

103^D CONGRESS
1ST SESSION

S. 1533

To improve access to health insurance and contain health care costs, and
for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 7 (legislative day, SEPTEMBER 27), 1993

Mr. LOTT introduced the following bill; which was read twice and referred to
the Committee on Finance

A BILL

To improve access to health insurance and contain health
care costs, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Affordable Health Care Now Act of 1993”.

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for
Employees and Their Families

PART 1—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE EMPLOYEES,
SPOUSES, AND DEPENDENTS

- Sec. 1001. Requiring employers to offer option of coverage for eligible individuals.
- Sec. 1002. Compliance with applicable requirements through multiple employer health arrangements.
- Sec. 1003. Coverage option under State Medical Health Allowance Program.

PART 2—PREEXISTING CONDITIONS AND CONTINUITY OF COVERAGE;
RENEWABILITY

- Sec. 1011. Limitation on pre-existing condition clauses.
- Sec. 1012. Assurance of continuity of coverage through previous satisfaction of pre-existing condition requirement.
- Sec. 1013. Requirements relating to renewability generally.

PART 3—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

- Sec. 1021. Enforcement.
- Sec. 1022. Effective dates.
- Sec. 1023. Definitions and special rules.

Subtitle B—Reform of Health Insurance Marketplace for Small Business

- Sec. 1101. Requirement for insurers to offer MedAccess plans.
- Sec. 1102. MedAccess plan defined.
- Sec. 1103. Establishment of other MedAccess standards.
- Sec. 1104. Limits on premiums and miscellaneous consumer protections.
- Sec. 1105. Limitation on annual premium increases.
- Sec. 1106. Establishment of reinsurance or allocation of risk mechanisms for high risk individuals in marketplace for small business.
- Sec. 1107. Definitions.
- Sec. 1108. Office of Private Health Care Coverage; annual reports on evaluation of health care coverage reform.
- Sec. 1109. Research and demonstration projects; development of a health risk pooling model.

Subtitle C—Preemption

PART 1—SCOPE OF STATE REGULATION

- Sec. 1201. Prohibition of State benefit mandates for group health plans.
- Sec. 1202. Prohibition of provisions prohibiting employer groups from purchasing health insurance.
- Sec. 1203. Restrictions on managed care.
- Sec. 1204. Definitions.

PART 2—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS

- Sec. 1211. Limited exemption under preemption rules for multiple employer plans providing health benefits subject to certain Federal standards.

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

- “Sec. 701. Definitions.

“Sec. 702. Exempted multiple employer plans providing benefits in the form of medical care relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.

“Sec. 703. Exemption procedure.

“Sec. 704. Eligibility requirements.

“Sec. 705. Additional requirements applicable to exempted arrangements.

“Sec. 706. Disclosure to participating employers by arrangements providing medical care.

“Sec. 707. Maintenance of reserves.

“Sec. 708. Corrective actions.

“Sec. 709. Expiration, suspension, or revocation of exemption.

“Sec. 710. Review of actions of the Secretary.

Sec. 1212. Clarification of scope of preemption rules.

Sec. 1213. Clarification of treatment of single employer arrangements.

Sec. 1214. Clarification of treatment of certain collectively bargained arrangements.

Sec. 1215. Employee leasing healthcare arrangements.

Sec. 1216. Enforcement provisions relating to multiple employer welfare arrangements and employee leasing healthcare arrangements.

Sec. 1217. Filing requirements for health benefit multiple employer welfare arrangements.

Sec. 1218. Cooperation between Federal and State authorities.

Sec. 1219. Effective date; transitional rules.

PART 3—ENCOURAGEMENT OF MULTIPLE EMPLOYER ARRANGEMENTS PROVIDING BASIC HEALTH BENEFITS

Sec. 1221. Eliminating commonality of interest or geographic location requirement for tax exempt trust status.

PART 4—SIMPLIFYING FILING OF REPORTS FOR EMPLOYERS COVERED UNDER INSURED MULTIPLE EMPLOYER HEALTH PLANS

Sec. 1231. Single annual filing for all employers covered under an insured multiple employer health plan.

PART 5—COMPLIANCE WITH COVERAGE OPTION REQUIREMENTS

Sec. 1241. Compliance with coverage requirements through multiple employer health arrangements.

SUBTITLE D—HEALTH DEDUCTION FAIRNESS

Sec. 1301. Permanent extension and increase in health insurance tax deduction for self-employed individuals.

Sec. 1302. Deduction of health insurance premiums for certain previously uninsured individuals.

SUBTITLE E—IMPROVED ACCESS TO COMMUNITY HEALTH SERVICES

PART 1—INCREASED AUTHORIZATION FOR COMMUNITY AND MIGRANT HEALTH CENTERS

Sec. 1401. Grant program to promote primary health care services for underserved populations.

PART 2—GRANTS FOR PROJECTS FOR COORDINATING DELIVERY OF SERVICES

Sec. 1411. Projects for coordinating delivery of outpatient primary health services.

SUBTITLE F—IMPROVED ACCESS TO RURAL HEALTH SERVICES

PART 1—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS UNDER MEDICARE

Sec. 1501. Rural emergency access care hospitals described.
 Sec. 1502. Coverage of and payment for services.
 Sec. 1503. Effective date.

PART 2—RURAL MEDICAL EMERGENCIES AIR TRANSPORT

Sec. 1511. Grants to States regarding aircraft for transporting rural victims of medical emergencies.

PART 3—EMERGENCY MEDICAL SERVICES AMENDMENTS

Sec. 1521. Establishment of Office of Emergency Medical Services.
 Sec. 1522. State offices of emergency medical services.
 Sec. 1523. Programs for rural areas.
 Sec. 1524. Funding.
 Sec. 1525. Conforming amendments.
 Sec. 1526. Effective date.

SUBTITLE G—STATE FLEXIBILITY IN THE MEDICAID PROGRAM: THE MEDICAL HEALTH ALLOWANCE PROGRAM

Sec. 1601. Establishment of program.
 Sec. 1602. Optional use of program to offer coverage to some or all State residents.

SUBTITLE H—MEDICAID PROGRAM FLEXIBILITY

Sec. 1701. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under medicaid.
 Sec. 1702. Period of certain waivers.

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

SUBTITLE A—MEDICAL MALPRACTICE LIABILITY REFORM

PART 1—GENERAL PROVISIONS

Sec. 2001. Federal reform of medical malpractice liability actions.
 Sec. 2002. Definitions.
 Sec. 2003. Effective date.

PART 2—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

Sec. 2011. Requirement for initial resolution of action through alternative dispute resolution.
 Sec. 2012. Calculation and payment of damages.
 Sec. 2013. Treatment of attorney's fees and other costs.

- Sec. 2014. Joint and several liability.
- Sec. 2015. Statute of limitations.
- Sec. 2016. Uniform standard for determining negligence.
- Sec. 2017. Special provision for certain obstetric services.

PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

- Sec. 2031. Basic requirements.
- Sec. 2032. Certification of State systems; applicability of alternative Federal system.
- Sec. 2033. Reports on implementation and effectiveness of alternative dispute resolution systems.

PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

- Sec. 2041. Permitting State professional societies to participate in disciplinary activities.
- Sec. 2042. Study of incentives to encourage voluntary service by physicians.
- Sec. 2043. Requirements for risk management programs.
- Sec. 2044. Grants for medical safety promotion.

SUBTITLE B—ADMINISTRATIVE COST SAVINGS

PART 1—STANDARDIZATION OF CLAIMS PROCESSING

- Sec. 2101. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
- Sec. 2102. Application of standards.
- Sec. 2103. Periodic review and revision of standards.
- Sec. 2104. Health benefit plan defined.

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

- Sec. 2111. Medical data standards for hospitals and other providers.
- Sec. 2112. Application of electronic data standards to certain hospitals.
- Sec. 2113. Electronic transmission to Federal agencies.
- Sec. 2114. Limitation on data requirements where standards in effect.
- Sec. 2115. Advisory commission.

PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

- Sec. 2121. State comparative value information programs for health care purchasing.
- Sec. 2122. Federal implementation.
- Sec. 2123. Comparative value information concerning Federal programs.
- Sec. 2124. Development of model systems.

PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS; RESEARCH AND DEMONSTRATIONS

- Sec. 2131. Standards relating to use of medicare and medicaid magnetized health benefit cards; secondary payor data bank.
- Sec. 2132. Preemption of State quill pen laws.
- Sec. 2133. Use of standard identification numbers.
- Sec. 2134. Coordination of benefit standards.

Sec. 2135. Research and demonstrations.

SUBTITLE C—DEDUCTION FOR COST OF CATASTROPHIC HEALTH PLAN;
MEDICAL SAVINGS ACCOUNTS

Sec. 2201. Individuals allowed deduction from gross income for cost of catastrophic health plan.

Sec. 2202. Medical savings accounts.

SUBTITLE D—ANTI-FRAUD

PART 1—CRIMINAL PROSECUTION OF HEALTH CARE FRAUD

Sec. 2301. Penalties for health care fraud.

Sec. 2302. Broadening application of mail fraud statute.

Sec. 2303. Authorization of appropriations.

Sec. 2304. Rewards for information leading to prosecution and conviction.

PART 2—COORDINATION OF HEALTH CARE ANTI-FRAUD AND ABUSE
ACTIVITIES

Sec. 2311. Establishment of all-payer anti-fraud and abuse program.

Sec. 2312. Authorization of additional appropriations for investigators and other personnel.

Sec. 2313. Establishment of anti-fraud and abuse trust fund.

Sec. 2314. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health benefit plan.

SUBTITLE E—MEDICARE PAYMENT CHANGES; PART B PREMIUM TAX FOR
HIGH-INCOME INDIVIDUALS

PART 1—MEDICARE PAYMENT CHANGES

Sec. 2401. Elimination of membership limitation for medicare hmos.

Sec. 2402. Expansion and revision of medicare select policies.

Sec. 2403. Improved efficiency through consolidation of administration of parts A and B.

PART 2—PART B PREMIUM TAX FOR HIGH-INCOME INDIVIDUALS

Sec. 2411. Increase in medicare part B premium for individuals with high income.

SUBTITLE F—REMOVING ANTI-TRUST IMPEDIMENTS

Sec. 2501. Establishment of limited exemption program for health care joint ventures.

Sec. 2502. Issuance of health care certificates of public advantage.

Sec. 2503. Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care.

Sec. 2504. Definitions.

SUBTITLE G—ENCOURAGING ENFORCEMENT ACTIVITIES OF MEDICAL SELF-
REGULATORY ENTITIES

PART 1—APPLICATION OF THE CLAYTON ACT TO MEDICAL SELF-
REGULATORY ENTITIES

Sec. 2601. Antitrust exemption for medical self-regulatory entities.

Sec. 2602. Definitions.

PART 2—CONSULTATION BY FEDERAL AGENCIES

Sec. 2611. Consultation with medical self-regulatory entities respecting medical professional guidelines and standards.

SUBTITLE H—PREFUNDING GOVERNMENT HEALTH BENEFITS FOR CERTAIN ANNUITANTS

Sec. 2701. Requirement that certain agencies prefund government health benefits contributions for their annuitants.

SUBTITLE I—MISCELLANEOUS PROVISIONS

Sec. 2801. Increase in minimum age required in order to be eligible for an immediate civil service annuity.

TITLE III—LONG-TERM CARE

SUBTITLE A—TAX TREATMENT OF LONG-TERM CARE INSURANCE

Sec. 3001. Treatment of long-term care insurance or plans.

Sec. 3002. Exclusion for benefits provided under long-term care insurance; inclusion of employer-provided coverage.

Sec. 3003. Qualified long-term services treated as medical care.

Sec. 3004. Certain exchanges of life insurance contracts for long-term care insurance contracts not taxable.

Sec. 3005. Exclusion from gross income for amounts withdrawn from individual retirement plans or 401(k) plans for long-term care insurance.

Sec. 3006. Tax treatment of accelerated death benefits under life insurance contracts.

Sec. 3007. Effective date.

SUBTITLE B—PROTECTION OF ASSETS UNDER MEDICAID THROUGH USE OF QUALIFIED LONG-TERM CARE INSURANCE

Sec. 3101. Protection of assets through use of qualified long-term care insurance.

SUBTITLE C—STUDIES

Sec. 3201. Feasibility of encouraging health care providers to donate services to homebound patients.

Sec. 3202. Feasibility of tax credit for heads of households who care for elderly family members in their homes.

Sec. 3203. Case management of current long-term care benefits.

SUBTITLE D—VOLUNTEER SERVICE CREDIT DEMONSTRATION PROJECTS

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1 **TITLE I—IMPROVED ACCESS TO**
2 **AFFORDABLE HEALTH CARE**
3 **Subtitle A—Increased Availability**
4 **and Continuity of Health Cov-**
5 **erage for Employees and Their**
6 **Families**

7 **PART 1—REQUIRED COVERAGE OPTIONS**
8 **FOR ELIGIBLE EMPLOYEES, SPOUSES,**
9 **AND DEPENDENTS**

10 **SEC. 1001. REQUIRING EMPLOYERS TO OFFER OPTION OF**
11 **COVERAGE FOR ELIGIBLE INDIVIDUALS.**

12 (a) IN GENERAL.—Each employer shall make avail-
13 able with respect to each eligible employee a group health
14 plan under which—

15 (1) coverage of each eligible individual with re-
16 spect to such an eligible employee may be elected on
17 an annual basis for each plan year,

18 (2) subject to subsection (d), coverage is pro-
19 vided for at least the required coverage specified in
20 subsection (c), and

21 (3) each eligible employee electing such cov-
22 erage may elect to have any premiums owed by the
23 employee collected through payroll deduction.

24 An employer is not required under this subsection to make
25 any contribution to the cost of coverage under such a plan.

1 (b) SPECIAL RULES.—

2 (1) EXCLUSION OF NEW EMPLOYERS AND CER-
3 TAIN SMALL EMPLOYERS.—Subsection (a) shall not
4 apply to any employer for any plan year if, as of the
5 beginning of such plan year—

6 (A) such employer (including any prede-
7 cessor thereof) has been an employer for less
8 than 2 years,

9 (B) such employer has no more than 2 eli-
10 gible employees, or

11 (C) no more than 2 eligible employees are
12 not covered under any group health plan.

13 (2) EXCLUSION OF FAMILY MEMBERS.—Under
14 such procedures as the Secretary may prescribe, any
15 relative of an employer may be, at the election of the
16 employer, excluded from consideration as an eligible
17 employee for purposes of applying the requirements
18 of subsection (a). In the case of an employer that is
19 not an individual, an employee who is a relative of
20 a key employee (as defined in section 416(i)(1) of
21 the Internal Revenue Code of 1986) of the employer
22 may, at the election of the key employee, be consid-
23 ered a relative excludible under this paragraph.

24 (3) OPTIONAL APPLICATION OF WAITING PE-
25 RIOD.—A group health plan shall not be treated as

1 failing to meet the requirements of subsection (a)
2 solely because a period of service by an eligible em-
3 ployee of not more than 60 days is required under
4 the plan for coverage under the plan of eligible indi-
5 viduals with respect to such employee.

6 (c) REQUIRED COVERAGE.—

7 (1) IN GENERAL.—Except as provided in para-
8 graph (2), the required coverage specified in this
9 subsection is standard coverage (consistent with sec-
10 tion 1102(c)).

11 (2) SPECIAL TREATMENT OF SMALL EMPLOY-
12 ERS NOT CONTRIBUTING TO EMPLOYEE COV-
13 ERAGE.—In the case of a small employer (as defined
14 in section 1107(9)) that has not contributed during
15 the previous plan year to the cost of coverage for
16 any eligible employee under any group health plan,
17 the required coverage specified in this subsection for
18 the plan year (with respect to each eligible employee)
19 is—

20 (A) coverage under a MedAccess standard
21 plan,

22 (B) coverage under a MedAccess cata-
23 strophic plan, and

24 (C) coverage under a MedAccess medisave
25 plan,

1 as such terms are defined in section 1102(a)(2).

2 (3) CONSTRUCTION.—Nothing in this section
3 shall be construed as limiting the group health
4 plans, or types of coverage under such a plan, that
5 an employer may offer to an employee.

6 (d) 5-YEAR TRANSITION FOR EXISTING GROUP
7 HEALTH PLANS.—

8 (1) IN GENERAL.—The requirement of sub-
9 section (a)(2), and section 1002(c)(2), shall not
10 apply to a group health plan for a plan year if—

11 (A) the group health plan is in effect in
12 the plan year in which September 1, 1993, oc-
13 curs, and

14 (B) the employer makes (or offers to
15 make), in such plan year and the plan year in-
16 volved, a contribution to the plan on behalf of
17 each employee who is eligible to participate in
18 the plan.

19 (2) SUNSET.—Paragraph (1) shall only apply to
20 a group health plan for each of the 5 plan years be-
21 ginning with the first plan year to which the require-
22 ment of subsection (a) applies.

1 **SEC. 1002. COMPLIANCE WITH APPLICABLE REQUIRE-**
2 **MENTS THROUGH MULTIPLE EMPLOYER**
3 **HEALTH ARRANGEMENTS.**

4 For provision easing compliance with applicable re-
5 quirements through multiemployer plans and through
6 other multiple employer health arrangements, see section
7 1241.

8 **SEC. 1003. COVERAGE OPTION UNDER STATE MEDICAL**
9 **HEALTH ALLOWANCE PROGRAM.**

10 For a provision permitting a State medical health al-
11 lowance program under the medicaid program or other
12 State program to offer health insurance coverage to resi-
13 dents of the State without regard to income, see the
14 amendment made by section 1602.

15 **PART 2—PREEXISTING CONDITIONS AND**
16 **CONTINUITY OF COVERAGE; RENEW-**
17 **ABILITY**

18 **SEC. 1011. LIMITATION ON PREEXISTING CONDITION**
19 **CLAUSES.**

20 A group health plan may not impose (and an insurer
21 may not require an employer under a group health plan
22 to impose through a waiting period for coverage under a
23 plan or similar requirement) a limitation or exclusion of
24 benefits relating to treatment of a condition based on the
25 fact that the condition preexisted the effective date of the
26 plan with respect to an individual if—

1 (1) the condition relates to a condition that was
2 not diagnosed or treated within 3 months before the
3 date of coverage under the plan;

4 (2) the limitation or exclusion extends over
5 more than 6 months after the date of coverage
6 under the plan;

7 (3) the limitation or exclusion applies to an in-
8 dividual who, as of the date of birth, was covered
9 under the plan; or

10 (4) the limitation or exclusion relates to preg-
11 nancy.

12 In the case of an individual who is eligible for coverage
13 under a plan but for a waiting period imposed by the em-
14 ployer, in applying paragraphs (1) and (2), the individual
15 shall be treated as having been covered under the plan
16 as of the earliest date of the beginning of the waiting pe-
17 riod.

18 **SEC. 1012. ASSURANCE OF CONTINUITY OF COVERAGE**
19 **THROUGH PREVIOUS SATISFACTION OF PRE-**
20 **EXISTING CONDITION REQUIREMENT.**

21 (a) IN GENERAL.—Each group health plan shall
22 waive any period applicable to a preexisting condition for
23 similar benefits with respect to an individual to the extent
24 that the individual, prior to the date of such individual's
25 enrollment in such plan, was covered for the condition

1 under any other health plan that was in effect before such
2 date.

3 (b) CONTINUOUS COVERAGE REQUIRED.—

4 (1) IN GENERAL.—Subsection (a) shall no
5 longer apply if there is a continuous period of more
6 than 60 days (or, in the case of an individual de-
7 scribed in paragraph (3), 6 months) on which the in-
8 dividual was not covered under a group health plan.

9 (2) TREATMENT OF WAITING PERIODS.—In ap-
10 plying paragraph (1), any waiting period imposed by
11 an employer before an employee is eligible to be cov-
12 ered under a plan shall be treated as a period in
13 which the employee was covered under a group
14 health plan.

15 (3) JOB TERMINATION.—An individual is de-
16 scribed in this paragraph if the individual loses cov-
17 erage under a group health plan due to termination
18 of employment.

19 (4) EXCLUSION OF CASH-ONLY AND DREAD
20 DISEASE PLANS.—In this subsection, the term
21 “group health plan” does not include any group
22 health plan which is offered primarily to provide—

23 (A) coverage for a specified disease or ill-
24 ness, or

1 (B) a hospital or fixed indemnity policy,
2 unless the Secretary determines that such a
3 plan provides sufficiently comprehensive cov-
4 erage of a benefit so that it should be treated
5 as a group health plan under this subsection.

6 **SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY**
7 **GENERALLY.**

8 (a) MULTIEMPLOYER PLANS AND EXEMPTED MUL-
9 TIPLE EMPLOYER HEALTH PLANS.—A multiemployer
10 plan and an exempted multiple employer health plan may
11 not cancel coverage or deny renewal of coverage under
12 such a plan with respect to an employer other than—

- 13 (1) for nonpayment of contributions,
14 (2) for fraud or other misrepresentation by the
15 employer,
16 (3) for noncompliance with plan provisions,
17 (4) for misuse of a provider network provision,
18 or
19 (5) because the plan is ceasing to provide any
20 coverage in a geographic area.

21 (b) INSURERS.—

22 (1) IN GENERAL.—An insurer may not cancel a
23 health insurance plan or deny renewal of coverage
24 under such a plan other than—

- 25 (A) for nonpayment of premiums,

1 (B) for fraud or other misrepresentation
 2 by the insured,

3 (C) for noncompliance with plan provi-
 4 sions,

5 (D) for misuse of a provider network provi-
 6 sion, or

7 (E) because the insurer is ceasing to pro-
 8 vide any health insurance plan in a State, or,
 9 in the case of a health maintenance organiza-
 10 tion, in a geographic area.

11 (2) LIMITATION ON MARKET REENTRY.—If an
 12 insurer terminates the offering of health insurance
 13 plans in an area, the insurer may not offer such a
 14 health insurance plan to any employer in the area
 15 until 5 years after the date of the termination.

16 **PART 3—ENFORCEMENT; EFFECTIVE**
 17 **DATES; DEFINITIONS**

18 **SEC. 1021. ENFORCEMENT.**

19 (a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR
 20 EMPLOYERS AND GROUP HEALTH PLANS.—

21 (1) IN GENERAL.—For purposes of part 5 of
 22 subtitle B of title I of the Employee Retirement In-
 23 come Security Act of 1974, the provisions of parts
 24 1 and 2 of this subtitle shall be deemed to be provi-

1 sions of title I of such Act irrespective of exclusions
2 under section 4(b) of such Act.

3 (2) REGULATORY AUTHORITY.—With respect to
4 the regulatory authority of the Secretary of Labor
5 under this subtitle pursuant to subsection (a), sec-
6 tion 505 of the Employee Retirement Income Secu-
7 rity Act of 1974 (29 U.S.C. 1135) shall apply.

8 (b) ENFORCEMENT BY EXCISE TAX FOR INSUR-
9 ERS.—

10 (1) IN GENERAL.—Chapter 43 of the Internal
11 Revenue Code of 1986 (relating to qualified pension,
12 etc., plans) is amended by adding at the end thereof
13 the following new section:

14 **“SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH**
15 **HEALTH INSURANCE STANDARDS.**

16 **“(a) IMPOSITION OF TAX.—**

17 **“(1) IN GENERAL.—**There is hereby imposed a
18 tax on the failure of an insurer to comply with the
19 requirements applicable to the insurer under part 2
20 of subtitle A of title I of the Affordable Health Care
21 Now Act of 1993.

