fiscal year 1999, the base amount for the State (as determined under clause (ii)) updated through the midpoint of fiscal year 1998 by the estimated percentage change in the consumer price index during the period beginning on October 1, 1994 and ending at that midpoint; and

(II) for succeeding fiscal years, an amount equal to the amount determined under this clause for the previous fiscal year updated through the midpoint of the year by the estimated percentage change in the consumer

price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the projected percentage change in the consumer price index.

(ii) STATE BASE AMOUNT.—The base amount for a State is an amount equal to the total expenditures from State funds made under the State plan under title XIX of the Social Security Act during fiscal year 1994 with respect to medical assistance consisting of the services described in subparagraph (C).

(C) MEDICAID SERVICES DESCRIBED.—The services described in this subparagraph are the following:

(i) Personal care services (as described in section 1905(a)(24) of the Social Security Act).

(ii) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915 of such Act.

(iii) Home and community care furnished to functionally disabled elderly individuals under section 1929 of such Act.

(iv) Community supported living arrangements services under section 1930 of such Act.

(2) ELIGIBILITY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), within the amounts provided by the State and under section 2107 for such plan, the plan shall provide that services under the plan will be available to individuals with disabilities (as defined in section 2102(a)) in the State.

(B) INITIAL SCREENING.—The plan shall provide a process for the initial screening of an individual who appears to have some reasonable likelihood of being an individual with disabilities. Any such process shall require the provision of assistance to individuals who wish to apply but whose disability limits their ability to apply. The initial screening and the determination of disability (as defined under section 2102(b)(1)) shall be conducted by a public agency.

(C) RESTRICTIONS.—The plan may not limit the eligibility of individuals with disabilities based on—

(i) income,

(ii) age,

(iii) residential setting (other than an institutional setting), or

(iv) other grounds specified by the Secretary.

(D) CONTINUATION OF SERVICES.—The plan must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under the State medicaid plan under title XIX of the Social Security Act as of the date a State's plan is approved under this subtitle, the State will continue to make available (either under this plan, under the State medicaid plan, or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

(3) SERVICES.—

(A) NEEDS ASSESSMENT.—Not later than the end of the second year of implementation, the plan or its amendments shall include the results of a statewide assessment of the needs of individuals with disabilities in a format required by the Secretary. The needs assessment shall include demographic data concerning the number of individuals within each category of disability described in this subtitle, and the services available to meet the needs of such individuals.

(B) SPECIFICATION.—Consistent with section 2103, the plan shall specify—

(i) the services made available under the plan,

(ii) the extent and manner in which such services are allocated and made available to individuals with disabilities, and

(iii) the manner in which services under the plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

(C) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in

determining the amount and array of services made available to covered individuals with disabilities, the availability of informal care.

(D) ALLOCATION.—The State plan—

(i) shall specify how services under the plan will be allocated among covered individuals with disabilities,

(ii) shall attempt to meet the needs of individuals with a variety of disabilities within the limits of available funding,

(iii) shall include services that assist all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions,

(iv) shall demonstrate that services are allocated equitably, in accordance with the needs assessment required under subparagraph (A), and

(v) shall ensure that—

(I) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the

plan, under the State medicaid plan, or under both, is not less than,

(II) the proportion of the population of the State that represents individuals who are low-income individuals.

(E) LIMITATION ON LICENSURE OR CERTIFICATION.—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(F) CONSUMER CHOICE.—To the extent feasible, the State shall follow the choice of an individual with disabilities (or that individual's designated representative who may be a family member) regarding which covered services to receive and the providers who will provide such services.

(4) COST SHARING.—The plan shall impose cost sharing with respect to covered services in accordance with section 2104.

(5) TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.—The plan shall specify—

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers of personal assistance services, except that the plan—

(i) may not limit benefits to services provided by registered nurses or licensed practical nurses; and

(ii) may not limit benefits to services provided by agencies or providers certified under title XVIII; and

(B) any requirements for participation applicable to each type of service provider.

(6) PROVIDER REIMBURSEMENT.—

(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. In the case of payment to consumer-directed providers of personal assistance services, including payment through the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax and health care coverage provisions.

(B) PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set payment rates.

(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted or provided for under section 2104 as payment in full for services furnished under the plan.

(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 2105.

(8) ADVISORY GROUP.—The State plan shall assure the establishment and maintenance of an advisory group under section 2106(b).

(9) ADMINISTRATION AND ACCESS.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) COORDINATION.—The plan shall specify how it will—

(i) coordinate services provided under the plan, including eligibility prescreening, service coordination, and referrals for individuals with disabilities who are ineligible for services under this subtitle with other Federal or State programs that provide services or assistance targeted to individuals with disabilities; and

(ii) coordinate with health plans.

(C) ADMINISTRATIVE EXPENDITURES.—Effective beginning with fiscal year 2004, the plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary such data and information as the Secretary may require in a uniform format as specified by the Secretary.

(11) USE OF STATE FUNDS FOR MATCHING.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this subtitle.

(12) HEALTH CARE WORKER REDEPLOYMENT.—The plan shall provide for the following:

(A) Before initiating the process of implementing the State program under such plan, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(B) Negotiations under subparagraph (A) will address the following:

(i) The impact of the implementation of the program upon the workforce.

(ii) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the program.

(C) The plan will provide evidence that there has been compliance with subparagraphs (A) and (B), including a description of the results of the negotiations.

(13) TERMINOLOGY.—The plan shall adhere to uniform definitions of terms, as specified by the Secretary.

(b) APPROVAL OF PLANS.—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after a public comment period of not less than 30 days, and

(2) meets the requirements of subsection (a).

The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before January 1, 1998, shall be effective as of January 1, 1998). In order to budget funds allotted under this subtitle, the Secretary shall establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year. Any significant changes to the State plan shall be submitted to the Secretary in the form of plan amendments and shall be subject to approval by the Secretary.

(c) MONITORING.—The Secretary shall annually monitor the compliance of State plans with the requirements of this subtitle according to specified performance standards. In accordance with section 2107(e), States that fail to comply with such requirements may be subject to a reduction in the Federal matching rates available to the State under section 2107(a) or the withholding of Federal funds for services or administration until such time as compliance is achieved.

(d) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this subtitle on a timely basis.

SEC. 2102. INDIVIDUALS WITH DISABILITIES DEFINED.

(a) IN GENERAL.—For purposes of this subtitle, the term 'individual with disabilities' means any individual within one or more of the following categories of individuals:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living (as defined in subsection (d)), and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 90 days.

(2) INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either se-

vere cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living;

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies; or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

(C) who is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 90 days.

Not later than 2 years after the date of enactment of this subtitle, the Secretary shall make recommendations regarding the most appropriate duration of disability under this paragraph.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) YOUNG CHILDREN WITH SEVERE DISABILITIES.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the standards established under paragraphs (1), (2), or (3), and

(B) is expected to have such a disability or condition and require such services over a period of at least 90 days.

(b) DETERMINATION.—

(1) IN GENERAL.—In formulating eligibility criteria under subsection (a), the Secretary shall establish criteria for assessing the functional level of disability among all categories of individuals with disabilities that are comparable in severity, regardless of the age or the nature of the disabling condition of the individual. The determination of whether an individual is an individual with disabilities shall be made by a public or nonprofit agency that is speci-

fied under the State plan and that is not a provider of home and community-based services under this subtitle and by using a uniform protocol consisting of an initial screening and a determination of disability specified by the Secretary. A State may not impose cost sharing with respect to a determination of disability. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 2103(b) or for other purposes.

(2) PERIODIC REASSESSMENT.—The determination that an individual is an individual with disabilities shall be considered to be effective under the State plan for a period of not more than 6 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(c) ACTIVITY OF DAILY LIVING DEFINED.—For purposes of this subtitle, the term 'activity of daily living' means any of the following: eating, toileting, dressing, bathing, and transferring.

SEC. 2103. HOME AND COMMUNITY-BASED SERVICES COVERED UNDER STATE PLAN.

(a) SPECIFICATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the State plan under this subtitle shall specify—

(A) the home and community-based services available under the plan to individuals with disabilities (or to such categories of such individuals), and

(B) any limits with respect to such services.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Subject to subsection (f)(2), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(b) REQUIREMENT FOR NEEDS ASSESSMENT AND PLAN OF CARE.—

(1) IN GENERAL.—The State plan shall provide for home and community-based services to an individual with disabilities only if the following requirements are met:

(A) COMPREHENSIVE ASSESSMENT.—A comprehensive assessment of an individual's need for home and community-based services

(regardless of whether all need services are available under the plan) shall be made in accordance with a uniform, comprehensive assessment tool that shall be used by a State under this paragraph with the approval of the Secretary. The Secretary shall provide guidance to the States with regard to the appropriate qualifications for individuals who conduct comprehensive assessments.

(B) INDIVIDUALIZED PLAN OF CARE.—An individualized plan of care based on the assessment made under subparagraph (A) shall be developed. A plan of care under this subparagraph shall—

(i) specify which services included under the individual plan will be provided under the State plan under this subtitle;

(ii) identify (to the extent possible) how the individual will be provided any services specified under the plan of care and not provided under the State plan;

(iii) specify how the provision of services to the individual under the plan will be coordinated with the provision of other health care services to the individual; and

(iv) be reviewed and updated every 6 months (or more frequently if there is a change in the individual's condition).

The State shall make reasonable efforts to identify and arrange for services described in clause (ii). Nothing in this subsection shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(C) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under subparagraph (B) for an individual with disabilities shall—

(i) be developed by qualified individuals (specified under the State plan);

(ii) be developed and implemented in close consultation with the individual (or the individual's designated representative); and

(iii) be approved by the individual (or the individual's designated representative).

(c) REQUIREMENT FOR CARE MANAGEMENT.—

(1) IN GENERAL.—The State shall make available to each category of individuals with disabilities care management services that at a minimum include—

(A) arrangements for the provision of such services, and

(B) monitoring of the delivery of services.

(2) CARE MANAGEMENT SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the care management services described in paragraph (1) shall be provided by a public or private entity that is not providing home and community-based services under this subtitle.

(B) EXCEPTION.—A person who provides home and community-based services under this subtitle may provide care management services if—

(i) the State determines that there is an insufficient pool of entities willing to provide such services in an area due to a low population of individuals eligible for home and community-based services under this subtitle residing in such area; and

(ii) the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(d) MANDATORY COVERAGE OF PERSONAL ASSISTANCE SERVICES.—The State plan shall include, in the

array of services made available to each category of individuals with disabilities, both agency-administered and consumer-directed personal assistance services (as defined in subsection (h)).

(e) ADDITIONAL SERVICES.—Subject to subsection (f), services available under a State plan under this subtitle may include any (or all) of the following:

(1) Homemaker and chore assistance.

(2) Home modifications.

(3) Respite services.

(4) Assistive devices, as defined in the Technology Related Assistance for Individuals with Disabilities Act.

(5) Adult day services.

(6) Habilitation and rehabilitation.

(7) Supported employment.

(8) Home health services.

(9) Transportation.

(10) Any other care or assistive services specified by the State and approved by the Secretary that will help individuals with disabilities to remain in their homes and communities.

(f) EXCLUSIONS AND LIMITATIONS.—A State plan may not provide for coverage of—

(1) room and board,

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary, or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(g) PAYMENT FOR SERVICES.—In order to pay for covered services, a State plan may provide for the use of—

(1) vouchers,

(2) cash payments directly to individuals with disabilities,

(3) capitation payments to health plans, and

(4) payment to providers.

(h) PERSONAL ASSISTANCE SERVICES.—

(1) IN GENERAL.—For purposes of this subtitle, the term ''personal assistance services'' means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living, whether agency-administered or consumer-directed (as defined in paragraph (2)).

(2) CONSUMER-DIRECTED.—For purposes of this subtitle:

(A) IN GENERAL.—The term ''consumer-directed'' means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) STATE RESPONSIBILITIES.—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) RIGHT OF CONSUMERS.—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representa-

tive, shall retain the right to independently select, hire, terminate, and direct (including manage, train, schedule, and verify services provided) the work of a home care provider.

(3) AGENCY ADMINISTERED.—For purposes of this subtitle, the term 'agency-administered' means, with respect to such services, services that are not consumer-directed.

SEC. 2104. COST SHARING.

(a) NO COST SHARING FOR POOREST.—

(1) IN GENERAL.—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (d)) less than 150 percent of the official poverty level (referred to in paragraph (2)) applicable to a family of the size involved.

(2) OFFICIAL POVERTY LEVEL.—The term 'applicable poverty level' means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(b) SLIDING SCALE FOR REMAINDER.—

(1) REQUIRED COINSURANCE.—The State plan shall impose cost sharing in the form of coinsurance

(based on the amount paid under the State plan for a service)—

(A) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 175 percent, of such official poverty line (as so applied);

(B) at a rate of 15 percent for such individuals with income not less than 175 percent, and less than 225 percent, of such official poverty line (as so applied);

(C) at a rate of 25 percent for such individuals with income not less than 225 percent, and less than 275 percent, of such official poverty line (as so applied);

(D) at a rate of 30 percent for such individuals with income not less than 275 percent, and less than 325 percent, of such official poverty line (as so applied);

(E) at a rate of 35 percent for such individuals with income not less than 325 percent, and less than 400 percent, of such official poverty line (as so applied); and

(F) at a rate of 40 percent for such individuals with income equal to at least 400 percent of such official poverty line (as so applied).

(2) REQUIRED ANNUAL DEDUCTIBLE.—The State plan shall impose cost sharing in the form of an annual deductible—

(A) of $100 for individuals with disabilities with income not less than 150 percent, and less than 175 percent, of such official poverty line (as so applied);

(B) of $200 for such individuals with income not less than 175 percent, and less than 225 percent, of such official poverty line (as so applied);

(C) of $300 for such individuals with income not less than 225 percent, and less than 275 percent, of such official poverty line (as so applied);

(D) of $400 for such individuals with income not less than 275 percent, and less than 325 percent, of such official poverty line (as so applied);

(E) of $500 for such individuals with income not less than 325 percent, and less than 400 percent, of such official poverty line (as so applied); and

(F) of $600 for such individuals with income equal to at least 400 percent of such official poverty line (as so applied).

(c) RECOMMENDATION OF THE SECRETARY.—The Secretary shall make recommendations to the States as to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the cost-sharing provisions of this section could jeopardize their ability to take advantage of the services offered under this subtitle. The Secretary shall establish a methodology for reducing the cost-sharing burden under this subtitle for individuals with exceptionally high out-of-pocket costs.

(d) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

SEC. 2105. QUALITY ASSURANCE AND SAFEGUARDS.

(a) QUALITY ASSURANCE.—

(1) IN GENERAL.—The State plan shall specify how the State will ensure and monitor the quality of services.

(2) ISSUANCE OF REGULATIONS.—Not later than 1 year after the date of enactment of this sub-

title, the Secretary shall issue regulations implementing the quality provisions of this subsection.

(b) FEDERAL STANDARDS.—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) The mandatory reporting of abuse, neglect, or exploitation.

(3) The development of a registry of provider agencies or home care workers and consumer directed providers of personal assistance services against whom any complaints have been sustained, which shall be available to the public.

(4) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(5) Surveys of client satisfaction.

(6) State optional training programs for informal caregivers.

(c) CLIENT ADVOCACY.—The State plan shall provide that the State will expend the amount allocated under section 2108(b)(2) for client advocacy activities. The State may use such funds to augment the budgets of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the

Developmental Disabilities Assistance and Bill of Rights Act) or may establish a separate and independent client advocacy office to administer a new program designed to advocate for client rights.

SEC. 2106. ADVISORY GROUPS.

(a) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group, to advise the Secretary and States on all aspects of the program under this subtitle.

(2) COMPOSITION.—The group shall be composed of individuals with disabilities and their representatives, providers, Federal and State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives.

(b) STATE ADVISORY GROUPS.—

(1) IN GENERAL.—Each State plan shall provide for the establishment and maintenance of an advisory group to advise the State on all aspects of the State plan under this subtitle.

(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representa-

tives, providers, State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives. The members of the advisory group shall be selected from those nominated as described in paragraph (3).

SEC. 2107. PAYMENTS TO STATES.

(a) IN GENERAL.—Subject to section 2101(a)(9)(C) (relating to limitation on payment for administrative costs), the Secretary, in accordance with the Cash Management Improvement Act, shall authorize payment to each State with a plan approved under this subtitle, for each quarter (beginning on or after January 1, 1998), from its allotment under section 2108(b), an amount equal to—

(1)(A) if the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan for individuals with disabilities does not exceed 20 percent of the amount allotted to the State under section 2108(b), 100 percent of the amount demonstrated by State claims to have been expended during the quarter for such services for such individuals; or

(B) for the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan for individuals with disabilities that exceeds 20 percent of the amount allotted to the State under section 2108(b), the Federal home and community-based services matching percentage (as defined in subsection (b)) of such amount; plus

(2) an amount equal to 90 percent of the amount demonstrated by the State to have been expended during the quarter for quality assurance activities under the plan; plus

(3) an amount equal to 90 percent of amount expended during the quarter under the plan for activities (including preliminary screening) relating to determination of eligibility and performance of needs assessment; plus

(4) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2004, 75 percent) of the amount expended during the quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

(5) an amount equal to 50 percent of the remainder of the amounts expended during the quar-

ter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PERCENTAGE.—In subsection (a), the term ''Federal home and community-based services matching percentage'' means, with respect to a State, the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) increased by 15 percentage points, except that the Federal home and community-based services matching percentage shall in no case be more than 95 percent.

(c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of the total sum to be expended in such quarter, and such other information as the Secretary may find necessary.

(2) From the allotment available therefore, the Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this

section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

(d) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act.

(e) FAILURE TO COMPLY WITH STATE PLAN.—If a State furnishing home and community-based services under this subtitle fails to comply with the State plan approved under this subtitle, the Secretary may either reduce the Federal matching rates available to the State under subsection (a) or withhold an amount of funds determined appropriate by the Secretary from any payment to the State under this section.

SEC. 2108. APPROPRIATIONS; ALLOTMENTS TO STATES.

(a) APPROPRIATIONS.—

(1) FISCAL YEARS 1998 THROUGH 2003.—Subject to paragraph (5)(C), for purposes of this subtitle, the appropriation authorized under this subtitle

for each of fiscal years 1997 through 2004 is the following:

(A) For fiscal year 1997, $3,900,000,000.

(B) For fiscal year 1998, $6,800,000,000.

(C) For fiscal year 1999, $9,600,000,000.

(D) For fiscal year 2000, $12,900,000,000.

(E) For fiscal year 2001, $16,400,000,000.

(F) For fiscal year 2002, $23,400,000,000.

(G) For fiscal year 2003, $31,100,000,000.

(H) For fiscal year 2004, $33,600,000,000.

(2) SUBSEQUENT FISCAL YEARS.—For purposes of this subtitle, the appropriation authorized for State plans under this subtitle for each fiscal year after fiscal year 2003 is the appropriation authorized under this subsection for the preceding fiscal year multiplied by—

(A) a factor (described in paragraph (3)) reflecting the change in the consumer price index for the fiscal year, and

(B) a factor (described in paragraph (4)) reflecting the change in the number of individuals with disabilities for the fiscal year.

(3) CPI INCREASE FACTOR.—For purposes of paragraph (2)(A), the factor described in this paragraph for a fiscal year is the ratio of—

(A) the annual average index of the consumer price index for the preceding fiscal year, to—

(B) such index, as so measured, for the second preceding fiscal year.

(4) DISABLED POPULATION FACTOR.—For purposes of paragraph (2)(B), the factor described in this paragraph for a fiscal year is 100 percent plus (or minus) the percentage increase (or decrease) change in the disabled population of the United States (as determined for purposes of the most recent update under subsection (b)(3)(D)).

(5) ADDITIONAL FUNDS DUE TO MEDICAID OFFSETS.—

(A) IN GENERAL.—Each participating State must provide the Secretary with information concerning offsets and reductions in the medicaid program resulting from home and community-based services provided disabled in-

dividuals under this subtitle, that would have been paid for such individuals under the State medicaid plan but for the provision of similar services under the program under this subtitle. At the time a State first submits its plan under this subtitle and before each subsequent fiscal year (through fiscal year 2005), the State also must provide the Secretary with such budgetary information (for each fiscal year through fiscal year 2005), as the Secretary determines to be necessary to carry out this paragraph.

(B) REPORTS.—Each State with a program under this subtitle shall submit such reports to the Secretary as the Secretary may require in order to monitor compliance with subparagraph (A). The Secretary shall specify the format of such reports and establish uniform data reporting elements.

(C) ADJUSTMENTS TO APPROPRIATION.—

(i) IN GENERAL.—For each fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2004) and based on a review of information submitted under subparagraph (A), the Secretary shall determine the amount by which the appropria-

tion authorized under subsection (a) will increase. The amount of such increase for a fiscal year shall be limited to the reduction in Federal expenditures of medical assistance (as determined by Secretary) that would have been made under part A of title XIX for home and community based services for disabled individuals but for the provision of similar services under the program under this subtitle.

(ii) ANNUAL PUBLICATION.—The Secretary shall publish before the beginning of such fiscal year, the revised appropriation authorized under this subsection for such fiscal year.

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring States to determine eligibility for medical assistance under the State medicaid plan on behalf of individuals receiving assistance under this subtitle.

(b) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall allot the amounts available under the appropriation authorized for the fiscal year (specified in subsection (a)) to the States with plans approved under this subtitle

in accordance with an allocation formula developed by the Secretary which takes into account—

(A) the percentage of the total number of individuals with disabilities in all States that reside in a particular State;

(B) the per capita costs of furnishing home and community-based services to individuals with disabilities in the State; and

(C) the percentage of all individuals with incomes at or below 150 percent of the official poverty line (as described in section 2104(a)(2)) in all States that reside in a particular State.

(2) ALLOCATION FOR CLIENT ADVOCACY ACTIVITIES.—Each State with a plan approved under this subtitle shall allocate one-half of one percent of the State's total allotment under paragraph (1) for client advocacy activities as described in section 2105(c).

(3) NO DUPLICATE PAYMENT.—No payment may be made to a State under this section for any services provided to an individual to the extent that the State received payment for such services under section 1903(a) of the Social Security Act.

(4) REALLOCATIONS.—Any amounts allotted to States under this subsection for a year that are not

expended in such year shall remain available for State programs under this subtitle and may be reallocated to States as the Secretary determines appropriate.

(c) STATE ENTITLEMENT.—This subtitle constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

Subtitle B—Life Care

SEC. 2201. SHORT TITLE.

This subtitle may be cited as the ''Life Care Act''.

SEC. 2202. LIFE CARE: PUBLIC INSURANCE PROGRAM FOR NURSING HOME CARE.

The Public Health Service Act is amended by adding at the end thereof the following new title:

''TITLE XXVII—LIFE CARE: PUBLIC INSURANCE PROGRAM FOR NURSING HOME CARE

''SEC. 2701. ESTABLISHMENT OF VOLUNTARY LONG-TERM CARE INSURANCE PROGRAM.

''The Secretary shall establish a voluntary insurance program for individuals 35 years of age and over to cover the nursing home stays of such individuals. The Secretary

shall establish a process for enrollment in the Life Care program.

"SEC. 2702. BENEFITS.

''(a) IN GENERAL.—

''(1) ELIGIBILITY FOR COVERAGE.—Subject to subsection (c), an individual who meets the eligibility criteria prescribed in section 2703 shall be eligible under the program established under this title for coverage for necessary services described in subsection (b) (in the amounts described in subsection (c)) that are provided to the individual by a nursing facility while the individual is an inpatient of the facility.

''(2) NONFORFEITURE.—The Secretary shall establish standards to ensure the nonforfeiture of benefits for which premiums have been paid.

''(b) TYPES.—Coverage may be provided under this title for—

''(1) nursing care provided by or under the supervision of a registered professional nurse;

''(2) physical, occupational, or speech therapy furnished by a facility or by others under arrangements with a facility;

''(3) medical social work services;

''(4) drug, biological, supply, appliance, and equipment for use in the facility, that is ordinarily furnished by the facility for the care and treatment of an inpatient;

''(5) such other services necessary to the functioning of a patient, including personal care and assistance with activities of daily living, as are generally provided by a nursing home facility; and

''(6) with respect to the initial 6 months of covered residence in a nursing facility, such room and board costs as are not covered by beneficiary copayment.

''(c) COVERAGE AMOUNT.—

''(1) IN GENERAL.—The amount of coverage provided with respect to an eligible individual for the services described in subsection (b) shall, based on an election made by the individual, not exceed $30,000, $60,000, or $90,000 over the lifetime of the eligible individual. Such amounts shall be adjusted by the Secretary to reflect increases in the Consumer Price Index.

''(2) ASSET PROTECTION.—An eligible individual shall be entitled to the asset protection provided under section 2708.

"(d) PAYMENT.—Amounts provided under this title with respect to an eligible individual for the services described in subsection (b) shall be paid from the general fund of the Treasury of the United States.

"(e) RESIDENTIAL CARE FACILITIES.—The Secretary shall consider the feasibility of making payments under this title for services delivered in residential care facilities. Not later than 2 years after the date of enactment of this Act, the Secretary shall report the findings of the Secretary to the Congress with respect to the feasibility of making such payments.

"SEC. 2703. ELIGIBILITY.

"(a) IN GENERAL.—An individual shall be eligible for benefits under this title if—

"(1) the individual—

"(A) is a legal resident of the United States and has elected coverage under subsection (c); and

"(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2707)—

"(i)(I) to require hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living; or

''(II) to require hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies; or

''(III) to display symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; or

''(IV) has achieved a score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, that indicates either severe cognitive impairment or severe mental impairment, or both; and

''(ii) to require such assistance, supervision, or cueing over a period of at least 90 days; and

''(2)(A) the individual has filed an application for such benefits, and is in need of, benefits covered under this title; or

"(B) the legal guardian of the individual has filed an application on behalf of an individual who is in need of benefits covered under this title; or

"(C) the representative of an individual who is cognitively impaired and who is in need of benefits covered under this title has filed an application on behalf of the individual.

"(b) CURRENT INDIVIDUALS.—An individual who is in a hospital or nursing home on the date of the enrollment of the individual in the program established under this title shall be ineligible for coverage under this section until the individual's first spell of illness beginning after such date.

"(c) ELECTION OF COVERAGE.—

"(1) IN GENERAL.—Subject to this subsection, an individual shall have the option to purchase coverage under this title when the individual is 35 years of age, 45 years of age, 55 years of age, or 65 years of age.

"(2) INITIAL YEAR.—During the 1-year period beginning on the date on which final regulations that implement this title are issued, an individual who is 35 years of age or older shall be eligible to purchase insurance under this title, except that such

an individual shall not be eligible to purchase such insurance—

''(A) while confined to a hospital or nursing home;

''(B) within the 6-month period after the individual's confinement in a nursing home; or

''(C) within the 90-day period after the individual's confinement in a hospital.

Individuals described in the matter preceding subparagraph (A) shall become eligible to receive benefits under this title on the expiration of the 3-year period beginning on the date such individuals purchase insurance under this title.

''(3) EXTENSION BEYOND INITIAL YEAR.—If an individual is confined to a nursing home or hospital during a period that extends beyond the first year after the effective date of this title, an individual shall be eligible to enroll in the program established by this title during the 60-day period beginning after the individual's spell of illness.

''(4) SUBSEQUENT YEARS.—During years subsequent to the 1-year period referred to in paragraph (2), an individual shall be eligible to purchase insurance under this title within 6 months of the 35th, 45th, 55th, or 65th birthday of the individual.

"(5) ACTIVATION OF BENEFITS.—To receive coverage under the insurance program established by this title, an individual shall have purchased such coverage not later than 1 month prior to admission to a nursing facility, unless the reason for the need of services is a result of an accident or stroke subsequent to the date that such individual enrolled for coverage under this title.

"(d) PUBLIC EDUCATION.—In the 12 months preceding the initial enrollment period, the Secretary shall, either directly or through grants and contracts, conduct a public service and education campaign designed to inform potentially eligible individuals as to the nature of the benefits and the limited enrollment period. In conducting such campaigns the Secretary shall make information available to individuals through the open enrollment process for obtaining health care benefits under this Act.

"SEC. 2704. PREMIUM RATES.

"(a) IN GENERAL.—The Secretary shall determine one premium rate for individuals electing to purchase coverage under this title at age 35 (or between the ages of 35 and 44 during the initial enrollment period), a separate rate for those individuals who elect coverage at age 45 (or between the ages of 45 and 54 during the initial enrollment period), a separate rate for those individuals who

elect such coverage at age 55 (or between that ages of 55 and 64 during the initial enrollment period), and a separate rate for those individuals who elect such coverage at age 65 (or at age 65 and over during the initial enrollment period). During the initial enrollment period, the Secretary shall establish actuarily fair, age-rated premiums for persons age 65 and over.

''(b) REVISION.—The Secretary shall revise premium rates annually to increase such rates to reflect the amount of the increase in the cost of living adjustment with respect to benefits under title II of the Social Security Act.

''(c) RATES.—In developing premium rates under the program established under this title, the Secretary shall establish rates that are expected to cover 100 percent of the reimbursement amount provided under this title for nursing home stays for those individuals enrolled in the program.

''(d) WAIVER.—An individual electing to purchase coverage under this title shall not be required to pay premiums during any period in which such individual is receiving benefits under this title.

''(e) PAYMENT.—Premiums shall be paid under this section into the general fund of the Treasury of the United States.

"SEC. 2705. QUALIFIED SERVICE PROVIDERS.

''(a) IN GENERAL.—To be considered as a covered nursing home service under this title, such service must have been provided by a qualified service provider.

''(b) TYPES.—A provider shall be considered a qualified service provider under this title if the provider is a nursing facility that is certified by the State and meets the requirements of this title and any other standards established by the Secretary by regulation for the safe and efficient provision of services covered under this title.

"SEC. 2706. REIMBURSEMENT.

''(a) AMOUNT.—Monthly reimbursement for nursing facility services under this title shall equal 65 percent (or during the initial 6 months of coverage, 80 percent) of the amount the Secretary determines to be reasonable and appropriate to cover the cost of care provided under this title.

''(b) PROSPECTIVE PAYMENT.—To the extent feasible, the Secretary shall establish a prospective payment mechanism for payment for nursing home services under this title that takes into account the expected resource utilization of individual patients based on their degree of disability, the methodology recommended for reimbursement of skilled nursing facilities under title XVIII of the Social Security Act, and other factors determining service requirements.

"(c) ROOM AND BOARD PAYMENT.—An individual receiving benefits under this program shall be responsible for the payment of an amount for room and board that is equal to—

"(1) with respect to the initial 6 months of residence in a nursing facility, 20 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this title; and

"(2) with respect to subsequent periods of residence, 35 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this title. Payments under subsections (a) and (c) shall be considered payment in full for services received under this section.

"(d) PRIORITY PAYERS.—Notwithstanding any other provision of this title, reimbursement for nursing facility services provided under this title to an individual shall, to the extent available, be made under the Medicare program, under Department of Veterans Affairs' programs, or under private insurance policies prior to reimbursement under this title.

"SEC. 2707. LONG-TERM CARE SCREENING AGENCY.

"(a) ESTABLISHMENT.—The Secretary shall contract with entities to act as Long-Term Care Screening Agencies (hereafter referred to in this title as the 'Screening

Agency') for each designated area of a State. It shall be the responsibility of such agency to assess the eligibility of individuals residing in the geographic jurisdiction of the Agency, for services provided under this title according to the requirements of this title and regulations prescribed by the Secretary. In entering into such contracts, the Secretary shall give preference to State governmental entities and private nonprofit agencies.

''(b) ELIGIBILITY.—The Screening Agency shall determine the eligibility of an individual under this title based on the results of a preliminary telephone interview or written questionnaire (completed by the applicant, by the caregiver of the applicant, or by the legal guardian or representative of the applicant) that shall be validated through the use of a screening tool administered in person to each applicant determined eligible through initial telephone or written questionnaire interviews not later than 15 days from the date on which such individual initially applied for services under this title.

''(c) QUESTIONNAIRES AND SCREENING TOOLS.—

''(1) IN GENERAL.—The Secretary shall establish a telephone or written questionnaire and a screening tool to be used by the Screening Agency to determine the eligibility of an individual for services under this title consistent with requirements of

this title and the standards established by the Secretary by regulation.

''(2) QUESTIONNAIRES.—The questionnaire shall include questions about the functional impairment and mental status of an individual and other criteria that the Secretary shall prescribe by regulation.

''(3) SCREENING TOOLS.—The screening tool should measure functional impairment caused by physical or cognitive conditions as well as information concerning cognition disability, behavioral problems (such as wandering or abusive and aggressive behavior), and any other criteria that the Secretary shall prescribe by regulation. The screening tool shall be administered in person.

''(d) NOTIFICATION.—Not later than 15 days after the date on which an individual initially applied for services under this title (by telephone or written questionnaire), the Screening Agency shall notify such individual that such individual is not eligible for benefits, or that such individuals must schedule an in-person screening to determine final eligibility for benefits under this title. The Screening Agency shall notify such individual of its final decision not later than 2 working days after the in-person screening.

"(e) IN-PERSON SCREENING.—An individual (or the legal guardian or representative of such individual) whose application for benefits under this title is denied on the basis of information provided through a telephone or written questionnaire, shall be notified of such individual's right to an in-person screening by a nurse or appropriate health care professionals.

"(f) APPEALS.—The Secretary shall establish a mechanism for hearings and appeals in cases in which individuals contest the eligibility findings of the Screening Agency.

"(g) PAYMENT.—

"(1) PAYMENT FOR SCREENING.—The Screening Agency may require payment from individuals only in accordance with standards established by the Secretary.

"(2) NO PAYMENT FOR POOREST.—The Screening Agency may not require payment for individuals with incomes of less than 150 percent of the official poverty line.

"SEC. 2708. ASSET PROTECTION.

"Notwithstanding any other provision of law, the assets an eligible individual may retain and be determined eligible for nursing facility benefits, including payments of room and board under this title, under State Medicaid

programs (in accordance with section 1902(a)(10)) shall be increased by the amount of coverage ($30,000, $60,000, or $90,000) elected under section 2702.

"SEC. 2709. RELATION TO PRIVATE INSURANCE.

''(a) IN GENERAL.—Except as provided in subsection (b), an insurer may not offer a long-term care insurance policy to an individual who has purchased coverage under this title if the coverage under such policy duplicates the coverage provided under this title.

''(b) DEVELOPMENT OF STANDARD PACKAGES.—The Secretary shall develop standard long-term care insurance benefits packages that insurers may offer to insured individuals under this title. Such packages shall provide coverage for benefits that compliment, but do not duplicate, those covered under this title.

"SEC. 2710. DEFINITIONS.

''As used in this title:

''(1) NURSING FACILITY.—The term 'nursing facility' means—

''(A) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act); or

''(B) a facility that is a nursing facility (as defined in section 1919(a) of such Act) which meets the requirements of section

1819(b)(4)(C) of such Act (relating to nursing care).

''(2) SPELL OF ILLNESS.—The term 'spell of illness' means a period of consecutive days beginning with the first day on which an individual is furnished services as an inpatient in a hospital or nursing facility and ending with the close of the first 6 consecutive months thereafter during which the individual is no longer an inpatient of a nursing facility, or 90 days after the individual is no longer an inpatient in a hospital.

"SEC. 2711. REPORTS.

''(a) IN GENERAL.—Prior to the promulgation of regulations implementing this title, the Secretary shall report to Congress on—

''(1) the actuarially-sound premium rates to be used in the implementation of this Act, including whether the premiums and interest accrued thereon will cover 100 percent of the benefits paid out, and whether Federal funds will be required to support the payment of benefits;

''(2) an assessment of the impact of such premium rates on the affordability of coverage under this Act;

1 ''(3) a projected enrollment of individuals by
2 age category; and
3 ''(4) an estimate of current and projected en-
4 rollment of individuals, by age category in coverage
5 under private long-term care insurance.
6 ''(b) LIFE CARE REPORT.—Not later than 2 years
7 after the promulgation of regulations implementing this
8 title, the Secretary shall report to Congress on the follow-
9 ing aspects of the Life Care Act:
10 ''(1) The current and projected premium rates.
11 ''(2) The current and projected enrollment of
12 individuals, by age category and an estimate of cur-
13 rent and projected enrollment of individuals by age
14 category in private long-term care insurance.
15 ''(3) The projected use of benefits and the im-
16 pact of use on premium rates.
17 ''(4) An assessment of the impact of projected
18 premium rates on the affordability of coverage under
19 this Act.
20 ''(c) RECOMMENDATIONS.—The Secretary shall make
21 recommendations to Congress regarding necessary revi-
22 sions to the Life Care Act as a result of the findings pro-
23 vided in the reports submitted under this section.''.

Subtitle C—Sense of the Committee with Regard to Prescription Drugs

SEC. 2301. SENSE OF THE COMMITTEE WITH REGARD TO PRESCRIPTION DRUGS.

It is the Sense of the Committee on Labor and Human Resources of the Senate that when the Affordable Health Care for All Americans Act is enacted it should include a provision for coverage of outpatient prescription drugs under the medicare program comparable to the provision included in S. 1757, the Health Security Act (as introduced in the 103rd Congress) and providing for a drug deductible of not more than $200, coinsurance of not more than 20 percent, and an out-of-pocket limit of not more than $1,000.

TITLE III—PUBLIC HEALTH INITIATIVES

Subtitle A—Workforce Priorities Under Federal Payments

PART 1—INSTITUTIONAL COSTS OF GRADUATE MEDICAL EDUCATION; WORKFORCE PRIORITIES

Subpart A—National Council Regarding Workforce Priorities

SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—There is established within the Department of Health and Human Services a council to be known as the National Council on Graduate Medical Education.

(b) DUTIES.—The Secretary shall carry out subpart B acting through the National Council.

(c) COMPOSITION.—

(1) IN GENERAL.—The membership of the National Council shall include between 12 and 18 individuals who are appointed to the Council from among individuals who are not officers or employees of the United States. Such individuals shall be appointed by the Secretary, and shall include individuals from each of the following categories:

(A) Consumers of health care services, at least one of whom resides in a rural area.

(B) Physicians who are faculty members of medical schools.

(C) Physicians in private practice who are not physicians described in subparagraph (B).

(D) Officers or employees of regional and corporate health alliances.

(E) Officers or employees of health care plans that participate in such alliances.

(F) Executives of teaching hospitals.

(G) Nurses.

(H) Primary care physicians, at least one of whom practices in a rural area.

(I) Such other individuals as the Secretary determines to be appropriate.

(2) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the National Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary or other Federal officers who are appointed by the President with the advice and consent of the Senate.

(d) CHAIR.—The Secretary shall, from among members of the National Council appointed under subsection (c)(1), designate an individual to serve as the Chair of the Council.

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

(1) The term ''academic health center'' means an entity defined in section 3051(c)(1).

(2) The term ''medical school'' means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as defined in such section).

(3) The term ''National Council'' means the council established in subsection (a).

(f) CONFORMING AMENDMENT REPEALING THE COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME).—Effective on the date of the first meeting of the National Council, section 30 of the Health Professions Education Extension Amendments of 1992 (Public Law 102–408) is repealed.

Subpart B—Authorized Positions in Specialty Training

SEC. 3011. COOPERATION REGARDING APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—With respect to an approved physician training program in a medical specialty, a funding

agreement with a qualified applicant for payments under section 3031 for a calendar year is that the qualified applicant will ensure that the number of individuals enrolled in the program in the subsequent academic year is in accordance with this subpart.

(b) DEFINITIONS.—

(1) APPROVED PROGRAM.—For purposes of this subtitle:

(A) The term ''approved physician training program'', with respect to the medical speciality involved, means a residency or other postgraduate program that trains physicians and meets the following conditions:

(i) Participation in the program may be counted toward certification in the medical specialty.

(ii) The program is accredited by the Accreditation Council on Graduate Medical Education, or approved by the Council on Postgraduate Training of the American Osteopathic Association.

(B) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A) that provides health services in an ambulatory setting, with-

out regard to whether the program provides inpatient hospital services.

(C) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A), whether operated by academic health centers, teaching hospitals, multispecialty group practices, ambulatory care providers, prepaid health plans, or other entities.

(D) The term ''approved physician training program'' includes any postgraduate program described in subparagraph (A) that provides fellowship training in family medicine, general internal medicine or general pediatrics, and provides training for a faculty position in family medicine, general medicine or general pediatrics.

(2) QUALIFIED APPLICANT; SUBPART DEFINITION.—For purposes of this subpart, the term ''qualified applicant'', with respect to an academic year, means an entity that trains individuals in an approved physician program that receives payments under subpart C for the calendar year in which the academic year begins.

(3) OTHER DEFINITIONS.—For purposes of this subtitle:

(A)(i) The term ''academic year'' means the 1-year period beginning on July 1. The academic year beginning July 1, 1993, is academic year 1993–94.

(ii) With respect to the funding agreement described in subsection (a), the term ''subsequent academic year'' means the academic year beginning July 1 of the calendar year for which payments are to be made under the agreement.

(B) The term ''funding agreement'', with respect to payments under section 3031 to a qualified applicant, means that the Secretary may make the payments only if the qualified applicant makes the agreement involved.

(C) The term ''medical specialty'' includes all medical, surgical, and other physician specialties and subspecialties.

SEC. 3012. ANNUAL AUTHORIZATION OF NUMBER OF SPECIALTY POSITIONS; REQUIREMENTS REGARDING PRIMARY HEALTH CARE.

(a) ANNUAL AUTHORIZATION OF NUMBER OF POSITIONS.—In the case of each medical specialty, the National Council shall designate for each academic year the

number of individuals nationwide who are authorized to be enrolled in eligible programs. The preceding sentence is subject to subsection (c)(2).

(b) PRIMARY HEALTH CARE.—

(1) IN GENERAL.—Subject to paragraph (2), in carrying out subsection (a) for an academic year, the National Council shall ensure that, of the class of training participants entering eligible programs for academic year 2001–2002 or any subsequent academic year, the percentage of such class that completes eligible programs in primary health care is not less than 55 percent (without regard to the academic year in which the members of the class complete the programs).

(2) RULE OF CONSTRUCTION.—The requirement of paragraph (1) regarding a percentage applies in the aggregate to training participants entering eligible programs for the academic year involved, and not individually to any eligible program.

(c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

(1) DESIGNATION PERIODS.—For each medical specialty, the National Council shall make the annual designations under subsection (a) for periods of 3 academic years.

(2) INITIAL PERIOD.—The first designation period established by the National Council after the date of the enactment of this Act shall be the academic years 2001–2002 through 2003–2004.

(d) CERTAIN CONSIDERATIONS IN DESIGNATING ANNUAL NUMBERS.—

(1) IN GENERAL.—Factors considered by the National Council in designating the annual number of specialty positions for an academic year for a medical specialty shall include the extent to which there is a need for additional practitioners in the speciality, as indicated by the following:

(A) The characteristics of diseases, disorders, or health conditions treated, including—

(i) the incidence and prevalence (in the general population and in various other populations) of the diseases, disorders, or other health conditions with which the specialty is concerned;

(ii) the intensity of care required for each of these diseases, disorders, or health conditions;

(iii) the relevant training received and experience attained by primary care and specialist physicians in caring for each of

these diseases, disorders, or health conditions; and

(iv) when sufficient data becomes available, the extent to which individuals with certain diseases, disorders, or health conditions have better health outcomes when treated by health specialists than by primary care physicians.

(B) The number of physicians who will be practicing in the specialty in the academic year.

(C) The number of physicians who will be practicing in the specialty at the end of the 5-year period beginning on the first day of the academic year.

(2) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In designating the annual number of specialty positions for an academic year for a medical specialty, the National Council shall consider the recommendations of organizations representing physicians in the specialty, organizations representing academic medicine, and the recommendations of organizations representing consumers of the services of such physicians.

(3) TOTAL OF RESPECTIVE ANNUAL NUMBERS.—

(A) For academic year 2001–2002 and subsequent academic years, the National Council shall ensure that the total of the respective annual numbers designated under subsection (a) for an academic year is a total that—

(i) bears a relationship to the number of individuals who graduated from medical schools in the United States in the preceding academic year; and

(ii) is consistent with the purposes of this subpart.

(B) For each of the academic years 2001–2002 through 2005–2006, the total determined under subparagraph (A) shall be reduced by a percentage determined by the National Council.

(e) INTERIM VOLUNTARY TARGETS.—

(1) ESTABLISHMENT.—Not later than July 1, 1998, the National Council shall establish targets with respect to the aggregate number of individuals enrolled in approved physician training programs for each specialty to be achieved by the year 2001.

(2) VOLUNTARY COMPLIANCE.—Specialties that meet and continue to be in compliance with the aggregate targets established under paragraph (1), as determined by the National Council, shall not be

subject to the mandatory allocation system described in section 3013.

(3) MEASURE OF COMPLIANCE.—To be considered in compliance with the targets under paragraph (2), a specialty shall demonstrate, not later than July 1, 2000, that the number of individuals enrolled in approved physician training programs of the specialty is not less than the number of individuals enrolled in such programs as of July 1, 1995, increased or decreased, as the case may be, by 45 percent of the difference between such enrollment and the target enrollment established under paragraph (1) and, not later than January 1, 2001, have increased or decreased by 90 percent of such difference, and, by January 1, 2002, are deemed by the National Council to be in compliance with the target.

(4) LOSS OF COMPLIANCE.—The National Council may, at any time, determine that a specialty is not in compliance with the targets established under paragraph (1) and initiate, with respect to that specialty, the system of allocations described under section 3013.

(f) STUDY.—Not later than January 1, 2005, the Secretary shall arrange for the completion, by the Insti-

tute of Medicine or other similar entity, of an independent study concerning the effect of medical workforce planning. The results of such study together with recommendations concerning the appropriateness of modifying or eliminating the planning program included in this Act shall be compiled in a report and transmitted by the Secretary to the President and the Congress.

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

(1) The term ''annual number of specialty positions'', with respect to a medical specialty, means the number designated by the National Council under subsection (a) for eligible programs for the academic year involved.

(2) The term ''designation period'' means a 3-year period under subsection (c)(1) for which designations under subsection (a) are made by the National Council.

(3) The term ''primary health care'' means the following medical specialties: Family medicine, general internal medicine, general pediatrics, geriatric medicine, obstetrics and gynecology, and medical specialties (including psychiatry), if any, that have been designated to be medical shortage specialties or protected medical specialties by the Council on Graduate Medical Education, or other similar physi-

cian advisory body authorized by Congress to provide an ongoing assessment of physician workforce trends, and identify needs and be advisory to the Secretary, the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives. Only those participants in programs with a significant primary care training emphasis will be considered to have completed an eligible program in primary care for the purposes of subsection (b)(1). Determination of meeting the definition of a ''significant primary care training emphasis'' will be made by the National Board.

(4) The term ''specialty position'' means a position as a training participant.

(5) The term ''training participant'' means an individual who is enrolled in an approved physician training program.

SEC. 3013. ALLOCATIONS AMONG SPECIALTIES AND PROGRAMS.

(a) IN GENERAL.—For each academic year, the National Council shall for each medical specialty make allocations among eligible programs of the annual number of specialty positions that the Council has designated for

such year. The preceding sentence is subject to subsection (b)(3).

(b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

(1) IN GENERAL.—For each medical specialty, the National Council shall make the annual allocations under subsection (a) for periods of 3 academic years.

(2) ADVANCE NOTICE TO PROGRAMS.—With respect to the first academic year of an allocation period established by the National Council, the National Council shall, not later than July 1 of the preceding academic year, notify each eligible program of the allocations made for the program for each of the academic years of the period.

(3) INITIAL PERIOD.—The first allocation period established by the National Council after the date of the enactment of this Act shall be the academic years 2001–2002 through 2003–2004.

(c) CERTAIN CONSIDERATIONS.—

(1) GEOGRAPHIC AREAS; QUALITY OF PROGRAMS.—In making allocations under subsection (a) for eligible programs of the various geographic areas, the National Council shall include among the factors considered the historical distribution among

the areas of approved physician training programs, and the quality of such programs.

(2) UNDERREPRESENTATION OF MINORITY GROUPS AND WOMEN.—In making an allocation under subsection (a) for an eligible program, the National Council shall include among the factors considered the following:

(A) The extent to which the population of training participants in the program includes training participants who are members of racial or ethnic minority groups and women.

(B) With respect to a racial or ethnic group or women represented among the training participants, the extent to which the group is underrepresented in the field of medicine generally and in the various medical specialities.

(3) UNDERSERVED RURAL AND INNER-CITY COMMUNITIES.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the extent to which the population of training participants in the program includes training participants who have resided in rural or inner-city communities and the proportion of past participants in the program who are practicing in rural or inner-city communities.

(4) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the recommendations of organizations representing physicians in the medical specialties, the recommendations of organizations representing academic medicine and the recommendations of organizations representing consumers of the services of such physicians.

(d) DEFINITIONS.—For purposes of this subtitle, the term ''allocation period'' means a 3-year period under subsection (b)(1) for which allocations under subsection (a) are made by the National Council.

Subpart C—Costs of Graduate Medical Education

CHAPTER 1—OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

SEC. 3031. FEDERAL FORMULA PAYMENTS TO QUALIFIED ENTITIES FOR THE COSTS OF THE OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—In the case of a qualified entity that in accordance with section 3032 submits to the Secretary an application for calendar year 1997 or any subsequent calendar year, the Secretary shall make payments for such year to the qualified entity for the purpose speci-

fied in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3033, and may administer the payments as a contract, grant, or cooperative agreement.

(b) PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.—The purpose of payments under subsection (a) is to assist a qualified applicant with the costs of operation of an approved physician training program. A funding agreement for such payments is that the qualified applicant involved will expend the payments only for such purpose.

(c) QUALIFIED APPLICANT; SUBPART DEFINITION.—

(1) IN GENERAL.—For purposes of this subpart, the term ''qualified applicant'', with respect to the calendar year involved, means an entity—

(A) that trains individuals in approved physician training programs;

(B) that submits to the Secretary an application for such year in accordance with section 3032; and

(C) if the entity has an approved physician training program in primary health care, that rotates individuals enrolled in the program to health centers or other community programs in underserved urban or rural areas.

(2) ENTITIES INCLUDED.—The term ''qualified applicant'' may include a teaching hospital, medical school, group practice, an entity representing two or more parties engaged in a formal association, a community health center or another entity operating an approved physician training program.

(d) TREATMENT OF PODIATRIC AND DENTAL RESIDENCY PROGRAMS.—For the purposes of chapters 1 and 3 of subpart C, an approved physician training program includes training programs approved by the Commission on Dental Accreditation or the Council of Podiatric Medical Education of the American Podiatric Medical Association. This subsection shall not apply for purposes of subpart B.

SEC. 3032. APPLICATION FOR PAYMENTS.

(a) IN GENERAL.—

(1) IN GENERAL.—For purposes of section 3031(a), an application for payments under such section for a calendar year is in accordance with this section if—

(A) the eligible entity involved submits the application not later than the date specified by the Secretary;

(B) the application demonstrates that the condition described in subsection (b) is met with respect to the program;

(C) the application contains each funding agreement described in this part and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(D) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(2) CERTAIN ENTITIES.—If an applicant under paragraph (1) is an entity representing two or more parties—

(A) the application shall contain a written agreement, signed by all participants, in which all of the participants agree as to the manner in which the payments will be allocated; and

(B) the applicant shall agree to submit additional documentation, if requested by the National Council, that demonstrates that the funds are distributed in the manner agreed upon by all participants.

(b) CERTAIN CONDITIONS.—An eligible entity meets the condition described in this subsection for receiving payments under section 3031 for a calendar year if—

(1) the entity agrees to use such funds only to support an approved physician training program;

(2) with respect to—

(A) a specialty for which programs have received allocations under section 3013, the entity agrees that funds will only be used to support approved training programs for which the number of specialists in training is consistent with the allotment under section 3013; and

(B) a specialty for which a voluntary program has received allocations under section 3012(e), the entity agrees that funds will only be used to support approved training programs for which the number of specialists in training is consistent with the targets under section 3012(e); and

(3) the application of the entity contains a written agreement, signed by all participants, in which all participants agree to the manner in which the payments will be allocated; and

(4) the entity agrees to submit additional documentation, if requested by the National Council, that

demonstrates that the funds will be distributed in a manner agreed upon by all participants.

SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) ANNUAL HEALTH PROFESSIONS WORKFORCE ACCOUNT.—Subject to paragraph (2), the amount available for a calendar year for making payments under sections 3031 and 3061 (constituting an account to be known as the annual health professions workforce account) is the following, as applicable to the calendar year:

(1) In the case of calendar year 1997, $3,550,000,000.

(2) In the case of each of the calendar years 1998, 1999, and 2000, $5,800,000,000.

(3) In the case of each subsequent calendar year, the amount specified in paragraph (2) increased by the product of such amount and the general health care inflation factor for such year (as defined in subsection (d)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE ENTITIES.—

(1) IN GENERAL.—Payment amounts with respect to any physician training program under this section shall be equal to the product of the number of full time equivalent training participants in the

program, and the per resident amount for the training program.