22 **“(2) EXCEPTION.—**Paragraph (1) shall not
23 apply to a failure by an insurer in a State if the Sec-
24 retary of Health and Human Services determines
25 that the State has in effect a regulatory enforcement

1 mechanism that provides adequate sanctions with re-
2 spect to such a failure by such an insurer.

3 “(b) AMOUNT OF TAX.—

4 “(1) IN GENERAL.—Subject to paragraph (2),
5 the amount of the tax imposed by subsection (a)
6 shall be \$100 for each day during which such failure
7 persists for each individual to which such failure re-
8 lates. A rule similar to the rule of section
9 4980B(b)(3) shall apply for purposes of this section.

10 “(2) LIMITATION.—The amount of the tax im-
11 posed by subsection (a) for an insurer with respect
12 to a health insurance plan shall not exceed 25 per-
13 cent of the amounts received under the plan for cov-
14 erage during the period such failure persists.

15 “(c) LIABILITY FOR TAX.—The tax imposed by this
16 section shall be paid by the insurer.

17 “(d) EXCEPTIONS.—

18 “(1) CORRECTIONS WITHIN 30 DAYS.—No tax
19 shall be imposed by subsection (a) by reason of any
20 failure if—

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

23 “(B) such failure is corrected within the
24 30-day period beginning on the earliest date the

1 insurer knew, or exercising reasonable diligence
2 would have known, that such failure existed.

3 “(2) WAIVER BY SECRETARY.—In the case of a
4 failure which is due to reasonable cause and not to
5 willful neglect, the Secretary may waive part or all
6 of the tax imposed by subsection (a) to the extent
7 that payment of such tax would be excessive relative
8 to the failure involved.

9 “(e) DEFINITIONS.—For purposes of this section, the
10 terms ‘health insurance plan’ and ‘insurer’ have the re-
11 spective meanings given such terms in section 1023 of the
12 Affordable Health Care Now Act of 1993.”

13 (2) CLERICAL AMENDMENT.—The table of sec-
14 tions for chapter 43 of such Code is amended by
15 adding at the end thereof the following new items:

“Sec. 4980C. Failure of insurer to comply with health insurance
standards.”

16 **SEC. 1022. EFFECTIVE DATES.**

17 (a) PART 1.—The requirements of part 1 shall apply
18 to plans years beginning after December 31, 1996.

19 (b) PART 2.—The requirements of part 2 with re-
20 spect to—

21 (1) group health plans and employers shall
22 apply to plans years beginning after December 31,
23 1996, and

1 (2) insurers shall take effect on January 1,
2 1997.

3 **SEC. 1023. DEFINITIONS AND SPECIAL RULES.**

4 (a) IN GENERAL.—For purposes of this subtitle:

5 (1) DEPENDENT.—The term “dependent”
6 means, with respect to any individual, any person
7 who is—

8 (A) the spouse or surviving spouse of the
9 individual, or

10 (B) under regulations of the Secretary, a
11 child (including an adopted child) of such indi-
12 vidual and—

13 (i) under 19 years of age, or

14 (ii) under 25 years of age and a full-
15 time student.

16 (2) ELIGIBLE EMPLOYEE.—The term “eligible
17 employee” means, with respect to an employer, an
18 employee who normally performs on a monthly basis
19 at least 30 hours of service per week for that em-
20 ployer.

21 (3) ELIGIBLE INDIVIDUAL.—The term “eligible
22 individual” means, with respect to an eligible em-
23 ployee, such employee, and any dependent of such
24 employee.

1 (4) EMPLOYER.—The term “employer” shall
2 have the meaning applicable under section 3(5) of
3 the Employee Retirement Income Security Act of
4 1974.

5 (5) EXEMPTED MULTIPLE EMPLOYER HEALTH
6 PLAN.—The term “exempted multiple employer
7 health plan” means a multiple employer welfare ar-
8 rangement treated as an employee welfare benefit
9 plan by reason of an exemption under part 7 of sub-
10 title B of title I of the Employee Retirement Income
11 Security Act of 1974 (as added by part 2 of subtitle
12 C of this title).

13 (6) GROUP HEALTH PLAN; PLAN.—(A) The
14 term “group health plan” means an employee wel-
15 fare benefit plan providing medical care (as defined
16 in section 213(d) of the Internal Revenue Code of
17 1986) to participants or beneficiaries directly or
18 through insurance, reimbursement, or otherwise, but
19 does not include any type of coverage excluded from
20 the definition of a health insurance plan under sec-
21 tion 1107(4)(B).

22 (B) The term “plan” means, unless used with
23 a modifying term or the context specifically indicates
24 otherwise, a group health plan (including any such
25 plan which is a multiemployer plan), an exempted

1 multiple employer health plan, or an insured mul-
2 tiple employer health plan.

3 (7) HEALTH INSURANCE PLAN.—The term
4 “health insurance plan” has the meaning given such
5 term in section 1107(4).

6 (8) INSURED MULTIPLE EMPLOYER HEALTH
7 PLAN.—The term “insured multiple employer health
8 plan” has the meaning given such term in section
9 701(11) of Employee Retirement Income Security
10 Act of 1974 (as added by section 1211 of this title).

11 (9) INSURER.—The term “insurer” has the
12 meaning given such term in section 1107(6).

13 (b) SPECIAL RULES.—

14 (1) GENERAL RULE.—Except as otherwise pro-
15 vided in this subtitle, for definitions of terms used
16 in this subtitle, see section 3 of the Employee Re-
17 tirement Income Security Act of 1974 (29 U.S.C.
18 1002).

19 (2) SECRETARY.—Except with respect to ref-
20 erences specifically to the Secretary of Labor, the
21 term “Secretary” means the Secretary of Health
22 and Human Services.

1 **Subtitle B—Reform of Health In-**
 2 **surance Marketplace for Small**
 3 **Business**

4 **SEC. 1101. REQUIREMENT FOR INSURERS TO OFFER**
 5 **MEDACCESS PLANS.**

6 (a) REQUIREMENT.—

7 (1) IN GENERAL.—Each insurer (as defined in
 8 section 1107(6)) that makes available any health in-
 9 surance plan (as defined in section 1107(4)) to a
 10 small employer (as defined in section 1107(9)) in a
 11 State shall make available to each small employer in
 12 the State—

13 (A) a MedAccess standard plan (as defined
 14 in section 1102(a)(2)),

15 (B) a MedAccess catastrophic plan (as de-
 16 fined in section 1102(a)(2)), and

17 (C) a MedAccess medisave plan (as defined
 18 in section 1102(a)(2)).

19 (2) SPECIAL RULE FOR HEALTH MAINTENANCE
 20 ORGANIZATIONS.—The requirements of paragraphs
 21 (1)(B) and (1)(C) shall not apply with respect to a
 22 health insurance plan that—

23 (A) is a Federally qualified health mainte-
 24 nance organization (as defined in section
 25 1301(a) of the Public Health Service Act), or

1 (B) is not such an organization but is rec-
 2 ognized under State law as a health mainte-
 3 nance organization or managed care organiza-
 4 tion or a similar organization regulated under
 5 State law for solvency.

6 (3) EXCEPTION IF STATE PROVIDES FOR GUAR-
 7 ANTEED AVAILABILITY (RATHER THAN GUARANTEED
 8 ISSUE).—Paragraph (1) shall not apply to an insurer
 9 in a State if the State is providing—

10 (A) access to each small employer in the
 11 State to a MedAccess standard plan, to a
 12 MedAccess catastrophic plan, and to a
 13 MedAccess medisave plan, and

14 (B) a risk allocation mechanism described
 15 in subsection (c).

16 (b) GUARANTEED ISSUE OF MEDACCESS PLANS.—
 17 Subject to subsection (c)—

18 (1) IN GENERAL.—Subject to paragraph (2),
 19 each insurer that offers a MedAccess plan to a small
 20 employer in a State—

21 (A) must accept every small employer in
 22 the State that applies for coverage under the
 23 plan; and

24 (B) must accept for enrollment under the
 25 plan every eligible individual (as defined in

1 paragraph (4)) who applies for enrollment on a
2 timely basis (consistent with paragraph (3))
3 and may not place any restriction on the eligi-
4 bility of an individual to enroll so long as such
5 individual is an eligible individual.

6 (2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a plan of-
7 fered by a health maintenance organization, the plan
8 may—
9

10 (A) limit the employers that may apply for
11 coverage to those with eligible individuals resid-
12 ing in the service area of the plan;

13 (B) limit the individuals who may be en-
14 rolled under the plan to those who reside in the
15 service area of the plan; and

16 (C) within the service area of the plan,
17 deny coverage to such employers if the plan
18 demonstrates that—

19 (i) it will not have the capacity to de-
20 liver services adequately to enrollees of any
21 additional groups because of its obligations
22 to existing group contract holders and en-
23 rollees, and

24 (ii) it is applying this subparagraph
25 uniformly to all employers without regard

1 to the health status, claims experience, or
2 duration of coverage of those employers
3 and their employees.

4 In this paragraph, the term “health maintenance or-
5 ganization” includes an organization recognized
6 under State law as a health maintenance organiza-
7 tion or managed care organization or a similar orga-
8 nization regulated under State law for solvency.

9 (3) CLARIFICATION OF TIMELY ENROLL-
10 MENT.—

11 (A) GENERAL INITIAL ENROLLMENT RE-
12 QUIREMENT.—Except as provided in this para-
13 graph, a MedAccess plan may consider enroll-
14 ment of an eligible individual not to be timely
15 if the eligible employee or dependent fails to en-
16 roll in the plan during an initial enrollment pe-
17 riod, if such period is at least 30 days long.

18 (B) ENROLLMENT DUE TO LOSS OF PRE-
19 VIOUS EMPLOYER COVERAGE.—Enrollment in a
20 MedAccess plan is considered to be timely in
21 the case of an eligible individual who—

22 (i) was covered under another health
23 insurance plan or group health plan at the
24 time of the individual’s initial enrollment
25 period,

1 (ii) stated at the time of the initial en-
2 rollment period that coverage under a
3 health insurance plan or a group health
4 plan was the reason for declining enroll-
5 ment,

6 (iii) lost coverage under another
7 health insurance plan or group health plan
8 (as a result of the termination of the other
9 plan's coverage, termination or reduction
10 of employment, or other reason), and

11 (iv) requests enrollment within 30
12 days after termination of such coverage.

13 (C) REQUIREMENT APPLIES DURING OPEN
14 ENROLLMENT PERIODS.—Each MedAccess plan
15 shall provide for at least one period (of not less
16 than 30 days) each year during which enroll-
17 ment under the plan shall be considered to be
18 timely.

19 (D) EXCEPTION FOR COURT ORDERS.—
20 Enrollment of a spouse or minor child of an
21 employee shall be considered to be timely if—

22 (i) a court has ordered that coverage
23 be provided for the spouse or child under
24 a covered employee's group health plan,
25 and

1 (ii) a request for enrollment is made
2 within 30 days after the date the court is-
3 sues the order.

4 (E) ENROLLMENT OF SPOUSES AND DE-
5 PENDENTS.—

6 (i) IN GENERAL.—Enrollment of the
7 spouse (including a child of the spouse)
8 and any dependent child of an eligible em-
9 ployee shall be considered to be timely if a
10 request for enrollment is made either—

11 (I) within 30 days of the date of
12 the marriage or of the date of the
13 birth or adoption of a child, if family
14 coverage is available as of such date,
15 or

16 (II) within 30 days of the date
17 family coverage is first made avail-
18 able.

19 (ii) COVERAGE.—If a plan makes
20 family coverage available and enrollment is
21 made under the plan on a timely basis
22 under clause (i)(I), the coverage shall be-
23 come effective not later than the first day
24 of the first month beginning after the date

1 of the marriage or the date of birth or
2 adoption of the child (as the case may be).

3 (4) DEFINITIONS.—In this subsection, the
4 terms “eligible individual” and “group health plan”
5 have the meanings given such terms in section
6 1023(a).

7 (c) STATE OPTION OF GUARANTEED AVAILABILITY
8 THROUGH ALLOCATION OF RISK (RATHER THAN
9 THROUGH GUARANTEED ISSUE).—The requirements of
10 subsection (b) shall not apply in a State if the State has
11 provided (in accordance with standards established under
12 this subtitle) a mechanism under which—

13 (1) each insurer offering a health insurance
14 plan to a small employer in the State must partici-
15 pate in a program for assigning high-risk small em-
16 ployer groups (or individuals within such a group)
17 among some or all such insurers, and

18 (2) the insurers to which such high-risk small
19 employer groups or individuals are so assigned com-
20 ply with the requirements of subsection (b).

21 **SEC. 1102. MEDACCESS PLAN DEFINED.**

22 (a) MEDACCESS PLAN DEFINED.—In this subtitle:

23 (1) IN GENERAL.—The term “MedAccess plan”
24 means a health insurance plan (whether a managed-

1 care plan, indemnity plan, or other plan) that meets
2 the following requirements:

3 (A) The plan—

4 (i) is designed to provide standard
5 coverage (consistent with subsection (c))
6 with substantial cost-sharing,

7 (ii) is designed to provide only cata-
8 strophic coverage (consistent with sub-
9 section (d)), or

10 (iii) is designed to provide medisave
11 coverage (consistent with subsection (e)).

12 (B) The plan includes only essential and
13 medically necessary services, including medical,
14 surgical, hospital, and preventive services; ex-
15 cept that no specific procedure or treatment, or
16 classes thereof, is required to be covered in such
17 a plan, by this Act or through regulations.

18 (C) The plan meets the applicable require-
19 ments of section 1101(b) (relating to guaran-
20 teed issue).

21 (D) The plan meets the consumer protec-
22 tion standards established under section
23 1103(a)(1)(B).

24 (2) MEDACCESS STANDARD, CATASTROPHIC,
25 AND MEDISAVE PLANS.—The terms “MedAccess

1 standard plan”, “MedAccess catastrophic plan”,
 2 “MedAccess medisave plan” mean a MedAccess plan
 3 that provides for at least standard coverage (re-
 4 ferred to in paragraph (1)(A)(i)), for only cata-
 5 strophic coverage (referred to in paragraph
 6 (1)(A)(ii)), or medisave coverage (referred to in
 7 paragraph (1)(A)(iii)), respectively.

8 (b) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

9 (1) INITIAL DETERMINATION.—The NAIC is
 10 requested to submit to the Secretary, within 6
 11 months after the date of the enactment of this Act,
 12 a set of rules which the NAIC determines is suffi-
 13 cient for determining, in the case of any health in-
 14 surance plan and for purposes of this section, the
 15 actuarial value of the coverage offered by the plan.

16 (2) CERTIFICATION.—If the Secretary deter-
 17 mines that the NAIC has submitted a set of rules
 18 that comply with the requirements of paragraph (1),
 19 the Secretary shall certify such set of rules for use
 20 under this subtitle. If the Secretary determines that
 21 such a set of rules has not been submitted or does
 22 not comply with such requirements, the Secretary
 23 shall promptly establish a set of rules that meets
 24 such requirements.

25 (c) STANDARD COVERAGE.—

1 (1) IN GENERAL.—For purposes of this Act, a
2 health insurance plan is considered to provide stand-
3 ard coverage consistent with this subsection if the
4 benefits are determined, in accordance with the set
5 of actuarial equivalence rules certified under sub-
6 section (b), to have a value that is within 5 percent-
7 age points of the target actuarial value for standard
8 coverage established under paragraph (2).

9 (2) INITIAL DETERMINATION OF TARGET ACTU-
10 ARIAL VALUE FOR STANDARD COVERAGE.—

11 (A) INITIAL DETERMINATION.—The NAIC
12 is requested to submit to the Secretary, within
13 6 months after the date of the enactment of
14 this Act, a target actuarial value for standard
15 coverage equal to the average actuarial value of
16 a representative range of the different types of
17 health benefits provisions (which include cost-
18 sharing) typically offered as standard coverage
19 in the small employer health coverage market.
20 In determining the actuarial value, the plan
21 benefits considered should be sufficient to cover
22 only essential and medically necessary services,
23 including medical, surgical, hospital, and pre-
24 ventive services. However, no specific procedure
25 or treatment, or classes thereof, is required to

1 be considered in such determination by this Act
2 or through regulations. The determination of
3 such value shall be based on a representative
4 distribution of the population of eligible employ-
5 ees offered such coverage and a single set of
6 standardized utilization and cost factors.

7 (B) CERTIFICATION.—If the Secretary de-
8 termines that the NAIC has submitted a target
9 actuarial value for standard coverage that com-
10 ply with the requirements of subparagraph (A),
11 the Secretary shall certify such value for use
12 under this subtitle. If the Secretary determines
13 that such a value has not been submitted or
14 does not comply with such requirements, the
15 Secretary shall promptly determine such a tar-
16 get actuarial value that meets such require-
17 ments.

18 (d) CATASTROPHIC COVERAGE.—

19 (1) IN GENERAL.—For purposes of subsection
20 (a)(1)(B), a health insurance plan is considered to
21 provide catastrophic coverage consistent with this
22 subsection if—

23 (A) benefits are available under the plan
24 for a year only to the extent that expenses for
25 covered services in a year exceed a deductible

1 amount that is consistent with the requirement
 2 for a catastrophic health plan under section
 3 220(c)(2)(A) of the Internal Revenue Code of
 4 1986, as added by section 2202, and

5 (B) the benefits are determined, in accord-
 6 ance with the set of actuarial equivalence rules
 7 certified under subsection (b), to have a value
 8 that is within 5 percentage points of the target
 9 actuarial value for catastrophic coverage estab-
 10 lished under paragraph (2).

11 (2) INITIAL DETERMINATION OF TARGET ACTU-
 12 ARIAL VALUE FOR CATASTROPHIC COVERAGE.—

13 (A) INITIAL DETERMINATION.—The NAIC
 14 is requested to submit to the Secretary, within
 15 6 months after the date of the enactment of
 16 this Act, a target actuarial value for cata-
 17 strophic coverage equal to the actuarial value
 18 that would have been computed under sub-
 19 section (c)(2)(A) if a deductible that represents
 20 the midpoint of the range of deductibles per-
 21 mitted consistent with subsections (b)(2) and
 22 (c)(2)(A) of section 220 of the Internal Reve-
 23 nue Code of 1986 were used in place of any de-
 24 ductible that otherwise would be applicable.

1 (B) CERTIFICATION.—If the Secretary de-
 2 termines that the NAIC has submitted a target
 3 actuarial value for catastrophic coverage that
 4 comply with the requirements of subparagraph
 5 (A), the Secretary shall certify such value for
 6 use under this subtitle. If the Secretary deter-
 7 mines that such a value has not been submitted
 8 or does not comply with such requirements, the
 9 Secretary shall promptly determine such a tar-
 10 get actuarial value that meets such require-
 11 ments.

12 (e) MEDISAVE COVERAGE.—

13 (1) IN GENERAL.—For purposes of subsection
 14 (a)(1)(C), a health insurance plan is considered to
 15 provide medisave coverage consistent with this sub-
 16 section if such plan consists of—

17 (A) a catastrophic health plan (within the
 18 meaning of section 220(c)(2) of the Internal
 19 Revenue Code of 1986, as inserted by section
 20 2202 of this Act), and

21 (B) a medical savings account described in
 22 section 220(d)(1)(B) of such Code.

23 (f) SUBSEQUENT REVISIONS.—

24 (1) NAIC.—The NAIC may submit from time
 25 to time to the Secretary revisions of the set of rules

1 of actuarial equivalence and target actuarial values
2 previously established or determined under this sec-
3 tion if the NAIC determines such revision necessary
4 to take into account changes in the relevant types of
5 health benefits provisions, in deductible levels for
6 catastrophic coverage, or in demographic conditions
7 which form the basis for such set of rules or values.
8 The provisions of subsection (b)(2) shall apply to
9 such a revision in the same manner as they apply to
10 the initial determination of the set of rules.

11 (2) SECRETARY.—The Secretary may by regu-
12 lation revise such set or rules and values from time
13 to time if the Secretary determines such revision
14 necessary to take into account changes described in
15 paragraph (1).

16 **SEC. 1103. ESTABLISHMENT OF OTHER MEDACCESS STAND-**
17 **ARDS.**

18 (a) ESTABLISHMENT OF GENERAL STANDARDS.—

19 (1) ROLE OF NAIC.—The Secretary shall re-
20 quest the NAIC to develop, within 9 months after
21 the date of the enactment of this Act, model regula-
22 tions that specify standards with respect to each of
23 the following:

1 (A)(i) The requirement, under section
2 1101(a), that insurers make available
3 MedAccess plans.

4 (ii) The requirements of guaranteed avail-
5 ability of MedAccess plans to small employers
6 under section 1101(b).

7 (B)(i) The requirements of section 1104
8 (relating to limits on premiums and miscellane-
9 ous consumer protections).

10 (ii) The requirement of section 1105 (re-
11 lating to limitation on annual premium in-
12 creases).

13 If the NAIC develops recommended regulations
14 specifying such standards within such period, the
15 Secretary shall review the standards. Such review
16 shall be completed within 60 days after the date the
17 regulations are developed. Unless the Secretary de-
18 termines within such period that the standards do
19 not meet the requirements, such standards shall
20 serve as the standards under this section, with such
21 amendments as the Secretary deems necessary.

22 (2) CONTINGENCY.—If the NAIC does not de-
23 velop such model regulations within such period or
24 the Secretary determines that such regulations do
25 not specify standards that meet the requirements de-

1 scribed in paragraph (1), the Secretary shall specify,
2 within 15 months after the date of the enactment of
3 this Act, standards to carry out those requirements.

4 (3) EFFECTIVE DATE.—The MedAccess stand-
5 ards and consumer protection standards (as defined
6 in paragraph (5)) shall apply to MedAccess plans
7 and health insurance plans in a State on or after the
8 respective date the standards are implemented in the
9 State under subsections (b) and (c).

10 (4) NONPREEMPTION OF STATE LAW.—A State
11 may implement standards for health insurance plans
12 made available to small employers that are more
13 stringent than the requirements under this part; ex-
14 cept that a State may not implement standards that
15 prevent the offering by an insurer of at least one
16 MedAccess standard plan, one MedAccess cata-
17 strophic plan, and one MedAccess medical plan.

18 (5) DEFINITIONS.—In this section:

19 (A) CONSUMER PROTECTION STAND-
20 ARDS.—The term “consumer protection stand-
21 ards” means the standards established under
22 paragraph (1)(B).

23 (B) MEDACCESS STANDARDS.—The term
24 “MedAccess standards” means the standards
25 established under paragraph (1)(A) (relating to

1 the requirements of section 1101), and includes
 2 the consumer protection standards insofar as
 3 they relate to MedAccess plans.

4 (b) APPLICATION OF STANDARDS THROUGH
 5 STATES.—

6 (1) APPLICATION OF MEDACCESS STAND-
 7 ARDS.—

8 (A) IN GENERAL.—Each State shall sub-
 9 mit to the Secretary, by the deadline specified
 10 in subparagraph (B), a report on steps the
 11 State is taking to implement and enforce the
 12 consumer protection standards with respect to
 13 insurers, and MedAccess plans offered, not later
 14 than such deadline.

15 (B) DEADLINE FOR REPORT.—

16 (i) 1 YEAR AFTER STANDARDS ESTAB-
 17 LISHED.—Subject to clause (ii), the dead-
 18 line under this subparagraph is 1 year
 19 after the date the MedAccess standards
 20 are established under subsection (a).