(2) PER RESIDENT AMOUNT.—The per resident amount for a training program shall be equal to—

(A) with respect to—

(i) the first calendar years during which the program is in operation, 90 percent;

(ii) the second calendar years during which the program is in operation, 80 percent;

(iii) the third calendar years during which the program is in operation, 70 percent;

(iv) the fourth calendar years during which the program is in operation, 60 percent; and

(v) the fifth and subsequent calendar years during which the program is in operation, 50 percent;

of the all payer hospital per resident cost; and

(B) with respect to—

(i) the first calendar years during which the program is in operation, 10 percent;

(ii) the second calendar years during which the program is in operation, 20 percent;

(iii) the third calendar years during which the program is in operation, 30 percent;

(iv) the fourth calendar years during which the program is in operation, 40 percent; and

(v) the fifth and subsequent calendar years during which the program is in operation, 50 percent;

of the geographically adjusted national average per resident amount.

(3) ADJUSTMENT FACTOR.—Payments under this section shall be subject to an adjustment factor, as determined by the Secretary, so that total payments in any year will not exceed the amounts specified in section 3033(a) and as provided in section 3033(c).

(4) ADDITIONAL PROVISIONS REGARDING NATIONAL AVERAGE COST.—

(A) The Secretary shall in accordance with paragraph (1)(B) determine, for academic year 1992–93, an amount equal to the national aver-

age described in such paragraph with respect to training a participant in an approved physician training program in the medical specialty involved. The national average applicable under such paragraph for a calendar year for such programs is, subject to subparagraph (B), the amount determined under the preceding sentence increased by the amount necessary to offset the effects of inflation occurring since academic year 1992–93, as determined through use of the consumer price index.

(B) The national average determined under subparagraph (A) and applicable to a calendar year shall, in the case of the eligible entity involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

(5) FUNDING LEVEL AND ALLOCATION METHOD.—Not later than January 1, 2000, the Secretary shall complete a study to determine the effect of the funding level and allocation method described in subsection (a) and paragraphs (1) and (2) of this subsection on the operation of training programs and shall compile the findings and recommendations de-

rived from such study in a report to be submitted to the President and the Congress.

(c) LIMITATION.—If, subject to subsection (a)(2), the annual health professions workforce account available for a calendar year is insufficient for providing each eligible entity with the amount of payments determined under subsection (b) for the entity for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under section 3031 for such year equals the total of such account.

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

(1) The term ''annual health professions workforce account'' means the account established pursuant to subsection (a)(1).

(2) The term ''consumer price index'' has the meaning given such term in section 1702.

(3) The term ''general health care inflation factor'', with respect to a year, has the meaning given such term in section 5001(a)(3) for such year.

CHAPTER 2—MEDICAL SCHOOL FUND ACCOUNT

SEC. 3041. FEDERAL PAYMENTS TO THE MEDICAL SCHOOL FUND.

(a) IN GENERAL.—In the case of an eligible medical school that in accordance with section 3042 submits to the Secretary an application for academic year 1997, or any subsequent academic year, the Secretary shall make payments for such year to the school for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3043, and shall administer the payments as a grant.

(b) PAYMENTS FOR THE MEDICAL SCHOOL FUND.—The purpose specified in this subsection is to assist an eligible medical school with the direct costs of academic programs, including the education of medical students (especially in ambulatory and preventive medicine), graduate students in biomedical sciences, and otherwise unfunded faculty research. A funding agreement for such payments is that the medical school involved will expend the payments only for direct expenses determined as allowable by the Secretary.

(c) ELIGIBLE MEDICAL SCHOOL; SUBPART DEFINITION.—For purposes of this subpart, the term ''eligible medical school'' with respect to the academic year in-

volved, means an approved medical school that submits to the Secretary an application for such year in accordance with section 3043.

SEC. 3042. APPLICATION FOR PAYMENTS.

For purposes of section 3041(a), an application for payments under such section for an academic year is in accordance with this section if—

(1) the dean (or appropriate presiding official) of the eligible medical school submits the application not later than the date specified by the Secretary;

(2) the application contains each funding agreement described in this subpart and provides such assurances of compliance with the agreements as the Secretary may require; and

(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

SEC. 3043. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) ANNUAL MEDICAL SCHOOL FUND ACCOUNT.—Subject to section 3043, the amount available for an academic year for making payments under section 3041 (constituting an account to be known as the annual medical

school fund account) shall be the following, as applicable to the academic year:

(1) In the case of academic year 1997, $200,000,000.

(2) In the case of academic year 1998, $300,000,000.

(3) In the case of academic year 1999, $400,000,000.

(4) In the case of academic year 2000, $500,000,000.

(5) In the case of academic year 2001, $600,000,000.

(6) In the case of each subsequent calendar year, the amount specified in paragraph (5) increased by the product of such amount and the general health care inflation factor (as defined in subsection (d)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE PROGRAMS.—Subject to the annual medical school fund account available for an academic year, the amount of payment required under section 3041 to be made to an eligible medical school for the academic year is an amount equal to the sum of—

(1) the product of ¾ of the fund account available and the proportion of full-time equivalent stu-

dents at the eligible medical school in academic year 1993–1994 compared to all full-time equivalent students enrolled in eligible medical schools nationwide in academic year 1993–1994; and

(2) the product of ¼ of the fund account available and the proportion of research conducted by the faculty at the eligible medical school compared to all research conducted by the faculty at all eligible medical schools nationwide.

The Secretary shall establish a method for measuring faculty research contributions.

(c) STUDIES.—

(1) FUNDING LEVEL AND ALLOCATION METHOD.—Not later than January 1, 1999, the Secretary shall arrange for an independent study and report to be completed, by the Institute of Medicine or other similar entity, concerning the amount of and allocation method for medical school funding. Such report shall be submitted to the President and the Congress and shall include findings and recommendation as to the appropriateness of modifying funding levels or allocation.

(2) Not later than January 1, 2001, the Secretary shall arrange for an independent study and report to be completed, by the Institute of Medicine

or other similar entity, concerning the impact of health reform on undergraduate and graduate medical education. Such report shall be submitted to the President and the Congress and shall include appropriate findings and recommendations.

(d) DEFINITIONS.—As used in this subtitle:

(1) The term ''annual medical school fund account'' means the account established under subsection (a).

(2) The term ''general health care inflation factor'' with respect to a year, has the meaning given such term in section 5001(a)(3) for such year.

CHAPTER 3—ACADEMIC HEALTH CENTERS

SEC. 3051. FEDERAL FORMULA PAYMENTS TO ACADEMIC HEALTH CENTERS.

(a) IN GENERAL.—In the case of a qualified academic health center or qualified teaching hospital that in accordance with section 3052 submits to the Secretary a written request for calendar year 1997 or any subsequent calendar year, the Secretary shall make payments for such year to the center or hospital for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3053,

and may administer the payments as a contract, grant, or cooperative agreement.

(b) PAYMENTS FOR COSTS ATTRIBUTABLE TO ACADEMIC NATURE OF INSTITUTIONS.—The purpose of payments under subsection (a) is to assist eligible institutions with costs that are not routinely incurred by other entities in providing health services, but are incurred by such institutions in providing health services by virtue of the academic nature of such institutions. Such costs include—

(1) with respect to productivity in the provision of health services, costs resulting from the reduced rate of productivity of faculty due to teaching responsibilities;

(2) the uncompensated costs of clinical research; and

(3) exceptional costs associated with the treatment of health conditions with respect to which an eligible institution has specialized expertise (including treatment of rare diseases, treatment of unusually severe conditions, and providing other specialized health care).

(c) DEFINITIONS.—

(1) ACADEMIC HEALTH CENTER.—For purposes of this subtitle, the term ''academic health center'' means an entity that operates a teaching hospital

that carries out an approved physician training program.

(2) TEACHING HOSPITAL.—For purposes of this subtitle, the term ''teaching hospital'' means a hospital that operates an approved physician training program (as defined in section 3011(b) or section 3031(d)).

(3) QUALIFIED CENTER OR HOSPITAL.—For purposes of this subtitle:

(A) The term ''qualified academic health center'' means an academic health center that operates a teaching hospital.

(B) The term ''qualified teaching hospital'' means any teaching hospital other than a teaching hospital that is operated by an academic health center.

(4) ELIGIBLE INSTITUTION.—For purposes of this subtitle, the term ''eligible institution'', with respect to a calendar year, means a qualified academic health center, or a qualified teaching hospital, that submits to the Secretary a written request in accordance with section 3052.

SEC. 3052. REQUEST FOR PAYMENTS.

(a) IN GENERAL.—For purposes of section 3051, a written request for payments under such section is in ac-

cordance with this section if the qualified academic health center or qualified teaching hospital involved submits the request not later than the date specified by the Secretary; the request is accompanied by each funding agreement described in this part; and the request is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(b) CONTINUED STATUS AS ACADEMIC HEALTH CENTER.—A funding agreement for payments under section 3051 is that the qualified academic health center or qualified teaching hospital involved will maintain status as such a center or hospital, respectively. For purposes of this subtitle, the term ''funding agreement'', with respect to payments under section 3051 to such a center or hospital, means that the Secretary may make the payments only if the center or hospital makes the agreement involved.

SEC. 3053. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) ANNUAL ACADEMIC HEALTH CENTER ACCOUNT.—The amount available for a calendar year for making payments under section 3051 (constituting an account to be known as the annual academic health center

account) is the following, as applicable to the calendar year:

(1) In the case of calendar year 1997, $7,250,000,000.

(2) In the case of calendar year 1998, $8,220,000,000.

(3) In the case of calendar year 1999, $9,400,000,000.

(4) In the case of calendar year 2000, $10,640,000,000.

(5) In the case of each subsequent calendar year, the amount specified in paragraph (4) increased by the product of such amount and the general health care inflation factor (as defined in subsection (d)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE INSTITUTIONS.—

(1) FORMULA.—The amount of payments required in section 3051 to be made to an eligible institution for a calendar year is an amount equal to the product of—

(A) the annual academic health center account available for the calendar year; and

(B) the percentage constituted by the ratio of—

(i) the product of—

(I) the sum, for all discharges of individuals, of the amounts otherwise paid on behalf of such individuals; and

(II) an adjustment factor equal to 1.200 multiplied by (((1 + r) to the nth power) − 1), where ''r'' equals the ratio of the hospital's full-time equivalent interns and residents to beds and ''n'' equals .405; and

(ii) the sum of the respective amounts determined under clause (i) for eligible institutions.

(2) ADJUSTMENT FACTOR.—Payments under this section shall be subject to an adjustment factor, as determined by the Secretary, so that total payments in any year will not exceed the amounts specified in section 3053(a).

(c) REPORT REGARDING MODIFICATIONS IN FORMULA.—Not later than July 1, 2001, the Secretary shall submit to the Congress a report containing any recommendations of the Secretary for the modification of the program of formula payments described in this chapter. In preparing such report the Secretary shall consider—

(1) the costs described in subsection (b) incurred by academic health centers;

(2) the adequacy of the formula payments established in this chapter to cover such costs, taking into account any additional revenues to cover such costs paid by other payers, including private health plans;

(3) the importance to the maintenance of a quality national health care system of academic health centers in providing for the training of health professionals, in conducting clinical research, and in providing innovative, technically advanced care; and

(4) the overall impact of the reformed health care system on the ability of academic health centers to perform such functions.

(d) DEFINITION.—For purposes of this subtitle:

(1) The term ''annual academic health center account'' means the account established pursuant to subsection (a).

(2) The term ''general health care inflation factor'', with respect to a year, has the meaning given such term in section 5001(a)(3) for such year.

Subpart D—Transitional Provisions

SEC. 3061. TRANSITIONAL PAYMENTS TO INSTITUTIONS.

(a) PAYMENTS REGARDING EFFECTS OF SUBPART B ALLOCATIONS.—For each of the four calendar years specified in subsection (b)(2), in the case of an eligible entity that submits to the Secretary an application for such year in accordance with subsection (d), the Secretary shall make payments for the year to the entity for the purpose specified in subsection (c). The Secretary shall make the payments in an amount determined in accordance with subsection (e), and may administer the payments as a contract, grant, or cooperative agreement.

(b) ELIGIBLE ENTITIES LOSING SPECIALTY POSITIONS; RELEVANT YEARS REGARDING PAYMENTS.—

(1) ELIGIBLE ENTITIES LOSING SPECIALTY POSITIONS.—The Secretary may make payments under subsection (a) to an eligible entity only if, with respect to the calendar year involved, the entity meets the following conditions:

(A) The entity operates or operated in the year preceding the initiation of transitional payments one or more programs that—

(i) are or were at the time they terminated approved physician training programs; and

(ii) are or were at the time they terminated receiving payments under section 3031 for such year.

(B) The aggregate number of speciality positions in such programs (in the medical specialities with respect to which such payments are made) is below the aggregate number of such positions at the entity for academic year 1993–94 as a result of allocations under subpart B, or as a result of voluntary changes under section 3012(e) prior to January 1, 2001.

(2) RELEVANT YEARS.—The Secretary may make payments under subsection (a) to an eligible entity only for the first four calendar years after the initial calendar year for which the entity meets the conditions described in paragraph (1).

(3) ELIGIBLE ENTITY.—For purposes of this section, the term ''eligible entity'' means an entity that submits to the Secretary an application in accordance with subsection (d).

(c) PURPOSE OF PAYMENTS.—The purpose of payments under subsection (a) is to assist an eligible entity with the costs of operation. A funding agreement for such payments is that the entity involved will expend the payments only for such purpose.

(d) APPLICATION FOR PAYMENTS.—For purposes of subsection (a), an application for payments under such subsection is in accordance with this subsection if—

(1) the eligible entity involved submits the application not later than the date specified by the Secretary;

(2) the application demonstrates that the entity meets the conditions described in subsection (b)(1) and that the entity has cooperated with the approved physician training programs of the entity in meeting the condition described in section 3032(b);

(3) the application contains each funding agreement described in this subpart and the application provides such assurances of compliance with the agreements as the Secretary may require; and

(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

(e) AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—Subject to the annual health professions workforce account available for the calendar year involved, the amount of payments required in subsection (a) to be made to an eligible entity for such year is the product of the amount de-

termined under paragraph (2) and the applicable percentage specified in paragraph (3).

(2) NUMBER OF SPECIALTY POSITIONS LOST.—For purposes of paragraph (1), the amount determined under this paragraph for an eligible entity for the calendar year involved is the product of—

(A) an amount equal to the aggregate number of full-time equivalent specialty positions lost; and

(B) the amount that would be received under section 3033 for each speciality position lost.

(3) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage for a calendar year is the following, as applicable to such year:

(A) For the first calendar year after calendar year 1997 for which the eligible entity involved meets the conditions described in subsection (b)(1), 100 percent.

(B) For the second such year, 75 percent.

(C) For the third such year, 50 percent.

(D) For the fourth such year, 25 percent.

(4) DETERMINATION OF SPECIALTY POSITIONS LOST.—

(A) For purposes of this subsection, the aggregate number of specialty positions lost, with respect to a calendar year, is the difference between—

(i) the aggregate number of specialty positions described in subparagraph (B) that are estimated for the eligible entity involved for the academic year beginning in such calendar year; and

(ii) the aggregate number of such specialty positions at the entity for academic year 1993–94.

(B) For purposes of subparagraph (A), the specialty positions described in this subparagraph are specialty positions in the medical specialities with respect to which payments under section 3031 are made to the approved physician training programs of the eligible entities involved.

(5) ADDITIONAL PROVISION REGARDING NATIONAL AVERAGE SALARY.—

(A) The Secretary shall determine, for academic year 1992–93, an amount equal to the national average described in paragraph (2)(B). The national average applicable under such

paragraph for a calendar year is, subject to subparagraph (B), the amount determined under the preceding sentence increased by an amount necessary to offset the effects of inflation occurring since academic year 1992–93, as determined through use of the consumer price index.

(B) The national average determined under subparagraph (A) and applicable to a calendar year shall, in the case of the eligible entity involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

PART 2—INSTITUTIONAL COSTS OF GRADUATE NURSING EDUCATION; WORKFORCE PRIORITIES

SEC. 3071. AUTHORIZED GRADUATE NURSE TRAINING POSITIONS; INSTITUTIONAL COSTS.

(a) PROGRAM REGARDING GRADUATE NURSE TRAINING PROGRAMS.—The Secretary shall, in accordance with this part, carry out a program with respect to graduate nurse training programs that is equivalent to the program carried out under part 1 with respect to approved physician training programs.

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

(1) The term ''graduate nurse training programs'' means programs for advanced nurse education, programs for education as nurse practitioners, programs for education as nurse midwives, programs for education as nurse anesthetists, and such other programs for training in clinical nurse specialties as are determined by the Secretary to require advanced education.

(2) The term ''graduate nurse training position'' means a position as an individual who is enrolled in a graduate nurse training program.

(3) The term ''programs for advanced nurse education'' means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 821 of the Public Health Service Act.

(4) The term ''programs for education as nurse practitioners'' means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as a nurse practitioners.

(5) The term ''programs for education as nurse midwives'' means programs meeting the conditions to be programs for which awards of grants and con-

tracts may be made under section 822 of the Public Health Service Act for education as nurse midwives.

(6) The term ''programs for education as nurse anesthetists'' means programs meeting the conditions to be programs for which awards of grants may be made under section 831 of the Public Health Service Act for education as nurse anesthetists.

SEC. 3072. APPLICABILITY OF PART 1 PROVISIONS.

(a) IN GENERAL.—The provisions of part 1 apply to the program carried out under section 3071 to the same extent and in the same manner as such provisions apply to the program carried out under part 1, subject to the subsequent provisions of this section. Section 3061 does not apply for purposes of the preceding sentence.

(b) NATIONAL COUNCIL.—With respect to section 3001 as applied to this part, the council shall be known as the National Council on Graduate Nurse Education (in this part referred to as the ''National Council''). The provisions of section 851 of the Public Health Service Act regarding the composition of the council under such section apply to the composition of the National Council to the same extent and in the same manner as such provisions apply to the council under such section 851.

(c) ALLOCATION OF GRADUATE NURSE TRAINING POSITIONS; FORMULA PAYMENTS FOR OPERATING

COSTS.—With respect to subparts B and C of part 1 as applied to this part—

(1) the funding agreement described in section 3011 is to be made by graduate nurse training programs;

(2) the applicable accrediting bodies described in section 3011 for graduate nurse training programs are the National League of Nursing and others determined to be appropriate by the Secretary;

(3) designations under section 3012 and allocations under section 3013 apply to graduate nurse training positions; and

(4) payments under section 3031 are to be made to graduate nurse training programs, subject to the requirements for such payments.

SEC. 3073. FUNDING.

(a) IN GENERAL.—With respect to section 3033 as applied to this part, the provisions of this section apply.

(b) ANNUAL GRADUATE NURSE TRAINING ACCOUNT.—The amount available for each of the calendar years 1997 through 2000 for making payments pursuant to section 3072(c)(4) to graduate nurse training programs (constituting an account to be known as the annual graduate nurse training account) is $200,000,000.

Subpart B—Transitional Provisions for Workforce Stability

SEC. 3081. APPLICATION.

(a) LIMITATION TO TRANSITION PERIOD.—The provisions of this subpart are intended to minimize, to the extent possible, disruptions in established employment relationships during the period of transition to a restructured health care delivery system, and shall terminate December 31, 2000.

(b) HEALTH CARE ENTITIES COVERED BY SUBPART.—The provisions of this subpart, including references to displacing employers, hiring employers, successors and contractors, apply only to health care entities that employ more than 25 individuals.

SEC. 3082. DEFINITIONS.

(a) HEALTH CARE ENTITY.—As used in this subpart, the term ''health care entity'' includes individuals, sole proprietorships, partnerships, associations, business trusts, corporations, governmental institutions, and public agencies (including state governments and political subdivisions thereof) that—

(1) provide health care services under title I (including nonmandatory health care services under title I) or under the amendments made or programs referred to in titles IV and VIII; or

(2) provide necessary related services, including administrative, food service, janitorial or maintenance services, to an entity that provides health care services (as described in subparagraph (1));

except that an entity that solely manufactures or provides goods or equipment to a health care entity shall not be considered a health care entity.

(b) AFFILIATED ENTERPRISE.—As used in this subpart, the term ''affiliated enterprise'' means a health care entity that, together with the displacing employer, is considered a single employer as defined under 414 of the Internal Revenue Code of 1986.

(c) PREFERENCE ELIGIBLE EMPLOYEE.—As used in this subpart, the term ''preference eligible employee'' means an employee who—

(1) has been employed for in excess of 1 year by a health care entity; and

(2) has been displaced by or has received notice of an impending displacement by such entity.

(d) DISPLACEMENT.—As used in this subpart, the term ''displacement'' includes a layoff, termination, significant cutback in paid work hours, or other loss of employment, except that a discharge for just cause shall not constitute a displacement within the meaning of this paragraph.

SEC. 3083. OBLIGATIONS OF DISPLACING EMPLOYER AND AFFILIATED ENTERPRISES IN EVENT OF DISPLACEMENT.

(a) NOTICE.—A health care entity which displaces a preference eligible employee shall provide such employee with—

(1) written notice, no later than the date of displacement, of employment rights under this subpart, including employment rights with respect to affiliated enterprises of the displacing employer; and

(2) notice of any existing or subsequent vacancies with the displacing employer or an affiliated enterprise, which notice may be given by posting of such vacancies wherever notices to applicants for employment are customarily posted, by listing such vacancies with the local employment services agency, or in such other manner as the Secretary of Labor, by regulation, may hereafter specify.

Any such vacancy shall remain open for applications by preference eligible employees for not less than 14 calendar days from the date on which the initial notice is provided.

(b) HIRING PREFERENCE.—

(1) IN GENERAL.—A qualified preference eligible employee who applies during the notice period described in subsection (a)(2) for a vacant position with the displacing employer or an affiliated enter-

prise, which position is in the employee's occupational specialty and is located in the same State or Standard Metropolitan Statistical Area in which the employee was employed prior to the displacement, shall be given the right to accept or decline the position before the employer may offer the position to a nonpreference eligible employee.

(2) MULTIPLE APPLICATIONS.—When considering applications from more than one qualified preference eligible employee, the hiring health care entity shall have discretion as to which of such employees will be offered the position.

(3) EMPLOYMENT QUALIFICATIONS.—Nothing in this subsection shall be construed to prohibit the hiring health care entity from establishing reasonable employment qualifications for a vacancy to which this subpart applies, except that employees who performed essentially the same work prior to their displacement shall be deemed presumptively qualified for comparable positions.

(c) TERMINATION OF PREFERENCE ELIGIBILITY.—A displaced employee's preference eligibility shall terminate—

(1) at such time as the displaced employee obtains substantially equivalent employment with the displacing employer; or

(2) if the employee does not obtain such employment—

(A) with respect to health care entities other than the displacing employer, 2 years after the date of the displacement; or

(B) with respect to the displacing employer, upon the termination of this subpart pursuant to section 3081(a).

SEC. 3084. EMPLOYMENT WITH SUCCESSORS.

A health care entity that succeeds another health care entity through merger, consolidation, acquisition, contract, or other similar manner shall provide employees of the previous health care entity who would otherwise be displaced the right to continued employment in the job positions held by such employees prior thereto, unless the employer can establish that such positions no longer exist.

SEC. 3085. COLLECTIVE BARGAINING OBLIGATIONS DURING TRANSITION PERIOD.

(a) CONTINUATION OF PREVIOUSLY RECOGNIZED BARGAINING REPRESENTATIVES AND AGREEMENTS.—If a majority of the employees in an appropriate bargaining unit consists of employees who were previously covered by

a bargaining agreement or represented by an exclusive representative with respect to terms and conditions of employment, and there has not been a substantial change in the operations performed by the employees in that unit, the employer shall recognize such representative as the exclusive representative for the unit and shall assume the bargaining agreement, except that where application of this subsection would result in the recognition of more than one bargaining representative for a single unit, the question concerning which representative shall be recognized as the exclusive representative for the unit shall be resolved in accordance with applicable Federal or State law.

(b) JOINT EMPLOYER STATUS.—If employees of a contractor are assigned on a regular basis to perform work on the premises of a contracting entity and the tasks performed by these employees are functionally integrated with the operations of the contracting entity on whose premises such employees work, both the contractor and the contracting entity shall be considered joint employers of the employees with respect to work performed on those premises for purposes of determining compliance with labor relations laws. Employees of such joint employers may not be excluded from a bargaining unit within either entity on the basis of such joint employer status.

SEC. 3086. GENERAL PROVISIONS.

(a) REGULATIONS.—Not later than 120 days after the date of enactment of this Act, the Secretary shall promulgate regulations to implement the requirements of section 3083.

(b) OTHER LAWS.—The standards and requirements of this subpart shall not preempt or excuse noncompliance with any other applicable Federal or State law, regulation or municipal ordinance that establishes additional notice and preference standards or requirements concerning employee dislocation, employee representation, or collective bargaining.

(c) RULES OF CONSTRUCTION.—Nothing in this subpart shall be construed—

(1) to excuse or otherwise limit the obligation of an employer to comply with any collective bargaining agreement or any employment benefit plan that provides rights to employees in addition to those provided under this subpart; or

(2) to require an employer to recognize or bargain with a labor organization in violation of State law.

(d) ENFORCEMENT.—Unless otherwise specifically provided in this subpart, the enforcement provisions of section 107 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2617) shall apply with respect to the enforce-

ment of the individual rights, including notice requirements, provided under section 3083. The collective bargaining and contractual rights provided under sections 3084 and 3085 shall be enforced through administrative and judicial procedures otherwise provided under Federal or State law with respect to such rights.

Subtitle B—Health Research Initiatives

PART 1—PROGRAMS FOR CERTAIN AGENCIES

SEC. 3101. BIOMEDICAL AND BEHAVIORAL RESEARCH.

(a) AVAILABILITY OF FUNDS.—

(1) IN GENERAL.—With respect to each calendar year, the Secretary shall pay, from funds in the Treasury not otherwise appropriated, for activities under this section in an amount equal to 0.25 percent in 1997, 0.50 percent in 1998, 0.75 percent in 1999, and 1.0 percent in 2000 and subsequent years, of all private premiums required to be paid under this Act.

(2) For purposes of this subsection, the term ''private health premiums'' means all premium related payments made by employers, individuals, and families for coverage under this Act.

(b) PURPOSES FOR EXPENDITURES.—Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et

seq.) is amended by adding at the end thereof the following new section:

"SEC. 404F. EXPENDITURES FOR HEALTH RESEARCH.

''(a) IN GENERAL.—From amounts made available under section 3101 of the Affordable Health Care for All Americans Act, the Secretary shall distribute—

''(1) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

''(A) for carrying out the responsibilities of the Office of the Director, in including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Alternative Medicine and the Office of Rare Diseases Research; and

''(B) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

''(2) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

''(3) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV with respect to health information communications; and

''(4) the remainder of such amounts during any fiscal year to member institutes of the National Institutes of Health and Centers in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

''(b) PLANS OF ALLOCATION.—The amounts transferred under subsection (a) shall be allocated by the Director of NIH or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.''.

SEC. 3102. HEALTH SERVICES RESEARCH.