21 (ii) EXCEPTION FOR LEGISLATION.—

22 In the case of a State which the Secretary
 23 identifies, in consultation with the NAIC,
 24 as—

1 (I) requiring State legislation
2 (other than legislation appropriating
3 funds) in order for insurers and
4 MedAccess plans offered to meet the
5 MedAccess standards established
6 under subsection (a), but

7 (II) having a legislature which is
8 not scheduled to meet in 1994 in a
9 legislative session in which such legis-
10 lation may be considered,

11 the date specified in this subparagraph is
12 the first day of the first calendar quarter
13 beginning after the close of the first legis-
14 lative session of the State legislature that
15 begins on or after January 1, 1996. For
16 purposes of the previous sentence, in the
17 case of a State that has a 2-year legislative
18 session, each year of such session shall be
19 deemed to be a separate regular session of
20 the State legislature.

21 (2) FEDERAL ROLE.—If the Secretary deter-
22 mines that a State has failed to submit a report by
23 the deadline specified under paragraph (1) or finds
24 that the State has not implemented and provided
25 adequate enforcement of the MedAccess standards

1 under such paragraph, the Secretary shall notify the
2 State and provide the State a period of 60 days in
3 which to submit such report or to implement and en-
4 force such standards under such paragraph. If, after
5 such 60-day period, the Secretary finds that such a
6 failure has not been corrected, the Secretary shall
7 provide for such mechanism for the implementation
8 and enforcement of such standards in the State as
9 the Secretary determines to be appropriate. Such
10 implementation and enforcement shall take effect
11 with respect to insurers, and MedAccess plans of-
12 fered or renewed, on or after 3 months after the
13 date of the Secretary's finding under the previous
14 sentence, and until the date the Secretary finds that
15 such a failure has been corrected. In exercising au-
16 thority under this subparagraph, the Secretary shall
17 determine whether the use of a risk-allocation mech-
18 anism, described in section 1101(c), would be more
19 consistent with the small employer group health cov-
20 erage market in the State than the guaranteed avail-
21 ability provisions of section 1101(b).

22 (2) APPLICATION OF CONSUMER PROTECTION
23 STANDARDS.—

24 (A) IN GENERAL.—Each State shall sub-
25 mit to the Secretary, by the deadline specified

1 in subparagraph (B), a report on steps the
2 State is taking to implement and enforce the
3 MedAccess standards with respect to insurers,
4 and health insurance plans (other than
5 MedAccess plans) offered, not later than such
6 deadline.

7 (B) DEADLINE FOR REPORT.—

8 (i) 1 YEAR AFTER STANDARDS ESTAB-
9 LISHED.—Subject to clause (ii), the dead-
10 line under this subparagraph is 1 year
11 after the date the consumer protection
12 standards are established under subsection
13 (a).

14 (ii) EXCEPTION FOR LEGISLATION.—

15 In the case of a State which the Secretary
16 identifies, in consultation with the NAIC,
17 as—

18 (I) requiring State legislation
19 (other than legislation appropriating
20 funds) in order for insurers and
21 health insurance plans offered to meet
22 the consumer protection standards es-
23 tablished under subsection (a), but

24 (II) having a legislature which is
25 not scheduled to meet in 1994 in a

1 legislative session in which such legis-
2 lation may be considered,
3 the date specified in this subparagraph is
4 the first day of the first calendar quarter
5 beginning after the close of the first legis-
6 lative session of the State legislature that
7 begins on or after January 1, 1996. For
8 purposes of the previous sentence, in the
9 case of a State that has a 2-year legislative
10 session, each year of such session shall be
11 deemed to be a separate regular session of
12 the State legislature.

13 (2) FEDERAL ROLE.—If the Secretary deter-
14 mines that a State has failed to submit a report by
15 the deadline specified under paragraph (1) or finds
16 that the State has not implemented and provided
17 adequate enforcement of the consumer protection
18 standards under such paragraph, the Secretary shall
19 notify the State and provide the State a period of
20 60 days in which to submit such report or to imple-
21 ment and enforce such standards under such para-
22 graph. If, after such 60-day period, the Secretary
23 finds that such a failure has not been corrected, the
24 Secretary shall provide for such mechanism for the
25 implementation and enforcement of such standards

1 in the State as the Secretary determines to be ap-
 2 propriate. Such implementation and enforcement
 3 shall take effect with respect to insurers, and health
 4 insurance plans (other than MedAccess plans) of-
 5 fered or renewed, on or after 3 months after the
 6 date of the Secretary's finding under the previous
 7 sentence, and until the date the Secretary finds that
 8 such a failure has been corrected.

9 **SEC. 1104. LIMITS ON PREMIUMS AND MISCELLANEOUS**
 10 **CONSUMER PROTECTIONS.**

11 (a) LIMITS ON PREMIUMS.—

12 (1) LIMIT ON VARIATION OF INDEX RATES BE-
 13 TWEEN CLASSES OF BUSINESS.—

14 (A) IN GENERAL.—As a standard under
 15 section 1103(a)(1)(B)(i), the index rate for a
 16 rating period for any class of business of an in-
 17 surer may not exceed by more than 20 percent
 18 the index rate for any other class of business.

19 (B) EXCEPTION.—The limitation of sub-
 20 paragraph (A) shall not apply to a class of busi-
 21 ness if—

22 (i) the class is one for which the in-
 23 surer does not reject, and never has re-
 24 jected, small employers included within the
 25 definition of employers eligible for the class

1 of business or otherwise eligible employees
2 and dependents who enroll on a timely
3 basis, based upon their claim experience or
4 health status,

5 (ii) the insurer does not involuntarily
6 transfer, and never has involuntarily trans-
7 ferred, a health insurance plan into or out
8 of the class of business, and

9 (iii) the class of business is currently
10 available for purchase.

11 (2) LIMIT ON VARIATION OF PREMIUM RATES
12 WITHIN A CLASS OF BUSINESS.—For a class of busi-
13 ness of an insurer, as a standard under section
14 1103(a)(1)(B)(i), the highest premium rates charged
15 during a rating period to small employers with simi-
16 lar demographic and other similar objective charac-
17 teristics (and not relating to claims experience,
18 health status, industry, occupation, or duration of
19 coverage since issue) for the same or similar cov-
20 erage, or the highest rates which could be charged
21 to such employers under the rating system for that
22 class of business, shall not exceed an amount that is
23 1.5 times the base premium rate for the class of
24 business for a rating period (or portion thereof) that
25 occurs in the first 3 years in which this section is

1 in effect, and 1.35 times the base premium rate
2 thereafter.

3 (3) OBJECTIVE BASIS FOR DIFFERENCES IN
4 PREMIUMS FOR STANDARD AND CATASTROPHIC
5 MEDACCESS PLANS.—The difference between the
6 index rates for MedAccess catastrophic plans and
7 the index rates for MedAccess standard plans shall
8 be reasonable and shall reflect the difference in plan
9 design and shall not take into account differences
10 due to the nature of the groups assumed to select
11 particular health plans.

12 (4) LIMIT ON TRANSFER OF EMPLOYERS
13 AMONG CLASSES OF BUSINESS.—As a standard
14 under section 1103(a)(1)(B)(i), an insurer may not
15 involuntarily transfer a small employer into or out of
16 a class of business. An insurer may not offer to
17 transfer a small employer into or out of a class of
18 business unless such offer is made to transfer all
19 small employers in the class of business without re-
20 gard to demographic characteristics, claim experi-
21 ence, health status, industry, occupation, or duration
22 since issue.

23 (5) DEFINITIONS.—In this subsection:

24 (A) BASE PREMIUM RATE.—The term
25 “base premium rate” means, for each class of

1 business for each rating period, the lowest pre-
2 mium rate charged or which could have been
3 charged under a rating system for that class of
4 business by the insurer to small employers with
5 similar demographic characteristics and other
6 similar objective characteristics (not relating to
7 claims experience, health status, industry, occu-
8 pation, or duration of coverage since issue) for
9 health insurance plans with the same or similar
10 coverage.

11 (B) CLASS OF BUSINESS.—The term
12 “class of business” means, with respect to an
13 insurer, all (or a distinct group of) small em-
14 ployers as shown on the records of the insurer.

15 (C) RULES FOR ESTABLISHING CLASSES
16 OF BUSINESS.—For purposes of subparagraph
17 (B)—

18 (i) an insurer may establish, subject
19 to clause (ii), a distinct group of small em-
20 ployers on the basis that the applicable
21 health insurance plans either—

22 (I) are marketed and sold
23 through individuals and organizations
24 which are not participating in the
25 marketing or sale of other distinct

1 groups of small employers for the in-
2 surer,

3 (II) have been acquired from an-
4 other insurer as a distinct group, or

5 (III) are provided through an as-
6 sociation that has a membership of
7 not less than 100 small employers and
8 that has been formed for purposes
9 other than obtaining health coverage;

10 (ii) an insurer may not establish more
11 than 2 groupings under each class of busi-
12 ness based on the insurer's use of man-
13 aged-care techniques if the techniques are
14 expected to produce substantial variation
15 in health care costs; and

16 (iii) notwithstanding clauses (i) and
17 (ii), a State commissioner of insurance,
18 upon application and if authorized under
19 State law, may approve additional distinct
20 groups upon a finding that such approval
21 would enhance the efficiency and fairness
22 of the small employer marketplace.

23 (D) INDEX RATE.—The term “index rate”
24 means, with respect to a class of business, the
25 arithmetic average of the applicable base pre-

1 mium rate and the corresponding highest pre-
2 mium rate for the class.

3 (E) DEMOGRAPHIC CHARACTERISTICS.—

4 Except as otherwise permitted under the stand-
5 ard under section 1103(b)(1)(B)(i), the term
6 “demographic characteristics” means age, gen-
7 der, geographic area, family composition, and
8 group size.

9 (b) FULL DISCLOSURE OF RATING PRACTICES.—At
10 the time an insurer offers a health insurance plan to a
11 small employer, the insurer shall fully disclose to the em-
12 ployer rating practices for health insurance plans, includ-
13 ing rating practices for different populations and benefit
14 designs.

15 (c) ACTUARIAL CERTIFICATION.—Each insurer that
16 offers a health insurance plan to a small employer in a
17 State shall file annually with the State commissioner of
18 insurance a written statement by a member of the Amer-
19 ican Academy of Actuaries (or other individual acceptable
20 to the commissioner) that, based upon an examination by
21 the individual which includes a review of the appropriate
22 records and of the actuarial assumptions of the insurer
23 and methods used by the insurer in establishing premium
24 rates for applicable health insurance plans—

1 (1) the insurer is in compliance with the appli-
2 cable provisions of this section, and

3 (2) the rating methods are actuarially sound.

4 Each such insurer shall retain a copy of such statement
5 for examination at its principal place of business.

6 (d) REGISTRATION AND REPORTING.—Each insurer
7 that issues any health insurance plan to a small employer
8 in a State shall be registered or licensed with the State
9 commissioner of insurance and shall comply with any re-
10 porting requirements of the commissioner relating to such
11 a plan.

12 **SEC. 1105. LIMITATION ON ANNUAL PREMIUM INCREASES.**

13 An insurer may not provide for an increase in the
14 premium charged a small employer for a health insurance
15 plan in a percentage that exceeds the percentage change
16 in the premium charged under the plan for a newly cov-
17 ered small employer within the same class of business rate
18 plus 15 percentage points.

19 **SEC. 1106. ESTABLISHMENT OF REINSURANCE OR ALLOCA-**
20 **TION OF RISK MECHANISMS FOR HIGH RISK**
21 **INDIVIDUALS IN MARKETPLACE FOR SMALL**
22 **BUSINESS.**

23 (a) ESTABLISHMENT OF STANDARDS.—

24 (1) ROLE OF NAIC.—The Secretary shall re-
25 quest the NAIC to develop, within 9 months after

1 the date of the enactment of this Act, models for re-
2 insurance or allocation of risk mechanisms (each in
3 this section referred to as a “reinsurance or alloca-
4 tion of risk mechanism”) for health insurance plans
5 made available to small employers and for whom an
6 insurer is at risk of incurring high costs under the
7 plan. If the NAIC develops such models within such
8 period, the Secretary shall review such models to de-
9 termine if they provide for an effective reinsurance
10 or allocation of risk mechanism. Such review shall be
11 completed within 30 days after the date the models
12 are developed. Unless the Secretary determines with-
13 in such period that such a model is not an effective
14 reinsurance or allocation of risk mechanism, such re-
15 maining models shall serve as the models under this
16 section, with such amendments as the Secretary
17 deems necessary.

18 (2) CONTINGENCY.—If the NAIC does not de-
19 velop such models within such period or the Sec-
20 retary determines that all such models do not pro-
21 vide for an effective reinsurance or allocation of risk
22 mechanism, the Secretary shall specify, within 15
23 months after the date of the enactment of this Act,
24 models to carry out this section.

1 (b) IMPLEMENTATION OF REINSURANCE OR ALLOCA-
2 TION OF RISK MECHANISMS.—

3 (1) BY STATES.—Each State shall establish
4 and maintain one or more reinsurance or allocation
5 of risk mechanisms that are consistent with a model
6 established under subsection (a) by not later than
7 the deadline specified in section 1103(b)(1)(B). A
8 State may establish and maintain such a mechanism
9 jointly with one or more other States.

10 (2) FEDERAL ROLE.—

11 (A) IN GENERAL.—If the Secretary deter-
12 mines that a State has failed to establish or
13 maintain a reinsurance or allocation of risk
14 mechanism in accordance with paragraph (1),
15 the Secretary shall establish and maintain such
16 a reinsurance or allocation of risk mechanism
17 meeting the requirements of this paragraph.

18 (B) REINSURANCE MECHANISM.—Unless
19 the Secretary determines under subparagraph
20 (C) that an allocation of risk mechanism is the
21 appropriate mechanism to use in a State under
22 this paragraph, the Secretary shall establish
23 and maintain for use under this section for
24 each State an appropriate reinsurance mecha-
25 nism.

1 (C) ALLOCATION OF RISK MECHANISM.—If
2 the Secretary determines that, due to the na-
3 ture of the health coverage market in the State
4 (including a relatively small number of health
5 insurance plans offered or a relatively small
6 number of uninsurable small employers), an al-
7 location of risk mechanism would be a better
8 mechanism than a reinsurance mechanism, the
9 Secretary shall establish and maintain for use
10 under this section for a State an allocation of
11 risk mechanism under which uninsurable small
12 employers would be equitably assigned among
13 insurers offering health insurance plans to
14 small employers.

15 (D) FINANCING DEFICIT FOR REINSUR-
16 ANCE MECHANISMS.—

17 (i) IN GENERAL.—Chapter 43 of the
18 Internal Revenue Code of 1986 (relating to
19 qualified pension plans, etc.) is amended
20 by adding at the end thereof the following
21 new section:

1 **“SEC. 4980D. ADDITIONAL TAX TO FUND REINSURANCE IN**
 2 **STATES UNDER FEDERAL REINSURANCE.**

3 “(a) IMPOSITION OF TAX.—There is hereby imposed
 4 a tax on the providing of any health insurance plan which
 5 covers any employee in a Federal reinsurance State.

6 “(b) AMOUNT OF TAX.—

7 “(1) IN GENERAL.—The tax imposed by sub-
 8 section (a) shall be equal to the applicable percent-
 9 age of the amount received by the insurer for provid-
 10 ing such plan in such Federal reinsurance State.

11 “(2) APPLICABLE PERCENTAGE.—For purposes
 12 of paragraph (1), the term ‘applicable percentage’
 13 means, with respect to any State for any period, the
 14 lowest percentage estimated by the Secretary as gen-
 15 erating sufficient revenues to carry out section
 16 1106(b)(2) of the Affordable Health Care Now Act
 17 of 1993 in such State for such period.

18 “(c) LIABILITY FOR TAX.—The tax imposed by this
 19 section shall be paid by the insurer.

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

21 “(1) INSURER.—The term ‘insurer’ has the
 22 meaning given such term in section 1107(6) of the
 23 Affordable Health Care Now Act of 1993.

24 “(2) FEDERAL REINSURANCE STATE.—The
 25 term ‘Federal reinsurance State’ means any State
 26 with respect to which a determination is in effect

1 under section 1106(b)(2) of the Affordable Health
 2 Care Now Act of 1993 and for which the Secretary
 3 of Health and Human Services has established and
 4 is maintaining a reinsurance mechanism under sub-
 5 paragraph (B) of such section for the State.”

6 (ii) CLERICAL AMENDMENT.—The
 7 table of sections for chapter 43 of such
 8 Code is amended by adding at the end
 9 thereof the following new item:

“Sec. 4980D. Additional tax to fund reinsurance in States under
 Federal reinsurance.”

10 (c) CONSTRUCTION.—Nothing in this section shall be
 11 construed to prohibit reinsurance or allocation of risk ar-
 12 rangements relating to health insurance plans, whether on
 13 a State or multi-State basis, not required under this sec-
 14 tion.

15 **SEC. 1107. DEFINITIONS.**

16 Except as otherwise specifically provided, for pur-
 17 poses of this subtitle:

18 (1) DEPENDENT CHILD.—The term “dependent
 19 child” means a child (including an adopted child)
 20 who is under 19 years of age or who is a full-time
 21 student and under 25 years of age.

22 (2) ELIGIBLE EMPLOYEE.—The term “eligible
 23 employee” means, with respect to an employer, an
 24 employee who normally performs on a monthly basis

1 at least 30 hours of service per week for that em-
2 ployer.

3 (3) EMPLOYER.—The term “employer” shall
4 have the meaning applicable under section 3(5) of
5 the Employee Retirement Income Security Act of
6 1974.

7 (4) HEALTH INSURANCE PLAN.—

8 (A) IN GENERAL.—Except as provided in
9 subparagraph (B), the term “health insurance
10 plan” means any hospital or medical service
11 policy or certificate, hospital or medical service
12 plan contract, or health maintenance organiza-
13 tion group contract offered by an insurer.

14 (B) EXCEPTION.—Such term does not in-
15 clude any of the following—

16 (i) coverage only for accident, dental,
17 vision, disability income, or long-term care
18 insurance, or any combination thereof,

19 (ii) medicare supplemental health in-
20 surance,

21 (iii) coverage issued as a supplement
22 to liability insurance,

23 (iv) worker’s compensation or similar
24 insurance, or

1 (v) automobile medical-payment insur-
2 ance,
3 or any combination thereof.

4 (5) HEALTH MAINTENANCE ORGANIZATION.—
5 The term “health maintenance organization” in-
6 cludes, as defined in standards established under
7 section 1103, a health insurance plan that meets
8 specified standards and that offers to provide health
9 services on a prepaid, at-risk basis primarily through
10 a defined set of providers.

11 (6) INSURER.—The term “insurer” means a li-
12 censed insurance company, a prepaid hospital or
13 medical service plan, and a health maintenance orga-
14 nization offering such a plan to an employer, and in-
15 cludes a similar organization regulated under State
16 law for solvency.

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

19 (8) SECRETARY.—The term “Secretary” means
20 the Secretary of Health and Human Services.

21 (9) SMALL EMPLOYER.—The term “small em-
22 ployer” means, with respect to a calendar year, an
23 employer that normally employs more than 1 but
24 less than 51 eligible employees on a typical business
25 day. For the purposes of this paragraph, the term

1 “employee” includes a self-employed individual. For
 2 purposes of determining if an employer is a small
 3 employer, rules similar to the rules of subsection (b)
 4 and (c) of section 414 of the Internal Revenue Code
 5 of 1986 shall apply.

6 (10) STATE.—The term “State” means the 50
 7 States, the District of Columbia, Puerto Rico, the
 8 Virgin Islands, Guam, and American Samoa.

9 (11) STATE COMMISSIONER OF INSURANCE.—
 10 The term “State commissioner of insurance” in-
 11 cludes a State superintendent of insurance.

12 **SEC. 1108. OFFICE OF PRIVATE HEALTH CARE COVERAGE;**
 13 **ANNUAL REPORTS ON EVALUATION OF**
 14 **HEALTH CARE COVERAGE REFORM.**

15 (a) IN GENERAL.—In order to carry out the respon-
 16 sibilities of the Secretary under this subtitle, the Secretary
 17 shall establish an Office of Private Health Care Coverage,
 18 to be headed by a Director (in this section and section
 19 1109 referred to as the “Director”) appointed by the Sec-
 20 retary.

21 (b) ANNUAL REPORT.—

22 (1) IN GENERAL.—The Director shall submit to
 23 Congress an annual report on the implementation of
 24 this subtitle.

1 (2) INFORMATION TO BE INCLUDED.—Each an-
2 nual report shall include information concerning at
3 least the following:

4 (A) Implementation and enforcement of
5 the applicable MedAccess standards and
6 consumer protection standards under this sub-
7 title by the States and by the Secretary.

8 (B) An evaluation of the impact of the re-
9 forms under this subtitle on the availability of
10 affordable health coverage for small employers
11 that purchase group health coverage and for
12 their employees, and, in particular, the impact
13 of—

14 (i) guaranteed availability of health
15 coverage,

16 (ii) limitations of restrictions from
17 coverage of preexisting conditions,

18 (iii) requirement for continuity of cov-
19 erage,

20 (iv) risk-management mechanisms for
21 health coverage,

22 (v) limits on premium variations,

23 (vi) limits on annual premium in-
24 creases, and

1 (vii) preemption of State benefit man-
2 dates.

3 In performing such evaluation, the Secretary
4 shall seek to discount the effect of the insur-
5 ance cycle on health insurance premiums.

6 (C) An assessment of the implications of
7 the reforms on adverse selection among health
8 insurance plans and the distribution of risk
9 among health insurance plans.

10 (c) ADVISORY COMMITTEE.—The Secretary shall pro-
11 vide for appointment of an advisory committee to advise
12 the Director concerning activities of the Office under this
13 subtitle. Membership on the committee shall consist of 17
14 individuals and shall include individuals from the general
15 public, small and large business, labor, insurance and
16 other group health plans, and health care providers, and
17 shall include individuals who are experts in the fields of
18 the actuarial science, health economics, and health services
19 research. The Secretary may include, as additional, ex
20 officio members of the committee, such representatives of
21 government agencies as the Secretary deems appropriate.
22 The chairperson of the committee shall not be a health
23 care provider or receive any direct or indirect compensa-
24 tion from an insurer, health insurance plan, or a health
25 care provider.

1 **SEC. 1109. RESEARCH AND DEMONSTRATION PROJECTS;**
2 **DEVELOPMENT OF A HEALTH RISK POOLING**
3 **MODEL.**

4 (a) RESEARCH AND DEMONSTRATIONS.—The Direc-
5 tor is authorized, directly, by contract, and through grants
6 and cooperative agreements within the Department of
7 Health and Human Services and outside the Depart-
8 ment—

9 (1) to conduct research on the impact of this
10 subtitle on the availability of affordable health cov-
11 erage for employees and dependents in the small em-
12 ployers group health care coverage market and other
13 topics described in section 1108(b), and

14 (2) to conduct demonstration projects relating
15 to such topics.

16 (b) DEVELOPMENT OF METHODS OF MEASURING
17 RELATIVE HEALTH RISK.—

18 (1) IN GENERAL.—The Director shall develop
19 methods for measuring, in terms of the expected
20 costs of providing benefits under health insurance
21 plans and, in particular, MedAccess plans, the rel-
22 ative health risks of eligible individuals.

23 (2) METHODOLOGY.—The methods—

24 (A) shall rely on diagnosis or other health-
25 related information that is predictive of individ-
26 ual health care needs,

1 (B) may rely upon information routinely
2 collected in the process of making payments
3 under group health plans, and

4 (C) may provide for such random, sample
5 audits of records as may be necessary to verify
6 the accuracy of measurements.

7 (c) DEVELOPMENT OF A HEALTH RISK POOLING
8 MODEL.—

9 (1) IN GENERAL.—The Director shall develop a
10 model, based on the methods of measuring risks
11 under subsection (b), for equitably distributing
12 health risks among insurers in the small employer
13 health care coverage market.

14 (2) REDISTRIBUTION OF RISK.—Under such
15 model, insurers with below average health risks
16 would be required to contribute to a common fund
17 for payment to insurers with above average health
18 risks, each in relation to the degree of their favor-
19 able or adverse risk selection.

20 (3) INCENTIVES.—Such model shall include in-
21 centives to encourage continuous coverage of eligible
22 individuals and small employers.

23 (d) CONSULTATION.—The methods and model under
24 this section shall be developed in consultation with the

1 NAIC and the advisory committee established under sec-
 2 tion 1108(c).

3 (e) REPORT.—By not later than January 1, 1995,
 4 the Director shall submit to Congress a report on the
 5 methods and model developed under this section (as well
 6 as on research and demonstration projects conducted
 7 under subsection (a)). The Director shall include in the
 8 report such recommendations respecting the application of
 9 the model to insurers (and, in particular, to MedAccess
 10 plans) under this subtitle as the Director deems appro-
 11 priate.

12 (f) AUTHORIZATION OF APPROPRIATIONS.—There
 13 are authorized to be appropriated to carry out this section,
 14 \$5,000,000 in each of fiscal years 1994 through 1998.

15 **Subtitle C—Preemption**

16 **PART 1—SCOPE OF STATE REGULATION**

17 **SEC. 1201. PROHIBITION OF STATE BENEFIT MANDATES** 18 **FOR GROUP HEALTH PLANS.**

19 In the case of a group health plan, no provision of
 20 State or local law shall apply that requires the coverage
 21 of one or more specific benefits, services, or categories of
 22 health care, or services of any class or type of provider
 23 of health care.

1 **SEC. 1202. PROHIBITION OF PROVISIONS PROHIBITING EM-**
2 **PLOYER GROUPS FROM PURCHASING**
3 **HEALTH INSURANCE.**

4 No provision of State or local law shall apply that
5 prohibits 2 or more employers from obtaining coverage
6 under an insured multiple employer health plan.

7 **SEC. 1203. RESTRICTIONS ON MANAGED CARE.**

8 (a) PREEMPTION OF STATE LAW PROVISIONS.—Sub-
9 ject to subsection (c), the following provisions of State law
10 are preempted and may not be enforced:

11 (1) RESTRICTIONS ON REIMBURSEMENT RATES
12 OR SELECTIVE CONTRACTING.—Any law that re-
13 stricts the ability of a group health plan to negotiate
14 reimbursement rates with providers or to contract
15 selectively with one provider or a limited number of
16 providers.

17 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
18 CIAL INCENTIVES.—Any law that limits the financial
19 incentives that a group health plan may require a
20 beneficiary to pay when a non-plan provider is used
21 on a non-emergency basis.

22 (3) RESTRICTIONS ON UTILIZATION REVIEW
23 METHODS.—Any law that—

24 (A) prohibits utilization review of any or
25 all treatments and conditions,

1 (B) requires that such review be made (i)
2 by a resident of the State in which the treat-
3 ment is to be offered or by an individual li-
4 censed in such State, or (ii) by a physician in
5 any particular specialty or with any board cer-
6 tified specialty of the same medical specialty as
7 the provider whose services are being reviewed,

8 (C) requires the use of specified standards
9 of health care practice in such reviews or re-
10 quires the disclosure of the specific criteria used
11 in such reviews,

12 (D) requires payments to providers for the
13 expenses of responding to utilization review re-
14 quests, or

15 (E) imposes liability for delays in perform-
16 ing such review.

17 Nothing in subparagraph (B) shall be construed as
18 prohibiting a State from (i) requiring a licensed phy-
19 sician or other health care professional be available
20 at some time in the review or appeal process, or (ii)
21 requiring that any decision in an appeal from such
22 a review be made by a licensed physician.

23 (b) GAO STUDY.—

24 (1) IN GENERAL.—The Comptroller General
25 shall conduct a study of the benefits and cost effec-

1 tiveness of the use of managed care in the delivery
2 of health services.

3 (2) REPORT.—By not later than 4 years after
4 the date of the enactment of this Act, the Comptrol-
5 ler General shall submit a report to Congress on the
6 study conducted under paragraph (1) and shall in-
7 clude in the report such recommendations (including
8 whether the provisions of subsection (a) should be
9 extended) as may be appropriate.

10 (c) SUNSET.—Unless otherwise provided, subsection
11 (a) shall not apply 5 years after the date of the enactment
12 of this Act.

13 **SEC. 1204. DEFINITIONS.**

14 For purposes of this part, the terms “dependent”,
15 “employee”, “employer”, “group health plan”, “health in-
16 surance plan”, “insured multiple employer health plan”,
17 and “State” have the meanings given such terms in sec-
18 tion 1023(a).

PART 2—MULTIPLE EMPLOYER HEALTH

BENEFITS PROTECTIONS

**SEC. 1211. LIMITED EXEMPTION UNDER PREEMPTION
RULES FOR MULTIPLE EMPLOYER PLANS
PROVIDING HEALTH BENEFITS SUBJECT TO
CERTAIN FEDERAL STANDARDS.**

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

“SEC. 701. DEFINITIONS.

“For purposes of this part—

“(1) INSURER.—The term ‘insurer’ means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

“(2) PARTICIPATING EMPLOYER.—The term ‘participating employer’ means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such arrangement in connection with the employment of the employees.

“(3) EXCESS/STOP LOSS COVERAGE.—The term ‘excess/stop loss coverage’ means, in connection with a multiple employer welfare arrangement, a contract

1 under which an insurer provides for payment with
2 respect to claims under the arrangement, relating to
3 participants or beneficiaries individually or other-
4 wise, in excess of an amount or amounts specified in
5 such contract.

6 “(4) QUALIFIED ACTUARY.—The term ‘quali-
7 fied actuary’ means an individual who is a member
8 of the American Academy of Actuaries or meets
9 such reasonable standards and qualifications as the
10 Secretary may provide by regulation.

11 “(5) SPONSOR.—The term ‘sponsor’ means, in
12 connection with a multiple employer welfare arrange-
13 ment, the association or other entity which estab-
14 lishes or maintains the arrangement.

15 “(6) STATE LOCATION OF COVERED INDIVID-
16 UALS.—

17 “(A) IN GENERAL.—A multiple employer
18 welfare arrangement shall be treated as cover-
19 ing individuals located in a State only if the
20 minimum required number of individuals who
21 are covered under the arrangement are located
22 in such State, except that if the minimum re-
23 quired number of individuals are not located in
24 any State, such arrangement shall be treated as

1 covering individuals in any State in which any
2 covered individual is located.

3 “(B) MINIMUM REQUIRED NUMBER.—For
4 purposes of subparagraph (A), the minimum re-
5 quired number is the greater of—

6 “(i) 5 percent of the total number of
7 individuals described in subparagraph (A),
8 or

9 “(ii) 50.

10 “(C) LOCATION OF INDIVIDUALS IN
11 STATE.—For purposes of subparagraph (A), an
12 individual shall be treated as located in a State
13 if such individual is employed in such State or
14 the address of such individual last known by
15 the arrangement is located in such State.

16 “(7) STATE INSURANCE COMMISSIONER.—The
17 term ‘State insurance commissioner’ means the in-
18 surance commissioner (or similar official) of a State.

19 “(8) DOMICILE STATE.—The term ‘domicile
20 State’ means, in connection with a multiple employer
21 welfare arrangement, the State in which, according
22 to the application for an exemption under this part,
23 most individuals to be covered under the arrange-
24 ment are located, except that, in any case in which
25 information contained in the latest annual report of

1 the arrangement filed under this part indicates that
2 most individuals covered under the arrangement are
3 located in a different State, such term means such
4 different State.

5 “(9) FULLY INSURED ARRANGEMENT.—A mul-
6 tiple employer welfare arrangement shall be treated
7 as fully insured only if one or more insurers, health
8 maintenance organizations, similar organizations
9 regulated under State law for solvency, or any com-
10 bination thereof are liable under one or more insur-
11 ance policies or contracts for all benefits under the
12 arrangement (irrespective of any recourse they may
13 have against other parties).

14 “(10) MULTIPLE EMPLOYER HEALTH PLAN.—
15 The term ‘multiple employer health plan’ means a
16 multiple employer welfare arrangement treated as an
17 employee welfare benefit plan by reason of an
18 exemption under this part.

19 “(11) INSURED MULTIPLE EMPLOYER HEALTH
20 PLAN.—The term ‘insured multiple employer health
21 plan’ means a fully insured multiple employer wel-
22 fare arrangement under which benefits consist solely
23 of medical care described in section 607(1) (dis-
24 regarding such incidental benefits as the Secretary
25 shall specify by regulations).

1 “(12) PREPAID HEALTH CARE ARRANGE-
 2 MENT.—The term ‘prepaid health care arrangement’
 3 means a nonprofit entity which—

4 “(A) offers benefits consisting of medical
 5 care described in section 607(1) on a prepaid
 6 basis, and

7 “(B) is established and controlled by a
 8 group medical practice or similar group, by a
 9 hospital, or by such a practice (or group) and
 10 a hospital.

11 **“SEC. 702. EXEMPTED MULTIPLE EMPLOYER PLANS PRO-**
 12 **VIDING BENEFITS IN THE FORM OF MEDICAL**
 13 **CARE RELIEVED OF CERTAIN RESTRICTIONS**
 14 **ON PREEMPTION OF STATE LAW AND TREAT-**
 15 **ED AS EMPLOYEE WELFARE BENEFIT PLANS.**

16 “(a) IN GENERAL.—Subject to subsection (b), a mul-
 17 tiple employer welfare arrangement which is not fully in-
 18 sured and with respect to which there is in effect an ex-
 19 emption granted by the Secretary under this part (or with
 20 respect to which there is pending a complete application
 21 for such an exemption and the Secretary determines that
 22 provisional protection under this part is appropriate)—

23 “(1) shall be treated for purposes of subtitle A
 24 and the preceding parts of this subtitle as an em-
 25 ployee welfare benefit plan, irrespective of whether

1 such arrangement is an employee welfare benefit
2 plan, and

3 “(2) shall be exempt from section
4 514(b)(6)(A)(ii).

5 “(b) BENEFITS MUST CONSIST OF MEDICAL
6 CARE.—Subsection (a) shall apply to a multiple employer
7 welfare arrangement only if the benefits provided there-
8 under consist solely of medical care described in section
9 607(1) (disregarding such incidental benefits as the
10 Secretary shall specify by regulation).

11 “(c) RESTRICTION ON COMMENCEMENT OF NEW AR-
12 RANGEMENTS.—A multiple employer welfare arrangement
13 providing benefits which consist of medical care described
14 in section 607(1) which has not commenced operations as
15 of January 1, 1994, may commence operations only if an
16 exemption granted to the arrangement under this part is
17 in effect (or there is pending with respect to the arrange-
18 ment a complete application for such an exemption and
19 the Secretary determines that provisional protection under
20 this part is appropriate).

21 **“SEC. 703. EXEMPTION PROCEDURE.**

22 “(a) IN GENERAL.—The Secretary shall grant an ex-
23 emption described in section 702(a) to a multiple employer
24 welfare arrangement if—

1 “(1) an application for such exemption with re-
2 spect to such arrangement, identified individually or
3 by class, has been duly filed in complete form with
4 the Secretary in accordance with this part,

5 “(2) such application demonstrates compliance
6 with the requirements of section 704 with respect to
7 such arrangement, and

8 “(3) the Secretary finds that such exemption
9 is—

10 “(A) administratively feasible,

11 “(B) not adverse to the interests of the in-
12 dividuals covered under the arrangement, and

13 “(C) protective of the rights and benefits
14 of the individuals covered under the arrange-
15 ment.

16 “(b) NOTICE AND HEARING.—Before granting an ex-
17 emption under this section, the Secretary shall publish no-
18 tice in the Federal Register of the pendency of the exemp-
19 tion, shall require that adequate notice be given to inter-
20 ested persons, including the State insurance commissioner
21 of each State in which covered individuals under the ar-
22 rangement are, or are expected to be, located, and shall
23 afford interested persons opportunity to present views.
24 The Secretary may not grant an exemption under this sec-
25 tion unless the Secretary affords an opportunity for a

1 hearing and makes a determination on the record with re-
2 spect to the findings required under subsection (a)(3). The
3 Secretary shall, to the maximum extent practicable, make
4 a final determination with respect to any application filed
5 under this section in the case of a newly established ar-
6 rangement within 90 days after the date which the Sec-
7 retary determines is the date on which such application
8 is filed in complete form.

9 **“SEC. 704. ELIGIBILITY REQUIREMENTS.**

10 “(a) APPLICATION FOR EXEMPTION.—

11 “(1) IN GENERAL.—An exemption may be
12 granted by the Secretary under this part only on the
13 basis of an application filed with the Secretary in
14 such form and manner as shall be prescribed in reg-
15 ulations of the Secretary. Any such application shall
16 be signed by the operating committee and the spon-
17 sor of the arrangement.

18 “(2) FILING FEE.—The arrangement shall pay
19 to the Secretary at the time of filing an application
20 under this section a filing fee in the amount of
21 \$5,000, which shall be available, to the extent pro-
22 vided in appropriation Acts, to the Secretary for the
23 sole purpose of administering the exemption proce-
24 dures under this part.

1 “(3) INFORMATION INCLUDED.—An application
2 filed under this section shall include, in a manner
3 and form prescribed in regulations of the Secretary,
4 at least the following information:

5 “(A) IDENTIFYING INFORMATION.—The
6 names and addresses of—

7 “(i) the sponsor, and

8 “(ii) the members of the operating
9 committee of the arrangement.

10 “(B) STATES IN WHICH ARRANGEMENT IN-
11 TENDS TO DO BUSINESS.—The States in which
12 individuals covered under the arrangement are
13 to be located and the number of such individ-
14 uals expected to be located in each such State.

15 “(C) BONDING REQUIREMENTS.—Evidence
16 provided by the operating committee that the
17 bonding requirements of section 412 will be met
18 as of the date of the application.

19 “(D) PLAN DOCUMENTS.—A copy of the
20 documents governing the arrangement (includ-
21 ing any bylaws and trust agreements), the sum-
22 mary plan description, and other material de-
23 scribing the benefits and coverage that will be
24 provided to individuals covered under the ar-
25 rangement.

1 “(E) AGREEMENTS WITH SERVICE PROVID-
2 ERS.—A copy of any agreements between the
3 arrangement and contract administrators and
4 other service providers.

5 “(F) FUNDING REPORT.—A report setting
6 forth information determined as of a date with-
7 in the 120-day period ending with the date of
8 the application, including the following:

9 “(i) RESERVES.—A statement, cer-
10 tified by the operating committee of the ar-
11 rangement, and a statement of actuarial
12 opinion, signed by a qualified actuary, that
13 all applicable requirements of section 707
14 are or will be met in accordance with regu-
15 lations which the Secretary shall prescribe.

16 “(ii) ADEQUACY OF CONTRIBUTION
17 RATES.—A statement of actuarial opinion,
18 signed by a qualified actuary, which sets
19 forth a description of the extent to which
20 contribution rates are adequate to provide
21 for the payment of all obligations and the
22 maintenance of required reserves under the
23 arrangement for the 12-month period be-
24 ginning with such date within such 120-
25 day period, taking into account the ex-

1 pected coverage and experience of the ar-
2 rangement. If the contribution rates are
3 not fully adequate, the statement of actu-
4 arial opinion shall indicate the extent to
5 which the rates are inadequate and the
6 changes needed to ensure adequacy.

7 “(iii) CURRENT AND PROJECTED
8 VALUE OF ASSETS AND LIABILITIES.—A
9 statement of actuarial opinion signed by a
10 qualified actuary, which sets forth the cur-
11 rent value of the assets and liabilities accu-
12 mulated under the arrangement and a pro-
13 jection of the assets, liabilities, income,
14 and expenses of the arrangement for the
15 12-month period referred to in clause (ii).
16 The income statement shall identify sepa-
17 rately the arrangement’s administrative ex-
18 penses and claims.

19 “(iv) COSTS OF COVERAGE TO BE
20 CHARGED AND OTHER EXPENSES.—A
21 statement of the costs of coverage to be
22 charged, including an itemization of
23 amounts for administration, reserves, and
24 other expenses associated with the oper-
25 ation of the arrangement.

1 “(v) OTHER INFORMATION.—Any
2 other information which may be prescribed
3 in regulations of the Secretary as nec-
4 essary to carry out the purposes of this
5 part.

6 “(b) OTHER REQUIREMENTS.—A complete applica-
7 tion for an exemption under this part shall include infor-
8 mation which the Secretary determines to be complete and
9 accurate and sufficient to demonstrate that the following
10 requirements are met with respect to the arrangement:

11 “(1) SPONSOR.—

12 “(A) IN GENERAL.—Except as provided in
13 subparagraph (B), the sponsor is, and has been
14 (together with its immediate predecessor, if
15 any) for a continuous period of not less than 3
16 years before the date of the application, orga-
17 nized and maintained in good faith, with a con-
18 stitution and bylaws specifically stating its pur-
19 pose, as a trade association, an industry asso-
20 ciation, a professional association, or a chamber
21 of commerce or other business group, for sub-
22 stantial purposes other than that of obtaining
23 or providing medical care described in section
24 607(1), and the applicant demonstrates to the
25 satisfaction of the Secretary that the sponsor is

1 established as a permanent entity which re-
2 ceives the active support of its members.

3 “(B) SPECIAL RULE FOR PREPAID HEALTH
4 CARE ARRANGEMENTS.—In the case of an ar-
5 rangement that is a prepaid health care ar-
6 rangement (as defined in section 701(12)), the
7 sponsor is the operating committee of the ar-
8 rangement.

9 “(2) OPERATING COMMITTEE.—

10 “(A) IN GENERAL.—Except as provided in
11 subparagraph (B), the arrangement is operated,
12 pursuant to a trust agreement, by an operating
13 committee which has complete fiscal control
14 over the arrangement and which is responsible
15 for all operations of the arrangement, and the
16 operating committee has in effect rules of oper-
17 ation and financial controls, based on a 3-year
18 plan of operation, adequate to carry out the
19 terms of the arrangement and to meet all re-
20 quirements of this title applicable to the ar-
21 rangement. The members of the committee are
22 individuals selected from individuals who are
23 the owners, officers, directors, or employees of
24 the participating employers or who are partners
25 in the participating employers and actively par-

1 ticipate in the business. No such member is an
2 owner, officer, director, or employee of, or part-
3 ner in, a contract administrator or other service
4 provider to the arrangement, except that offi-
5 cers or employees of a sponsor which is a serv-
6 ice provider (other than a contract adminis-
7 trator) to the arrangement may be members of
8 the committee if they constitute not more than
9 25 percent of the membership of the committee
10 and they do not provide services to the arrange-
11 ment other than on behalf of the sponsor. The
12 committee has sole authority to approve appli-
13 cations for participation in the arrangement
14 and to contract with a service provider to ad-
15 minister the day-to-day affairs of the arrange-
16 ment.

17 “(B) SPECIAL RULE FOR PREPAID HEALTH
18 CARE ARRANGEMENTS.—In the case of an ar-
19 rangement that is a prepaid health care ar-
20 rangement (as defined in section 701(12)), the
21 operating committee is the board of the entity
22 that is the arrangement.

23 “(3) CONTENTS OF GOVERNING INSTRU-
24 MENTS.—The instruments governing the arrange-
25 ment include a written instrument, meeting the re-

1 requirements of an instrument required under section
2 1212(a)(1), which—

3 “(A) provides that the committee serves as
4 the named fiduciary required for plans under
5 section 1212(a)(1) and serves in the capacity of
6 a plan administrator (referred to in section
7 3(16)(A)),

8 “(B) provides that the sponsor is to serve
9 as plan sponsor (referred to in section
10 3(16)(B)),

11 “(C) incorporates the requirements of sec-
12 tion 707, and

13 “(D) provides that, effective upon the
14 granting of an exemption under this part—

15 “(i) all participating employers must
16 be members or affiliated members of the
17 sponsor, except that, in the case of a spon-
18 sor which is a professional association or
19 other individual-based association, if at
20 least one of the officers, directors, or em-
21 ployees of an employer, or at least one of
22 the individuals who are partners in an em-
23 ployer and who actively participates in the
24 business, is a member or affiliated member

1 of the sponsor, participating employers
 2 may also include such employer, and

3 “(ii) all individuals thereafter com-
 4 mencing coverage under the arrangement
 5 must be—

6 “(I) active or retired owners, offi-
 7 cers, directors, or employees of, or
 8 partners in, participating employers,
 9 or

10 “(II) the beneficiaries of individ-
 11 uals described in subclause (I).

12 “(4) CONTRIBUTION RATES.—The contribution
 13 rates referred to in subsection (a)(3)(F)(ii) are
 14 adequate.

15 “(5) REGULATORY REQUIREMENTS.—Such
 16 other requirements as the Secretary may prescribe
 17 by regulation as necessary to carry out the purposes
 18 of this part.

19 “(c) TREATMENT OF PARTY SEEKING EXEMPTION
 20 WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

21 “(1) IN GENERAL.—In the case of any applica-
 22 tion for an exemption under this part with respect
 23 to a multiple employer welfare arrangement, if the
 24 Secretary determines that the sponsor of the ar-
 25 rangement or any other person associated with the

1 arrangement is subject to disqualification under
2 paragraph (2), the Secretary may deny the exemp-
3 tion with respect to such arrangement.

4 “(2) DISQUALIFICATION.—A person is subject
5 to disqualification under this paragraph if such per-
6 son—

7 “(A) has intentionally made a material
8 misstatement in the application for exemption;

9 “(B) has obtained or attempted to obtain
10 an exemption under this part through misrepre-
11 sentation or fraud;

12 “(C) has misappropriated or converted to
13 such person’s own use, or improperly withheld,
14 money held under a plan or any multiple
15 employer welfare arrangement;

16 “(D) is prohibited (or would be prohibited
17 if the arrangement were a plan) from serving in
18 any capacity in connection with the arrange-
19 ment under section 411,

20 “(E) has failed to appear without reason-
21 able cause or excuse in response to a subpoena,
22 examination, warrant, or any other order law-
23 fully issued by the Secretary compelling such
24 response,

1 “(F) has previously been subject to a de-
2 termination under this part resulting in the de-
3 nial, suspension, or revocation of an exemption
4 under this part on similar grounds, or

5 “(G) has otherwise violated any provision
6 of this title with respect to a matter which the
7 Secretary determines of sufficient consequence
8 to merit disqualification for purposes of this
9 part.

10 “(d) FRANCHISE NETWORKS.—In the case of a mul-
11 tiple employer welfare arrangement established and main-
12 tained by a franchisor for a franchise network consisting
13 of its franchisees, such franchisor shall be treated as the
14 sponsor referred to in the preceding provisions of this sec-
15 tion, such network shall be treated as an association re-
16 ferred to in such provisions, and each franchisee shall be
17 treated as a member (of the association and the sponsor)
18 referred to in such provisions, if all participating employ-
19 ers are such franchisees and the requirements of sub-
20 section (b)(1) with respect to a sponsor are met with
21 respect to the network.

22 “(e) CERTAIN COLLECTIVELY BARGAINED ARRANGE-
23 MENTS.—In applying the preceding provisions of this sec-
24 tion in the case of a multiple employer welfare arrange-
25 ment which would be described in section 3(40)(A)(i) but

1 for the failure to meet any requirement of section
2 3(40)(C)—

3 “(1) paragraphs (1) and (2) of subsection (b)
4 and subparagraphs (A), (B), and (D) of paragraph
5 (3) of subsection (b) shall be disregarded, and

6 “(2) the joint board of trustees shall be consid-
7 ered the operating committee of the arrangement.