Section 902 of the Public Health Service Act (42 U.S.C. 299a), as amended by section 2(b) of Public Law 102–410 (106 Stat. 2094), is amended by adding at the end the following subsection:

1 ''(f) RESEARCH ON HEALTH CARE REFORM.—

2 ''(1) IN GENERAL.—In carrying out section
3 901(b), the Administrator shall conduct and support
4 research on the reform of the health care system of
5 the United States, as directed by the Secretary.

6 ''(2) PRIORITIES.—In carrying out paragraph
7 (1), the Administrator shall give priority to the fol-
8 lowing:

9 ''(A) Conducting and supporting research
10 on the appropriateness and effectiveness of al-
11 ternative clinical strategies (including commu-
12 nity-based programs and preventive services),
13 the quality and outcomes of care, and adminis-
14 trative simplification.

15 ''(B) Conducting and supporting research
16 on the appropriateness and effectiveness of al-
17 ternative community-based and clinical strate-
18 gies including integrating preventive services
19 into primary care, the effectiveness of preven-
20 tive counseling and health education, and the
21 efficacy and cost-effectiveness of clinical preven-
22 tive services.

23 ''(C) Conducting and supporting research
24 on consumer choice and information resources;
25 the effects of health care reform on health de-

livery systems; workplace injury and illness prevention; intentional and unintentional injury prevention; methods for risk adjustment; factors influencing access to health care for vulnerable populations, including children, persons with low-income, persons with disabilities, or individuals with chronic or complex health conditions, and primary care.

''(D) The development of clinical practice guidelines consistent with section 913, the dissemination of such guidelines consistent with section 903, and the assessment of the effectiveness of such guidelines.''.

PART 2—FUNDING FOR PROGRAM

SEC. 3111. AUTHORIZATIONS OF APPROPRIATIONS.

(a) HEALTH SERVICES RESEARCH.—For the purpose of carrying out activities pursuant to the amendments made by section 3102, there are authorized to be appropriated $150,000,000 for fiscal year 1996, $400,000,000 for fiscal year 1997, $500,000,000 for fiscal year 1998, and $600,000,000 for each of the fiscal years 1999 through 2001.

(b) RELATION TO OTHER FUNDS.—The authorization of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that

are available for the purposes described in such subsection.

(c) TRIGGER AND RELEASE OF MONIES.—No expenditure shall be made pursuant to section 3101(c) during any fiscal year in which the annual amount appropriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year. With respect to amounts available for expenditure pursuant to section 3101(c) which, as a result of the application of this subsection remain unexpended, such amounts shall be obligated by the Secretary of Health and Human Services under the public health initiative under subtitle F.

Subtitle C—Health Services for Medically Underserved Populations

PART 1—INITIATIVES FOR ACCESS TO HEALTH CARE

Subpart A—Authorization of Appropriations

SEC. 3311. AUTHORIZATIONS OF APPROPRIATIONS.

(a) IMPROVING ACCESS TO HEALTH SERVICES.—

(1) SUBPART B.—

(A) Except as provided in subparagraph (B), for the purpose of carrying out subpart B, there are authorized to be appropriated $52,500,000 for fiscal year 1996, $122,500,000

for fiscal year 1997, $192,500,000 for fiscal year 1998, $157,500,000 for fiscal year 1999, $122,500,000 for fiscal year 2000, and $52,500,000 for fiscal year 2001.

(B) With respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) under subpart B, there are authorized to be appropriated $97,500,000 for fiscal year 1996, $227,500,000 for fiscal year 1997, $357,500,000 for fiscal year 1998, $292,500,000 for fiscal year 1999, $227,500,000 for fiscal year 2000, and $97,500,000 for fiscal year 2001.

(2) SUBPART C.—

(A) For the purpose of providing loans under subpart C, there are authorized to be appropriated such sums as may be necessary to support a loan level of $200,000,000 for each of the fiscal years 1996 through 2001.

(B) For the purpose of making grants under subpart C, there are authorized to be appropriated $35,000,000 for each of the fiscal year 1996 through 2001.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

(c) ELIGIBLE ENTITIES.—For purposes of this part, the term ''eligible entities'' means—

(1) covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), except that subsection (a)(4)(L)(iii) and (a)(7) of such section shall not apply;

(2) nonprofit hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act, except that subsection (a)(4)(L)(iii) of such section shall not apply, and children's hospitals meeting comparable criteria as determined appropriate by the Secretary;

(3) public and private, nonprofit community mental health centers and substance abuse treatment providers receiving funds from the Substance Abuse and Mental Health Services Administration;

(4) runaway homeless youth centers or transitional living programs for homeless youth for the

provision of health services under the Runaway Homeless Youth Act of 1974 (42 U.S.C. 5701 et seq.);

(5) rural referral centers under section 1886(d)(5)(C) of the Social Security Act, except that such eligibility is restricted to the receipt of grants under section 3341; and

(6) public or nonprofit entities in nonmetropolitan areas (as defined by the Department of Commerce) in a consortium of community-based providers that includes at least three of the following:

(A) community or migrant health centers;

(B) local health departments;

(C) community mental health centers;

(D) nonprofit hospitals;

(E) private practice health professionals, including rural health clinics; or

(F) other publicly funded health or social services agencies.

(d) PRIORITY.—In making awards from amounts appropriated under subsection (a)(1)(B) and section 3362, the Secretary shall give the highest priority to providing adequate assistance to federally qualified health centers in order to ensure the provision of comprehensive primary

health care services, other covered services and benefits, and enabling services to medically underserved populations that were served by such centers prior to the date of enactment of this Act, except that such federally qualified health centers must continue to meet the requirements for designation under section 1861(aa)(4) of the Social Security Act.

(e) EQUITABLE DISTRIBUTION.—The Secretary shall, in awarding grants, entering into contracts, and making loans under this part, assure an equitable distribution of funds between rural and urban areas.

Subpart B—Development of Community Health Groups and Health Care Sites and Services

SEC. 3321. GRANTS AND CONTRACTS FOR DEVELOPMENT OF PLANS AND NETWORKS AND THE EXPANSION AND DEVELOPMENT OF HEALTH CARE SITES AND SERVICES.

(a) IN GENERAL.—The Secretary may make grants to and enter into contracts with eligible entities described in section 3311(c) for—

(1) the development of community health groups whose principal purpose is to provide the benefits required under subtitle B of title I in one or more health professional shortage areas or to provide such items and services to a significant number

of individuals who are members of a medically underserved population; and

(2) the expansion of existing health delivery sites and services and the development of new health delivery sites and services.

(b) SERVICE AREA.—In making an award under subsection (a), the Secretary shall designate the geographic area with respect to which the community health group involved is to provide health services.

(c) PRIORITY.—In making awards under subsection (a)(1), the Secretary shall give priority to proposals in which a greater number of eligible entities and other health care providers are participants in the community health group, except in areas such as rural areas, where providers are severely limited in number.

(d) LIMITATION ON AWARDS.—The Secretary may not make awards under subsection (a)(1) for more than 5 years to the same community health group.

(e) DEFINITIONS.—For purposes of this subpart:

(1) The term ''community health group'' means—

(A) a community health network that—

(i) is a public or nonprofit private consortium of health care providers that principally provides some of the items and

services of the basic benefit package to medically underserved populations, and residents of health professional shortage areas; and

(ii) has a written agreement governing the participation of health care providers in the consortium to which each participating provider is a party; or

(B) a community health plan that—

(i) is a public or nonprofit private entity that principally provides all of the items and services of the basic benefit package to medically underserved populations, and residents of health professional shortage areas;

(ii) is a participant in one or more health alliances; and

(iii) has a written agreement governing the participation of health care providers in the consortium to which each participating provider is a party.

(2) The term ''health professional shortage areas'' means health professional shortage areas designated under section 332 of the Public Health Service Act.

(3) The term ''medically underserved population'' means a medically underserved population designated under section 330(b)(3) of the Public Health Service Act, populations residing in health professional shortage areas under section 332 of the Public Health Service Act, and populations eligible for premium subsidies and cost sharing reductions based on income under title I.

SEC. 3322. CERTAIN USES OF AWARDS.

(a) IN GENERAL.—Amounts awarded under section 3321 may be expended for—

(1) the development of a community health group, including entering into contracts between the recipient of the award and health care providers who are to participate in the group;

(2) the expansion, development and on-going operation of health delivery sites and services; and

(3) activities under paragraphs (1) and (2) which include—

(A) the recruitment, compensation, and training of health professionals and administrative staff;

(B) the purchase and upgrading of equipment, supplies, and information systems including telemedicine systems; and

(C) the establishment of reserves required for furnishing services on a prepaid or capitated basis, except that eligible entities may use non-cash mechanisms (including bonds, letters of credit and federally guaranteed reinsurance pools) for establishing and maintaining financial reserves.

(b) LOANS AND GRANTS.—The Secretary may expend, in any fiscal year, not to exceed 10 percent of the amounts appropriated to carry out this subpart to make loans and grants to eligible entities to support the types of activities described in section 3341, subject to the requirements of subpart C, except that, with respect to amounts available for non-federally qualified health center activities, such funds may be used to convert facilities from providers of acute care service to providers of primary, emergency or long-term care.

SEC. 3323. PURPOSES AND CONDITIONS.

Grants shall be made under this subpart for the purposes and subject to all of the conditions under which eligible entities otherwise receive funding to provide health services to medically underserved populations under the Public Health Service Act. The Secretary shall prescribe comparable purposes and conditions for eligible entities not receiving funding under the Public Health Service Act.

Subpart C—Capital Cost of Development of Community Health Groups and Other Purposes

SEC. 3341. DIRECT LOANS AND GRANTS.

(a) IN GENERAL.—The Secretary shall make grants and loans to—

(1) eligible entities (as defined in section 3312(c));

(2) hospitals designated by the Secretary as essential access community hospitals under section 1820(i)(1) of the Social Security Act; or

(3) rural primary care hospitals under section 1820(i)(2) of such Act;

for the capital costs of developing community health groups (as defined in section 3321(e)) and expanding existing health delivery sites or developing new health delivery sites.

(b) USE OF ASSISTANCE.—

(1) IN GENERAL.—The capital costs for which grants and loans made pursuant to subsection (a) may be expended are, subject to paragraphs (2) and (3), the following:

(A) The acquisition, modernization, expansion or construction of facilities, or the conversion of unneeded hospital facilities to facilities that will assure or enhance the provision and

accessibility of health care and enabling services to medically underserved populations.

(B) The purchase of major equipment, including equipment necessary for the support of external and internal information systems.

(C) The establishment of reserves required for furnishing services on a prepaid or capitated basis.

(D) Such other capital costs as the Secretary may determine are necessary to achieve the objectives of this section.

(2) PRIORITIES REGARDING USE OF FUNDS.—In providing grants and loans under subsection (a) for an entity, the Secretary shall give priority to authorizing the use of amounts for projects for the renovation and modernization of medical facilities necessary to prevent or eliminate safety hazards including asbestos removal, avoid noncompliance with licensure or accreditation standards, or projects to replace obsolete facilities.

(3) LIMITATION.—The Secretary may authorize the use of grants and loans under subsection (a) for the construction of new buildings only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding

or converting existing buildings, or that construction new buildings will cost less.

(c) AMOUNT OF ASSISTANCE.—

(1) IN GENERAL.—The principal amount of loans under subsection (a) may cover up to 90 percent of the costs involved.

(2) GRANTS.—Grants under this subsection may not exceed 75 percent of the costs involved.

(d) INTEREST SUBSIDIES.—Amounts provided under this section may be used to provide interest subsidies for loans provided under this section where such subsidies are necessary to make a project financial feasible.

SEC. 3342. CERTAIN REQUIREMENTS.

(a) IN GENERAL.—The Secretary may approve a loan under section 3341 only if—

(1) the Secretary is reasonably satisfied that the applicant for the project for which the loan would be made will be able to make payments of principal and interest thereon when due; and

(2) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(b) TERMS AND CONDITIONS.—Any loan made under section 3341 shall, subject to the Federal Credit Reform Act of 1990, meet such terms and conditions (including provisions for recovery in case of default) as the Secretary, in consultation with the Secretary of the Treasury, determines to be necessary to carry out the purposes of such section while adequately protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

(1) Security.

(2) Maturity date.

(3) Amount and frequency of installments.

(4) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

SEC. 3343. DEFAULTS; RIGHT OF RECOVERY.

(a) DEFAULTS.—The Secretary may take such action as may be necessary to prevent a default on loans under section 3341, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes.

(b) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure

procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to section 3341, including selling real property pledged as security for such a loan and for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan.

SEC. 3344. APPLICATION FOR ASSISTANCE.

The Secretary may provide loans under section 3341 only if an application for such assistance is submitted to the Secretary, the application meets such requirements, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

Subpart D—Enabling and Supplemental Services

SEC. 3361. GRANTS AND CONTRACTS FOR ENABLING AND SUPPLEMENTAL SERVICES.

(a) IN GENERAL.—The Secretary may make grants to and enter into contracts with eligible entities to assist such entities in providing the services described in subsections (b) and (c) for the purpose of increasing the capacity of individuals to utilize the items and services included in the benefits package required under title I, and to provide access to essential supplemental services that

are not fully reimbursable under title I prior to January 2002.

(b) ENABLING SERVICES.—Enabling services shall include transportation, community and patient outreach, patient and family education, translation services, case management, home visiting, and such other services as the Secretary determines to be appropriate in carrying out the purpose described in such subsection.

(c) SUPPLEMENTAL SERVICES.—Supplemental services shall include items or services described in section 1101 of this Act that would otherwise be excluded from coverage.

(d) CERTAIN REQUIREMENTS REGARDING PROJECT AREA.—The Secretary may make an award of a grant or contract under subsection (a) only if the applicant involved—

(1) submits to the Secretary—

(A) information demonstrating that the medically underserved populations in the community to be served under the award have a need for enabling services; and

(B) a proposed budget for providing such services;

(2) the applicant for the award agrees that the medically underserved residents of the community

will be consulted with respect to the design and implementation of the project carried out with the award;

(3) agrees that the services will not be denied because the individual is unable to pay for such services; and

(4) agrees that the applicant will utilize existing resources to the maximum extent practicable.

(e) APPLICATION FOR AWARDS OF ASSISTANCE.—The Secretary may make an award of a grant or contract under subsection (a) only if an application for the award is submitted to the Secretary, the application contains each agreement described in this subpart, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

SEC. 3362. AUTHORIZATIONS OF APPROPRIATIONS.

(a) ENABLING SERVICES.—For the purpose of carrying out section 3361(b), there are authorized to be appropriated $35,000,000 for fiscal year 1997, $140,000,000 for each of the fiscal years 1998 through 2000, and $175,000,000 for fiscal year 2001.

(b) SUPPLEMENTAL SERVICES.—For the purpose of carrying out section 3361(c), there are authorized to be

appropriated $100,000,000 for fiscal year 1996, $150,000,000 for fiscal year 1997, and $250,000,000 for each of the fiscal years 1998 through 2001.

(c) FEDERALLY QUALIFIED HEALTH CENTERS.—With respect to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act), for the purpose of carrying out section 3361(b), there are authorized to be appropriated $65,000,000 for fiscal year 1997, $260,000,000 for each of the fiscal years 1998 through 2000, and $325,000,000 for fiscal year 2001.

(d) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

PART 2—NATIONAL HEALTH SERVICE CORPS

SEC. 3371. AUTHORIZATIONS OF APPROPRIATIONS.

(a) ADDITIONAL FUNDING; GENERAL CORPS PROGRAM; ALLOCATIONS REGARDING NURSES.—For the purpose of carrying out subpart II of part D of title III of the Public Health Service Act, and for the purpose of carrying out section 3372, there are authorized to be appropriated $150,000,000 for fiscal year 1997, $150,000,000 for fiscal year 1998, and $250,000,000 for each of the fiscal years 1999 through 2001.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 3372. ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Of the amounts appropriated under section 3371, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program under section 338A of the Public Health Service Act, or in the Loan Repayment Program under section 338B of such Act, the total number who are being educated as nurse practitioners, nurse midwives, or nurse anesthetists or are serving as nurse practitioners, nurse midwives, or nurse anesthetists, respectively, is increased to 20 percent.

SEC. 3373. ALLOCATION FOR PARTICIPATION OF PSYCHIATRISTS, PSYCHOLOGISTS, AND CLINICAL SOCIAL WORKERS IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Of the amounts appropriate under section 3371, the Secretary shall reserve such amounts as may be necessary to ensure that of the aggregate number of individuals who

are participants in the scholarship program under section 338A of the Public Health Service Act, the number who are being educated as psychiatrists, psychologists, and clinical social workers or are serving as psychiatrists, psychologists, and clinical social workers, respectively, is increased to 15 percent.

PART 3—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

SEC. 3381. PAYMENTS TO HOSPITALS.

(a) ENTITLEMENT STATUS.—The Secretary shall make payments in accordance with this part to eligible hospitals described in section 3382. The preceding sentence—

(1) is an entitlement in the Secretary on behalf of such eligible hospitals (but is not an entitlement in the State in which any such hospital is located or in any individual receiving services from any such hospital); and

(2) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the fiscal years, specified in subsection (b).

(b) APPROPRIATIONS.—

(1) IN GENERAL.—For purposes of subsection (a)(2), the amounts and fiscal years specified in this subsection are (in the aggregate for all eligible hospitals) $1,300,000,000 for the fiscal year in which the general effective date occurs and for each subsequent fiscal year.

(2) SPECIAL RULE FOR YEARS BEFORE GENERAL EFFECTIVE DATE.—

(A) IN GENERAL.—For each of the fiscal years 1997 and 1998, the amount specified in this subsection for purposes of subsection (a)(2) shall be equal to the aggregate DSH percentage of the amount otherwise determined under paragraph (1).

(B) AGGREGATE DSH PERCENTAGE DEFINED.—In subparagraph (A), the ''aggregate DSH percentage'' for a year is the amount (expressed as a percentage) equal to—

(i) the total amount of payment made by the Secretary under section 1903(a) of the Social Security Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in the States in which eligible

hospitals for the year are located; divided by

(ii) the total amount of payment made by the Secretary under section 1903(a) of such Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in all States.

(c) PAYMENTS MADE ON QUARTERLY BASIS.—Payments to an eligible hospital under this section for a year shall be made on a quarterly basis during the year.

SEC. 3382. IDENTIFICATION OF ELIGIBLE HOSPITALS.

(a) STATE IDENTIFICATION.—In accordance with the criteria described in subsection (b) and such procedures as the Secretary may require, each State shall identify the hospitals in the State that meet such criteria and provide the Secretary with a list of such hospitals.

(b) CRITERIA FOR ELIGIBILITY.—A hospital meets the criteria described in this subsection if the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act) is not less than 25 percent.

SEC. 3383. AMOUNT OF PAYMENTS.

(a) DISTRIBUTION OF ALLOCATION FOR LOW-INCOME ASSISTANCE.—

(1) ALLOCATION FROM TOTAL AMOUNT.—Of the total amount available for payments under this section in a year, 66.66 percent shall be allocated to hospitals for low-income assistance in accordance with this subsection.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital from the allocation made under paragraph (1) during a year shall be the equal to the hospital's low-income percentage of the allocation for the year.

(b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE FOR UNCOVERED SERVICES.—

(1) ALLOCATION FROM TOTAL AMOUNT; DETERMINATION OF STATE-SPECIFIC PORTION OF ALLOCATION.—Of the total amount available for payments under this section in a year, 33.33 percent shall be allocated to hospitals for assistance in furnishing hospital services that are not covered services under title I (in accordance with regulations of the Secretary) or in furnishing hospital services to individuals, including those residing in Southwestern border States, who are not eligible individuals under title I, in accordance with this subsection. The

amount available for payments to eligible hospitals in a State shall be equal to an amount determined in accordance with a methodology specified by the Secretary that shall take into consideration the volume of such services provided by hospitals in the State as compared to the volume of such services provided by all eligible hospitals.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital in a State from the amount available for payments to eligible hospitals in the State under paragraph (1) during a year shall be the equal to the hospital's low-income percentage of such amount for the year.

(c) LOW-INCOME PERCENTAGE DEFINED.—

(1) IN GENERAL.—In this subsection, an eligible hospital's ''low-income percentage'' for a year is equal to the amount (expressed as a percentage) of the total low-income days for all eligible hospitals for the year that are attributable to the hospital.

(2) LOW-INCOME DAYS DESCRIBED.—For purposes of paragraph (1), an eligible hospital's low-income days for a year shall be equal to the product of—

(A) the total number of inpatient days for the hospital for the year (as reported to the Secretary by the State in which the hospital is located, in accordance with a reporting schedule and procedures established by the Secretary); and

(B) the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act).

SEC. 3384. BASE YEAR.

In this part, the ''base year'' is, with respect to a State and hospitals in a State, the year immediately prior to the year in which the general effective date occurs.

PART 4—SENSE OF THE COMMITTEE

SEC. 3391. SENSE OF THE COMMITTEE.

It is the sense of the Committee on Labor and Human Resources of the Senate that when the Affordable Health Care for All Americans Act is enacted, it and subsequent appropriations Acts should appropriately recognize the success of community and migrant health centers as a proven, cost-effective model for the delivery of health care services to those populations which are medically un-

derserved because of economic, geographic, and cultural barriers.

Subtitle D—Assistance For State Managed Mental Health And Substance Abuse Programs

SEC. 3431. AVAILABILITY OF ASSISTANCE.

(a) IN GENERAL.—The Secretary shall make grants to States for the development and operation of comprehensive managed mental health and substance abuse programs that are integrated with the health delivery system established under this Act. Such programs shall—

(1) promote the development of integrated delivery systems for the management of the mental health and substance abuse services provided under the comprehensive benefits package;

(2) give priority to providing services to low-income adults with serious mental illness or substance abuse disorders and children with serious emotional disturbance or substance abuse disorders and provide for the phase-in of such services for all eligible persons within 5 years;

(3) ensure that individuals participating in the program have access to all medically necessary mental health and substance abuse services;

(4) promote the linkage of mental health and substance abuse services with primary and preventive health care services; and

(5) meet such other requirements as the Secretary may impose.

(b) EXCEPTION.—Nothing in this subtitle shall be construed as preventing States that have separate administrative entities for mental health and for substance abuse services from establishing separate comprehensive managed care programs for such services and receiving assistance under this subtitle for either or both programs.

SEC. 3432. PLAN REQUIREMENTS.

In order to receive a grant under this subtitle, a State must have a plan for a comprehensive managed mental health and substance abuse program which is approved by the Secretary. Such plan shall—

(1) describe the management, access, and referral structure that the State will use to promote and achieve integration of mental health and substance abuse services with the health delivery system established under this Act for eligible individuals in the State;

(2) describe how the State will ensure that providers of specialized services will meet appropriate standards;

(3) describe payment, utilization review, and other mechanisms that the State will use to encourage appropriate service delivery and management of costs;

(4) describe uniform patient placement criteria that the State will use to ensure placement in appropriate substance abuse treatment programs;

(5) describe the processes the State will use to ensure that individuals will continue to have access to treatment through referrals from nonhealth public entities, such as the juvenile or criminal justice systems, or social service systems;

(6) specify the methods the State will use to ensure that individuals receiving services under the program have access to all medically necessary and appropriate mental health and substance abuse services;

(7) define terms that will be used by the State in determining the eligibility of individuals for services under the program;

(8) describe how health plans will use services under the comprehensive managed mental health and substance abuse programs established under this subtitle;

(9) describe the role of local government in financing and managing the integrated mental illness and substance abuse treatment system;

(10) describe the sources of funding, including Medicaid and the block grants authorized by title XIX of the Public Health Service Act, that will be used by the State, other than the grant received under this subtitle, to operate the program, and provide the status of any request for a Medicaid waiver made by the State to the Secretary;

(11) describe how the State provided for broad-based public input in the development of the plan, and the mechanism that will be used for ongoing public comment on and review of amendments to the plan; and

(12) describe grievance procedures that will be available for individuals dissatisfied with their health plan's participation in the comprehensive managed mental health and substance abuse program, and mechanisms that will be available to review the performance of health plans and fee-for-service arrangements to ensure against under treatment.

SEC. 3433. ADDITIONAL FEDERAL RESPONSIBILITIES.

The Secretary shall, upon the submission of a State's plan under section 3432, ensure the timely consideration

of any Medicaid waiver requests submitted by the State, affirm that **[section 1504]** has been implemented, and ensure the timely implementation of **[section 1641(b)(5)]**.

SEC. 3434. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this subtitle, $100,000,000 for each of the fiscal years 1996 through 2001.

Subtitle E—Comprehensive School Health Education; School-Related Health Services

PART 1—HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS FOR SCHOOL HEALTH EDUCATION

SEC. 3501. PURPOSES.

It is the purpose of this part—

(1) to support the development and implementation of comprehensive age appropriate health education programs in public schools for children and youth kindergarten through grade 12; and

(2) to increase access to preventive and primary health care services for children and youth through school-based or school-linked health service sites in accordance with locally determined needs.

SEC. 3502. HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Education, shall award grants to State educational agencies in eligible States to integrate comprehensive school health education in schools within the State, with priority given within States to those communities in greatest need as defined by section 3583(a).

(b) ELIGIBLE USES OF FUNDS.—Funds made available under this section shall be used—

(1) to implement comprehensive school health education programs, as defined in subsection (f)(1) through grants to local educational agencies;

(2) to provide staff development and technical assistance to local educational agencies, schools, local health agencies, and other community organizations involved in providing comprehensive school health education programs;

(3) to evaluate and report to the Secretary on the progress made towards attaining the goals and objectives described under subsection (c)(1)(A); and

(4) to conduct such other activities to achieve the objectives of this subpart as the Secretary may require.

(c) APPLICATION.—An application for a grant under subsection (a), shall be jointly developed by the State edu-

cational agency and the State health agencies of the State involved, and shall contain—

(1) a State plan for comprehensive school health education programs, that outlines—

(A) the goals and objectives of the State for school health education programs, and the manner in which the State will allocate funds to local educational agencies in order to achieve these goals and objectives;

(B) the manner in which the State will coordinate programs under this part with other Federal, State and local health education programs and resources, and school health services;

(C) the manner in which comprehensive school health education programs will be coordinated with other Federal, State and local education programs (such as programs under titles I, II, and IV of the Elementary and Secondary Education Act of 1965), with the school improvement plan of the State, if any, under title III of the Goals 2000: Educate America Act, and with any similar programs;

(D) the manner in which the State shall work with State and local educational agencies

and with State and local health agencies to reduce barriers to implementing school health education programs;

(E) the manner in which the State will monitor the implementation of such programs by local educational agencies and establish outcome criteria by which to evaluate their effectiveness in achieving progress towards the goals and objectives described in subparagraph (A);

(F) the manner in which the State will provide staff development and technical assistance to local educational agencies, and build capacity for professional development of health educators; and

(G) the manner in which such school health education programs will be, to the extent practicable, culturally competent and linguistically appropriate and responsive to the diverse needs of the students served;

(2) a description of the respective roles of the State educational agency, local educational agencies, the State health agency and local health agencies in developing and implementing the State's school health education plan and resulting programs;

(3) a description of the input of the local community (including students and parents) in the development and operation of comprehensive school health education programs;

(4) an assurance that communities identified in section 3583 receive priority as locations for comprehensive school health education programs for all grades to the extent that a State does not implement a statewide program; and

(5) an assurance that grants to local educational agencies under subsection (b)(1) are contingent upon submission by such agencies of a plan consistent with the requirements for the State plan as required under this subsection.