8 “(f) CERTAIN ARRANGEMENTS NOT MEETING SIN-
9 GLE EMPLOYER REQUIREMENT.—

10 “(1) IN GENERAL.—In any case in which the
11 majority of the employees covered under a multiple
12 employer welfare arrangement are employees of a
13 single employer (within the meaning of clauses (i)
14 and (ii) of section 3(40)(B)), if all other employees
15 covered under the arrangement are employed by em-
16 ployers who are related to such single employer, sub-
17 section (b)(3)(D) shall be disregarded.

18 “(2) RELATED EMPLOYERS.—For purposes of
19 paragraph (1), employers are ‘related’ if there is
20 among all such employers a common ownership in-
21 terest or a substantial commonality of business oper-
22 ations based on common suppliers or customers.

1 **“SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO**
2 **EXEMPTED ARRANGEMENTS.**

3 “(a) NOTICE OF MATERIAL CHANGES.—In the case
4 of any multiple employer welfare arrangement with respect
5 to which there is in effect an exemption granted under
6 this part, descriptions of material changes in any informa-
7 tion which was required to be submitted with the applica-
8 tion for the exemption shall be filed in such form and man-
9 ner as shall be prescribed in regulations of the Secretary.
10 The Secretary may require by regulation prior notice of
11 material changes with respect to specified matters which
12 might serve as the basis for suspension or revocation of
13 the exemption.

14 “(b) REPORTING REQUIREMENTS.—Under regula-
15 tions of the Secretary, the requirements of sections 102,
16 103, and 104 shall apply with respect to any multiple em-
17 ployer welfare arrangement with respect to which there is
18 or has been in effect an exemption granted under this part
19 in the same manner and to the same extent as such re-
20 quirements apply to employee welfare benefit plans, irre-
21 spective of whether such exemption continues in effect.
22 The annual report required under section 103 for any plan
23 year in the case of any such multiple employer welfare ar-
24 rangement shall also include information described in sec-
25 tion 704(a)(3)(F) with respect to the plan year and, not-

1 withstanding section 104(a)(1)(A), shall be filed not later
2 than 90 days after the close of the plan year.

3 “(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The
4 operating committee of each multiple employer welfare ar-
5 rangement with respect to which there is or has been in
6 effect an exemption granted under this part shall engage,
7 on behalf of all covered individuals, a qualified actuary
8 who shall be responsible for the preparation of the mate-
9 rials comprising information necessary to be submitted by
10 a qualified actuary under this part. The qualified actuary
11 shall utilize such assumptions and techniques as are nec-
12 essary to enable such actuary to form an opinion as to
13 whether the contents of the matters reported under this
14 part—

15 “(1) are in the aggregate reasonably related to
16 the experience of the arrangement and to reasonable
17 expectations, and

18 “(2) represent such actuary’s best estimate of
19 anticipated experience under the arrangement.

20 The opinion by the qualified actuary shall be made with
21 respect to, and shall be made a part of, the annual report.

22 “(d) FILING NOTICE OF EXEMPTION WITH
23 STATES.—An exemption granted to a multiple employer
24 welfare arrangement under this part shall not be effective
25 unless written notice of such exemption is filed with the

1 State insurance commissioner of each State in which at
 2 least 5 percent of the individuals covered under the ar-
 3 rangement are located. For purposes of this paragraph,
 4 an individual shall be considered to be located in the State
 5 in which a known address of such individual is located or
 6 in which such individual is employed. The Secretary may
 7 by regulation provide in specified cases for the application
 8 of the preceding sentence with lesser percentages in lieu
 9 of such 5 percent amount.

10 **“SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY**
 11 **ARRANGEMENTS PROVIDING MEDICAL CARE.**

12 “(a) IN GENERAL.—A multiple employer welfare ar-
 13 rangement providing benefits consisting of medical care
 14 described in section 607(1) shall issue to each participat-
 15 ing employer—

16 “(1) a document equivalent to the summary
 17 plan description required of plans under part 1,

18 “(2) information describing the contribution
 19 rates applicable to participating employers, and

20 “(3) a statement indicating—

21 “(A) whether or not the arrangement is
 22 fully insured,

23 “(B) whether or not there is in effect with
 24 respect to the arrangement an exemption grant-
 25 ed under this part and, if there is in effect such

1 an exemption, that the arrangement is (or is
2 treated as) an employee welfare benefit plan
3 under this title, and

4 “(C) that the arrangement is not a li-
5 censed insurer under the laws of any State.

6 “(b) TIME FOR DISCLOSURE.—Such information
7 shall be issued to employers within such reasonable period
8 of time before becoming participating employers as may
9 be prescribed in regulations of the Secretary.

10 **“SEC. 707. MAINTENANCE OF RESERVES.**

11 “(a) IN GENERAL.—Each multiple employer welfare
12 arrangement with respect to which there is or has been
13 in effect an exemption granted under this part and which
14 is not fully insured shall establish and maintain reserves,
15 consisting of—

16 “(1) a reserve for unearned contributions,

17 “(2) a reserve for payment of claims reported
18 and not yet paid and claims incurred but not yet re-
19 ported, and for expected administrative costs with
20 respect to such claims, and

21 “(3) a reserve, in an amount recommended by
22 the qualified actuary, for any other obligations of
23 the arrangement.

24 “(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—

25 The total of the reserves described in subsection (a)(2)

1 shall not be less than an amount equal to 25 percent of
2 expected incurred claims and expenses for the plan year.

3 “(c) REQUIRED MARGIN.—In determining the
4 amounts of reserves required under this section in connec-
5 tion with any multiple employer welfare arrangement, the
6 qualified actuary shall include a margin for error and
7 other fluctuations taking into account the specific
8 circumstances of such arrangement.

9 “(d) ADDITIONAL REQUIREMENTS.—The Secretary
10 may provide such additional requirements relating to re-
11 serves and excess/stop loss coverage as the Secretary con-
12 siders appropriate. Such requirements may be provided,
13 by regulation or otherwise, with respect to any arrange-
14 ment or any class of arrangements.

15 “(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COV-
16 ERAGE.—The Secretary may provide for adjustments to
17 the levels of reserves otherwise required under subsections
18 (a) and (b) with respect to any arrangement or class of
19 arrangements to take into account excess/stop loss cov-
20 erage provided with respect to such arrangement or ar-
21 rangements.

22 “(f) ALTERNATIVE MEANS OF COMPLIANCE.—The
23 Secretary may permit an arrangement (including a pre-
24 paid health care arrangement) to substitute, for all or part
25 of the reserves required under subsection (a), such secu-

1 rity, guarantee, or other financial arrangement as the Sec-
2 retary determines to be adequate to enable the arrange-
3 ment to fully meet all its financial obligations on a timely
4 basis.

5 **“SEC. 708. CORRECTIVE ACTIONS.**

6 “(a) ACTIONS TO AVOID DEPLETION OF RE-
7 SERVES.—A multiple employer welfare arrangement with
8 respect to which there is or has been in effect an exemp-
9 tion granted under this part shall continue to meet the
10 requirements of section 707, irrespective of whether such
11 exemption continues in effect. The operating committee of
12 such arrangement shall determine semiannually whether
13 the requirements of section 707 are met. In any case in
14 which the committee determines that there is reason to
15 believe that there is or will be a failure to meet such re-
16 quirements, or the Secretary makes such a determination
17 and so notifies the committee, the committee shall imme-
18 diately notify the qualified actuary engaged by the ar-
19 rangement, and such actuary shall, not later than the end
20 of the next following month, make such recommendations
21 to the committee for corrective action as the actuary deter-
22 mines necessary to ensure compliance with section 707.
23 Not later than 10 days after receiving from the actuary
24 recommendations for corrective actions, the committee
25 shall notify the Secretary (in such form and manner as

1 the Secretary may prescribe by regulation) of such rec-
2 ommendations of the actuary for corrective action, to-
3 gether with a description of the actions (if any) that the
4 committee has taken or plans to take in response to such
5 recommendations. The committee shall thereafter report
6 to the Secretary, in such form and frequency as the Sec-
7 retary may specify to the committee, regarding corrective
8 action taken by the committee until the requirements of
9 section 707 are met.

10 “(b) TERMINATION.—

11 “(1) NOTICE OF TERMINATION.—In any case in
12 which the operating committee of a multiple em-
13 ployer welfare arrangement with respect to which
14 there is or has been in effect an exemption granted
15 under this part determines that there is reason to
16 believe that the arrangement will terminate, the
17 committee shall so inform the Secretary, shall de-
18 velop a plan for winding up the affairs of the ar-
19 rangement in connection with such termination in a
20 manner which will result in timely payment of all
21 benefits for which the arrangement is obligated, and
22 shall submit such plan in writing to the Secretary.
23 Actions required under this paragraph shall be taken
24 in such form and manner as may be prescribed in
25 regulations of the Secretary.

1 “(2) ACTIONS REQUIRED IN CONNECTION WITH
2 TERMINATION.—In any case in which—

3 “(A) the Secretary has been notified under
4 subsection (a) of a failure of a multiple em-
5 ployer welfare arrangement with respect to
6 which there is or has been in effect an exemp-
7 tion granted under this part to meet the re-
8 quirements of section 707 and has not been no-
9 tified by the operating committee of the ar-
10 rangement that corrective action has restored
11 compliance with such requirements, and

12 “(B) the Secretary determines that the
13 continuing failure to meet the requirements of
14 section 707 can be reasonably expected to result
15 in a continuing failure to pay benefits for which
16 the arrangement is obligated,

17 the operating committee of the arrangement shall, at
18 the direction of the Secretary, terminate the ar-
19 rangement and, in the course of the termination,
20 take such actions as the Secretary may require as
21 necessary to ensure that the affairs of the arrange-
22 ment will be, to the maximum extent possible, wound
23 up in a manner which will result in timely payment
24 of all benefits for which the arrangement is
25 obligated.

1 **“SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF**
2 **EXEMPTION.**

3 “(a) EXPIRATION AND RENEWAL OF EXEMPTION.—

4 An exemption granted to a multiple employer welfare ar-
5 rangement under this part shall expire 3 years after the
6 date on which the exemption is granted. An exemption
7 which has expired may be renewed by means of application
8 for an exemption in accordance with section 704.

9 “(b) SUSPENSION OR REVOCATION OF EXEMPTION
10 BY SECRETARY.—The Secretary may suspend or revoke
11 an exemption granted to a multiple employer welfare
12 arrangement under this part—

13 “(1) for any cause that may serve as the basis
14 for the denial of an initial application for such an
15 exemption under section 704, or

16 “(2) if the Secretary finds that—

17 “(A) the arrangement, or the sponsor
18 thereof, in the transaction of business while
19 under the exemption, has used fraudulent, coer-
20 cive, or dishonest practices, or has dem-
21 onstrated incompetence, untrustworthiness, or
22 financial irresponsibility,

23 “(B) the arrangement, or the sponsor
24 thereof, is using such methods or practices in
25 the conduct of its operations, so as to render its
26 further transaction of operations hazardous or

1 injurious to participating employers, or covered
2 individuals,

3 “(C) the arrangement, or the sponsor
4 thereof, has refused to be examined in accord-
5 ance with this part or to produce its accounts,
6 records, and files for examination in accordance
7 with this part, or

8 “(D) any of the officers of the arrange-
9 ment, or the sponsor thereof, has refused to
10 give information with respect to the affairs of
11 the arrangement or the sponsor or to perform
12 any other legal obligation relating to such an
13 examination when required by the Secretary in
14 accordance with this part.

15 Any such suspension or revocation under this subsection
16 shall be effective only upon a final decision of the Sec-
17 retary made after notice and opportunity for a hearing
18 is provided in accordance with section 710.

19 “(c) SUSPENSION OR REVOCATION OF EXEMPTION
20 UNDER COURT PROCEEDINGS.—An exemption granted to
21 a multiple employer welfare arrangement under this part
22 may be suspended or revoked by a court of competent ju-
23 risdiction in an action by the Secretary brought under
24 paragraph (2), (5), or (6) of section 502(a), except that
25 the suspension or revocation under this subsection shall

1 be effective only upon notification of the Secretary of such
2 suspension or revocation.

3 “(d) NOTIFICATION OF PARTICIPATING EMPLOY-
4 ERS.—All participating employers in a multiple employer
5 welfare arrangement shall be notified of the expiration,
6 suspension, or revocation of an exemption granted to such
7 arrangement under this part, by such persons and in such
8 form and manner as shall be prescribed in regulations of
9 the Secretary, not later than 20 days after such expiration
10 or after receipt of notice of a final decision requiring such
11 suspension or revocation.

12 “(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS,
13 AND REVOCATIONS.—The Secretary shall publish all expi-
14 rations of, and all final decisions to suspend or revoke,
15 exemptions granted under this part.

16 **“SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.**

17 “(a) IN GENERAL.—Any decision by the Secretary
18 which involves the denial of an application by a multiple
19 employer welfare arrangement for an exemption under this
20 part or the suspension or revocation of such an exemption
21 shall contain a statement of the specific reason or reasons
22 supporting the Secretary’s action, including reference to
23 the specific terms of the exemption and the statutory pro-
24 vision or provisions relevant to the determination.

1 “(b) DENIALS OF APPLICATIONS.—In the case of the
2 denial of an application for an exemption under this part,
3 the Secretary shall send a copy of the decision to the appli-
4 cant by certified or registered mail at the address specified
5 in the records of the Secretary. Such decision shall con-
6 stitute the final decision of the Secretary unless the ar-
7 rangement, or any party that would be prejudiced by the
8 decision, files a written appeal of the denial within 30 days
9 after the mailing of such decision. The Secretary may af-
10 firm, modify, or reverse the initial decision. The decision
11 on appeal shall become final upon the mailing of a copy
12 by certified or registered mail to the arrangement or party
13 that filed the appeal.

14 “(c) SUSPENSIONS OR REVOCATIONS OF EXEMP-
15 TION.—In the case of the suspension or revocation of an
16 exemption granted under this part, the Secretary shall
17 send a copy of the decision to the arrangement by certified
18 or registered mail at its address, as specified in the
19 records of the Secretary. Upon the request of the arrange-
20 ment, or any party that would be prejudiced by the sus-
21 pension or revocation, filed within 15 days of the mailing
22 of the Secretary’s decision, the Secretary shall schedule
23 a hearing on such decision by written notice, sent by cer-
24 tified or registered mail to the arrangement or party
25 requesting such hearing. Such notice shall set forth—

1 “(1) a specific date and time for the hearing,
2 which shall be within the 10-day period commencing
3 20 days after the date of the mailing of the notice,
4 and

5 “(2) a specific place for the hearing, which shall
6 be in the District of Columbia or in the State and
7 county thereof (or parish or other similar political
8 subdivision thereof) in which is located the arrange-
9 ment’s principal place of business.

10 The decision as affirmed or modified in such hearing shall
11 constitute the final decision of the Secretary, unless such
12 decision is reversed in such hearing.”.

13 (b) CONFORMING AMENDMENT TO DEFINITION OF
14 PLAN SPONSOR.—Section 3(16)(B) of such Act (29
15 U.S.C. 1002(16)(B)) is amended by adding at the end the
16 following new sentence: “Such term also includes the spon-
17 sor (as defined in section 701(5)) of a multiple employer
18 welfare arrangement, or a multiple employer health plan
19 (as defined in section 701(10)), with respect to which
20 there is or has been in effect an exemption granted under
21 part 7.”.

22 (c) ALTERNATIVE MEANS OF DISTRIBUTION OF
23 SUMMARY PLAN DESCRIPTIONS.—Section 110 of such
24 Act (29 U.S.C. 1030) is amended by adding at the end
25 the following new subsection:

1 “(c) The Secretary shall prescribe, as an alternative
 2 method for distributing summary plan descriptions in
 3 order to meet the requirements of section 104(b)(1) in the
 4 case of multiple employer welfare arrangements providing
 5 benefits consisting of medical care described in section
 6 607(1), a means of distribution of such descriptions by
 7 participating employers.”.

8 (d) CLERICAL AMENDMENT.—The table of contents
 9 in section 1 of the Employee Retirement Income Security
 10 Act of 1974 is amended by inserting after the item relat-
 11 ing to section 608 the following new items:

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Exempted multiple employer welfare arrangements treated as em-
 ployee welfare benefit plans and exempt from certain restric-
 tions on preemption.

“Sec. 703. Exemption procedure.

“Sec. 704. Eligibility requirements.

“Sec. 705. Additional requirements applicable to exempted arrangements.

“Sec. 706. Disclosure to participating employers by arrangements providing
 medical care.

“Sec. 707. Maintenance of reserves.

“Sec. 708. Corrective actions.

“Sec. 709. Expiration, suspension, or revocation of exemption.

“Sec. 710. Review of actions of the Secretary.”.

12 **SEC. 1212. CLARIFICATION OF SCOPE OF PREEMPTION**

13 **RULES.**

14 (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the
 15 Employee Retirement Income Security Act of 1974 (29
 16 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting “, but
 17 only, in the case of an arrangement which provides medi-
 18 cal care described in section 607(1) and with respect to

1 which an exemption under part 7 is not in effect,” before
 2 “to the extent not inconsistent with the preceding sections
 3 of this title”.

4 (b) CROSS-REFERENCE.—Section 514(b)(6) of such
 5 Act (29 U.S.C. 1144(b)(6)) is amended by adding at the
 6 end the following new subparagraph:

7 “(E) For additional rules relating to exemption from
 8 subparagraph (A)(ii) of multiple employer welfare ar-
 9 rangements providing medical care, see part 7.”.

10 **SEC. 1213. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 11 **PLOYER ARRANGEMENTS.**

12 Section 3(40)(B) of the Employee Retirement Income
 13 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-
 14 ed—

15 (1) in clause (i), by inserting “for any plan year
 16 of any such plan, or any fiscal year of any such
 17 other arrangement,” after “single employer”, and by
 18 inserting “during such year or at any time during
 19 the preceding 1-year period” after “common con-
 20 trol”;

21 (2) in clause (iii), by striking “common control
 22 shall not be based on an interest of less than 25 per-
 23 cent” and inserting “an interest of greater than 25
 24 percent may not be required as the minimum inter-

1 est necessary for common control”, and by striking
2 “and” at the end,

3 (3) by redesignating clause (iv) as clause (v),
4 and

5 (4) by inserting after clause (iii) the following
6 new clause:

7 “(iv) in determining, after the application of
8 clause (i), whether benefits are provided to employ-
9 ees of two or more employers, the arrangement shall
10 be treated as having only 1 participating employer
11 if, at the time the determination under clause (i) is
12 made, the number of individuals who are employees
13 and former employees of any one participating em-
14 ployer and who are covered under the arrangement
15 is greater than 95 percent of the aggregate number
16 of all individuals who are employees or former em-
17 ployees of participating employers and who are
18 covered under the arrangement.”.

19 **SEC. 1214. CLARIFICATION OF TREATMENT OF CERTAIN**
20 **COLLECTIVELY BARGAINED ARRANGE-**
21 **MENTS.**

22 (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-
23 ployee Retirement Income Security Act of 1974 (29
24 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

1 “(i) under or pursuant to one or more collective
2 bargaining agreements,”.

3 (b) LIMITATIONS.—Section 3(40) of such Act (29
4 U.S.C. 1002(40)) is amended by adding at the end the
5 following new subparagraphs:

6 “(C) Clause (i) of subparagraph (A) shall
7 apply only if—

8 “(i) the plan or other arrangement,
9 and the employee organization or any other
10 entity sponsoring the plan or other ar-
11 rangement, do not—

12 “(I) utilize the services of any li-
13 censed insurance agent or broker for
14 soliciting or enrolling employers or in-
15 dividuals as participating employers or
16 covered individuals under the plan or
17 other arrangement, or

18 “(II) pay a commission or any
19 other type of compensation to a per-
20 son that is related either to the vol-
21 ume or number of employers or indi-
22 viduals solicited or enrolled as partici-
23 pating employers or covered individ-
24 uals under the plan or other arrange-
25 ment, or to the dollar amount or size

1 of the contributions made by partici-
2 pating employers or covered individ-
3 uals to the plan or other arrangement,

4 “(ii) not less than 85 percent of the
5 covered individuals under the plan or other
6 arrangement are individuals who—

7 “(I) are employed within a bar-
8 gaining unit covered by at least one of
9 the collective bargaining agreements
10 with a participating employer (or are
11 covered on the basis of an individual’s
12 employment in such a bargaining
13 unit), or

14 “(II) are present or former em-
15 ployees of the sponsoring employee or-
16 ganization, of an employer who is or
17 was a party to at least one of the col-
18 lective bargaining agreements, or of
19 the plan or other arrangement or a
20 related plan or arrangement (or are
21 covered on the basis of such present
22 or former employment),

23 “(iii) the plan or other arrangement
24 does not provide benefits to individuals
25 (other than individuals described in clause

1 (ii)(II)) who work outside the standard
2 metropolitan statistical area in which the
3 sponsoring employee organization rep-
4 resents employees (or to individuals (other
5 than individuals described in clause
6 (ii)(II)) on the basis of such work by oth-
7 ers), except that in the case of a sponsor-
8 ing employee organization that represents
9 employees who work outside of any stand-
10 ard metropolitan statistical area, this
11 clause shall be applied by reference to the
12 State in which the sponsoring organization
13 represents employees,

14 “(iv) the employee organization or
15 other entity sponsoring the plan or other
16 arrangement certifies to the Secretary each
17 year, in a form and manner which shall be
18 prescribed in regulations of the Sec-
19 retary—

20 “(I) that the plan or other ar-
21 rangement meets the requirements of
22 clauses (i), (ii), and (iii), and

23 “(II) if, for any year, 10 percent
24 or more of the covered individuals
25 under the plan are individuals not de-

1 scribed in subclause (I) or (II) of
2 clause (ii), the total number of cov-
3 ered individuals and the total number
4 of covered individuals not so de-
5 scribed.

6 “(D)(i) Clause (i) of subparagraph (A)
7 shall not apply to a plan or other arrangement
8 that is established or maintained pursuant to
9 one or more collective bargaining agreements
10 which the National Labor Relations Board de-
11 termines to have been negotiated or otherwise
12 agreed to in a manner or through conduct
13 which violates section 8(a)(2) of the National
14 Labor Relations Act (29 U.S.C. 158(a)(2)).

15 “(ii)(I) Whenever a State insurance com-
16 missioner has reason to believe that this sub-
17 paragraph is applicable to part or all of a plan
18 or other arrangement, the State insurance com-
19 missioner may file a petition with the National
20 Labor Relations Board for a determination
21 under clause (i), along with sworn written testi-
22 mony supporting the petition.

23 “(II) The Board shall give any such peti-
24 tion priority over all other petitions and cases,
25 other than other petitions under subclause (I)

1 or cases given priority under section 10 of the
2 National Labor Relations Act (29 U.S.C. 160).

3 “(III) The Board shall determine, upon
4 the petition and any response, whether, on the
5 facts before it, the plan or other arrangement
6 was negotiated, created, or otherwise agreed to
7 in a manner or through conduct which violates
8 section 8(a)(2) of the National Labor Relations
9 Act (29 U.S.C. 158(a)(2)). Such determination
10 shall constitute a final determination for pur-
11 poses of this subparagraph and shall be binding
12 in all Federal or State actions with respect to
13 the status of the plan or other arrangement
14 under this subparagraph.

15 “(IV) A person aggrieved by the deter-
16 mination of the Board under subclause (III)
17 may obtain review of the determination in any
18 United States court of appeals in the circuit in
19 which the collective bargaining at issue oc-
20 curred. Commencement of proceedings under
21 this subclause shall not, unless specifically or-
22 dered by the court, operate as a stay of any
23 State administrative or judicial action or pro-
24 ceeding related to the status of the plan or
25 other arrangement, except that in no case may

1 the court stay, before the completion of the re-
2 view, an order which prohibits the enrollment of
3 new individuals into coverage under a plan or
4 arrangement.”.

5 **SEC. 1215. EMPLOYEE LEASING HEALTHCARE ARRANGE-**
6 **MENTS.**

7 (a) EMPLOYEE LEASING HEALTHCARE ARRANGE-
8 MENT DEFINED.—Section 3 of the Employee Retirement
9 Income Security Act of 1974 (29 U.S.C. 1002) is amended
10 by adding at the end the following new paragraph:

11 “(43) EMPLOYEE LEASING HEALTHCARE ARRANGE-
12 MENT.—

13 “(A) IN GENERAL.—Subject to subparagraph
14 (B), the term ‘employee leasing healthcare arrange-
15 ment’ means any labor leasing arrangement, staff
16 leasing arrangement, extended employee staffing or
17 supply arrangement, or other arrangement under
18 which—

19 “(i) one business or other entity (herein-
20 after in this paragraph referred to as the ‘les-
21 see’), under a lease or other arrangement en-
22 tered into with any other business or other en-
23 tity (hereinafter in this paragraph referred to
24 as the ‘lessor’), receives from the lessor the

1 services of individuals to be performed under
2 such lease or other arrangement, and

3 “(ii) benefits consisting of medical care de-
4 scribed in section 607(1) are provided to such
5 individuals or such individuals and their de-
6 pendents as participants and beneficiaries.

7 “(B) EXCEPTION.—Such term does not include
8 an arrangement described in subparagraph (A) if,
9 under such arrangement, the lessor retains, both le-
10 gally and in fact, a complete right of direction and
11 control within the scope of employment over the in-
12 dividuals whose services are supplied under such
13 lease or other arrangement, and such individuals
14 perform a specified function for the lessee which is
15 separate and divisible from the primary business or
16 operations of the lessee.”.

17 (b) TREATMENT OF EMPLOYEE LEASING
18 HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER
19 WELFARE ARRANGEMENTS.—Section 3(40) of such Act
20 (29 U.S.C. 1002(40)) (as amended by the preceding provi-
21 sions of this title) is further amended by adding at the
22 end the following new subparagraph:

23 “(E) The term ‘multiple employer welfare arrange-
24 ment’ includes any employee leasing healthcare arrange-
25 ment, except that such term does not include any employee

1 leasing healthcare arrangement which is a multiple em-
 2 ployer health plan (as defined in section 701(10)).”.

3 (c) SPECIAL RULES FOR EMPLOYEE LEASING
 4 HEALTHCARE ARRANGEMENTS.—

5 (1) IN GENERAL.—Part 7 of subtitle B of title
 6 I of such Act (as added by the preceding provisions
 7 of this Act) is amended by adding at the end the fol-
 8 lowing new section:

9 **“SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING**
 10 **HEALTHCARE ARRANGEMENTS.**

11 “(a) IN GENERAL.—The requirements of paragraphs
 12 (1), (2), and (3) of section 704(b) shall be treated as satis-
 13 fied in the case of a multiple employer welfare arrange-
 14 ment that is an employee leasing healthcare arrangement
 15 if the application for exemption includes information
 16 which the Secretary determines to be complete and accu-
 17 rate and sufficient to demonstrate that the following
 18 requirements are met with respect to the arrangement:

19 “(1) 3-YEAR TENURE.—The lessor has been in
 20 operation for not less than 3 years.

21 “(2) SOLICITATION RESTRICTIONS.—Employee
 22 leasing services provided under the arrangement are
 23 not solicited, advertised, or marketed through li-
 24 censed insurance agents or brokers acting in such
 25 capacity.

1 “(3) CREATION OF EMPLOYMENT RELATION-
2 SHIP.—

3 “(A) DISCLOSURE STATEMENT.—Written
4 notice is provided to each applicant for employ-
5 ment subject to coverage under the arrange-
6 ment, at the time of application for employment
7 and before commencing coverage under the ar-
8 rangement, stating that the employer is the les-
9 sor under the arrangement.

10 “(B) INFORMED CONSENT.—Each such
11 applicant signs a written statement consenting
12 to the employment relationship with the lessor.

13 “(C) INFORMED RECRUITMENT OF LES-
14 SEE’S EMPLOYEES.—In any case in which the
15 lessor offers employment to an employee of a
16 lessee under the arrangement, the lessor in-
17 forms each employee in writing that his or her
18 acceptance of employment with the lessor is vol-
19 untary and that refusal of such offer will not be
20 deemed to be resignation from or abandonment
21 of current employment.

22 “(4) REQUISITE EMPLOYER-EMPLOYEE RELA-
23 TIONSHIP UNDER ARRANGEMENT.—Under the em-
24 ployer-employee relationship with the employees of
25 the lessor—

1 “(A) the lessor retains the ultimate author-
2 ity to hire, terminate, and reassign such em-
3 ployees,

4 “(B) the lessor is responsible for the pay-
5 ment of wages, payroll-related taxes, and em-
6 ployee benefits, without regard to payment by
7 the lessee to the lessor for its services,

8 “(C) the lessor maintains the right of di-
9 rection and control over its employees, except to
10 the extent that the lessee is responsible for su-
11 pervision of the work performed consistent with
12 the lessee’s responsibility for its product or
13 service, and

14 “(D) in accordance with section 301(a) of
15 the Labor Management Relations Act, 1947 (29
16 U.S.C. 185(a)), the lessor retains in the ab-
17 sence of an applicable collective bargaining
18 agreement, the right to enter into arbitration
19 and to decide employee grievances, and

20 “(E) no owner, officer, or director of, or
21 partner in, a lessee is an employee of the lessor,
22 and not more than 10 percent of the individuals
23 covered under the arrangement consist of own-
24 ers, officers, or directors of, or partners in,
25 such a lessee (or any combination thereof).

1 “(b) DEFINITIONS.—For purposes of this section—

2 “(1) LESSOR.—The term ‘lessor’ means the
3 business or other entity from which services of indi-
4 viduals are obtained under an employee leasing
5 healthcare arrangement.

6 “(2) LESSEE.—The term ‘lessee’ means a busi-
7 ness or other entity which receives the services of in-
8 dividuals provided under an employee leasing
9 healthcare arrangement.”.

10 (2) CLERICAL AMENDMENT.—The table of con-
11 tents in section 1 of such Act (as amended by the
12 preceding provisions of this title) is further amended
13 by inserting after the item relating to section 710
14 the following new item:

“Sec. 711. Employee leasing healthcare arrangements.”.

15 **SEC. 1216. ENFORCEMENT PROVISIONS RELATING TO MUL-**
16 **TIPLE EMPLOYER WELFARE ARRANGEMENTS**
17 **AND EMPLOYEE LEASING HEALTHCARE AR-**
18 **RANGEMENTS.**

19 (a) ENFORCEMENT OF FILING REQUIREMENTS.—
20 Section 502 of the Employee Retirement Income Security
21 Act of 1974 (29 U.S.C. 1132) is amended—

22 (1) in subsection (a)(6), by striking “subsection
23 (c)(2) or (i) or (l)” and inserting “paragraph (2) or
24 (4) of subsection (c) or subsection (i) or (l)”; and

1 (2) by adding at the end of subsection (c) the
2 following new paragraph:

3 “(4) The Secretary may assess a civil penalty against
4 any person of up to \$1,000 a day from the date of such
5 person’s failure or refusal to file the information required
6 to be filed with the Secretary under section 101(e).”.

7 (b) ACTIONS BY STATES IN FEDERAL COURT.—Sec-
8 tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

9 (1) in paragraph (5), by striking “or” at the
10 end;

11 (2) in paragraph (6), by striking the period and
12 inserting “, or”; and

13 (3) by adding at the end the following:

14 “(7) by a State official having authority under
15 the law of such State to enforce the laws of such
16 State regulating insurance, to enjoin any act or
17 practice which violates any provision of part 7 which
18 such State has the power to enforce under part 7.”.

19 (c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
20 MISREPRESENTATIONS.—Section 501 of such Act (29
21 U.S.C. 1131) is amended—

22 (1) by inserting “(a)” after “SEC. 501.”; and

23 (2) by adding at the end the following new sub-
24 section:

1 “(b) Any person who, either willfully or with willful
2 blindness, falsely represents, to any employee, any employ-
3 ee’s beneficiary, any employer, the Secretary, or any State,
4 an arrangement established or maintained for the purpose
5 of offering or providing any benefit described in section
6 3(1) to employees or their beneficiaries as being a multiple
7 employer welfare arrangement granted an exemption
8 under part 7, as being an employee leasing healthcare ar-
9 rangement under such an exemption, or as having been
10 established or maintained under or pursuant to a collective
11 bargaining agreement shall, upon conviction, be impris-
12 oned not more than five years, be fined under title 18,
13 United States Code, or both.”.

14 (d) CEASE ACTIVITIES ORDERS.—Section 502 of
15 such Act (29 U.S.C. 1132) is amended by adding at the
16 end the following new subsection:

17 “(m)(1) Subject to paragraph (2), upon application
18 by the Secretary showing the operation, promotion, or
19 marketing of a multiple employer welfare arrangement
20 providing benefits consisting of medical care described in
21 section 607(1) that—

22 “(A) is not licensed, registered, or otherwise ap-
23 proved under the insurance laws of the States in
24 which the arrangement offers or provides benefits, or

1 “(B) is not operating in accordance with the
2 terms of an exemption granted by the Secretary
3 under part 7,

4 a district court of the United States shall enter an order
5 requiring that the arrangement cease activities.

6 “(2) Paragraph (1) shall not apply in the case of a
7 multiple employer welfare arrangement if the arrangement
8 shows that it—

9 “(A) is fully insured, within the meaning of
10 section 701(9),

11 “(B) is licensed, registered, or otherwise ap-
12 proved in each State in which it offers or provides
13 benefits, except to the extent that such State does
14 not require licensing, registration, or approval of
15 fully insured multiple employer welfare arrange-
16 ments, and

17 “(C) with respect to each such State, is operat-
18 ing in accordance with applicable State insurance
19 laws that are not superseded under section 514.

20 “(3) The court may grant such additional equitable
21 or remedial relief, including any relief available under this
22 title, as it deems necessary to protect the interests of the
23 public and of persons having claims for benefits against
24 the arrangement.”.

1 (e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
 2 Section 503 of such Act (29 U.S.C. 1133) is amended by
 3 adding at the end (after and below paragraph (2)) the fol-
 4 lowing new sentence: “The terms of each multiple em-
 5 ployer welfare arrangement to which this section applies
 6 and which provides benefits consisting of medical care de-
 7 scribed in section 607(1) shall require the operating com-
 8 mittee or the named fiduciary (as applicable) to ensure
 9 that the requirements of this section are met in connection
 10 with claims filed under the arrangement.”.

11 **SEC. 1217. FILING REQUIREMENTS FOR HEALTH BENEFIT**
 12 **MULTIPLE EMPLOYER WELFARE ARRANGE-**
 13 **MENTS.**

14 Section 101 of the Employee Retirement Income Se-
 15 curity Act of 1974 (29 U.S.C. 1021) is amended—

16 (1) by redesignating subsection (e) as sub-
 17 section (f); and

18 (2) by inserting after subsection (d) the follow-
 19 ing new subsection:

20 “(e)(1) Each multiple employer welfare arrangement
 21 shall file with the Secretary a registration statement de-
 22 scribed in paragraph (2) within 60 days before commenc-
 23 ing operations (in the case of an arrangement commencing
 24 operations on or after January 1, 1994) and no later than
 25 February 15 of each year (in the case of an arrangement

1 in operation since the beginning of such year), unless, as
2 of the date by which such filing otherwise must be made,
3 such arrangement provides no benefits consisting of medi-
4 cal care described in section 607(1).

5 “(2) Each registration statement—

6 “(A) shall be filed in such form, and contain
7 such information concerning the multiple employer
8 welfare arrangement and any persons involved in its
9 operation (including whether the arrangement is
10 fully insured), as shall be provided in regulations
11 which shall be prescribed by the Secretary, and

12 “(B) if the arrangement is not fully insured,
13 shall contain a certification that copies of such reg-
14 istration statement have been transmitted by cer-
15 tified mail to—

16 “(i) in the case of an arrangement with re-
17 spect to which an exemption under part 7 is in
18 effect, the State insurance commissioner of the
19 domicile State of such arrangement, or

20 “(ii) in the case of an arrangement which
21 is not so exempt, the State insurance commis-
22 sioner of each State in which the arrangement
23 is located.

24 “(3) The person or persons responsible for filing the
25 annual registration statement are—

1 “(A) the trustee or trustees so designated by
2 the terms of the instrument under which the mul-
3 tiple employer welfare arrangement is established or
4 maintained, or

5 “(B) in the case of a multiple employer welfare
6 arrangement for which the trustee or trustees can-
7 not be identified, or upon the failure of the trustee
8 or trustees of an arrangement to file, the person or
9 persons actually responsible for the acquisition, dis-
10 position, control, or management of the cash or
11 property of the arrangement, irrespective of whether
12 such acquisition, disposition, control, or management
13 is exercised directly by such person or persons or
14 through an agent designated by such person or
15 persons.

16 “(4) Any agreement entered into under section
17 506(c) with a State as the primary domicile State with
18 respect to any multiple employer welfare arrangement
19 shall provide for simultaneous filings of reports required
20 under this subsection with the Secretary and with the
21 State insurance commissioner of such State.”.

1 **SEC. 1218. COOPERATION BETWEEN FEDERAL AND STATE**
2 **AUTHORITIES.**

3 Section 506 of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
5 at the end the following new subsection:

6 “(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE
7 EMPLOYER WELFARE ARRANGEMENTS.—

8 “(1) STATE ENFORCEMENT.—

9 “(A) AGREEMENTS WITH STATES.—A
10 State may enter into an agreement with the
11 Secretary for delegation to the State of some or
12 all of the Secretary’s authority under sections
13 502 and 504 to enforce the provisions of this
14 title applicable to multiple employer welfare ar-
15 rangements with respect to which an exemption
16 under part 7 is or has been in effect. The Sec-
17 retary shall enter into the agreement if the Sec-
18 retary determines that the delegation provided
19 for therein would not result in a lower level or
20 quality of enforcement of the provisions of this
21 title.

22 “(B) DELEGATIONS.—Any department,
23 agency, or instrumentality of a State to which
24 authority is delegated pursuant to an agree-
25 ment entered into under this paragraph may, if
26 authorized under State law and to the extent

1 consistent with such agreement, exercise the
2 powers of the Secretary under this title which
3 relate to such authority.

4 “(C) CONCURRENT AUTHORITY OF THE
5 SECRETARY.—If the Secretary delegates author-
6 ity to a State in an agreement entered into
7 under subparagraph (A), the Secretary may
8 continue to exercise such authority concurrently
9 with the State.

10 “(D) RECOGNITION OF PRIMARY DOMICILE
11 STATE.—In entering into any agreement with a
12 State under subparagraph (A), the Secretary
13 shall ensure that, as a result of such agreement
14 and all other agreements entered into under
15 subparagraph (A), only one State will be recog-
16 nized, with respect to any particular multiple
17 employer welfare arrangement, as the primary
18 domicile State to which authority has been dele-
19 gated pursuant to such agreements.

20 “(2) ASSISTANCE TO STATES.—The Secretary
21 shall—

22 “(A) provide enforcement assistance to the
23 States with respect to multiple employer welfare
24 arrangements, including, but not limited to, co-
25 ordinating Federal and State efforts through

1 the establishment of cooperative agreements
2 with appropriate State agencies under which
3 the Pension and Welfare Benefits Administra-
4 tion keeps the States informed of the status of
5 its cases and makes available to the States in-
6 formation obtained by it,

7 “(B) provide continuing technical assist-
8 ance to the States with respect to issues involv-
9 ing multiple employer welfare arrangements
10 and this Act,

11 “(C) assist the States in obtaining from
12 the Office of Regulations and Interpretations
13 timely and complete responses to requests for
14 advisory opinions on issues described in sub-
15 paragraph (B), and

16 “(D) distribute copies of all advisory opin-
17 ions described in subparagraph (C) to the State
18 insurance commissioner of each State.”.

19 **SEC. 1219. EFFECTIVE DATE; TRANSITIONAL RULES.**

20 (a) **EFFECTIVE DATE.**—The amendments made by
21 this part shall take effect January 1, 1994, except that
22 the Secretary of Labor may issue regulations before such
23 date under such amendments. The Secretary shall issue
24 all regulations necessary to carry out the amendments
25 made by this title before the effective date thereof.

1 (b) TRANSITIONAL RULES.—If the sponsor of a mul-
2 tiple employer welfare arrangement which, as of January
3 1, 1994, provides benefits consisting of medical care de-
4 scribed in section 607(1) of the Employee Retirement In-
5 come Security Act of 1974 (29 U.S.C. 1167(1)) files with
6 the Secretary of Labor an application for an exemption
7 under part 7 of subtitle B of title I of such Act within
8 180 days after such date and the Secretary has not, as
9 of 90 days after receipt of such application, found such
10 application to be materially deficient, section 514(b)(6)(A)
11 of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply
12 with respect to such arrangement during the 18-month pe-
13 riod following such date. If the Secretary determines, at
14 any time after the date of enactment of this Act, that any
15 such exclusion from coverage under the provisions of such
16 section 514(b)(6)(A) of such Act of a multiple employer
17 welfare arrangement would be detrimental to the interests
18 of individuals covered under such arrangement, such ex-
19 clusion shall cease as of the date of the determination.
20 Any determination made by the Secretary under this sub-
21 section shall be in the Secretary's sole discretion.

1 **PART 3—ENCOURAGEMENT OF MULTIPLE EM-**
2 **PLOYER ARRANGEMENTS PROVIDING BASIC**
3 **HEALTH BENEFITS**

4 **SEC. 1221. ELIMINATING COMMONALITY OF INTEREST OR**
5 **GEOGRAPHIC LOCATION REQUIREMENT FOR**
6 **TAX EXEMPT TRUST STATUS.**

7 (a) IN GENERAL.—Paragraph (9) of section 501(c)
8 of the Internal Revenue Code of 1986 (relating to exempt
9 organizations) is amended—

10 (1) by inserting “(A)” after “(9)”; and

11 (2) by adding at the end the following:

12 “(B) Any determination of whether a multiple
13 employer health plan (as defined in section 701(10)
14 of the Employee Retirement Income Security Act of
15 1974) or an insured multiple employer health plan
16 (as defined in section 701(11) of such Act) is a vol-
17 untary employees’ beneficiary association meeting
18 the requirements of this paragraph shall be made
19 without regard to any determination of commonality
20 of interest or geographic location if—

21 “(i) such plan provides at least standard
22 coverage (consistent with section 102(c) of the
23 Affordable Health Care Now Act of 1993), and

24 “(ii) in the case of an insured multiple em-
25 ployer health plan, it meets the requirements
26 enforceable under section 514(b)(6)(B)(i) of the

1 Employee Retirement Income Security Act of
 2 1974 to the extent not preempted by section
 3 1202 of the Affordable Health Care Now Act of
 4 1993.”.

5 (b) EFFECTIVE DATE.—The amendments made by
 6 subsection (a) shall apply with respect to determinations
 7 made on or after January 1, 1994.

8 **PART 4—SIMPLIFYING FILING OF REPORTS FOR**
 9 **EMPLOYERS COVERED UNDER INSURED**
 10 **MULTIPLE EMPLOYER HEALTH PLANS**

11 **SEC. 1231. SINGLE ANNUAL FILING FOR ALL EMPLOYERS**
 12 **COVERED UNDER AN INSURED MULTIPLE**
 13 **EMPLOYER HEALTH PLAN.**

14 (a) IN GENERAL.—Section 110 of the Employee Re-
 15 tirement Income Security Act of 1974 (29 U.S.C. 1030),
 16 as amended by section 1211(c) of this subtitle, is amended
 17 by adding at the end the following new subsection:

18 “(d) The Secretary shall prescribe by regulation or
 19 otherwise an alternative method providing for the filing
 20 of a single annual report (as referred to in section
 21 104(a)(1)(A)) with respect to all employers who are cov-
 22 ered under the same insured multiple employer health plan
 23 (as defined in section 701(11)).”

24 (b) EFFECTIVE DATE.—The amendment made by
 25 subsection (a) shall take effect on the date of the enact-

1 ment of this Act. The Secretary of Labor shall prescribe
2 the alternative method referred to in section 110(d) of the
3 Employee Retirement Income Security Act of 1974, as
4 added by such amendment, within 90 days after the date
5 of the enactment of this Act.

6 **PART 5—COMPLIANCE WITH COVERAGE OPTION**
7 **REQUIREMENTS**

8 **SEC. 1241. COMPLIANCE WITH COVERAGE REQUIREMENTS**
9 **THROUGH MULTIPLE EMPLOYER HEALTH AR-**
10 **RANGEMENTS.**

11 (a) COMPLIANCE WITH APPLICABLE REQUIREMENTS
12 THROUGH MULTIEMPLOYER PLANS.—In any case in
13 which an eligible employee is, for any plan year, a partici-
14 pant in a group health plan which is a multiemployer plan,
15 the requirements of section 1001(a) shall be deemed to
16 be met with respect to such employee for such plan year
17 if the employer requirements of subsection (c) are met
18 with respect to the eligible employee, irrespective of wheth-
19 er, or to what extent, the employer makes employer con-
20 tributions on behalf of the eligible employee.

21 (b) COMPLIANCE WITH APPLICABLE REQUIREMENTS
22 THROUGH OTHER MULTIPLE EMPLOYER HEALTH AR-
23 RANGEMENTS.—

24 (1) IN GENERAL.—In any case in which an em-
25 ployer is, for any plan year, a participating employer

1 (as defined in paragraph (3)) in an exempted mul-
2 tiple employer health plan or an insured multiple
3 employer health plan, the requirements of section
4 1001(a) shall be deemed to be met (and the ERISA
5 requirements of paragraph (2) shall be deemed to be
6 met by the employer) with respect to an eligible em-
7 ployee of the employer if—

8 (A) the employer requirements of sub-
9 section (c) are met with respect to the eligible
10 employee, and

11 (B) the applicable ERISA requirements of
12 paragraph (2) are met by the plan with respect
13 to the plan,

14 irrespective of whether, or to what extent, the em-
15 ployer makes employer contributions on behalf of the
16 eligible employee.

17 (2) APPLICABLE ERISA REQUIREMENTS.—The
18 applicable ERISA requirements of this paragraph
19 are the requirements of—

20 (A) part 1 of subtitle B of title I of the
21 Employee Retirement Income Security Act of
22 1974 (relating to reporting and disclosure),

23 (B) section 503 of such Act (relating to
24 claims procedure), and

1 (C) part 6 of subtitle B of such title I (re-
2 lating to group health plans),
3 to the extent that such requirements relate to em-
4 ployers as plan sponsors or plan administrators.

5 (3) PARTICIPATING EMPLOYER.—In this sub-
6 section, the term “participating employer” means, in
7 connection with an exempted multiple employer
8 health plan or an insured multiple employer health
9 plan, any employer if any of its employees, or any
10 of the dependents of its employees, are or were cov-
11 ered under such plan in connection with the employ-
12 ment of the employees.