(d) WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS.—

(1) WAIVERS.—Except as provided in paragraph (4), upon the request of an entity and under a relevant program described in paragraph (2), the Secretary of Health and Human Services and the Secretary of Education may grant to the entity a waiver of any requirement of such program regarding the use of funds, or of the regulations issued for the program by the Secretary involved, if the following conditions are met with respect to such program:

(A) The Secretary involved determines that the requirements of such program impede the ability of the State educational agency to achieve more effectively the purposes described in section 3501.

(B) The Secretary involved determines that, with respect to the use of funds under such program, the requested use of the funds by the entity would be consistent with the purposes described in section 3501.

(C) The State educational agency provides all interested local educational agencies in the State with notice and an opportunity to comment on the proposal and makes these comments available to the Secretary.

(2) RELEVANT PROGRAMS.—For purposes of paragraph (1), the programs described in this subparagraph are the following:

(A) In the case of programs administered by the Secretary of Health and Human Services, the following:

(i) The program known as the Prevention, Treatment, and Rehabilitation Model Projects for High Risk Youth, carried out

under section 517 of the Public Health Service Act.

(ii) The program known as the State and Local Comprehensive School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes, carried out under such Act.

(B) In the case of programs administered by the Secretary of Education, any program carried out under part B of the Drug-Free Schools and Communities Act of 1986, except that a component of such comprehensive school health education must be consistent with the statutory intent and purposes of such Act.

(3) WAIVER PERIOD.—A waiver under this paragraph shall be for a period not to exceed 3 years, unless the Secretary involved determines that—

(A) the waiver has been effective in enabling the State to carry out the activities for which it was requested and has contributed to improved performance of comprehensive health education programs; and

(B) such extension is in the public interest;

(4) WAIVERS NOT AUTHORIZED.—The Secretary involved under paragraph (1), may not waive, under this section, any statutory or regulatory requirements relating to—

(A) comparability of services;

(B) maintenance of effort;

(C) parental participation and involvement;

(D) the distribution of funds to States or to local educational agencies or other recipients of funds under the programs described in paragraph (2);

(E) maintenance of records;

(F) applicable civil rights requirements; or

(G) the requirements of sections 438 and 439 of the General Education Provisions Act.

(5) TERMINATION OF WAIVER.—The Secretary involved under paragraph (1) shall terminate a waiver under this subsection if the Secretary determines that the performance of the State affected by the waiver has been inadequate to justify a continuation of the waiver or if it is no longer necessary to achieve its original purpose.

(e) DEFINITIONS.—As used in this section:

(1) COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The term ''comprehensive school health

education'' means a planned, sequential program of health education that addresses the physical, emotional and social dimensions of student health in kindergarten through grade 12. Such program shall—

(A) be designed to assist students in developing the knowledge and behavioral skills needed to make positive health choices and maintain and improve their health, prevent disease and injuries, and reduce risk behaviors which adversely impact health;

(B) be comprehensive and include a variety of components addressing personal health, community and environmental health, injury prevention and safety, nutritional health, the effects of substance use and abuse, consumer health regarding the benefits and appropriate use of medical services including immunizations and other clinical preventive services, and other components deemed appropriate by the local educational agencies;

(C) be designed to be linguistically and culturally competent and responsive to the needs of the students served; and

(D) address locally relevant priorities as determined by parents, students, teachers, and school administrators and health officials.

(2) ELIGIBLE STATE.—The term ''eligible State'' means a State with a memorandum of understanding or a written cooperative agreement entered into by the agencies responsible for health and education concerning the planning and implementation of comprehensive school health education programs. Among these States a priority shall be given to qualified States as defined in section 3582(c).

(3) STATE EDUCATIONAL AGENCY.—The term ''State educational agency'' means the officer or agency primarily responsible for the State supervision of public elementary and secondary schools.

(4) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' means a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or such combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or

secondary schools. Such term includes any other public institution or agency having administrative control and direction of a public elementary or secondary school.

(f) AUTHORIZED FUNDING.—For the purpose of carrying out this section, out of the funds available under section 3581, there are made available, not to exceed $15,000,000 for fiscal year 1996, $20,000,000 for fiscal year 1997, $25,000,000 for fiscal year 1998, $30,000,000 for fiscal year 1999, $40,000,000 for fiscal year 2000, and $50,000,000 for fiscal year 2001.

SEC. 3503. HEALTHY STUDENTS-HEALTHY SCHOOLS INTERAGENCY TASK FORCE.

(a) ESTABLISHMENT.—Not later than 120 days after the date of enactment of this Act, the Secretary shall establish a Healthy Students-Healthy Schools Interagency Task Force to be composed of representatives of the Office of Disease Prevention and Health Promotion, the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Office of School Health Education within the Department of Education, and other Federal agencies and departments which have responsibility for components of school health and education.

(b) CO-CHAIRPERSONS.—The Assistant Secretary for Health and the Assistant Secretary for Elementary and Secondary Education shall serve as co-chairpersons of the task force established under subsection (a).

(c) FUNCTIONS AND ACTIVITIES.—The task force established under subsection (a) shall—

(1) review and coordinate all Federal efforts in school health education and health services;

(2) provide scientific and technical advice concerning the development and implementation of model comprehensive school health education programs and curricula;

(3) develop model student learning objectives and assessment instruments that shall be made available to all States;

(4) develop a uniform grant application form (a form that serves as the principal document containing the core information concerning a particular entity) and procedures that may be used with respect to all school health education-related programs (including supplementary information procedures to be implemented when an entity that has already submitted an application form is applying for additional assistance) that require the submission of an application; and

(5) recommend to the Secretary, for inclusion in the biennial report required by section 3504(2), methods for effectively linking school health education and health services research findings at the Federal level with implementation at the State and local levels.

(d) CONSOLIDATION OF INITIATIVES.—Not later than 12 months after the date of enactment of this Act, the task force established under subsection (a) shall prepare and submit to the Congress a report containing the recommendations of the task force for the consolidation of Federal school health education initiatives.

SEC. 3504. DUTIES OF THE SECRETARY.

The Secretary shall—

(1) establish and maintain a national clearinghouse, using advanced technologies to the maximum extent practicable, and mechanisms for the diverse dissemination of school health education material, including written, audio-visual, and electronically conveyed information to educators, schools, health care providers, and other individuals, organizations, and governmental entities;

(2) submit a biennial report to the Committee on Labor and Human Resources of the Senate and the appropriate committees of the House of Rep-

resentatives on the implementation and contribution of comprehensive school health education programs funded under this part toward achieving relevant National Healthy People 2000 objectives established by the Secretary; and

(3) encourage coordination among Federal agencies, State and local governments, educators, school health providers, community-based organizations, and private sector entities to support development of comprehensive school health education programs and school health services.

PART 5—SCHOOL-RELATED HEALTH SERVICES

Subpart A—Development and Operation

SEC. 3581. AUTHORIZATION OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subpart, there are authorized to be appropriated $100,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997, $325,000,000 for fiscal year 1998, $450,000,000 for fiscal year 1999, $575,000,000 for fiscal year 2000, and $700,000,000 for fiscal year 2001.

(b) FUNDING FOR PLANNING AND DEVELOPMENT GRANTS.—Of amounts made available under this section, not to exceed $10,000,000 for each of fiscal years 1996 and 1997 may be utilized to carry out section 3584.

SEC. 3582. ELIGIBILITY FOR GRANTS.

(a) IN GENERAL.—

(1) PLANNING AND DEVELOPMENT GRANTS.—Entities eligible to apply for and receive grants under section 3584 are—

(A) State health agencies that apply on behalf of local community partnerships; or

(B) local community partnerships in States in which health agencies have not successfully applied.

(2) OPERATIONAL GRANTS.—Entities eligible to apply for and receive grants under section 3585 are—

(A) a qualified State as designated under subsection (c) that apply on behalf of local community partnerships; or

(B) local community partnerships in States that are not designated under subparagraph (A).

(b) LOCAL COMMUNITY PARTNERSHIPS.—

(1) IN GENERAL.—A local community partnership under subsection (a)(1)(B) and (a)(2)(B) is an entity that, at a minimum includes—

(A) a local health care provider, which may be a local public health department, with expe-

rience in delivering services to children and youth or medically underserved populations;

(B) local educational agency on behalf of one or more public schools; and

(C) one community-based organization located in the community to be served that has a history of providing services to at-risk children and youth.

(2) RURAL COMMUNITIES.—In rural communities, local partnerships should seek to include, to the fullest extent practicable, providers and community-based organizations with experience in serving the target population.

(3) PARENT AND COMMUNITY PARTICIPATION.—An applicant described in subsection (a) shall, to the maximum extent feasible, involve broad-based community participation (including parents of the youth to be served).

(c) QUALIFIED STATE.—A qualified State under subsection (a)(2)(A) is a State that, at a minimum—

(1) demonstrates an organizational commitment (including a strategic plan) to providing a broad range of health, health education and support services to at-risk youth; and

(2) has a memorandum of understanding or cooperative agreement jointly entered into by the State agencies responsible for health and education regarding the planned delivery of health and support services in school-based or school-linked centers.

SEC. 3583. PREFERENCES.

In making grants under sections 3584 and 3585, the Secretary shall give priority to applicants whose communities to be served show the most substantial level of need for health services among children and youth.

SEC. 3584. PLANNING AND DEVELOPMENT GRANTS.

(a) IN GENERAL.—The Secretary may make grants during fiscal years 1996 and 1997 to entities eligible under section 3862 to develop school-based or school-linked health service sites.

(b) USE OF FUNDS.—Amounts provided under a grant under this section may be used for the following:

(1) Planning for the provision of school health services, including—

(A) an assessment of the need for health services among youth in the communities to be served;

(B) the health services to be provided and how new services will be integrated with existing services;

(C) assessing and planning for the modernization and expansion of existing facilities and equipment to accommodate such services; and

(D) an affiliation with relevant health plans.

(2) recruitment and training of staff for the administration and delivery of school health services;

(3) the establishment of local community partnerships as described in section 3582 (b);

(4) in the case of States, the development of memorandums of understanding or cooperative agreements for the coordinated delivery of health and support services through school health service sites; and

(5) other activities necessary to assume operational status.

(c) APPLICATION FOR GRANTS.—To be eligible to receive a grant under this section an entity described in section 3582(a) shall submit an application in a form and manner prescribed by the Secretary.

(d) NUMBER OF GRANTS.—Not more than one planning grant may be made to a single applicant. A planning grant may not exceed 2 years in duration.

(e) AMOUNT AVAILABLE FOR DEVELOPMENT GRANT.—The Secretary may award not to exceed—

(1) $150,000 to entities under section 3582(a)(1)(A) and to localities planning for a city-wide or countywide school health services delivery system; and

(2) $50,000 to entities under section 3582(a)(1)(B).

SEC. 3585. GRANTS FOR OPERATION OF SCHOOL HEALTH SERVICES.

(a) IN GENERAL.—The Secretary may make grants to eligible entities described in section 3582(a)(2) that submit applications consistent with the requirements of this section, to pay the cost of operating school-based or school-linked health service sites.

(b) USE OF GRANT.—Amounts provided under a grant under this section may be used for the following—

(1) health services, including diagnosis and treatment of simple illnesses and minor injuries;

(2) preventive health services, including health screenings, follow-up health care, mental health, and preventive health education;

(3) enabling services, as defined in section 3361, and other necessary support services;

(4) training, recruitment, and compensation of health professionals and other staff necessary for the administration and delivery of school health services; and

(5) referral services, including the linkage of individuals to health plans, and community-based health and social service providers.

(c) APPLICATION FOR GRANT.—To be eligible to receive a grant under this section an entity described in section 3582(a)(2) shall submit an application in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant must include in the application the following information—

(1) a description of the services to be furnished by the applicant;

(2) the amounts and sources of funding that the applicant will expend, including estimates of the amount of payments the applicant will receive from health plans and other sources;

(3) a description of local community partnerships, including parent and community participation;

(4) a description of the linkages with other health and social service providers; and

(5) such other information as the Secretary determines to be appropriate.

(d) ASSURANCES.—In order to receive a grant under this section, an applicant must meet the following conditions—

(1) school health service sites will, directly or indirectly, provide a broad range of health services, in accordance with the determinations of the local community partnership, that may include—

(A) diagnosis and treatment of simple illnesses and minor injuries;

(B) preventive health services, including health screenings and follow-up health care, mental health and preventive health education;

(C) enabling services, as defined in section 3361;

(D) referrals (including referrals regarding mental health and substance abuse) with follow-up to ensure that needed services are received;

(2) the applicant provides services recommended by the health provider, in consultation with the local community partnership, and with the approval of the local education agency;

(3) the applicant provides the services under this subsection to adolescents, and other school age children and their families as deemed appropriate by the local partnership;

(4) the applicant maintains agreements with community-based health care providers with a history of providing services to such populations for the provision of health care services not otherwise provided directly or during the hours when school health services are unavailable;

(5) the applicant establishes an affiliation with relevant health plans and will establish reimbursement procedures and will make every reasonable effort to collect appropriate reimbursement for services provided; and

(6) the applicant agrees to supplement and not supplant the level of State or local funds under the direct control of the applying State or participating local education or health authority expended for school health services as defined by this Act;

(7) services funded under this Act will be coordinated with existing school health services provided at a participating school; and

(8) for applicants in rural areas, the assurances required under paragraph (4) shall be fulfilled to the maximum extent possible.

(e) STATE LAWS.—Notwithstanding any other provision in this part, no school based health clinic may provide services, to any minor, when to do so is a violation of State

laws or regulations pertaining to informed consent for medical services to minors.

(f) LIMITATION ON ADMINISTRATIVE FUNDS.—In the case of a State applying on behalf of local educational partnerships, the applicant may retain not more than 5 percent of grants awarded under this subpart for administrative costs.

(g) DURATION OF GRANT.—A grant under this section shall be for a period determined appropriate by the Secretary.

(h) AMOUNT OF GRANT.—The annual amount of a grant awarded under this section shall not be more than $200,000 per school-based or school-linked health service site.

(i) FEDERAL SHARE.—

(1) IN GENERAL.—Subject to paragraph (3), a grant for services awarded under this section may not exceed—

(A) 90 percent of the non-reimbursed cost of the activities to be funded under the program for the first 2 fiscal years for which the program receives assistance under this section; and

(B) 75 percent of the non-reimbursed cost of such activities for subsequent years for which

the program receives assistance under this section.

The remainder of such costs shall be made available as provided in paragraph (2).

(2) FORM OF NON-FEDERAL SHARE.—The non-Federal share required by paragraph (1) may be in cash or in-kind, fairly evaluated, including facilities, equipment, personnel, or services, but may not include amounts provided by the Federal Government. In-kind contributions may include space within a school facilities, school personnel, program use of school transportation systems, outposted health personnel, and extension of health provider medical liability insurance.

(3) WAIVER.—The Secretary may waive the requirements of paragraph (1) for any year in accordance with criteria established by regulation. Such criteria shall include a documented need for the services provided under this section and an inability of the grantee to meet the requirements of paragraph (1) despite a good faith effort.

(j) TRAINING AND TECHNICAL ASSISTANCE.—Entities that receive assistance under this section may use not to exceed 10 percent of the amount of such assistance to provide staff training and to secure necessary technical as-

sistance. To the maximum extent feasible, technical assistance should be sought through local community-based entities. The limitation contained in this subsection shall apply to individuals employed to assist in obtaining funds under this part. Staff training should include the training of teachers and other school personnel necessary to ensure appropriate referral and utilization of services, and appropriate linkages between class-room activities and services offered.

(k) REPORT AND MONITORING.—The Secretary will submit to the Committee on Labor and Human Resources in the Senate and the Committee on Energy and Commerce in the House of Representatives a biennial report on the activities funded under this Act, consistent with the ongoing monitoring activities of the Department. Such reports are intended to advise the relevant Committees of the availability and utilization of services, and other relevant information about program activities.

Subtitle F—Public Health Service Initiative

SEC. 3601. PUBLIC HEALTH SERVICE INITIATIVE.

(a) IN GENERAL.—Subject to subsection (c), the Secretary of Health and Human Services shall pay, from funds in the Treasury not otherwise appropriated, individuals and entities that are eligible to receive assistance pur-

suant to the provisions referred to in paragraphs (1) through (8) of subsection (b), to the extent of the amounts specified under subsection (b).

(b) AMOUNTS SPECIFIED.—The amounts specified in subsection (a) with respect to a fiscal year shall be—

(1) with respect to the health services research activities authorized under the amendments made by section 3102, $150,000,000 for fiscal year 1996, $400,000,000 for fiscal year 1997, $500,000,000 for fiscal year 1998, and $600,000,000 for each of the fiscal years 1999 through 2001;

(2) with respect to activities for the development of plans and networks under subpart B of part 1 of subtitle C of title III—

(A) $52,500,000 for fiscal year 1996, $122,500,000 for fiscal year 1997, $192,500,000 for fiscal year 1998, $157,500,000 for fiscal year 1999, $122,500,000 for fiscal year 2000, and $52,500,000 for fiscal year 2001; and

(B) with respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) under such subpart, $97,500,000 for fiscal year 1996, $227,500,000 for fiscal year 1997,

$357,500,000 for fiscal year 1998, $292,500,000 for fiscal year 1999, $227,500,000 for fiscal year 2000, and $97,500,000 for fiscal year 2001;

(3) with respect to capital costs under subpart C of part 1 of subtitle C of title III, $50,000,000 for each of the fiscal years 1996 through 2001;

(4) with respect to enabling services under subpart D of part 1 of subtitle C of title III—

(A) $35,000,000 for fiscal year 1997, $140,000,000 for each of the fiscal years 1998 through 2000, and $175,000,000 for fiscal year 2001; and

(B) with respect to awards to federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) under such subpart, $65,000,000 for fiscal year 1997, $260,000,000 for each of the fiscal years 1998 through 2000, and $325,000,000 for fiscal year 2001;

(5) with respect to supplemental services under subpart D of part 1 of subtitle C of title III, $100,000,000 for fiscal year 1996, $150,000,000 for fiscal year 1997, and $250,000,000 for each of the fiscal years 1998 through 2001;

(6) with respect to the National Health Service Corps program referred to under section 3371, $150,000,000 for each of the fiscal years 1997 and 1998, and $250,000,000 for each of the fiscal years 1999 through 2001;

(7) with respect to the development and operation of comprehensive managed mental health and substance abuse programs under section 3434, $100,000,000 for each of the fiscal years 1996 through 2001; and

(8) with respect to school-related health service programs under subpart A of part 5 of subtitle E of title III, $100,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997, $325,000,000 for fiscal year 1998, and $450,000,000 for fiscal year 1999, $575,000,000 for fiscal year 2000, and $700,000,000 for fiscal year 2001.

(c) AUTHORITY TO TRANSFER FUNDS.—The Committee on Appropriations of the House of Representatives and the Committee on Appropriations of the Senate, acting through appropriations Acts, may transfer the amounts specified under subsection (b) in each fiscal year among the programs referred to in such subsection.

TITLE IV—MEDICAL MALPRACTICE

Subtitle A—Liability Reform

SEC. 4001. FEDERAL TORT REFORM.

(a) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in section 4002, this subtitle shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this subtitle shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(2) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this subtitle shall be construed to—

(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(B) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(3) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

(b) DEFINITIONS.—In this subtitle, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice claim,

and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(5) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice claim.

(6) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a cause of action brought in a State or Federal court against a health care provider or

health care professional by which the plaintiff alleges a medical malpractice claim.

(7) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means a claim brought against a health care provider or health care professional in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any claim based on an allegation of an intentional tort; or

(B) any claim based on an allegation that a product is defective that is brought against any individual or entity that is not a health care professional or health care provider.

SEC. 4002. STATE-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) APPLICATION TO MALPRACTICE CLAIMS UNDER PLANS.—Prior to or immediately following the commencement of any medical malpractice action, the parties shall participate in the alternative dispute resolution system administered by the State under subsection (b). Such participation shall be in lieu of any other provision of Federal or State law or any contractual agreement made by or on

behalf of the parties prior to the commencement of the medical malpractice action.

(b) ADOPTION OF MECHANISM BY STATE.—Each State shall—

(1) maintain or adopt at least one of the alternative dispute resolution methods satisfying the requirements specified under subsection (c) and (d) for the resolution of medical malpractice claims arising from the provision of (or failure to provide) health care services to individuals enrolled in a health plan; and

(2) clearly disclose to enrollees (and potential enrollees) the availability and procedures for consumer grievances, including a description of the alternative dispute resolution method or methods adopted under this subsection.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The Board shall, by regulation, develop alternative dispute resolution methods for the use by States in resolving medical malpractice claims under subsection (a). Such methods shall include at least the following:

(A) ARBITRATION.—The use of arbitration, a nonjury adversarial dispute resolution

process which may, subject to subsection (d), result in a final decision as to facts, law, liability or damages.

(B) CLAIMANT-REQUESTED BINDING ARBITRATION.—For claims involving a sum of money that falls below a threshold amount set by the Board, the use of arbitration not subject to subsection (d). Such binding arbitration shall be at the sole discretion of the claimant.

(C) MEDIATION.—The use of mediation, a settlement process coordinated by a neutral third party without the ultimate rendering of a formal opinion as to factual or legal findings.

(D) EARLY NEUTRAL EVALUATION.—The use of early neutral evaluation, in which the parties make a presentation to a neutral attorney or other neutral evaluator for an assessment of the merits, to encourage settlement. If the parties do not settle as a result of assessment and proceed to trial, the neutral evaluator's opinion shall be kept confidential.

(E) CERTIFICATE OF MERIT.—The requirement that a medical malpractice plaintiff submit to the court before trial a written report by a qualified specialist that includes the spe-

cialist's determination that, after a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under paragraph (1), the Board shall assure that the methods promote the resolution of medical malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) provides for timely resolution of claims;

(C) provides for the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution for individuals enrolled in plans.

(3) WAIVER AUTHORITY.—Upon application of a State, the Board may grant the State the authority to fulfill the requirement of subsection (b) by adopting a mechanism other than a mechanism established by the Board pursuant to this subsection, except that such mechanism must meet the standards set forth in paragraph (2).

(d) FURTHER REDRESS.—Except with respect to the claimant-requested binding arbitration method set forth in subsection (c)(1)(B), and notwithstanding any other provision of a law or contractual agreement, a plan enrollee dissatisfied with the determination reached as a result of an alternative dispute resolution method applied under this section may, after the final resolution of the enrollee's claim under the method, bring a cause of action to seek damages or other redress with respect to the claim to the extent otherwise permitted under State law. The results of any alternative dispute resolution procedure are inadmissible at any subsequent trial, as are all statements, offers, and other communications made during such procedures, unless otherwise admissible under State law.

SEC. 4003. LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

(a) IN GENERAL.—An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with such action (including the resolution of the claim that is the subject of the action under any alternative dispute resolution system) in excess of—

(1) 33⅓ percent of the first $150,000 of the total amount recovered by judgment or settlement in such action; plus

(2) 25 percent of any amount recovered above the amount described in paragraph (1);

unless otherwise determined under State law. Such amount shall be computed after deductions are made for all the expenses associated with the claim other than those attributable to the normal operating expenses of the attorney.

(b) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) may, in the discretion of the court, be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 4004. REDUCTION OF AWARDS FOR RECOVERY FROM COLLATERAL SOURCES.

(a) REDUCTION OF AWARD.—The total amount of damages recovered by a plaintiff in a medical malpractice liability action shall be reduced by an amount that equals—

(1) the amount of any payment which the plaintiff has received or to which the plaintiff is presently entitled on account of the same injury for which the damages are awarded, including payment under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) private disability insurance programs;

(D) employer wage continuation programs; and

(E) any other program, if the payment is intended to compensate the plaintiff for the same injury for which damages are awarded; less

(2) the amount of any premiums or any other payments that the plaintiff has paid to be eligible to receive the payment described in paragraph (1) and any portion of the award subject to a subrogation lien or claim.

(b) SUBROGATION.—The court may reduce a subrogation lien or claim described in subsection (a)(2) by an amount representing reasonable costs incurred in securing the award subject to the lien or claim.

(c) INAPPLICABILITY OF SECTION.—This section shall not apply to any case in which the court determines that the reduction of damages pursuant to subsection (a) would compound the effect of any State law limitation on damages so as to render the plaintiff less than fully compensated for his or her injuries.

SEC. 4005. PERIODIC PAYMENT OF AWARDS.

(a) IN GENERAL.—A party to a medical malpractice liability action may petition the court to instruct the trier of fact to award any future damages on an appropriate periodic basis. If the court, in its discretion, so instructs the trier of fact, and damages are awarded on a periodic basis, the court may require the defendant to purchase an annuity or other security instrument (typically based on future damages discounted to present value) adequate to assure payments of future damages.

(b) FAILURE OR INABILITY TO PAY.—With respect to an award of damages described in subsection (a), if a defendant fails to make payments in a timely fashion, or if the defendant becomes or is at risk of becoming insolvent, upon such a showing the claimant may petition the

court for an order requiring that remaining balance be discounted to present value and paid to the claimant in a lump-sum.

(c) MODIFICATION OF PAYMENT SCHEDULE.—The court shall retain authority to modify the payment schedule based on changed circumstances.

(d) FUTURE DAMAGES DEFINED.—As used in this section, the term ''future damages'' means any economic or noneconomic loss other than that incurred or accrued as of the time of judgment.

SEC. 4006. CONSTRUCTION.

Nothing in this subtitle shall be construed to preempt any State law that sets a maximum limit on total damages.

Subtitle B—Other Provisions Relating to Medical Malpractice Liability

SEC. 4101. STATE MALPRACTICE REFORM DEMONSTRATION PROJECTS.

(a) ESTABLISHMENT.—The Secretary shall award grants to States for the establishment of malpractice reform demonstration projects in accordance with this section. Each such project shall be designed to assess the fairness and effectiveness of one or more of the following models:

(1) No-fault liability.

(2) Enterprise liability.

(3) Practice guidelines.

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

(1) MEDICAL ADVERSE EVENT.—The term ''medical adverse event'' means an injury that is the result of medical management as opposed to a disease process that creates disability lasting at least one month after discharge, or that prolongs a hospitalization for more than one month, and for which compensation is available under a no-fault medical liability system established under this section.

(2) NO-FAULT MEDICAL LIABILITY SYSTEM.—The terms ''no-fault medical liability system'' and ''system'' mean a system established by a State receiving a grant under this section which replaces the common law tort liability system for medical injuries with respect to certain qualified health care organizations and qualified insurers and which meets the requirements of this section.

(3) PROVIDER.—The term ''provider'' means physician, physician assistant, or other individual furnishing health care services in affiliation with a qualified health care organization.

(4) QUALIFIED HEALTH CARE ORGANIZATION.—The term ''qualified health care organization'' means a hospital, a hospital system, a managed care network, or other entity determined appropriate by the Secretary which elects in a State receiving a grant under this section to participate in a no-fault medical liability system and which meets the requirements of this section.

(5) QUALIFIED INSURER.—The term ''qualified insurer'' means a health care malpractice insurer, including a self-insured qualified health care organization, which elects in a State receiving a grant under this section to participate in a no-fault medical liability system and which meets the requirements of this section.

(6) ENTERPRISE LIABILITY.—The term ''enterprise liability'' means a system in which State law imposes malpractice liability on the health plan in which a physician participates in place of personal liability on the physician in order to achieve improved quality of care, reductions in defensive medical practices, and better risk management.

(7) PRACTICE GUIDELINES.—The term ''practice guidelines'' means guidelines established by the

Agency for Health Care Policy and Research pursuant to the Public Health Service Act or this Act.

(c) APPLICATIONS BY STATES.—

(1) IN GENERAL.—Each State desiring to establish a malpractice reform demonstration project shall submit an application to the Secretary at such time and in such manner as the Secretary shall require.

(2) CONTENTS OF APPLICATION.—An application under paragraph (1) shall include—

(A) an identification of the State agency or agencies that will administer the demonstration project and be the grant recipient of funds for the State;

(B) a description of the manner in which funds granted to a State will be expended and a description of fiscal control, accounting, and audit procedures to ensure the proper dispersal of and accounting for funds received under this section; and

(C) such other information as the Secretary determines appropriate.

(3) CONSIDERATION OF APPLICATIONS.—In reviewing all applications received from States desiring

to establish malpractice demonstration projects under paragraph (1), the Secretary shall consider—

(A) data regarding medical malpractice and malpractice litigation patterns in each State;

(B) the contributions that any demonstration project will make toward reducing malpractice and costs associated with health care injuries;

(C) diversity among the populations serviced by the systems;

(D) geographic distribution; and

(E) such other criteria as the Secretary determines appropriate.

(d) EVALUATION AND REPORTS.—

(1) BY THE STATES.—Each State receiving a grant under this section shall conduct on-going evaluations of the effectiveness of any demonstration project established in such State and shall submit an annual report to the Secretary concerning the results of such evaluations at such times and in such manner as the Secretary shall require.

(2) BY THE SECRETARY.—The Secretary shall submit an annual report to Congress concerning the fairness and effectiveness of the demonstration

projects conducted under this section. Such report shall analyze the reports received by the Secretary under paragraph (1).

(e) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) LIMITATIONS ON EXPENDITURES.—

(A) ADMINISTRATIVE EXPENSES.—Not more than 10 percent of the amount of each grant awarded to a State under this section may be used for administrative expenses.

(B) WAIVER OF COST LIMITATIONS.—The limitation under subparagraph (A) may be waived as determined appropriate by the Secretary.

(f) ELIGIBILITY FOR NO-FAULT DEMONSTRATION.—A State is eligible to receive a no-fault liability demonstration grant if the application of the State under subsection (c) includes—

(1) an identification of each qualified health care organization selected by the State to participate in the system, including—

(A) the location of each organization;

(B) the number of patients generally served by each organization;

(C) the types of patients generally served by each organization;

(D) an analysis of any characteristics of each organization which makes such organization appropriate for participation in the system;

(E) whether the organization is self-insured for malpractice liability; and

(F) such other information as the Secretary determines appropriate;

(2) an identification of each qualified insurer selected by the State to participate in the system, including—

(A) a schedule of the malpractice insurance premiums generally charged by each insurer under the common law tort liability system; and

(B) such other information as the Secretary determines appropriate;

(3) a description of the procedure under which qualified health care organizations and insurers elect to participate in the system;

(4) a description of the system established by the State to assure compliance with the require-

ments of this section by each qualified health care organization and insurer; and

(5) a description of procedures for the preparation and submission to the State of an annual report by each qualified health care organization and qualified insurer participating in a system that shall include—

(A) a description of activities conducted under the system during the year; and

(B) the extent to which the system exceeded or failed to meet relevant performance standards including compensation for and deterrence of medical adverse events.

(g) ELIGIBILITY FOR ENTERPRISE LIABILITY DEMONSTRATION.—A State is eligible to receive an enterprise liability demonstration grant if the State—

(1) has entered into an agreement with a health plan (other than a fee-for-service plan) operating in the State under which the plan assumes legal liability with respect to any medical malpractice claim arising from the provision of (or failure to provide) services under the plan by any physician participating in the plan; and

(2) has provided that, under the law of the State, a physician participating in a plan that has

entered into an agreement with the State under paragraph (1) may not be liable in damages or otherwise for such a claim and the plan may not require such physician to indemnify the plan for any such liability.

(h) ELIGIBILITY FOR PRACTICE GUIDELINES DEMONSTRATION.—A State is eligible to receive a practice guidelines demonstration grant if the law of the State provides that in the resolution of any medical malpractice action, compliance or non-compliance with an appropriate practice guideline shall be admissible at trial as a rebuttable presumption regarding medical negligence.

TITLE V—FALL-BACK PREMIUM LIMITS IN CASES OF INEFFECTIVE COMPETITION; PREMIUM-BASED FINANCING; ASSISTANCE TO LOW INCOME INDIVIDUALS AND TO BUSINESSES

SEC. 5000. GENERAL DEFINITIONS.

(a) DEFINITIONS RELATING TO PREMIUM RATES.—In this title:

(1) FILED COMMUNITY BID.—The term ''filed community bid'' means the premium bid that is filed with a State for a class of enrollment for a commu-

nity-rated plan offered in a community rating area pursuant to section 1413(b).

(2) ACCEPTED COOPERATIVE BID.—The term ''accepted cooperative bid'' means the premium rate agreed upon by a cooperative and a plan taking into account any discount to such bid.

(3) FINAL COMMUNITY RATE.—The term ''final community rate'' means the filed community bid, taking into account any voluntary reduction in such bid made under section 5004(e).

(4) FINAL COOPERATIVE RATE.—The term ''final cooperative bid'' means the accepted cooperative bid, taking into account any voluntary reductions in such bid made under section 5004(e).

(b) DEFINITIONS RELATED TO WEIGHTED AVERAGE PREMIUM RATES.—In this title:

(1) WEIGHTED AVERAGE ACCEPTED BID.—The term ''weighted average accepted bid'' means, for a class of enrollment for a community rating area for a year, the average across all plans of—

(A) the filed community bid for such class for each community-rated health plan offered in a community rating area weighted to reflect the relative enrollment (net of any enrollment

through a cooperative) of community rate eligible individuals among such plans; and

(B) the accepted cooperative bid for such class for each community-rated health plan offered in a community rating area weighted to reflect the relative enrollment of community rate eligible individuals through a cooperative among such plans.

(2) WEIGHTED AVERAGE PREMIUM.—The term ''weighted average premium'' means, for a class of enrollment for a community rating area for a year, the lesser of—

(A) the baseline premium for such class for the community rating area (as defined in section 5003) for the year; or

(B) the average across all plans of the lesser of—

(i) the final community rate; or

(ii) the final cooperative rate, for such class (applicable only for plans offered through the cooperative);

for each community-rated health plan, weighted to reflect the total enrollment of community rate eligible individuals in such class among such plans.

(d) INCORPORATION OF OTHER DEFINITIONS.—Except as otherwise provided in this title, the definitions of terms in subtitle H of title I of this Act shall apply to this title.

Subtitle A—Fall-Back Premium Limits

PART 1—HEALTH EXPENDITURES OF COMMUNITY RATING AREAS

Subpart A—Computation of Targets and Accepted Bids

SEC. 5001. COMPUTATION OF AREA INFLATION FACTORS.

(a) COMPUTATION.—

(1) IN GENERAL.—The Secretary shall compute and publish, not later than March 1 of each year (beginning with 1996) the area inflation factor (as defined in paragraph (2)) for each community rating area for the following year.

(2) COMMUNITY RATING AREAS INFLATION FACTOR.—The term ''area inflation factor'' means, for a year for a community rating area—

(A) the general health care inflation factor for the year (as defined in paragraph (3));

(B) adjusted under subsection (c) (to take into account material changes in the demographic and socio-economic characteristics of

the population of community rate eligible individuals); and

(C) decreased by the percentage adjustment (if any) provided with respect to the community rating area under subsection (d) (relating to adjustment for previous excess expenditures).

(3) GENERAL HEALTH CARE INFLATION FACTOR.—

(A) 1997 THROUGH 2001.—In this part, the term ''general health care inflation factor'', for a year, means the percentage increase in the CPI (as specified under subsection (b)) for the year plus the following:

(i) For 1997, 1.5 percentage points.

(ii) For 1998, 1.0 percentage points.

(iii) For 1999, 0.5 percentage points.

(iv) For 2000 and for 2001, 0 percentage points.

(B) YEARS AFTER 2001.—

(i) RECOMMENDATION TO CONGRESS.—In 2000, the Secretary shall submit to Congress recommendations, after consultation with the Federal Reserve Board, on what the general health care in-

flation factor should be for years beginning with 2002.

(ii) FAILURE OF CONGRESS TO ACT.—If the Congress fails to enact a law specifying the general health care inflation factor for a year after 2001, the Secretary, in January of the year before the year involved, shall compute such factor for the year involved. Such factor shall be the product of the factors described in subparagraph (C) for that fiscal year, minus 1.

(C) FACTORS.—The factors described in this subparagraph for a year are the following:

(i) CPI.—1 plus the percentage change in the CPI for the year, determined based upon the percentage change in the average of the CPI for the 12-month period ending with August 31 of the previous fiscal year over such average for the preceding 12-month period.

(ii) REAL GDP PER CAPITA.—1 plus the average annual percentage change in the real, per capita gross domestic product of the United States during the 3-year pe-

riod ending in the preceding calendar year, determined by the Secretary based on data supplied by the Department of Commerce.

(b) PROJECTION OF INCREASE IN CPI.—

(1) IN GENERAL.—For purposes of this section, the Secretary shall specify, as of the time of publication, the annual percentage increase in the CPI (as defined in section 1701(d)) for the following year.

(2) DATA TO BE USED.—Such increase shall be the projection of the CPI contained in the budget of the United States transmitted by the President to the Congress in the year.

(c) SPECIAL ADJUSTMENT FOR MATERIAL CHANGES IN DEMOGRAPHIC CHARACTERISTICS OF POPULATION.—

(1) IN GENERAL.—The Secretary shall develop a method for adjusting the area inflation factor for each community rating area in order to reflect material changes in the demographic characteristics of community rate eligible individuals residing in the coverage area in comparison to national trend for factors that affect utilization of health care services.

(2) NEUTRAL ADJUSTMENT.—Such method (and any annual adjustment under this paragraph) shall be designed to result in the adjustment effected

under this paragraph for a year not changing the weighted average of the area inflation factors.

(d) CONSULTATION PROCESS.—The Secretary shall have a process for consulting with representatives of States before establishing the area inflation factors for each year under this section.

SEC. 5002. ESTABLISHMENT OF BASELINE PREMIUMS.

(a) IN GENERAL.—Not later than January 1, 1996, the Secretary shall determine baseline premium amounts applicable under this title. Such premiums shall be—

(1) the premium amount as of January 1, 1995 for employee-only coverage under Blue Cross/Blue Shield standard option plan available through the Federal Employees Health Benefits Program (in the case of the individual class of enrollment); and

(2) such amounts as determined appropriate by the Secretary after making the necessary adjustments to the amount described in (1) to reflect the relative difference in actuarial value among the different classes of family enrollment (in the case of the classes described in section 1413(b)(2)(B);

updated in accordance with sections (b), (c), and (d).

(b) ADJUSTMENT FOR ELIGIBLE POPULATION.—The premium amounts described in paragraphs (1) and (2) of subsection (a) shall be adjusted to reflect the difference

in expected health care spending of the population enrolled in the plan described in paragraph (1) of subsection (a) and of the population of community rate eligible individuals (exclusive of individuals receiving AFDC or SSI).

(c) REMOVAL OF UNCOMPENSATED CARE.—The premium amounts described in paragraphs (1) and (2) of subsection (a) shall be reduced to remove assumed uncompensated and undercompensated care that will be eliminated by this Act.

(d) UPDATING.—

(1) IN GENERAL.—Subject to paragraph (3), the Secretary shall update the amount determined under subsection (b)(1) for each of 1995 and 1996 by the update factor described in paragraph (2) for the year.

(2) UPDATE FACTOR.—In paragraph (1), the update factor for a year is 1 plus the annual percentage increase for the year for the premium charged for individual enrollment in Blue Cross/Blue Shield standard option plan offered through the Federal Employees Health Benefits Program.

(3) LIMIT.—The total cumulative update under this subsection shall not exceed 15 percent.

SEC. 5003. DETERMINATION OF AREA BASELINE PREMIUMS.

(a) INITIAL DETERMINATION.—Not later than January 1, 1996, the Secretary shall determine, for each community rating area for 1997, area baseline premiums. For each class of enrollment, the baseline premium shall equal—

(1) the national baseline premium for such class (determined by the Secretary under section 5002),

(2) updated by the area inflation factor (as determined under section 5001) for 1997, and

(3) adjusted by the adjustment factor for the community rating area (determined under subsection (c)).

(b) SUBSEQUENT DETERMINATIONS.—

(1) DETERMINATION.—Not later than March 1 of each year (beginning with 1997) the Secretary shall determine, for each community rating area for the succeeding year area baseline premiums.

(2) GENERAL RULE.—Subject to subsection (e), such baseline premium shall equal—

(A) the area baseline premium determined under this section (without regard to subsection (e)) for the community rating area for the previous year,

(B) updated by the area inflation factor (as determined in section 5001) for the year.

(3) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF INCREASE IN EXPENDITURES.—Such target for a year is subject to a decrease under section 5003(e).

(c) ADJUSTMENT FACTORS FOR COMMUNITY RATING AREAS FOR INITIAL DETERMINATION.—

(1) IN GENERAL.—The Secretary shall establish an adjustment factor for each community rating area.

(2) CONSIDERATIONS.—In establishing such factor, the Secretary shall consider, the difference between the national average and the community rating area in such measures as health care expenditures, rates of uninsurance and underinsurance, and in the proportion of expenditures for services provided by academic health centers. The Secretary shall also take into consideration—

(A) information on variations in the extent to which States and community rating areas need additional investment because they have successfully controlled health care costs; and

(B) information on variations among States and community rating areas due to underutilization of health care services resulting

from geographic barriers and lack of access to health care services, particularly in underserved rural and urban areas.

(3) APPLICATION OF FACTORS IN NEUTRAL MANNER.—The application of the adjustment factors under this subsection for 1997 shall be done in a manner so that the weighted average of the area baseline premiums for a class of enrollment for 1997 is equal to the national baseline premium for such class determined under section 5002. Such weighted average shall be based on the Secretary's estimate of the expected distribution of community rate eligible individuals (taken into account under section 5002) among the community rating areas.

(4) CONSULTATION PROCESS.—The Secretary shall have a process for consulting with representatives of States and purchasing cooperatives before establishing the adjustment for community rating areas under this subsection.

(d) TREATMENT OF CERTAIN STATES.—In the case of a State that is not a participating State or otherwise has not established community rating areas, the entire State shall be treated under the provisions of this part as composing a single community rating area.

(e) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF INCREASE IN EXPENDITURES.—If the actual weighted average premium for a community rating area for a class of enrollment for a year (as determined by the Secretary based on actual enrollment in the first month of the year) exceeds the area baseline premiums (determined under this section) for the year, then the area baseline premium shall be reduced, by ½ of the excess for the year, for each of the 2 succeeding years.

SEC. 5004. INITIAL RATE FILING AND BID NEGOTIATION PROCESS.

(a) FILING AND BIDDING PROCESS.—

(1) FILING COMMUNITY BIDS.—

(A) IN GENERAL.—Each participating State shall establish rules and procedures for a plan seeking to participate as a community-rated health plan to file a premium rate with the State and submit a premium bid to cooperatives for coverage of the benefits as required under section 1101.

(B) CONDITION.—Each community bid filed and cooperative bid submitted under this subsection with respect to a community-rated health plan shall be conditioned upon the plan's

agreement to accept any payment reduction that may be imposed under section 5011.

(2) NEGOTIATION PROCESS.—Following the bidding process under paragraph (1), a State or a cooperative may conduct negotiations with health plans relating to the premiums to be charged for such community-rated health plans within a State or cooperative. Such negotiations may result in the resubmission of bids to the State or cooperative, but in no case shall a health plan resubmit a bid that exceeds its prior bid.

(3) LEGALLY BINDING BIDS.—All rates filed and bids submitted under this subsection must be legally binding with respect to the plans involved.

(4) ACCEPTANCE.—

(A) COMMUNITY BID.—The final community rate for a community-rated health plan under this subsection shall be considered to be the accepted bid for such plan, except as provided in subsection (e).

(B) COOPERATIVE BID.—The final cooperative bid submitted to a cooperative for a community-rated health plan under this subsection shall be considered to be the accepted bid for such plan, except as provided in subsection (e).

(5) ASSISTANCE.—The Secretary shall provide States and cooperatives with such information and technical assistance as may assist such States and cooperatives in carrying out the provisions of this subsection.

(b) SUBMISSION OF INFORMATION TO THE SECRETARY.—By not later than September 1 of each year for which community bids are filed under subsection (a), each State shall submit to the Secretary such information as the Secretary determines necessary to conduct the process described in subsection (c).

(c) COMPUTATION OF WEIGHTED AVERAGE ACCEPTED BID.—

(1) IN GENERAL.—For each community rating area the Secretary shall determine a weighted average accepted bid for each class of enrollment for each year for which rates are filed with the State under subsection (a). Such determination shall be based on information, submitted under subsection (b).

(2) EXCLUSION OF WORKSITE HEALTH PROMOTION DISCOUNTS.—For purposes of calculating the weighted average accepted bid and enforcing baseline premiums in a community rating area in a State, the Secretary shall consider the accepted bids

for the year, without consideration or inclusion of any worksite health promotion discount.

(d) NOTICE TO CERTAIN STATES.—

(1) IN GENERAL.—By not later than October 1 of each year for which rates are filed with a State, the Secretary shall notify a State if the weighted average accepted bid for a class of enrollment (determined under subsection (c)) for the community rating area is greater than the area baseline premium for such class for such area (determined under section 5003) for the year.

(2) NOTICE OF PREMIUM REDUCTIONS.—If notice is provided to a State under paragraph (1), the Secretary shall notify the State and each noncomplying plan of any plan payment reduction computed under section 5011 for such a plan and the opportunity to voluntarily reduce the accepted bid under subsection (e) in order to avoid such a reduction.

(e) VOLUNTARY REDUCTION OF ACCEPTED BIDS.—After the Secretary has determined under subsection (c) the weighted average accepted bid for a class of enrollment for a community rating area and the Secretary has determined plan payment reductions, before such date as the Secretary may specify (in order to provide for an open enrollment period), a noncomplying plan has the opportunity

to voluntarily reduce its filed community bid (and if applicable, its accepted cooperative bid) for such class by the amount of the plan payment reduction that would otherwise apply to the plan. Such reduction shall not affect the amount of the plan payment reduction for any other plan for that year.

SEC. 5005. STATE FINANCIAL INCENTIVES.

(a) ELECTION.—Any participating State may elect to assume responsibility for containment of health care expenditures in the State consistent with the targets established by this part upon the approval of an application by the Secretary.

(b) ALTERNATIVE STATE PROVIDER PAYMENT SYSTEMS.—Notwithstanding any other provision of law, in the case of an alternative State provider payment system that has been approved by the Secretary and in continuous operation since July 1, 1977, the payment rates and methodologies required under the State system for services provided in that State shall apply to all purchasers and payors, including those under employee welfare benefit plans authorized under the Employee Retirement Income Security Act of 1974, workers' compensation programs under State law, the Federal Employees' Compensation Act under chapter 81 of title 5, United States Code, and

Federal employee health benefit plans under chapter 89 of title 5, United States Code.

Subpart B—Plan and Provider Payment Reductions to Maintain Adequate Financing

SEC. 5011. PLAN PAYMENT REDUCTION.

(a) PLAN PAYMENT REDUCTION.—In order to assure that premium-related payments to community-rated health plans offered in a community rating area are consistent with the applicable area baseline premium for the community rating area (computed under this subtitle), the Secretary shall develop and utilize a methodology to reduce payments to each noncomplying plan within a noncomplying community rating area proportionate to the excess premium of each such plan and the relative share of enrollment of community rate eligible individuals in each such plan. Such methodology shall include mechanisms for automatic reductions in payments made by noncomplying plans to network and nonnetwork providers affiliated with such plan. Such mechanism shall take into account induced volume offsets.

(b) NONCOMPLYING COMMUNITY RATING AREA AND NONCOMPLYING PLAN DEFINED.—In this part:

(1) NONCOMPLYING COMMUNITY RATING AREA.—The term ''noncomplying community rating area'' means, for a year, a community rating area

for which the weighted average accepted bid (computed under section 5004(c)) exceeds the community rating area baseline premium for the year.

(2) NONCOMPLYING PLAN.—The term ''noncomplying plan'' means, for a year, a community rated health plan offered in a noncomplying community rating area if the applicable premium rate for a class of enrollment for the plan for the year exceeds the baseline premiums for such class for the year.

(c) EXCESS PREMIUM.—In this section, the ''excess premium'', with respect to a noncomplying plan for a year for a class of enrollment, is the amount by which—

(1) the accepted bid for the year for such class (taking into account any voluntary reduction under section 5004(e)), exceeds

(2) the baseline premium for such class (as defined in subsection (d)) for the plan for the year.

(d) COMMUNITY-RATED HEALTH PLANS WITH AN ACCEPTED COOPERATIVE BID NOT EQUAL TO THE FINAL COMMUNITY RATE FOR SUCH PLAN.—For the purposes of this section (relating to determining plan compliance and plan payment reduction), if a community-rated health plan has more than one applicable premium rate for a class of enrollment, such health plan shall be treated as

a separate health plan with respect to each applicable premium rate for such class and the enrollment in each such health plan shall be considered to be the number of community-rated individuals enrolled in the community-rated plan at the applicable premium rate.

SEC. 5012. PROVIDER PAYMENT AGREEMENTS.

(a) PARTICIPATING PROVIDERS.—Each community-rated health plan in the community rating area, as part of its contract or agreement with any participating provider or provider group of participating providers shall include a provision that provides that if the plan is a non-complying plan for a year, payments to the provider (or provider group) shall be reduced by an amount determined appropriate by the Secretary under section 5011(a).

(b) APPLICATION TO COST SHARING AND TO BALANCE BILLING RESTRICTIONS.—For purposes of applying section 1103 (relating to balance billing prohibitions) and subtitle B of title I (relating to computation of cost sharing), the payment basis otherwise used for computing any limitation on billing or cost sharing shall be such payment basis as adjusted by any reductions effected under this section.

PART 2—HEALTH EXPENDITURES OF LARGE EMPLOYERS

SEC. 5021. CALCULATION OF PREMIUM EQUIVALENTS.

(a) IN GENERAL.—By January 1, 1997, the Secretary shall develop a methodology for calculating an annual per capita expenditure equivalent for amounts paid for coverage for the benefit package by a large employer.

(b) ADJUSTMENT PERMITTED.—Such methodology shall permit a large employer to petition the Secretary of Labor for an adjustment of the inflation adjustment that would otherwise apply to compensate for material changes in the demographic characteristics of the experience rate eligible individuals receiving coverage through plans offered by the employer in a community rating area.

(c) REPORTING.—

(1) IN GENERAL.—In 1999 and each subsequent year, each large employer offering a health plan prior to 1999, shall report to the Secretary of Labor, in a form and manner specified by the Secretary, the average of the annual per capita expenditure equivalent for the previous 3-year period.

(2) OTHER EMPLOYERS.—Each large employer not previously offering a plan shall make such a report in 2002 and in each subsequent year.

SEC. 5022. SANCTIONS FOR LARGE EMPLOYER FOR EXCESS INCREASE IN EXPENDITURES.

(a) SANCTION.—

(1) ACTIONS AGAINST LARGE EMPLOYERS.—If a large employer has two excess years (as defined in subsection (b)) in a 3-year-period, then, effective beginning with the second year following the second excess year in such period, the Secretary of Labor shall take action under section 1502, and such employer shall be considered to be a small employer for purposes of this Act and shall be required to make premium payments in accordance with section 5124.

(2) TERMINATION OF SPONSORSHIP FOR OTHER EXPERIENCE-RATED PLANS.—If an association, church, or multi-employer plan has two excess years (as defined in subsection (b)) in a 3-year-period, then, effective beginning with the second year following the second excess year in such period—

(A) the Secretary of Labor shall terminate the election of the large employer under section 1502; and

(B) an employer that was an experience-rated employer with respect to such purchaser shall become a community-rated employer (unless the employer is a large employer).

(b) EXCESS YEAR.—

(1) IN GENERAL.—In subsection (a), the term ''excess year'' means, for a large employer referred to in section 5021(c)(2), a year (after 2000) and for an employer or plan referred to in section 5021(c)(1) or 5022(a)(2) a year (after 1998), for which the rate of increase for the large employer (specified in paragraph (2)) for the year, exceeds the national corporate inflation factor (specified in paragraph (3)) for the year.

(2) RATE OF INCREASE FOR LARGE EMPLOYER.—The rate of increase for a large employer for a year, specified in this paragraph, is the percentage by which the average of the annual per capita expenditure equivalent for the large employer (reported under section 5021 (c)) for the 3-year period ending with such year, exceeds the average of the annual per capita expenditure equivalent for the large group purchaser (reported under such subsection) for the 3-year period ending with the previous year adjusted for any changes in the actuarial value of the benefit package provided by such large employer.

(3) NATIONAL CORPORATE INFLATION FACTOR.—The national corporate inflation factor for a year, specified in this paragraph, is the average of

the general health care inflation factors (as defined in section 5001(a)(3)) for each of the 3 years ending with such year.

PART 3—TREATMENT OF SINGLE-PAYER STATES

SEC. 5031. SPECIAL RULES FOR SINGLE-PAYER STATES.

In the case of a Statewide single-payer State, the Secretary shall compute a Statewide per capita premium target for each year in the same manner as the community rating area per capita premium target is determined under section 5003.

Subtitle B—Premium-Related Financings

PART 1—FAMILY PREMIUM PAYMENTS

Subpart A—Family Share

SEC. 5101. FAMILY SHARE OF PREMIUM.