13 (c) EMPLOYER REQUIREMENTS.—The employer re-
14 quirements of this subsection are met under a plan with
15 respect to an eligible employee if—

16 (1) the employee is eligible under the plan to
17 elect coverage on an annual basis and is provided a
18 reasonable opportunity to make the election in such
19 form and manner and at such times as are provided
20 by the plan,

21 (2) subject to section 1001(c), such coverage in-
22 cludes at least the standard coverage (consistent
23 with section 1102(c)),

24 (3) the employer facilitates collection of any
25 employee contributions under the plan and permits

1 the employee to elect to have employee contributions
 2 under the plan collected through payroll deduction,
 3 and

4 (4) in the case of a plan to which part 1 of sub-
 5 title B of title I of the Employee Retirement Income
 6 Security Act of 1974 does not otherwise apply, the
 7 employer provides to the employee a summary plan
 8 description described in section 102(a)(1) of such
 9 Act in the form and manner and at such times as
 10 are required under such part 1 with respect to em-
 11 ployee welfare benefit plans.

12 **Subtitle D—Health Deduction** 13 **Fairness**

14 **SEC. 1301. PERMANENT EXTENSION AND INCREASE IN** 15 **HEALTH INSURANCE TAX DEDUCTION FOR** 16 **SELF-EMPLOYED INDIVIDUALS.**

17 (a) PERMANENT EXTENSION OF DEDUCTION.—

18 (1) IN GENERAL.—Subsection (l) of section 162
 19 of the Internal Revenue Code of 1986 (relating to
 20 special rules for health insurance costs of self-em-
 21 ployed individuals) is amended by striking paragraph
 22 (6).

23 (2) EFFECTIVE DATE.—The amendment made
 24 by this subsection shall apply to taxable years begin-
 25 ning after December 31, 1993.

1 (b) INCREASE IN AMOUNT OF DEDUCTION; INSUR-
 2 ANCE PURCHASED MUST MEET CERTAIN STANDARDS.—

3 (1) INCREASE IN AMOUNT OF DEDUCTION.—

4 Paragraph (1) of section 162(l) of such Code is
 5 amended by striking “25 percent of” and inserting
 6 “100 percent (50 percent in the case of taxable
 7 years beginning in 1996 or 1997) of”.

8 (2) INSURANCE PURCHASED MUST MEET CER-
 9 TAIN STANDARDS.—Paragraph (2) of section 162(l)
 10 of such Code is amended by adding at the end there-
 11 of the following new subparagraph:

12 “(C) INSURANCE MUST MEET CERTAIN
 13 STANDARDS.—Paragraph (1) shall apply only to
 14 insurance which is—

15 “(i) a MedAccess plan (as defined in
 16 section 1102(a)(2) of such Act), or

17 “(ii) a health plan which provides at
 18 least the standard coverage (consistent
 19 with section 1102(c) of the Affordable
 20 Health Care Now Act of 1993) with sub-
 21 stantial cost-sharing (as defined for pur-
 22 poses of section 1102(a)(1)(A)(i) of such
 23 Act).

24 “(D) TREATMENT OF GROUP HEALTH
 25 PLANS.—For purposes of this subsection, an

1 amount paid into a multiple employer health
 2 plan (as defined in section 701(10) of the Em-
 3 ployee Retirement Income Security Act of
 4 1974) shall be deemed to be an amount paid for
 5 insurance which constitutes medical care.”

6 (3) EFFECTIVE DATE.—The amendments made
 7 by this subsection shall apply to taxable years begin-
 8 ning after December 31, 1993.

9 **SEC. 1302. DEDUCTION OF HEALTH INSURANCE PREMIUMS**
 10 **FOR CERTAIN PREVIOUSLY UNINSURED INDIVIDUALS.**
 11 **VIDUALS.**

12 (a) IN GENERAL.—Section 213 of the Internal Reve-
 13 nue Code of 1986 (relating to medical, dental, etc., ex-
 14 penses) is amended by adding at the end thereof the fol-
 15 lowing new subsection:

16 “(f) DEDUCTION FOR CERTAIN HEALTH INSURANCE
 17 COSTS DETERMINED WITHOUT REGARD TO ADJUSTED
 18 GROSS INCOME THRESHOLD.—

19 “(1) IN GENERAL.—Subsection (a) shall be ap-
 20 plied without regard to the limitation based on ad-
 21 justed gross income in the case of the applicable per-
 22 centage of the amounts paid for insurance referred
 23 to in section 162(l)(2)(C) (and including payments
 24 referred to in section 162(l)(2)(D)).

1 “(2) APPLICABLE PERCENTAGE.—For purposes
2 of paragraph (1), the term ‘applicable percentage’
3 means—

4 “(A) 25 percent for taxable years begin-
5 ning in 1994 or 1995,

6 “(B) 50 percent for taxable years begin-
7 ning in 1996 or 1997, and

8 “(C) 100 percent for taxable years begin-
9 ning after 1997.

10 “(3) DEDUCTION NOT ALLOWED TO INDIVID-
11 UALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COV-
12 ERAGE.—

13 “(A) IN GENERAL.—Paragraph (1) shall
14 not apply to any individual—

15 “(i) who is eligible to participate in
16 any subsidized health plan maintained by
17 an employer of such individual or the
18 spouse of such individual, or

19 “(ii) who is (or whose spouse is) a
20 member of a subsidized class of employees
21 of an employer.

22 “(B) SUBSIDIZED CLASS.—For purposes of
23 subparagraph (A), an individual is a member of
24 a subsidized class of employees of an employer
25 if, at any time during the 3 calendar years end-

1 ing with or within the taxable year, any mem-
2 ber of such class was eligible to participate in
3 any subsidized health plan maintained by such
4 employer.

5 “(C) SPECIAL RULES.—

6 “(i) CONTROLLED GROUPS.—All per-
7 sons treated as a single employer under
8 subsection (a) or (b) of section 52 or sub-
9 section (m) or (o) of section 414 shall be
10 treated as a single employer for purposes
11 of subparagraph (B).

12 “(ii) CLASSES.—Classes of employees
13 shall be determined under regulations pre-
14 scribed by the Secretary based on such fac-
15 tors as the Secretary determines appro-
16 priate to carry out the purposes of this
17 subsection.

18 “(4) COORDINATION WITH DEDUCTION FOR
19 OTHER AMOUNTS.—Amounts allowable as a deduc-
20 tion under subsection (a) by reason of this sub-
21 section shall not be taken into account in determin-
22 ing the deduction under subsection (a) for other
23 amounts.

24 “(5) SUBSECTION NOT TO APPLY TO INDIVID-
25 UALS ELIGIBLE FOR MEDICARE.—This subsection

1 shall not apply to amount paid for insurance cover-
 2 ing an individual who is eligible for benefits under
 3 title XVIII of the Social Security Act.”

4 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL
 5 ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
 6 of section 62 of such Code is amended by inserting after
 7 paragraph (15) the following new paragraph:

8 “(16) COSTS OF CERTAIN HEALTH INSURANCE.—The deduction allowed by section 213 to the
 9 extent allowable by reason of section 213(f).”

11 (c) EFFECTIVE DATE.—The amendments made by
 12 this section shall apply to taxable years beginning after
 13 December 31, 1993.

14 **Subtitle E—Improved Access to**
 15 **Community Health Services**

16 **PART 1—INCREASED AUTHORIZATION**
 17 **FOR COMMUNITY AND MIGRANT**
 18 **HEALTH CENTERS**

19 **SEC. 1401. GRANT PROGRAM TO PROMOTE PRIMARY**
 20 **HEALTH CARE SERVICES FOR UNDERSERVED**
 21 **POPULATIONS.**

22 (a) AUTHORIZATION.—The Secretary of Health and
 23 Human Services shall provide for a program of grants to
 24 migrant and community health centers (receiving grants
 25 or contracts under section 329, 330, or 340 of the Public

1 Health Service Act) in order to promote the provision of
2 primary health care services for underserved individuals.

3 Such grants may be used—

4 (1) to promote the provision of off-site services
5 (through means such as mobile medical clinics);

6 (2) to improve birth outcomes in areas with
7 high infant mortality and morbidity;

8 (3) to establish primary care clinics in areas
9 identified as in need of such clinics; and

10 (4) for recruitment and training costs of nec-
11 essary providers and operating costs for unreim-
12 bursed services.

13 (b) CONDITIONS.—(1) Grants under this subsection
14 shall only be made upon application, approved by the Sec-
15 retary.

16 (2) The amount of grants made under this section
17 shall be determined by the Secretary.

18 (c) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated—

20 (1) in fiscal year 1994, \$100,000,000,

21 (2) in fiscal year 1995, \$200,000,000,

22 (3) in fiscal year 1996, \$300,000,000,

23 (4) in fiscal year 1997, \$400,000,000, and

24 (5) in fiscal year 1998, \$500,000,000,

1 to carry out this section. Of the amounts appropriated
2 each fiscal year under this section, at least 10 percent
3 shall be used for grants described in subsection (a)(1) and
4 at least 10 percent shall be used for grants described in
5 subsection (a)(2). The Secretary may use not to exceed
6 50 percent of the amounts appropriated to carry out this
7 section for the purpose of making new grants or contracts
8 under sections 329, 330, and 340 of the Public Health
9 Service Act.

10 (d) STUDY AND REPORT.—The Secretary shall con-
11 duct a study of the impact of the grants made under this
12 section to migrant and community health centers on ac-
13 cess to health care, birth outcomes, and the use of emer-
14 gency room services. Not later than 2 years after the date
15 of the enactment of this Act, the Secretary shall submit
16 to Congress a report on such study and on recommenda-
17 tions for changes in the programs under this section in
18 order to promote the appropriate use of cost-effective out-
19 patient services.

1 **PART 2—GRANTS FOR PROJECTS FOR**
 2 **COORDINATING DELIVERY OF SERVICES**
 3 **SEC. 1411. PROJECTS FOR COORDINATING DELIVERY OF**
 4 **OUTPATIENT PRIMARY HEALTH SERVICES.**

5 Part D of title III of the Public Health Service Act
 6 (42 U.S.C. 254b et seq.) is amended by adding at the end
 7 the following new subpart:

8 “Subpart VII—Delivery of Services

9 “PROJECTS FOR COORDINATING DELIVERY OF SERVICES

10 “SEC. 340E. (a) AUTHORITY FOR GRANTS.—

11 “(1) IN GENERAL.—The Secretary may make
 12 grants to public and nonprofit private entities to
 13 carry out demonstration projects for the purpose of
 14 increasing access to outpatient primary health serv-
 15 ices in geographic areas described in subsection (b)
 16 through coordinating the delivery of such services
 17 under Federal, State, local, and private programs.

18 “(2) REQUIREMENT REGARDING PLAN.—The
 19 Secretary may make a grant under paragraph (1)
 20 only if—

21 “(A) the applicant involved has received a
 22 grant under subsection (l) and the Secretary
 23 has approved the plan developed with such
 24 grant; and

1 “(B) the applicant agrees to carry out the
2 project under paragraph (1) in accordance with
3 the plan.

4 “(b) QUALIFIED HEALTH SERVICE AREAS.—

5 “(1) IN GENERAL.—A geographic area de-
6 scribed in this subsection is a geographic area
7 that—

8 “(A) is a rational area for the delivery of
9 health services;

10 “(B) has a population of not more than
11 500,000 individuals; and

12 “(C)(i) has been designated by the Sec-
13 retary as an area with a shortage of personal
14 health services; or

15 “(ii) has a significant number of individ-
16 uals who have low incomes or who have insuffi-
17 cient insurance regarding health care.

18 “(2) AUTHORITY REGARDING MULTIPLE POLIT-
19 ICAL SUBDIVISIONS.—The Secretary shall make a
20 determination of whether a geographic area is a geo-
21 graphic area described in paragraph (1) without re-
22 gard to whether the area is a political subdivision,
23 without regard to whether the area is located in 2
24 or more political subdivisions or States, and without

1 regard to whether the area encompasses 2 or more
2 political subdivisions.

3 “(c) PREFERENCES IN MAKING GRANTS.—In making
4 grants under subsection (a), the Secretary shall give pref-
5 erence to applicants demonstrating that, with respect to
6 the outpatient primary health services that will be the sub-
7 ject of the project conducted by the applicant under such
8 subsection—

9 “(1)(A) the project will result in the reduction
10 of administrative expenses associated with such serv-
11 ices by increasing the efficiency of the administrative
12 processes of the providers participating in the
13 project, and (B) the resulting savings will be ex-
14 pended for the direct provision of such services for
15 the designated population; or

16 “(2) the services that will be the subject of the
17 project will be provided in facilities that are
18 underutilized.

19 “(d) ACTIVITIES OF PROJECT MUST SERVE DES-
20 IGNATED POPULATION.—The Secretary may make a
21 grant under subsection (a) to an applicant only if the ap-
22 plicant demonstrates that carrying out the project under
23 such subsection will increase access to outpatient primary
24 health services for a significant segment of the designated
25 population.

1 “(e) MATCHING FUNDS.—

2 “(1) IN GENERAL.—With respect to the costs of
3 the project to be carried out under subsection (a) by
4 an applicant, the Secretary may make a grant under
5 such subsection only if the applicant agrees to make
6 available (directly or through donations from public
7 or private entities) non-Federal contributions toward
8 such costs in an amount that is not less than 50
9 percent of such costs.

10 “(2) DETERMINATION OF AMOUNT CONTRIB-
11 UTED.—Non-Federal contributions required in para-
12 graph (1) may be in cash or in kind, fairly evalu-
13 ated, including plant, equipment, or services.
14 Amounts provided by the Federal Government, or
15 services assisted or subsidized to any significant ex-
16 tent by the Federal Government, may not be in-
17 cluded in determining the amount of such non-Fed-
18 eral contributions.

19 “(f) CERTAIN LIMITATIONS REGARDING GRANTS.—

20 “(1) PROVISION OF HEALTH SERVICES; CON-
21 STRUCTION OF FACILITIES.—The Secretary may
22 make a grant under subsection (a) only if the appli-
23 cant involved agrees that the grant will not be ex-
24 pended for the direct provision of any health service
25 or for the construction or renovation of facilities.

1 “(2) DURATION AND AMOUNT OF GRANT.—The
2 period during which payments are made for a
3 project under subsection (a) may not exceed 4 years,
4 and the aggregate amount of such payments for the
5 period may not exceed \$200,000. The provision of
6 such payments shall be subject to annual approval
7 by the Secretary of the payments and subject to the
8 availability of appropriations for the fiscal year in-
9 volved to make the payments.

10 “(3) FINANCIAL CAPACITY FOR CONTINUATION
11 OF PROJECT AFTER TERMINATION OF GRANT.—The
12 Secretary may make a grant under subsection (a)
13 only if the Secretary determines that there is a rea-
14 sonable basis for believing that, after termination of
15 payments under such subsection pursuant to para-
16 graph (2), the project under such subsection will
17 have the financial capacity to continue operating.

18 “(g) AGREEMENTS AMONG PARTICIPANTS IN
19 PROJECTS.—

20 “(1) REQUIRED PARTICIPANTS.—The Secretary
21 may make a grant under subsection (a) only if the
22 applicant for the grant has, for purposes of carrying
23 out a project under such subsection, entered into
24 agreements with—

1 “(A) the chief public health officers, and
2 the chief health officers for the elementary and
3 secondary schools, of each of the political sub-
4 divisions of the qualified health service area in
5 which the project under such subsection is to be
6 carried out (or, in the case of a political sub-
7 division that does not have such an official,
8 with another appropriate official of such sub-
9 division);

10 “(B) each hospital in the qualified health
11 service area;

12 “(C) representatives of entities in such
13 area that provide outpatient primary health
14 services under Federal, State, local, or private
15 programs;

16 “(D) representatives of businesses in such
17 area, including small businesses; and

18 “(E) representatives of nonprofit private
19 entities in such area.

20 “(2) OPTIONAL PARTICIPANTS.—With respect
21 to compliance with this section, a grantee under sub-
22 section (a) may, for purposes of carrying out a
23 project under such subsection, enter into such agree-
24 ments with public and private entities in the quali-
25 fied health service area involved (in addition to the

1 entities specified in paragraph (1)) as the grantee
2 may elect.

3 “(h) EXPENDITURES OF GRANT.—With respect to a
4 project under subsection (a), the purposes for which a
5 grant under such subsection may be expended include (but
6 are not limited to) expenditures to increase the efficiency
7 of the administrative processes of providers participating
8 in the project, paying the costs of hiring and compensating
9 staff, obtaining computers and other equipment (including
10 vehicles to transport individuals to programs providing
11 outpatient primary health services), and developing and
12 operating provider networks.

13 “(i) MAINTENANCE OF EFFORT.—In the case of serv-
14 ices and populations that are the subject of a project
15 under subsection (a), the Secretary may make such a
16 grant for a fiscal year only if the applicant involved agrees
17 that the applicant, and each entity making an agreement
18 under subsection (g), will maintain expenditures of non-
19 Federal amounts for such services and populations at a
20 level that is not less than the level of such expenditures
21 maintained by the applicant and the entity, respectively,
22 for the fiscal year preceding the first fiscal year for which
23 the applicant receives such a grant.

24 “(j) REPORTS TO SECRETARY.—The Secretary may
25 make a grant under subsection (a) only if the applicant

1 involved agrees to submit to the Secretary such reports
2 on the project carried out under such subsection as the
3 Secretary may require.

4 “(k) EVALUATIONS AND DISSEMINATION OF INFOR-
5 MATION.—The Secretary shall provide for evaluations of
6 projects carried out under subsection (a), and for the col-
7 lection and dissemination of information developed as a
8 result of such projects and as a result of similar projects.

9 “(l) PLANNING GRANTS.—

10 “(1) IN GENERAL.—The Secretary may make
11 grants to public and nonprofit private entities for
12 the purpose of developing plans to carry out projects
13 under subsection (a). Such a grant may be made
14 only if the applicant involved submits to the Sec-
15 retary information—

16 “(A) providing a detailed statement of the
17 proposal of the applicant for carrying out the
18 project;

19 “(B) identifying the geographic area in
20 which the project is to be carried out; and

21 “(C) demonstrating that the area is a
22 qualified health service area and that the pro-
23 posal otherwise is in accordance with the re-
24 quirements established in this section for the
25 receipt of a grant under subsection (a).

1 “(2) DURATION AND AMOUNT OF GRANT.—The
2 period during which payments are made under para-
3 graph (1) for the development of a plan under such
4 paragraph may not exceed 1 year, and the amount
5 of such payments may not exceed \$100,000.

6 “(m) APPLICATION FOR GRANT.—The Secretary may
7 make a grant under subsection (a) or (l) only if the appli-
8 cant for the grant submits an application to the Secretary
9 that—

10 “(1) contains any agreements, assurances, and
11 information required in this section with respect to
12 the grant; and

13 “(2) is in such form, is made in such manner,
14 and contains such other agreements, assurances, and
15 information as the Secretary determines to be nec-
16 essary to carry out the purpose for which the grant
17 is to be provided.

18 “(n) DEFINITIONS.—For purposes of this section:

19 “(1) The term ‘designated population’ means
20 individuals described in subsection (b)(1)(C)(ii).

21 “(2) The term ‘primary health services’ includes
22 preventive health services.

23 “(3) The term ‘qualified health service area’
24 means a geographic area described in subsection (b).

25 “(o) AUTHORIZATION OF APPROPRIATIONS.—

1 “(1) PLANNING FOR PROJECTS.—For the pur-
 2 pose of grants under subsection (l), there is author-
 3 ized to be appropriated \$5,000,000 for fiscal year
 4 1994, to remain available until expended.

5 “(2) OPERATION OF PROJECTS.—For the pur-
 6 pose of grants under subsection (a), there is author-
 7 ized to be appropriated an aggregate \$10,000,000
 8 for the fiscal years 1995 through 1998.”.

9 **Subtitle F—Improved Access to**
 10 **Rural Health Services**

11 **PART 1—ESTABLISHMENT OF RURAL**
 12 **EMERGENCY ACCESS CARE HOS-**
 13 **PITALS UNDER MEDICARE**

14 **SEC. 1501. RURAL EMERGENCY ACCESS CARE HOSPITALS**
 15 **DESCRIBED.**

16 Section 1861 of the Social Security Act (42 U.S.C.
 17 1395x) is amended by adding at the end the following new
 18 subsection:

19 “Rural Emergency Access Care Hospital; Rural
 20 Emergency Access Care Hospital Services

21 “(oo)(1) The term ‘rural emergency access care hos-
 22 pital’ means, for a fiscal year, a facility with respect to
 23 which the Secretary finds the following:

24 “(A) The facility is located in a rural area (as
 25 defined in section 1886(d)(2)(D)).

1 “(B) The facility was a hospital under this title
2 at any time during the 5-year period that ends on
3 the date of the enactment of this subsection.

4 “(C) The facility is in danger of closing due to
5 low inpatient utilization rates and negative operating
6 losses, and the closure of the facility would limit the
7 access of individuals residing in the facility’s service
8 area to emergency services.

9 “(D) The facility has entered into (or plans to
10 enter into), with a hospital with a participation
11 agreement in effect under section 1866(a), and
12 under such agreement the hospital shall accept pa-
13 tients transferred to the hospital from the facility
14 and receives data from and transmits data to the fa-
15 cility.

16 “(E) There is a practitioner who is qualified to
17 provide advanced cardiac life support services (as de-
18 termined by the State in which the facility is lo-
19 cated) on-site at the facility on a 24-hour basis.

20 “(F) A physician is available on-call to provide
21 emergency medical services on a 24-hour basis.

22 “(G) The facility meets such staffing require-
23 ments as would apply under section 1861(e) to a
24 hospital located in a rural area, except that—

1 “(i) the facility need not meet hospital
2 standards relating to the number of hours dur-
3 ing a day, or days during a week, in which the
4 facility must be open, except insofar as the fa-
5 cility is required to provide emergency care on
6 a 24-hour basis under subparagraphs (E) and
7 (F); and

8 “(ii) the facility may provide any services
9 otherwise required to be provided by a full-time,
10 on-site dietician, pharmacist, laboratory techni-
11 cian, medical technologist, or radiological tech-
12 nologist on a part-time, off-site basis.

13 “(H) The facility meets the requirements appli-
14 cable to clinics and facilities under subparagraphs
15 (C) through (J) of paragraph (2) of section
16 1861(aa) and of clauses (ii) and (iv) of the second
17 sentence of such paragraph (or, in the case of the
18 requirements of subparagraph (E), (F), or (J) of
19 such paragraph, would meet the requirements if any
20 reference in such subparagraph to a ‘nurse practi-
21 tioner’ or to ‘nurse practitioners’ was deemed to be
22 a reference to a ‘nurse practitioner or nurse’ or to
23 ‘nurse practitioners or nurses’), except that in deter-
24 mining whether a facility meets the requirements of
25 this subparagraph, subparagraphs (E) and (F) of

1 that paragraph shall be applied as if any reference
 2 to a ‘physician’ is a reference to a physician as de-
 3 fined in section 1861(r)(1).

4 “(2) The term ‘rural emergency access care hospital
 5 services’ means medical and other health services fur-
 6 nished by a rural emergency access care hospital.”.

7 **SEC. 1502. COVERAGE OF AND PAYMENT FOR SERVICES.**

8 (a) COVERAGE UNDER PART B.—Section 1832(a)(2)
 9 of the Social Security Act (42 U.S.C. 1395k(a)(2)) is
 10 amended—

11 (1) by striking “and” at the end of subpara-
 12 graph (I);

13 (2) by striking the period at the end of sub-
 14 paragraph (J) and inserting “; and”; and

15 (3) by adding at the end the following new sub-
 16 paragraph:

17 “(K) rural emergency access care hospital
 18 services (as defined in section 1861(oo)(2)).”.