(a) REQUIREMENT.—Each family enrolled in a community-rated health plan or in a, experienced-rated health plan in a class of family enrollment is responsible for payment of the family share of premium payable respecting such enrollment. Such premium may be paid by an employer or other person on behalf of such a family.

(b) FAMILY SHARE OF PREMIUM DEFINED.—

(1) IN GENERAL.—In this subtitle, the term ''family share of premium'' means, with respect to enrollment of a family—

(A) in a community-rated health plan, the amount specified in paragraph (2) for the class, or

(B) in an experienced-rated health plan, the amount specified in paragraph (3) for the class.

(2) COMMUNITY-RATED PLANS.—

(A) IN GENERAL.—The amount specified in this paragraph for a health plan based on a class of family enrollment is the base amount described in subparagraph (B) reduced (but not below zero) by the sum of the amounts described in subparagraph (C).

(B) BASE.—The base amounts described in this subparagraph (for a plan for a class of enrollment) is the applicable premium with respect to such class of enrollment.

(C) CREDITS AND DISCOUNTS.—The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) FAMILY CREDIT.—The amount of the family credit under section 5102(a).

(ii) INCOME RELATED DISCOUNT.—The amount of any income-related discount provided under section 5103.

(D) LIMIT ON MISCELLANEOUS CREDITS.—In no case shall the family share, due to credits under subparagraph (C), be less than zero.

(3) EXPERIENCE-RATED PLANS.—

(A) IN GENERAL.—The amount specified in this paragraph for an experience-rated health plan based on a class of family enrollment is the applicable premium (for a plan for a class of enrollment) reduced (but not below zero) by the sum of the amounts described in subparagraph (B).

(B) CREDITS AND DISCOUNTS.—The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) FAMILY CREDIT.—The amount of the family credit under section 5102.

(ii) INCOME RELATED DISCOUNT.—The amount of any income-related discount provided under section 5103.

SEC. 5102. FAMILY CREDIT.

(a) COMMUNITY-RATED PLANS.—The credit provided under this section for a family enrolled in a community-rated plan for a class of family enrollment is equal to 80 percent of the weighted average premium (as defined

in section 5000(b)) for community-rated plans offered in the community rating area for the class.

(b) EXPERIENCE-RATED PLANS.—The credit provided under this section for a family enrolled in an experience-rated health plan for a class of family enrollment is equal to the minimum employer premium payment required under section 5131 with respect to the family.

SEC. 5103. PREMIUM DISCOUNT BASED ON INCOME.

(a) IN GENERAL.—

(1) ENROLLEES IN COMMUNITY-RATED PLANS.—Subject to paragraph (2), each family enrolled with a community-rated or experience-rated plan is entitled to a premium discount under this section, in the amount specified in subsection (b)(1) if the family—

(A) is an AFDC or SSI family;

(B) is determined, under this title, to have family adjusted income below 150 percent of the applicable poverty level; or

(C) is a family described in subsection (c)(3) for which the family obligation amount under subsection (c) for the year would otherwise exceed a specified percent of family adjusted income described in such subsection.

(2) MONTHLY APPLICATION TO AFDC AND SSI FAMILIES.—Paragraph (1)(A) (and the family obligation amount under subsection (c) insofar as it relates to an AFDC or SSI family) shall be applied to the premium or family obligation amount only for months in which the family is such an AFDC or SSI family.

(b) AMOUNT OF PREMIUM DISCOUNT.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the amount of the premium discount under this subsection for a family under a class of family enrollment is equal to—

(A) 20 percent of—

(i) for a family enrolled in a community-rated plan offered in a community-rating area, the weighted average premium for community-rated plans offered in the community-rating area, increased by any amount provided under paragraph (2); or

(ii) for a family enrolled in an experience-rated plan offered in a premium area, the weighted average premium for experience-rated plans offered by the employer in the premium area (as determined under section 5131(b)(1)(A)) or, if less, the

amount determined under clause (i) for the community-rating area in which the family resides;

reduced (but not below zero) by—

(B) the sum of—

(i) the family obligation amount described in subsection (c); and

(ii) the amount of any employer payment (not required under part 2) towards the family share of premiums for covered members of the family.

(2) INCREASE FOR COMMUNITY-RATED FAMILIES TO ASSURE ENROLLMENT IN AT-OR-BELOW-AVERAGE-COST PLAN.—In the case of a family enrolled in a community-rated plan, if a State determines that a family eligible for a discount under this section is unable to enroll in an at-or-below-average-cost plan (as defined in paragraph (3)) that serves the area in which the family resides, the amount of the premium discount under this subsection is increased to the extent that such amount will permit the family to enroll in a community-rated plan without the need to pay a family share of premium under this part in excess of the sum described in paragraph (1)(B).

(3) AT-OR-BELOW-AVERAGE-COST PLAN DEFINED.—In this section, the term ''at-or-below-average-cost plan'' means a community-rated plan the premium for which does not exceed, for the class of family enrollment involved, the weighted average premium for the community-rating area.

(c) FAMILY OBLIGATION AMOUNT.—

(1) DETERMINATION.—Subject to paragraphs (2) and (3), the family obligation amount under this subsection is determined as follows:

(A) NO OBLIGATION IF INCOME BELOW INCOME THRESHOLD AMOUNT OR IF AFDC OR SSI FAMILY.—If the family adjusted income (as defined in section 5302(d)) of the family is less than the income threshold amount (specified in paragraph (4)) or if the family is an AFDC or SSI family, the family obligation amount is zero.

(B) INCOME ABOVE INCOME THRESHOLD AMOUNT.—If such income is at least such income threshold amount and the family is not an AFDC or SSI family, the family obligation amount is the sum of the following:

(i) FOR INCOME (ABOVE INCOME THRESHOLD AMOUNT) UP TO THE POV-

ERTY LEVEL.—The product of the initial marginal rate (specified in paragraph (2)) and the amount by which—

(I) the family adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds;

(II) such income threshold amount.

(ii) GRADUATED PHASE OUT OF DISCOUNT UP TO 150 PERCENT OF POVERTY LEVEL.—The product of the final marginal rate (specified in paragraph (2)) and the amount by which the family adjusted income exceeds 100 percent (but is less than 150 percent) of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1), for a year:

(A) INITIAL MARGINAL RATE.—The initial marginal rate is the ratio of—

(i) 3 percent of the applicable poverty level for the class of enrollment involved for the year; to

(ii) the amount by which such poverty level exceeds such income threshold amount.

(B) FINAL MARGINAL RATE.—The final marginal rate is 5.7 percent.

(3) LIMITATION TO 3.9 PERCENT FOR ALL FAMILIES.—

(A) IN GENERAL.—In no case shall the family obligation amount under this subsection for the year exceed 3.9 percent.

(B) INDEXING OF PERCENTAGE.—

(i) IN GENERAL.—The percentage specified in subparagraph (A) shall be adjusted for any year after 1995 so that the percentage for the year bears the same ratio to the percentage so specified as the ratio of—

(I) 1 plus the general health care inflation factor (as defined in section 5001(a)(3)) for the year, bears to

(II) 1 plus the percentage specified by the Secretary in the establishment of cost sharing schedules in subtitle B of title I (relating to indexing

of dollar amounts related to cost sharing) for the year.

(ii) ROUNDING.—Any adjustment under clause (i) for a year shall be rounded to the nearest multiple of 1/10 of 1 percentage point.

(4) INCOME THRESHOLD AMOUNT.—

(A) IN GENERAL.—For purposes of this subtitle, the income threshold amount specified in this paragraph is $1,000 (adjusted under subparagraph (B)).

(B) INDEXING.—For the 1-year period beginning on January 1, 1996, the income threshold amount specified in subparagraph (A) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1702(12)) for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 1994.

(C) ROUNDING.—Any increase or decrease under subparagraph (B) for a year shall be rounded to the nearest multiple of $10.

Subpart B—Repayment of Family Credit by Certain Families

SEC. 5110. REPAYMENT OF FAMILY CREDIT BY CERTAIN FAMILIES.

(a) IN GENERAL.—Subject to the succeeding provisions of this subpart, each family which is provided a family credit under section 5102 for a class of enrollment is liable for repayment of an amount equal to the base employment monthly premium (applicable to such class) for the month under section 5122.

(b) REDUCTION FOR SELF-EMPLOYMENT PAYMENTS.—The liability of a family under this section for a year shall be reduced (but not below zero) by the amount of any employer payments made in the year under section 5126 based on the net earnings from self-employment of a family member.

SEC. 5111. NO LIABILITY FOR FAMILIES EMPLOYED FULL-TIME; REDUCTION IN LIABILITY FOR PART-TIME EMPLOYMENT.

(a) IN GENERAL.—The amount of any liability under section 5110 shall be reduced, in accordance with rules established by the Secretary consistent with this section, based on employer premiums payable under section 5121 with respect to the employment of a family member who is a qualifying employee or with respect to a family mem-

ber. In no case shall the reduction under this section result in any payment owing to a family.

(b) CREDIT FOR FULL-TIME AND PART-TIME EMPLOYMENT.—

(1) IN GENERAL.—Under rules of the Secretary, in the case of a family enrolled under a class of family enrollment, if a family member is a qualifying employee for a month and the employer is liable for payment under section 5121 based on such employment—

(A) FULL-TIME EMPLOYMENT CREDIT.—If the employment is on a full-time basis (as defined in section 1701(b)(2)(A)) the liability under section 5110 shall be reduced by the credit amount described in subparagraph (C).

(B) PART-TIME EMPLOYMENT CREDIT.—If the employment is on a part-time basis (as defined in section 1701(b)(2)(A)) the liability under section 5110 shall be reduced by the employment ratio of the credit amount described in subparagraph (C).

(C) FULL-TIME MONTHLY CREDIT.—The amount of the credit under this subparagraph, with respect to employment by an employer in a month, is 1/12 (or, if applicable, the fraction

described in paragraph (2)) of the amount owed under section 5110, based on the class of enrollment, for the year.

(2) COVERAGE DURING ONLY PART OF A YEAR.—In the case of a family that is not enrolled in a community-rated health plan for all the months in a year, the fraction described in this paragraph is 1 divided by the number of months in the year in which the family was enrolled in such a plan.

SEC. 5112. LIMITATION OF LIABILITY BASED ON INCOME.

(a) IN GENERAL.—In the case of an eligible family described in subsection (b), the repayment amount required under this subpart (after taking into account any work credit earned under section 5111) with respect to a year shall not exceed the amount of liability described in subsection (c) for the year.

(b) ELIGIBLE FAMILY DESCRIBED.—An eligible family described in this subsection is a family which is determined by the State for the community rating area in which the family resides, to have wage-adjusted income (as defined in subsection (d)) below 300 percent of the applicable poverty level.

(c) AMOUNT OF LIABILITY.—

(1) DETERMINATION.—Subject to subsection (f), in the case of a family enrolled in a class of en-

rollment with wage-adjusted income (as defined in subsection (d)), the amount of liability under this subsection is determined as follows:

(A) NO OBLIGATION IF INCOME BELOW INCOME THRESHOLD AMOUNT OR IF AFDC OR SSI FAMILY.—If such income is than the income threshold amount (specified in section 5103(c)(4)) or if the family is an AFDC or SSI family, the amount of liability is zero.

(B) INCOME ABOVE INCOME THRESHOLD AMOUNT.—If such income is at least such income threshold amount and the family is not an AFDC or SSI family, the amount of liability is the sum of the following:

(i) FOUR PERCENT OF INCOME (ABOVE INCOME THRESHOLD AMOUNT) UP TO THE POVERTY LEVEL.—The initial marginal rate (specified in paragraph (2)(A)) of the amount by which—

(I) the wage-adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds

(II) such income threshold amount.

(ii) SECOND MARGINAL RATE.—The second marginal rate (specified in paragraph (2)(B) of the amount by which—

(I) the wage adjusted income (not including any portion that exceeds twice the applicable poverty level for the class of family involved), exceeds

(II) the applicable poverty level for the class of family enrollment.

(iii) FINAL MARGINAL RATE.—Where wage-adjusted income exceeds 200 percent of the applicable poverty level, the final marginal rate (specified in paragraph (2)(C)) of the amount by which the wage-adjusted income exceeds 100 percent of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1)—

(A) INITIAL MARGINAL RATE.—The initial marginal rate, for a year for a class of enrollment, is the ratio of—

(i) 4 percent of the applicable poverty level for the class of enrollment for the year, to

(ii) the amount by which such poverty level exceeds such income threshold amount.

(B) SECOND MARGINAL RATE.—The second marginal rate, for a year for the class of enrollment, is 7.6 percent.

(C) FINAL MARGINAL RATE.—The final marginal rate, for a year for a class of enrollment, is the ratio of—

(i) the amount by which (I) the amount of the repayment amount described in section 5111(a) exceeds (II) 5.8 percent of twice the applicable poverty level (for the class and year); to

(ii) 200 percent of such poverty level.

(3) SECOND MARGINAL RATE.—

(A) IN GENERAL.—If, for a class of enrollment for a community rating area in a State, the second marginal rate exceeds the final marginal rate, the State may adjust such marginal rates so that the second marginal rate and the final marginal rate are the same and equal to the ratio of—

(i) the amount by which (I) the amount of the repayment amount de-

scribed in section 5111(a) exceeds (II) 4 percent of the applicable poverty level (for the class and year); to

(ii) 200 percent of such poverty level.

(d) WAGE-ADJUSTED INCOME DEFINED.—In this subtitle, the term ''wage-adjusted income'' means, for a family, family adjusted income of the family, reduced by the sum of the following:

(1)(A) Subject to subparagraph (B), the amount of any wages included in such family's income that is received for employment which is taken into account in the computation of the amount of employer premiums under section 5121 (without consideration of section 5125).

(B) The reduction under subparagraph (A) shall not exceed for a year $5,000 (adjusted under section 5103(c)(3)(B)) multiplied by the number of months (including portions of months) of employment with respect to which employer premiums were payable under section 5121 (determined in a manner consistent with section 1701(b)(3)).

(2) The amount of net earnings from self employment of the family taken into account under section 5125.

(3) The amount of unemployment compensation included in income under section 85 of the Internal Revenue Code of 1986.

SEC. 5113. PAYMENTS BY NONQUALIFYING EMPLOYEES.

(a) IN GENERAL.—In the case of an eligible family described in paragraph (b), the net liability of the family under this section shall be the amount described in subsection (c), limited by the amount described in subsection (d) plus the amount described in subsection (e).

(b) ELIGIBLE FAMILY DESCRIBED.—The family described in this paragraph is a family that has one or more nonqualifying employees and has no full-time qualifying employees. The Secretary shall develop rules for applying this section to families whose employment status with respect to exempt employers changes during the year.

(c) AMOUNT.—The amount described in this subsection is the sum of—

(1) the family share as defined in section 5101 (including any discounts under 5103); and

(2) the family credit repayment amount described in subpart B of title VI (including any reductions under section 5103); reduced by—

(3) the amount (if any) by which that the premium with respect to such family exceeds the weighted average premium (applicable to the family).

(d) LIMIT.—The limit described in this subsection is the following:

(1) for a family with family adjusted income of less than 150 percent of the applicable poverty level, 4 percent of family adjusted income;

(2) for a family with family adjusted income of at least 150 percent but less than 175 percent of the applicable poverty level, 4.5 percent of family adjusted income;

(3) for a family with family adjusted income of at least 175 percent but less than 225 percent of the applicable poverty level, 5 percent of family adjusted income; and

(4) for a family with family adjusted income of at least 225 percent but less than 400 percent of the applicable poverty level, 6 percent of family adjusted income.

(e) The amount described in this subsection is the amount in subsection (c)(3).

(f) INDEXING OF PERCENTAGES.—

(1) IN GENERAL.—The percentage of family adjusted income specified in paragraphs (1) through (4) of subsection (d) shall be adjusted for any year after 1994 so that the percentage for the year bears

the same ratio to the percentage so specified as the ratio of—

(A) 1 plus the general health care inflation factor (as defined in section 5001(a)(3)) for the year, bears to

(B) 1 plus the percentage specified by the Secretary in the establishment of cost sharing schedules in subtitle B of title I.

(2) ROUNDING.—Any adjustment under paragraph (1) for a year shall be rounded to the nearest multiple of 1/10 of 1 percentage point.

SEC. 5114. SPECIAL TREATMENT OF CERTAIN MEDICARE BENEFICIARIES.

In the case of an individual who would be a medicare-eligible individual in a month but for the application of section 1012(a) on the basis of employment (in the month or a previous month) of the individual or the individual's spouse or parent, the individual (or spouse or parent, as the case may be) so employed is considered, for purposes of section 5112, to be a full-time employee described in such section in such month.

PART 2—EMPLOYER PREMIUM PAYMENTS

Subpart A—Small Business Exemption

SEC. 5116. EXEMPTION FROM COVERAGE OBLIGATIONS.

An exempt employer as defined section 5117 shall be exempt from requirements described in this part, unless the employer elects under section 5118 to be treated as a community-rated employer.

SEC. 5117. EXEMPT EMPLOYER DEFINED.

(a) IN GENERAL.—In this section—

(1) the term ''exempt employer'' means an employer that does not employ, on average, more than 10 full-time equivalent employees;

(2) and is an employer with average annual wages per full-time equivalent employee of less than $24,000; and

(3) the average number of full-time equivalent employees shall be determined by averaging the number of full-time equivalent employees employed by the employer in each countable month during the year.

(b) DETERMINATIONS.—The number of full-time equivalent employees shall be determined using the rules under section 1701(b)(2).

(c) EXEMPT EMPLOYER.—The term ''exempt employer'' shall not include an individual described in section 5126(c)(2).

SEC. 5118. ELECTION.

A exempt employer may elect to be treated as a community-rated employer under the procedures determined by the Secretary.

SEC. 5119. TREATMENT OF EXEMPT EMPLOYERS.

(a) IN GENERAL.—

(1) COMMUNITY RATED EMPLOYER.—An exempt employer shall be treated as a community rated employer as of the first date of the first year following an election made under section 5118.

(2) ELIGIBILITY FOR DISCOUNTS.—An exempt employer making an election under section 5118 shall be eligible for discounts under 5123.

SEC. 5120. NONELECTING EXEMPT EMPLOYER.

(a) IN GENERAL.—The term ''nonelecting exempt employer'' means an exempt employer that has not made an election under section 5118.

(b) APPLICATION OF RULES SIMILAR TO MEDICARE NONDISCRIMINATION RULES TO NON-ELECTING EMPLOYERS.—Subject to subsection (b), the provisions of paragraphs (1)(A), (1)(D), (1)(E), (3)(A), and (3)(C) of section 1862(b) of the Social Security Act shall apply to an individual eligible for premium assistance under this title in relation to any non-electing employer in the same manner as such provisions apply to an individual age 65 or over who is entitled to benefits under title XVIII of

such Act under section 226(a) of such Act in relation to such employer.

Subpart B—Community-Rated Employers

SEC. 5121. EMPLOYER PREMIUM PAYMENT REQUIRED.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each community-rated employer described in paragraph (2) for a month shall pay at least an amount equal to the sum across all qualifying employees of the amount specified in subsection (b) for each such qualifying employee of the employer.

(2) EMPLOYER DESCRIBED.—An employer described in this paragraph for a month is an employer that—

(A) in a month employs one or more qualifying employees (as defined in section 1701(b)(1)); and

(B) is not exempt under section 3127 of the Internal Revenue Code of 1986 from the taxes imposed in section 3111 of such code.

(3) TREATMENT OF CERTAIN EMPLOYMENT BY EXPERIENCE-RATED EMPLOYERS.—An experience-rated employer shall be deemed, for purposes of this subpart, to be a community-rated employer with re-

spect to qualifying employees who are not experience rate eligible individuals.

(b) PREMIUM PAYMENT AMOUNT.—

(1) IN GENERAL.—Except as provided in section 5123 (relating to a discount for certain employers), the amount of the employer premium payment, for a month for each qualifying employee of the employer who is residing in a community rating area, is the payment amount computed under paragraph (2) with respect to such employee in such area.

(2) PAYMENT AMOUNT FOR EACH EMPLOYEE IN A CLASS OF FAMILY ENROLLMENT.—The payment amount under this paragraph, for an employer for each qualifying employee residing in a community rating area, is the product of—

(A) the base employment monthly premium determined under section 5122 for the applicable class of family enrollment for the previous month for the community rating area, and

(B) the full-time employment ratio (as defined in section 1701 for the previous month.

(3) SPECIAL RULES FOR DIVIDED FAMILIES.—In the case of an individual who is a qualifying employee of an employer, if the individual has a spouse

or child who is not treated as part of the individual's family because of section 1012—

(A) the employer premium payment under this section shall be computed as though such section had not applied, and

(B) the State shall provide for proportional payments (consistent with rules established by the Secretary) to the health plans (if different) of the qualifying employee and of the employee's spouse and children.

SEC. 5122. COMPUTATION OF BASE EMPLOYMENT MONTHLY PREMIUM.

Each State shall provide for the computation for each year (beginning with the first year) of a base employment monthly premium for each class of family enrollment equal to 1/12 of 80 percent of the weighted average premium for the community rating area for such class of enrollment adjusted to account for the average number of workers per family within such class. Any such adjustment made regarding the dual parent family class of enrollment shall also be made to the single parent family class.

SEC. 5123. PREMIUM DISCOUNT FOR CERTAIN EMPLOYERS.

(a) EMPLOYER DISCOUNT.—

(1) IN GENERAL.—Subject to section 5124(c), the amount of the employer premium payment re-

quired under section 5121(b) for a community-rated employer for any year for a qualifying employee shall not exceed the limiting percentage (as defined in subsection (b)) of such qualifying employee's wages for that year.

(2) EXCLUSION OF FEDERAL GOVERNMENT EMPLOYERS.—Paragraph (1) shall not apply to the Federal Government.

(b) LIMITING PERCENTAGE DEFINED.—In subsection (a)—

(1) ANY EMPLOYER.—For an employer that is not a medium-sized employer (as defined in subsection (c)) or an exempt employer (as defined in subsection 5117), the limiting percentage is 12 percent.

(2) MEDIUM-SIZED EMPLOYERS.—For an employer that is a medium-sized employer and that has an average number of full-time equivalent employees and average annual wages per full-time equivalent employee (as determined under subsection (d)), the limiting percentage is the applicable percentage determined based on following table:

Average number of full-time equivalent employees	$0–$12,000	$12,001–$15,000	$15,001–$18,000	$18,001–$21,000	$21,001–$24,000	$24,001 or more
Fewer than 15	4.2%	5.5%	6.8%	8.1%	9.4%	12%

Average number of full-time equivalent employees	$0–$12,000	$12,001–$15,000	$15,001–$18,000	$18,001–$21,000	$21,001–$24,000	$24,001 or more
15 but fewer than 25	5.5%	6.8%	8.1%	9.4%	10.7%	12%
25 but fewer than 50	6.8%	8.1%	9.4%	10.7%	12%	12%
50 but not over 75	8.1%	9.4%	10.7%	12%	12%	12%

(3) SMALL EMPLOYERS.—For an employer that is an exempt employer and elects to be a community-rated employer (in accordance of section 5119), the limiting percentage is the limiting percentage described in paragraph (2).

(4) EXPERIENCE-RATED EMPLOYERS.—The value of discounts provided to an experience-rated employer shall not exceed the amount that the employer would receive if the employer was treated as a community-rated employer.

(c) MEDIUM-SIZED EMPLOYER DEFINED.—

(1) IN GENERAL.—In this section, the term ''medium-sized employer'' means an employer that does not employ, on average, less than 11 full-time equivalent employees or more than 75 full-time equivalent employees.

(2) DETERMINATIONS.—The number of full-time equivalent employees shall be determined using the rules under section 1701(b)(2).

(d) AVERAGE ANNUAL WAGES PER FULL-TIME EQUIVALENT EMPLOYEE DEFINED.—

(1) IN GENERAL.—In this section, the term ''average annual wages per full-time equivalent employee'' means, for an employer for a year—

(A) the total wages paid in the year to individuals who, at the time of payment of the wages, are qualifying employees of the employer; divided by

(B) the number of full-time equivalent employees of the employer in the year.

(2) DETERMINATION.—The Secretary may establish rules relating to the computation of the average annual wages for employers.

(e) TREATMENT OF CERTAIN SELF-EMPLOYED INDIVIDUALS.—In the case of an individual who is a partner in a partnership, is a 2-percent shareholder in an S corporation (within the meaning of section 1372 of the Internal Revenue Code of 1986), or is any other individual who carries on a trade or business as a sole proprietorship, for purposes of this section—

(1) the individual is deemed to be an employee of the partnership, S corporation, or proprietorship, and

(2) the individual's net earnings from self employment attributable to the partnership, S corporation, or sole proprietorship are deemed to be wages from the partnership, S corporation, or proprietorship.

(f) APPLICATION TO EMPLOYERS.—An employer that claims that this section applies—

(1) shall provide notice to the State of the claim at the time of making payments under this subpart; and

(2) shall make available such information (and provide access to such information) as the State may require (in accordance with regulations of the Secretary of Labor) to audit the determination of—

(A) whether the employer is a medium employer, and, if so, the average number of full-time equivalent employees and average annual wages of the employer; and

(B) the total wages paid by the employer for qualifying employees.

(g) TREATMENT OF MULTI-AREA EMPLOYERS.—In the case in which this section is applied to an employer that makes employer premium payments in more than one community rating areas, the reduction under this section

shall be applied in a pro-rated manner to the premium payments made to all such areas.

SEC. 5124. PAYMENT ADJUSTMENT FOR CERTAIN LARGE EMPLOYERS.

If the Secretary determines that the average anticipated cost for employees (and dependents of such employees) of an employer described in section 5022 exceeds the anticipated average cost for all community-rate eligible individuals residing in the area, including costs to the government, such employee's payments shall be adjusted by an amount determined appropriate by the Secretary.

SEC. 5125. APPLICATION TO SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—A self-employed individual (as defined in section 1701(c)(2)) shall be considered, for purposes of this subpart to be an employer of himself or herself and to pay wages to himself or herself equal to the amount of net earnings from self-employment (as defined in section 1701(c)(1)).

(b) SPECIAL RULE FOR CERTAIN SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—In the case of certain self-employed individuals described in paragraph (2), the payment obligation under this section shall be limited to the liability described in subsection (c) of section 5113 (substituting the amount of net earnings

from self employment (defined in section 1701(c)(1)) of such individual for wage adjusted income).

(2) SELF-EMPLOYED INDIVIDUALS.—The individuals described in this paragraph are self-employed individuals (as defined in section 1701(c)(2)) for a year who are not employers with respect to other qualifying employees in such year.

(3) SPECIAL RULE FOR CERTAIN CLOSELY-HELD BUSINESSES.—

(A) IN GENERAL.—In the case of an individual who—

(i) has wage-adjusted income (as defined in section 5113(d), determined without regard to paragraphs (1)(B) and (2) thereof) that exceeds 300 percent (or such higher percentage as the Secretary may establish) of the applicable poverty level, and

(ii) is both a substantial owner and an employee of a closely held business,

the amount of any reduction under paragraph (1)(A) that is attributable to the individual's employment by that business shall be appropriately reduced in accordance with rules prescribed by the Secretary, in order to prevent individuals from avoiding payment of the full

amount owed through fraudulent or secondary employment arrangements.

(B) CLOSELY HELD BUSINESS.—For purposes of subparagraph (A), a business is ''closely held'' if it is an employer that meets the requirements of section 542(a)(2) of the Internal Revenue Code of 1986 or similar requirements as appropriate in the case of a partnership or other entity.

Subpart C—Large Employers

SEC. 5131. LARGE EMPLOYER PREMIUM PAYMENT REQUIRED.

(a) PER EMPLOYEE PREMIUM PAYMENT.—Subject to section 5124, each experience-rated large employer that in a month in a year employs a qualifying employee who is—

(1) enrolled in an experience-rated health plan, shall provide for a payment toward the premium for the plan for such employee in an amount at least equal to the large employer premium payment specified in subsection (b); or

(2) is not so enrolled, shall make employer premium payments with respect to such employment under subpart B in the same manner as if the em-

ployer were a community-rated employer (except as otherwise provided in such subpart).

(b) LARGE EMPLOYER PREMIUM.—

(1) AMOUNT.—

(A) IN GENERAL.—The amount of the large employer premium payment for a month in a year for a class of family enrollment for a family residing in a geographic area is 80 percent of the weighted average monthly premium of the experience-rated health plans offered by the large employer for that class of enrollment for families residing in that area.

(B) APPLICATION TO SELF-INSURED PLANS.—In applying this paragraph in the case of one or more experience-rated health plans that are self-insured plans—

(i) the ''premium'' for the plan is the actuarial equivalent of such premium, based upon the methodology (or such other consistent methodology) used under section 5021(a); and

(ii) the premium amount, for different classes and, if applicable, for different premium areas, shall be computed in a manner based on such factors as may bear a

reasonable relationship to costs for the provision of the benefit package to the different classes in such areas.

The Secretary of Labor shall establish rules to carry out this subparagraph.

(2) LOW-INCOME EMPLOYEES.—In the case of a low-income employee entitled to a premium discount under section 5103(a), the amount of the employer premium payment for a month in a year for a class of family enrollment shall be increased by the amount of such premium discount.

(c) DETERMINATIONS.—Determinations under this section shall be made based on such information as the Secretary of Labor shall specify.

Subtitle C—Payments to Health Plans and Miscellaneous Provisions

SEC. 5201. ASSISTANCE TO PLANS.

States shall be responsible for assisting health plans and cooperatives in the collection of premium payments. A State may establish administrative systems (including arrangements with private entities) to facilitate the collection of premiums from employers and families and the distribution of such premiums to health plans, consistent with rules promulgated by the Secretary.

SEC. 5202. COMPUTATION OF BLENDED PLAN PAYMENT AMOUNT.

(a) IN GENERAL.—For purposes of section 5203, the payment amount for a community-rated health plan in a community rating area in a year is equal to a blended payment amount reflecting the final accepted bid for each plan, the number of enrollees in each premium class, and the proportion of AFDC and SSI beneficiaries throughout the community rating area served by the plan.

(b) METHODOLOGY.—The Secretary shall establish a methodology by which the blended payment amount described in subsection (a) shall be computed and applied.

SEC. 5203. ADJUSTMENT TO HEALTH PLAN REVENUES

(a) IN GENERAL.—States shall develop and implement revenue adjustment mechanisms and collect such information as may be necessary for ensuring that payments to health plans are appropriate and sufficient.

(b) ADJUSTMENTS.—Mechanisms under subsection (a) shall include methods for risk adjustment and reinsurance (in accordance with title I), the payment of premium discounts (in accordance with subtitle B of title VI), payment adjustments to reflect each area's share of AFDC and SSI beneficiaries (in accordance with section 5202), and other adjustments necessary to reconcile the amounts collected by plans with the amounts plans are owed.

SEC. 5204. CALCULATION AND PUBLICATION OF GENERAL FAMILY SHARE AND GENERAL EMPLOYER PREMIUM AMOUNTS.

(a) FAMILY SHARE.—Each State shall compute and publish the following components of the general family share of premiums for each community rating area designated by the State:

(1) PLAN PREMIUMS.—For each plan offered, the applicable premiums for such plan for each class of family enrollment (including the amount of any family collection shortfall).

(2) QUALIFIED WORKSITE HEALTH PROMOTION.—For each plan offered, the premium discount for each level of qualified worksite health promotion program.

(3) FAMILY CREDIT.—The family credit amount for each class of family enrollment, under section 5102.

(b) EMPLOYER PREMIUMS.—Each State shall compute and publish the following components of the general employer premium payment amount for each community rating area designated by the State:

(1) BASE EMPLOYER MONTHLY PREMIUM PER WORKER.—The base employer monthly premium determined under section 5122 for each class of family enrollment.

(2) QUALIFIED WORKSITE HEALTH PROMOTION.—The base monthly premium discount for each level of qualified worksite health promotion program.

(c) RECONCILIATION OF FAMILY SHARE.—Each State shall provide for the reconciliation of family payments in cases where the State determines that there has been an overpayment or underpayment by or on the behalf of such families in accordance with rules promulgated by the Secretary.

SEC. 5205. EMPLOYER PAYMENT REQUIREMENT.

(a) IN GENERAL.—Each employer shall provide for payments required under section 5121 or 5131 in accordance with the applicable provisions of this Act.

(b) EMPLOYERS IN SINGLE-PAYER STATES.—In the case of an employer with respect to employees who reside in a single-payer State, the responsibilities of such employer under such system shall supersede the obligations of the employer under subsection (a), except as the Secretary may provide.

SEC. 5206. REQUIREMENT FOR EMPLOYER PAYMENT AND RECONCILIATION REPORTING.

(a) RECONCILIATION OF EMPLOYER PREMIUM PAYMENTS.—Each employer (whether or not the employer claimed (or claims) an employer premium discount under

section 5123 for a year) that is liable for employer premium payments for any month in a year shall provide such information as may be required (consistent with rules of the Secretary of Labor) to determine—

(1) the amount of employee premium payments made for all months in the year (taking into account any employer premium discount under section 5123); and

(2) the appropriate amount of employer premium payments that should have been made for all months in the year. Such reconciliation process shall be conducted by the State (with respect to community-rated employers) and by the Secretary of Labor (with respect to experience-rated employers).

(b) NOTICE TO CERTAIN INDIVIDUALS WHO ARE NOT EMPLOYEES.—

(1) IN GENERAL.—A person that carries on a trade or business shall notify in writing each individual described in paragraph (2) that the person is not obligated to make any employer health care premium payment (under section 5121) in relation to the services performed by the individual for the person.

(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph, with respect to a person, is an individual who normally performs services for

the person in the person's trade or business for more than 40 hours per month but who is not an employee of the person (within the meaning of section 1701(a)).

(3) EXCEPTIONS.—The Secretary shall issue regulations providing exceptions to the notice requirement of paragraph (1) with respect to individuals performing services on an irregular, incidental, or casual basis.

(4) MODEL NOTICE.—The Secretary shall publish a model notice that is easily understood by the average reader and that persons may use to satisfy the requirements of paragraph (1).

(c) INFORMATION CLEARINGHOUSE FUNCTIONS.—The Secretary shall perform information clearinghouse functions under this section with respect to employers, States, the Federal Government, and consumer purchasing cooperatives.

SEC. 5207. EQUAL VOLUNTARY CONTRIBUTION REQUIREMENT.

(a) IN GENERAL.—

(1) EQUAL VOLUNTARY EMPLOYER PREMIUM PAYMENT REQUIREMENT.—

(A) COMMUNITY-RATED HEALTH PLANS.—

If an employer makes available a voluntary em-

ployer premium payment (as defined in subsection (d)) on behalf of a full-time employee (as defined in section 1701(b)(2)(C)) who is enrolled in a community-rated health plan of a community rating area in a class of family enrollment, the employer shall make available such a voluntary employer premium payment in the same dollar amount to all qualifying employees (as defined in section 1701(b)(1)) of the employer who are enrolled in any community-rated health plan of the same coverage area in the same class of family enrollment.

(B) EXPERIENCE-RATED HEALTH PLANS.—If an experience-rated employer makes available a voluntary employer premium payment on behalf of a full-time employee who is enrolled in an experience-rated health plan of a large employer in a class of family enrollment in a premium area, the employer shall make available such a voluntary employer premium payment in the same dollar amount to all qualifying employees of the employer enrolled in any experience-rated health plan of the same purchaser in the same class of family enrollment in the same premium area.

(C) TREATMENT OF PART-TIME EMPLOYEES.—In applying subparagraphs (A) and (B) in the case of a qualifying employee employed on a part-time basis (within the meaning of section 1701(b)(2)(A)(ii)), the dollar amount shall be equal to the full-time employment ratio (as defined in section 1701(b)(2)(B)) multiplied by the dollar amount otherwise required.

(2) NONDISCRIMINATION AMONG PLANS SELECTED.—An employer may not discriminate in the wages or compensation paid, or other terms or conditions of employment, with respect to an employee based on the health plan (or premium of such a plan) in which the employee is enrolled.

(b) REBATE REQUIRED IN CERTAIN CASES.—Subject to subsection (c), if—

(1) an employer makes available a voluntary employer premium payment on behalf of an employee, and

(2)(A) the sum of the amount of the applicable family credit (under section 5102) and the voluntary employer premium payment, exceeds (B) the premium for the plan selected,

the employer must rebate to the employee an amount equal to the excess described in subparagraph (B).

(c) EXCEPTION FOR COLLECTIVE BARGAINING AGREEMENT.—Subsections (a) and (b) shall not apply with respect to voluntary employer premium payments made pursuant to a bona fide collective bargaining agreement.

(d) VOLUNTARY EMPLOYER PREMIUM PAYMENT.—In this section, the term ''voluntary employer premium payment'' means any payment designed to be used exclusively (or primarily) towards the cost of the family share of premiums for a health plan. Such term does not include any employer premiums required to be paid under part 3 of subtitle B of title VI.

SEC. 5208. PAYMENT ARRANGEMENTS.

(a) WITHHOLDING.—

(1) IN GENERAL.—In the case of a family that includes a qualifying employee of an employer, the employer shall deduct from the wages of the qualifying employee (in a manner consistent with any rules of the Secretary of Labor) the amount of the family share of the premium for the plan in which the family is enrolled.

(2) MULTIPLE EMPLOYMENT.—In the case of a family that includes more than one qualifying employee, the family shall choose the employer to which paragraph (1) will apply.

(3) SATISFACTION OF LIABILITY.—An amount deducted from wages of a qualifying employee by an employer is deemed to have been paid by the employee and to have satisfied the employee's obligation under subsection (a) to the extent of such amount.

(b) OTHER METHODS.—In the case of a family that does not include a qualifying employee, the State shall require payment to be made prospectively. Such payment may be required to be made not less frequently than monthly. The Secretary may issue regulations in order to assure the timely and accurate collection of the family share due.

Subtitle D—Cost-Sharing Assistance, Application for Assistance and Premium Discounts, and Income Reconciliation

SEC. 5301. REDUCTION IN COST SHARING FOR LOW-INCOME FAMILIES.

(a) REDUCTION.—

(1) IN GENERAL.—Subject to subsection (b), in the case of a family that is enrolled in a health plan and that is either (A) an AFDC or SSI family or (B) is determined under this subpart to have family adjusted income below 200 percent of the applicable

poverty level, the family is entitled to a reduction in cost sharing in accordance with this section.

(2) TIMING OF REDUCTION.—The reduction in cost sharing shall only apply to items and services furnished after the date the application for such reduction is approved under section 5302 and before the date of termination of the reduction under this subpart, or, in the case of an AFDC or SSI family, during the period in which the family is such a family.

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

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

(1) community-rated families residing in a health care coverage area if the State for the area determines that there are sufficient at or below average cost plans (as defined in section 5104(b)(3)), which are plans with cost-sharing similar to the model certified preferred provider network plans or model certified health maintenance organization

plans established by the Secretary under section 1101(h), available in the area to enroll AFDC and SSI families and families with family adjusted income below 150 percent of the applicable poverty level;

(2) experience-rated families whose employer offers a plan described in paragraph (1); or

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

(c) AMOUNT OF COST SHARING REDUCTION.—

(1) IN GENERAL.—Subject to paragraph (2), the reduction in cost sharing under this section shall be such reduction as will reduce cost sharing to the level of plans with cost-sharing similar to the model certified preferred provider network plans or model certified health maintenance organization plans established by the Secretary under section 1101(h)

(2) SPECIAL TREATMENT OF CERTAIN FAMILIES.—

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

(i) is enrolled in a health plan;

(ii) is an AFDC, SSI family or a family that is determined under this subpart

to have a family adjusted income below 100 percent of the applicable poverty level; and

(iii) is enrolled in a plan with cost-sharing similar to the model certified preferred provider network plans or model certified health maintenance organization plans established by the Secretary under section 1101(h), or receiving a reduction in cost sharing under paragraph (1);

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

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

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

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

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

(iv) is enrolled in a plan with cost-sharing similar to the model certified preferred provider network plans or model certified health maintenance organization plans established by the Secretary under section 1101(h), or receiving a reduction in cost sharing under paragraph (1);

the amount of cost sharing applied with respect to an item or service (other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) shall be an amount equal to 40 percent of the cost sharing amount otherwise applicable, rounded to the nearest dollar.

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

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

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

(iii) is not an AFDC or SSI family;

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

(d) ADMINISTRATION.—

(1) IN GENERAL.—In the case of an approved family (as defined in section 5302(b)(2)) enrolled in a community-rated health plan, the State shall pay the plan for cost sharing reductions (other than cost sharing reductions under subsection (c)(2)(A), (B) and (C)) provided under this section out of Federal subsidy payments provided in section 6001. Payments made by health plans to providers shall in-

clude appropriate payments for cost sharing reductions.

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

SEC. 5302. APPLICATION PROCESS FOR COST-SHARING REDUCTIONS AND PREMIUM DISCOUNTS.

(a) IN GENERAL.—A family may apply for a determination of the family adjusted income or wage adjusted income of the family, for the purpose of establishing eligibility for cost sharing reductions under section 5301, and for premium discounts and reductions in liability under sections 5103 and 5112.

(b) ACTION ON APPLICATION.—

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

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

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

(d) FAMILY ADJUSTED INCOME.—

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

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

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

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

(3) PRESENCE OF ADDITIONAL DEPENDENTS.—At the option of an individual, a family may include (and not be required to separate out) the income of other individuals who are claimed as de-

pendents of the family for income tax purposes, but such individuals shall not be counted as part of the family for purposes of determining the size of the family.

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

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

(A) confirmed periodically by the State; and

(B) verified (through the filing of a new application under this section) by the State at the time income reconciliation statements are required to be filed under section 5303.

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

(f) PENALTIES FOR INACCURATE INFORMATION.—

(1) INTEREST FOR UNDERSTATEMENTS.—Each individual who knowingly understates income re-

ported in an application to a State under this subpart or otherwise makes a material misrepresentation of information in such an application shall be liable to the State for excess payments made based on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Secretary.

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

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

(h) TREATMENT OF AFDC AND SSI RECIPIENTS.—

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

(2) NOTICE REQUIREMENT FOR SSI RECIPIENTS.—The Secretary shall notify each State, in a manner specified by the Secretary of the identity (and period of eligibility under the SSI program) of each SSI recipient, unless such a recipient elects (in a manner specified by the Secretary) not to accept the reduction in cost sharing or premium discounts under this part.

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

SEC. 5303. END-OF-YEAR RECONCILIATION.

(a) IN GENERAL.—In the case of a family whose application for a premium discount or reduction of liability for a year has been approved before the end of the year under this subpart, the family shall, subject to subsection (c), file with the State an income reconciliation statement to verify the family's adjusted income or wage-adjusted income, as appropriate, for the previous year. Such a

statement shall contain such information as the Secretary shall require. Each State shall coordinate the submission of such statements with the notice and payment of family premium payments.

(b) RECONCILIATION OF PREMIUM DISCOUNT AND LIABILITY ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to a family, the State shall compute the amount of premium discount or reduction in liability that should have been provided under section 5103 or section 5112 with respect for the family for the year involved. If the amount of such discount or liability reduction computed is—

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

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

(c) NO RECONCILIATION FOR AFDC AND SSI FAMILIES; NO RECONCILIATION FOR COST SHARING REDUC-

TIONS.—No reconciliation statement is required under this section—

(1) with respect to cost sharing reductions provided under section 5301, or

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

(d) DISQUALIFICATION FOR FAILURE TO FILE.—In the case of any family that is required to file a statement under this section in a year and that fails to file such a statement by the deadline specified, members of the family shall not be eligible for premium reductions under section 5103 or reductions in liability under section 5112 until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the family establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

(e) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under subsection (a) is subject to the same liabilities as are provided under section 5302 for a misrepresentation of material fact described in such section.

(f) NOTICE OF REQUIREMENT.—Each State shall provide for written notice, at the end of each year, of the

requirement of this section to each family which had received premium discount or reduction in liability under this subpart in any month during the preceding year and to which such requirement applies.

(g) TRANSMITTAL OF INFORMATION; VERIFICATION.—

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

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

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

SEC. 5304. ELIGIBILITY ERROR RATES.

Each State shall make eligibility determinations for premium discounts, liability reductions, and cost sharing reductions under sections 5104 and 5123, section 5113, and section 5301, respectively, in a manner that maintains the error rates below an applicable maximum permissible error rate specified by the Secretary (or the Secretary of Labor with respect to section 5123). In specifying such a rate, the Secretary shall take into account maximum permissible error rates recognized by the Federal Government under comparable State-administered programs.

TITLE VI—AGGREGATE GOVERNMENT PAYMENTS

Subtitle A—Aggregate Federal Payments to Participating State

SEC. 6001. CAPPED FEDERAL PAYMENTS.

(a) CAPPED ENTITLEMENT.—

(1) PAYMENT.—The Secretary shall provide for each calendar quarter (beginning on or after January 1, 1997) for payment to each participating State of an amount equal to the capped Federal payment amount (as defined in subsection (b)(1)) for each State for the quarter.

(2) ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Govern-

ment to provide for the payment to States of the capped Federal payment amount under this section.

(b) CAPPED FEDERAL PAYMENT AMOUNT.—

(1) IN GENERAL.—In this section, the term ''capped Federal payment amount'' means, for a State for a calendar quarter in a year and subject to paragraph (6) and subsection (e), the amount by which—

(A) ¼ of the total payment obligation (described in paragraph (2)) owed to community-rated and experience-rated plans in a State for the year, exceeds

(B) ¼ of the total amounts receivable (described in paragraph (3)) by community-rated and experience-rated plans for the year.

(2) TOTAL PAYMENT OBLIGATION.—The total payment obligation described in this paragraph in a State for a year is the total amount payable to community-rated and experience-rated plans under title V.

(3) TOTAL AMOUNTS RECEIVABLE.—The total amounts receivable in a State for a year is the sum of the following:

(A) PREMIUMS.—The amount payable to community-rated and experience-rated plans for

the family share of premiums (and premium equivalents), employer premiums (and premium equivalents), and liabilities owed to health plans pursuant to section 6201, not taking into account any failure to make or collect such payments.

(B) OTHER GOVERNMENT PAYMENTS.—The amounts payable to health plans under this section and payable under subparagraph (C).

(C) PAYMENT TO HEALTH PLANS.—Each participating State is responsible for paying to community-rated health plans a share of its savings under this Act. Such amount shall equal 25 percent of the net reduction in the projected expenditures of the State for health care and related services that the Secretary estimates the State will experience as the result of the enactment of this Act. A State may request the Secretary to review its estimate and shall be entitled to present its case to the Secretary under procedures to be established by the Secretary. This subparagraph shall not be construed as providing a State with a right to bring suit for such payment.

(D) ADDITIONAL AMOUNT.—The amount collected by the State under section 1715.

(4) NO PAYMENT FOR CERTAIN AMOUNTS.—

(A) IN GENERAL.—Each participating State is responsible for the payment of amounts attributable to administrative errors (described in subparagraph (B)).

(B) ADMINISTRATIVE ERRORS DESCRIBED.—The administrative errors described in this subparagraph include the following:

(i) An eligibility error rate for premium discounts, liability reductions, and cost sharing reductions to the extent the applicable error rate exceeds the maximum permissible error rate, specified by the applicable Secretary, with respect to the section involved.

(ii) Misappropriations or other State expenditures that the Secretary finds are attributable to malfeasance or misfeasance by the State.

(5) SPECIAL RULES FOR SINGLE-PAYER STATES.—In applying this subsection in the case of a single-payer State, the Secretary shall develop and apply a methodology for computing an amount of

payment (with respect to each calendar quarter) that is equivalent to the amount of payment that would have been made to the State for the quarter if the State were not a single-payer State.

(6) LARGE GROUP PURCHASERS.—The Secretary, in consultation with the Secretary of Labor, shall withhold an appropriate amount from the capped Federal payment amount as may be necessary to make payments to plans offered by large group purchasers.

(c) DETERMINATION OF CAPPED FEDERAL PAYMENT AMOUNTS.—

(1) REPORTS.—At such time as the Secretary may require before the beginning of each fiscal year, each State shall submit to the Secretary such information as the Secretary may require to estimate the capped Federal payment amount under this section for the succeeding calendar year (and the portion of such year that falls in such fiscal year).

(2) ESTIMATION.—Before the beginning of each year, the Secretary shall estimate the capped Federal payment amount for calendar quarters in such year. Such estimate shall be based on factors including prior financial experience in the State, future estimates of income, wages, and employment, and

other characteristics of the area found relevant by the Secretary. The Secretary shall transmit to Congress, on a timely basis consistent with the timely appropriation of funds under this section, a report that specifies an estimate of the total capped Federal amounts owed to States under this section for the fiscal and calendar year involved.

(d) CAP ON PAYMENTS.—

(1) IN GENERAL.—The total amount of the capped Federal payments made under this section for quarters in a fiscal year may not exceed the cap specified under paragraph (2) for the fiscal year.

(2) CAP.—Subject to paragraphs (3) and (6)—

(A) FISCAL YEARS 1997 THROUGH 2000.—The cap under this paragraph for fiscal years 1997 through 2000 shall be established by the Secretary, in consultation with the Director of the Office of Management and Budget, not later than 6 months prior to the beginning of fiscal year 1997. The cap for each such fiscal year shall be equal to the estimated increase in revenues and savings provided for by this Act to finance the cost of capped Federal payments under this section.

(B) SUBSEQUENT FISCAL YEAR.—The cap under this paragraph for a fiscal year after fiscal year 2000 is the cap under this paragraph for the previous fiscal year (not taking into account paragraph (3)) multiplied by the product of the factors described in subparagraph (C) for that fiscal year and for each previous year after fiscal year 2000.

(C) FACTOR.—The factor described in this subparagraph for a fiscal year is 1 plus the following:

(i) CPI.—The percentage change in the CPI for the fiscal year, determined based upon the percentage change in the average of the CPI for the 12-month period ending with May 31 of the previous fiscal year over such average for the preceding 12-month period.

(ii) POPULATION.—The average annual percentage change in the population of the United States during the 3-year period ending in the preceding calendar year, determined by the Secretary based on data supplied by the Bureau of the Census.

(iii) REAL GDP PER CAPITA.—The average annual percentage change in the real, per capita gross domestic product of the United States during the 3-year period ending in the preceding calendar year, determined by the Secretary based on data supplied by the Department of Commerce.

(3) CARRYFORWARD.—If the total of the capped Federal payment amounts for all States for all calendar quarters in a fiscal year is less than the cap specified in paragraph (2) for the fiscal year, then the amount of such surplus shall be accumulated and will be available in the case of a year in which the cap would otherwise be breached.

(4) NOTIFICATION.—

(A) IN GENERAL.—If the Secretary anticipates that the amount of the cap, plus any carryforward from a previous year accumulated under paragraph (3), will not be sufficient for a fiscal year, the Secretary shall notify the President, the Congress, and each State. Such notification shall include information about the anticipated amount of the shortfall and the anticipated time when the shortfall will first occur.

(B) REQUIRED ACTION.—Within 30 days after receiving such a notice, the President shall submit to Congress a report containing specific legislative recommendations for actions which would eliminate the shortfall.

(5) CONGRESSIONAL CONSIDERATION.—

(A) EXPEDITED CONSIDERATION.—If a joint resolution the substance of which approves the specific recommendations submitted under paragraph (4)(B) is introduced, subject to subparagraph (B), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of the joint resolution in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(B) SPECIAL RULES.—For purposes of applying subparagraph (A) with respect to such provisions, any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of rec-

ommendations under paragraph (4)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the Senate (specified by the Majority Leader of the Senate at the time of submission of such recommendations).

(6) FAILURE OF THE CONGRESS TO ACT.—If the Congress disapproves the President's recommendations under this section and fails to enact an alternative proposal which is signed to law by the President which is designed to eliminate such shortfall, the Secretary shall provide for a schedule of proportional reductions in discounts to businesses and individuals to be applied by States and an equal reduction in capped Federal payments to States sufficient to eliminate the shortfall within a reasonable period of time.

(7) METHOD FOR ADJUSTING THE CAP FOR CHANGES IN INFLATION.—If the inflation rate, as measured by the percentage increase in the CPI, is projected to be significantly different from the inflation rate projected by the Council of Economic Advisors to the President as of October 1993, the Secretary may adjust the caps under paragraph (2) so as to reflect such deviation from the projection.

Subtitle B—Borrowing Authority to Cover Cash-flow Shortfalls

SEC. 6101. BORROWING AUTHORITY TO COVER CASH-FLOW SHORTFALLS.

The Secretary may make available loans to States in order to cover any period of temporary cash-flow shortfall at a rate of interest determined by the Secretary of the Treasury. Loans under this section shall be repayable with interest over a period not to exceed two years.

SEC. 6102. CONTINGENCIES.

Each State shall provide that any surplus of funds resulting from an estimation discrepancy described in section 6200(e)(1), up to a reasonable amount specified by the Secretary, shall be used to fund any future shortfalls resulting from such a discrepancy.

Subtitle C—Miscellaneous Provisions

SEC. 6201. SENSE OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES.

It is the sense of the Committee on Labor and Human Resources that when the Affordable Health Care for All Americans Act is enacted it should include the following provisions:

(1) A requirement that States pay premiums for AFDC and SSI recipients at a level established

in the same manner as that described in title IX of S. 1757 (the Health Security Act), as introduced on November 22, 1993.

(2) A requirement that States make maintenance of effort payments to be included in the amounts receivable under section 6001(b)(3) at a level established in the same manner as that described in title IX of S. 1757 (the Health Security Act), as introduced on November 22, 1993.

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