19 (b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT
 20 RURAL PRIMARY CARE HOSPITAL SERVICES.—

21 (1) IN GENERAL.—Section 1833(a)(6) of the
 22 Social Security Act (42 U.S.C. 1395l(a)(6)) is
 23 amended by striking “services,” and inserting “serv-
 24 ices and rural emergency access care hospital serv-
 25 ices,”.

1 (2) PAYMENT METHODOLOGY DESCRIBED.—
2 Section 1834(g) of such Act (42 U.S.C. 1395m(g))
3 is amended—

4 (A) in the heading, by striking “SERV-
5 ICES” and inserting “SERVICES AND RURAL
6 EMERGENCY ACCESS CARE HOSPITAL SERV-
7 ICES”; and

8 (B) in paragraph (1), by striking “during
9 a year before 1993” and inserting “during a
10 year before the prospective payment system de-
11 scribed in paragraph (2) is in effect”;

12 (C) in paragraph (1), by adding at the end
13 the following:

14 “The amount of payment shall be determined under
15 either method without regard to the amount of the
16 customary or other charge.”;

17 (D) in paragraph (2), by striking “Janu-
18 ary 1, 1993,” and inserting “January 1,
19 1996,”; and

20 (E) by adding at the end the following new
21 paragraph:

22 “(3) APPLICATION OF METHODS TO PAYMENT
23 FOR RURAL EMERGENCY ACCESS CARE HOSPITAL
24 SERVICES.—The amount of payment for rural emer-
25 gency access care hospital services provided during

1 a year shall be determined using the applicable
 2 method provided under this subsection for determin-
 3 ing payment for outpatient rural primary care hos-
 4 pital services during the year.”.

5 **SEC. 1503. EFFECTIVE DATE.**

6 The amendments made by sections 1501 and 1502
 7 shall apply to fiscal years beginning on or after October
 8 1, 1993.

9 **PART 2—RURAL MEDICAL EMERGENCIES**

10 **AIR TRANSPORT**

11 **SEC. 1511. GRANTS TO STATES REGARDING AIRCRAFT FOR**
 12 **TRANSPORTING RURAL VICTIMS OF MEDICAL**
 13 **EMERGENCIES.**

14 Part E of title XII of the Public Health Service Act
 15 (42 U.S.C. 300d–51 et seq.) is amended by adding at the
 16 end thereof the following new section:

17 **“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**
 18 **VICTIMS OF MEDICAL EMERGENCIES.**

19 “(a) IN GENERAL.—The Secretary shall make grants
 20 to States to assist such States in the creation or enhance-
 21 ment of air medical transport systems that provide victims
 22 of medical emergencies in rural areas with access to treat-
 23 ments for the injuries or other conditions resulting from
 24 such emergencies.

25 “(b) APPLICATION AND PLAN.—

1 “(1) APPLICATION.—To be eligible to receive a
2 grant under subsection (a), a State shall prepare
3 and submit to the Secretary an application in such
4 form, made in such manner, and containing such
5 agreements, assurances, and information, including
6 a State plan as required in paragraph (2), as the
7 Secretary determines to be necessary to carry out
8 this section.

9 “(2) STATE PLAN.—An application submitted
10 under paragraph (1) shall contain a State plan that
11 shall—

12 “(A) describe the intended uses of the
13 grant proceeds and the geographic areas to be
14 served;

15 “(B) demonstrates that the geographic
16 areas to be served, as described under subpara-
17 graph (A), are rural in nature;

18 “(C) demonstrate that there is a lack of
19 facilities available and equipped to deliver ad-
20 vanced levels of medical care in the geographic
21 areas to be served;

22 “(D) demonstrate that in utilizing the
23 grant proceeds for the establishment or en-
24 hancement of air medical services the State
25 would be making a cost-effective improvement

1 to existing ground-based or air emergency medi-
2 cal service systems;

3 “(E) demonstrate that the State will not
4 utilize the grant proceeds to duplicate the capa-
5 bilities of existing air medical systems that are
6 effectively meeting the emergency medical needs
7 of the populations they serve;

8 “(F) demonstrate that in utilizing the
9 grant proceeds the State is likely to achieve a
10 reduction in the morbidity and mortality rates
11 of the areas to be served, as determined by the
12 Secretary;

13 “(G) demonstrate that the State, in utiliz-
14 ing the grant proceeds, will—

15 “(i) maintain the expenditures of the
16 State for air and ground medical transport
17 systems at a level equal to not less than
18 the level of such expenditures maintained
19 by the State for the fiscal year preceding
20 the fiscal year for which the grant is re-
21 ceived; and

22 “(ii) ensure that recipients of direct
23 financial assistance from the State under
24 such grant will maintain expenditures of
25 such recipients for such systems at a level

1 at least equal to the level of such expendi-
2 tures maintained by such recipients for the
3 fiscal year preceding the fiscal year for
4 which the financial assistance is received;

5 “(H) demonstrate that persons experienced
6 in the field of air medical service delivery were
7 consulted in the preparation of the State plan;
8 “(I) contain such other information as the
9 Secretary may determine appropriate.

10 “(c) CONSIDERATIONS IN AWARDING GRANTS.—In
11 determining whether to award a grant to a State under
12 this section, the Secretary shall—

13 “(1) consider the rural nature of the areas to
14 be served with the grant proceeds and the services
15 to be provided with such proceeds, as identified in
16 the State plan submitted under subsection (b); and

17 “(2) give preference to States with State plans
18 that demonstrate an effective integration of the pro-
19 posed air medical transport systems into a com-
20 prehensive network or plan for regional or statewide
21 emergency medical service delivery.

22 “(d) STATE ADMINISTRATION AND USE OF
23 GRANT.—

24 “(1) IN GENERAL.—The Secretary may not
25 make a grant to a State under subsection (a) unless

1 the State agrees that such grant will be adminis-
2 tered by the State agency with principal responsibil-
3 ity for carrying out programs regarding the provi-
4 sion of medical services to victims of medical emer-
5 gencies or trauma.

6 “(2) PERMITTED USES.—A State may use
7 amounts received under a grant awarded under this
8 section to award subgrants to public and private en-
9 tities operating within the State.

10 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—
11 The Secretary may not make a grant to a State
12 under subsection (a) unless that State agrees that,
13 in developing and carrying out the State plan under
14 subsection (b)(2), the State will provide public notice
15 with respect to the plan (including any revisions
16 thereto) and facilitate comments from interested
17 persons.

18 “(e) NUMBER OF GRANTS.—The Secretary shall
19 award grants under this section to not less than 7 States.

20 “(f) REPORTS.—

21 “(1) REQUIREMENT.—A State that receives a
22 grant under this section shall annually (during each
23 year in which the grant proceeds are used) prepare
24 and submit to the Secretary a report that shall con-
25 tain—

1 “(A) a description of the manner in which
2 the grant proceeds were utilized;

3 “(B) a description of the effectiveness of
4 the air medical transport programs assisted
5 with grant proceeds; and

6 “(C) such other information as the Sec-
7 retary may require.

8 “(2) TERMINATION OF FUNDING.—In reviewing
9 reports submitted under paragraph (1), if the Sec-
10 retary determines that a State is not using amounts
11 provided under a grant awarded under this section
12 in accordance with the State plan submitted by the
13 State under subsection (b), the Secretary may termi-
14 nate the payment of amounts under such grant to
15 the State until such time as the Secretary deter-
16 mines that the State comes into compliance with
17 such plan.

18 “(g) DEFINITION.—As used in this section, the term
19 ‘rural areas’ means geographic areas that are located out-
20 side of standard metropolitan statistical areas, as identi-
21 fied by the Secretary.

22 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to make grants under
24 this section, \$15,000,000 for fiscal year 1994, and such

1 sums as may be necessary for each of the fiscal years 1995
2 and 1996.”.

3 **PART 3—EMERGENCY MEDICAL SERVICES**
4 **AMENDMENTS**

5 **SEC. 1521. ESTABLISHMENT OF OFFICE OF EMERGENCY**
6 **MEDICAL SERVICES.**

7 Title XII of the Public Health Service Act (42 U.S.C.
8 300d et seq.) is amended—

9 (1) in the heading for the title, by striking
10 “TRAUMA CARE” and inserting “EMERGENCY
11 MEDICAL SERVICES”;

12 (2) in the heading for part A, by striking
13 “GENERAL” and all that follows and inserting
14 “GENERAL AUTHORITIES AND DUTIES”; and

15 (3) by amending section 1201 to read as fol-
16 lows:

17 **“SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY**
18 **MEDICAL SERVICES.**

19 “(a) IN GENERAL.—The Secretary shall establish an
20 office to be known as the Office of Emergency Medical
21 Services, which shall be headed by a director appointed
22 by the Secretary. The Secretary shall carry out this title
23 acting through the Director of such Office.

1 “(b) GENERAL AUTHORITIES AND DUTIES.—With
2 respect to emergency medical services (including trauma
3 care), the Secretary shall—

4 “(1) conduct and support research, training,
5 evaluations, and demonstration projects;

6 “(2) foster the development of appropriate,
7 modern systems of such services through the sharing
8 of information among agencies and individuals in-
9 volved in the study and provision of such services;

10 “(3) sponsor workshops and conferences;

11 “(4) as appropriate, disseminate to public and
12 private entities information obtained in carrying out
13 paragraphs (1) through (4);

14 “(5) provide technical assistance to State and
15 local agencies;

16 “(6) coordinate activities of the Department of
17 Health and Human Services; and

18 “(7) as appropriate, coordinate activities of
19 such Department with activities of other Federal
20 agencies.

21 “(c) CERTAIN REQUIREMENTS.—With respect to
22 emergency medical services (including trauma care), the
23 Secretary shall ensure that activities under subsection (b)
24 are carried out regarding—

1 “(1) maintaining an adequate number of health
2 professionals with expertise in the provision of the
3 services, including hospital-based professionals and
4 prehospital-based professionals;

5 “(2) developing, periodically reviewing, and re-
6 vising as appropriate, in collaboration with appro-
7 priate public and private entities, guidelines for the
8 provision of such services (including, for various typ-
9 ical circumstances, guidelines on the number and va-
10 riety of professionals, on equipment, and on train-
11 ing);

12 “(3) the appropriate use of available tech-
13 nologies, including communications technologies; and

14 “(4) the unique needs of underserved inner-city
15 areas and underserved rural areas.

16 “(d) GRANTS, COOPERATIVE AGREEMENTS, AND
17 CONTRACTS.—In carrying out subsections (b) and (c), the
18 Secretary may make grants and enter into cooperative
19 agreements and contracts.

20 “(e) DEFINITIONS.—For purposes of this part:

21 “(1) The term ‘hospital-based professional’
22 means a health professional (including an allied
23 health professional) who has expertise in providing
24 one or more emergency medical services and who
25 normally provides the services at a medical facility.

1 “(2) The term ‘prehospital-based professional’
 2 means a health professional (including an allied
 3 health professional) who has expertise in providing
 4 one or more emergency medical services and who
 5 normally provides the services at the site of the med-
 6 ical emergency or during transport to a medical fa-
 7 cility.”.

8 **SEC. 1522. STATE OFFICES OF EMERGENCY MEDICAL SERV-**
 9 **ICES.**

10 (a) TECHNICAL AMENDMENTS TO FACILITATE ES-
 11 TABLISHMENT OF PROGRAM.—

12 (1) IN GENERAL.—Title XII of the Public
 13 Health Service Act (42 U.S.C. 300d et seq.) is
 14 amended—

15 (A) by redesignating section 1239 as sec-
 16 tion 1235;

17 (B) by redesignating sections 1231 and
 18 1233 as sections 1236 and 1237, respectively;
 19 and

20 (C) by redesignating sections 1211 through
 21 1222 as sections 1221 through 1232, respec-
 22 tively.

23 (2) MODIFICATIONS IN FORMAT OF TITLE
 24 XII.—Title XII of the Public Health Service Act, as

1 amended by paragraph (1) of this subsection, is
 2 amended—

3 (A) by striking “PART B” and all that fol-
 4 low through “STATE PLANS” and inserting the
 5 following:

6 “Subpart II—Formula Grants With Respect to
 7 Modifications of State Plans”;

8 (B) by striking “PART C—GENERAL PRO-
 9 VISIONS” and inserting the following:

10 “Subpart III—General Provisions”;

11 (C) by redesignating sections 1202 and
 12 1203 as sections 1211 and 1212, respectively;
 13 and

14 (D) by inserting before section 1211 (as so
 15 redesignated) the following:

16 “PART B—TRAUMA CARE

17 “Subpart I—Advisory Council; Clearinghouse”.

18 (b) STATE OFFICES.—Title XII of the Public Health
 19 Service Act, as amended by subsection (a) of this section,
 20 is amended by inserting after section 1201 the following
 21 new section:

22 **“SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL**
 23 **SERVICES.**

24 “(a) PROGRAM OF GRANTS.—The Secretary may
 25 make grants to States for the purpose of improving the

1 availability and quality of emergency medical services
2 through the operation of State offices of emergency medi-
3 cal services.

4 “(b) REQUIREMENT OF MATCHING FUNDS.—

5 “(1) IN GENERAL.—The Secretary may not
6 make a grant under subsection (a) unless the State
7 involved agrees, with respect to the costs to be in-
8 curred by the State in carrying out the purpose de-
9 scribed in such subsection, to provide non-Federal
10 contributions toward such costs in an amount that—

11 “(A) for the first fiscal year of payments
12 under the grant, is not less than \$1 for each \$3
13 of Federal funds provided in the grant;

14 “(B) for any second fiscal year of such
15 payments, is not less than \$1 for each \$1 of
16 Federal funds provided in the grant; and

17 “(C) for any third fiscal year of such pay-
18 ments, is not less than \$3 for each \$1 of Fed-
19 eral funds provided in the grant.

20 “(2) DETERMINATION OF AMOUNT OF NON-
21 FEDERAL CONTRIBUTION.—

22 “(A) Subject to subparagraph (B), non-
23 Federal contributions required in paragraph (1)
24 may be in cash or in kind, fairly evaluated, in-
25 cluding plant, equipment, or services. Amounts

1 provided by the Federal Government, or serv-
2 ices assisted or subsidized to any significant ex-
3 tent by the Federal Government, may not be in-
4 cluded in determining the amount of such non-
5 Federal contributions.

6 “(B) The Secretary may not make a grant
7 under subsection (a) unless the State involved
8 agrees that—

9 “(i) for the first fiscal year of pay-
10 ments under the grant, 100 percent or less
11 of the non-Federal contributions required
12 in paragraph (1) will be provided in the
13 form of in-kind contributions;

14 “(ii) for any second fiscal year of such
15 payments, not more than 50 percent of
16 such non-Federal contributions will be pro-
17 vided in the form of in-kind contributions;
18 and

19 “(iii) for any third fiscal year of such
20 payments, such non-Federal contributions
21 will be provided solely in the form of cash.

22 “(c) CERTAIN REQUIRED ACTIVITIES.—The Sec-
23 retary may not make a grant under subsection (a) unless
24 the State involved agrees that activities carried out by an
25 office operated pursuant to such subsection will include—

1 “(1) coordinating the activities carried out in
2 the State that relate to emergency medical services;

3 “(2) activities regarding the matters described
4 in paragraphs (1) through (4) section 1201(b);

5 “(3) identifying Federal and State programs re-
6 garding emergency medical services and providing
7 technical assistance to public and nonprofit private
8 entities regarding participation in such programs.

9 “(d) REQUIREMENT REGARDING ANNUAL BUDGET
10 FOR OFFICE.—The Secretary may not make a grant
11 under subsection (a) unless the State involved agrees that,
12 for any fiscal year for which the State receives such a
13 grant, the office operated pursuant to subsection (a) will
14 be provided with an annual budget of not less than
15 \$50,000.

16 “(e) CERTAIN USES OF FUNDS.—

17 “(1) RESTRICTIONS.—The Secretary may not
18 make a grant under subsection (a) unless the State
19 involved agrees that—

20 “(A) if research with respect to emergency
21 medical services is conducted pursuant to the
22 grant, not more than 10 percent of the grant
23 will be expended for such research; and

1 “(B) the grant will not be expended to pro-
2 vide emergency medical services (including pro-
3 viding cash payments regarding such services).

4 “(2) ESTABLISHMENT OF OFFICE.—Activities
5 for which a State may expend a grant under sub-
6 section (a) include paying the costs of establishing
7 an office of emergency medical services for purposes
8 of such subsection.

9 “(f) REPORTS.—The Secretary may not make a
10 grant under subsection (a) unless the State involved
11 agrees to submit to the Secretary reports containing such
12 information as the Secretary may require regarding activi-
13 ties carried out under this section by the State.

14 “(g) REQUIREMENT OF APPLICATION.—The Sec-
15 retary may not make a grant under subsection (a) unless
16 an application for the grant is submitted to the Secretary
17 and the application is in such form, is made in such man-
18 ner, and contains such agreements, assurances, and infor-
19 mation as the Secretary determines to be necessary to
20 carry out this section.”.

21 **SEC. 1523. PROGRAMS FOR RURAL AREAS.**

22 (a) IN GENERAL.—Title XII of the Public Health
23 Service Act, as amended by section 1522, is amended—

24 (1) by transferring section 1204 to part A;

1 (2) by redesignating such section as section
2 1203;

3 (3) by inserting such section after section 1202;
4 and

5 (4) in section 1203 (as so redesignated)—

6 (A) by redesignating subsection (c) as sub-
7 section (d); and

8 (B) by inserting after subsection (b) the
9 following new subsection:

10 “(c) DEMONSTRATION PROGRAM REGARDING TELE-
11 COMMUNICATIONS.—

12 “(1) LINKAGES FOR RURAL FACILITIES.—

13 Projects under subsection (a)(1) shall include dem-
14 onstration projects to establish telecommunications
15 between rural medical facilities and medical facilities
16 that have expertise or equipment that can be utilized
17 by the rural facilities through the telecommuni-
18 cations.

19 “(2) MODES OF COMMUNICATION.—The Sec-
20 retary shall ensure that the telecommunications
21 technologies demonstrated under paragraph (1) in-
22 clude interactive video telecommunications, static
23 video imaging transmitted through the telephone
24 system, and facsimiles transmitted through such sys-
25 tem.”.

1 (b) CONFORMING AMENDMENT.—Section 1203 of the
 2 Public Health Service Act, as redesignated by subsection
 3 (a)(2) of this section, is amended in the heading for the
 4 section by striking “**ESTABLISHMENT**” and all that fol-
 5 lows and inserting “**PROGRAMS FOR RURAL AREAS.**”.

6 **SEC. 1524. FUNDING.**

7 Title XII of the Public Health Service Act, as amend-
 8 ed by the preceding provisions of this title, is amended—

9 (1) by redesignating parts C through F as parts
 10 D through G, respectively;

11 (2) by inserting after subpart III of part B the
 12 following:

13 “PART C—FUNDING”;

14 (3) by transferring section 1239 to part C (as
 15 so added); and

16 (4) in such section, by striking subsections (a)
 17 and (b) and inserting the following:

18 “(a) EMERGENCY MEDICAL SERVICES GEN-
 19 ERALLY.—

20 “(1) IN GENERAL.—For the purpose of carry-
 21 ing out section 1201 other than with respect to trau-
 22 ma care, there are authorized to be appropriated
 23 \$2,000,000 for fiscal year 1994, and such sums as
 24 may be necessary for each of the fiscal years 1995
 25 and 1996.

1 “(2) STATE OFFICES.—For the purpose of car-
2 rying out section 1202, there are authorized to be
3 appropriated \$3,000,000 for fiscal year 1994, and
4 such sums as may be necessary for each of the fiscal
5 years 1995 and 1996.

6 “(3) CERTAIN TELECOMMUNICATIONS DEM-
7 ONSTRATIONS.—For the purpose of carrying out sec-
8 tion 1203(c), there are authorized to be appro-
9 priated \$10,000,000 for fiscal year 1994 and such
10 sums as may be necessary for each of the fiscal
11 years 1995 and 1996.

12 “(b) TRAUMA CARE AND CERTAIN OTHER ACTIVI-
13 TIES.—

14 “(1) IN GENERAL.—For the purpose of carry-
15 ing out part B, section 1201 with respect to trauma
16 care, and section 1203 (other than subsection (c) of
17 such section), there are authorized to be appro-
18 priated \$60,000,000 for fiscal year 1994, and such
19 sums as may be necessary for each of the fiscal
20 years 1995 and 1996.

21 “(2) ALLOCATION OF FUNDS BY SECRETARY.—

22 “(A) For the purpose of carrying out sub-
23 part I of part B, section 1201 with respect to
24 trauma care, and section 1203 (other than sub-
25 section (c) of such section), the Secretary shall

1 make available 10 percent of the amounts ap-
2 propriated for a fiscal year under paragraph
3 (1).

4 “(B) For the purpose of carrying out sec-
5 tion 1203 (other than subsection (c) of such
6 section), the Secretary shall make available 10
7 percent of the amounts appropriated for a fiscal
8 year under paragraph (1).

9 “(C)(i) For the purpose of making allot-
10 ments under section 1221(a), the Secretary
11 shall, subject to subsection (c), make available
12 80 percent of the amounts appropriated for a
13 fiscal year under paragraph (1).

14 “(ii) Amounts paid to a State under sec-
15 tion 1221(a) for a fiscal year shall, for the pur-
16 poses for which the amounts were paid, remain
17 available for obligation until the end of the fis-
18 cal year immediately following the fiscal year
19 for which the amounts were paid.”.

20 **SEC. 1525. CONFORMING AMENDMENTS.**

21 Title XII of the Public Health Service Act, as amend-
22 ed by the preceding provisions of this title, is amended—

23 (1) in section 1203(b), by striking “1214(c)(1)”
24 and inserting “1224(c)(1)”;

1 (2) in section 1211(b)(3), by striking “1213(c)”
2 and inserting “1223(c)”;

3 (3) in section 1221—

4 (A) in subsection (a)—

5 (i) by striking “1218” and inserting
6 “1228”; and

7 (ii) by striking “1217” and inserting
8 “1227”; and

9 (B) in subsection (b)—

10 (i) by striking “1233” and inserting
11 “1237”; and

12 (ii) by striking “1213” and inserting
13 “1223”;

14 (4) in section 1222—

15 (A) in subsection (a)—

16 (i) in paragraph (1), by striking
17 “1211(a)” and inserting “1221(a)”;

18 (ii) in paragraph (2)(A), by striking
19 “1211(c)” and inserting “1221(c)”;

20 (B) in subsection (b), by striking
21 “1211(a)” and inserting “1221(a)”;

22 (5) in section 1223—

23 (A) in subsection (a), by striking
24 “1211(b)” and inserting “1221(b)”;

25 (B) in subsection (b)—

1 (i) in paragraph (1), by striking
2 “1211(a)” and inserting “1221(a)”; and

3 (ii) in paragraph (3), by striking
4 “1211(a)” and inserting “1221(a)”; and

5 (C) in subsection (d), by striking
6 “1211(a)” and inserting “1221(a)”; and

7 (6) in section 1224—

8 (A) in each of subsections (a) through (c),
9 by striking “1211(a)” and inserting “1221(a)”;
10 and

11 (B) in subsection (b), by striking
12 “1213(a)(7)” and inserting “1223(a)(7)”; and

13 (7) in section 1225—

14 (A) in subsection (a)—

15 (i) by striking “1211(a)” and insert-
16 ing “1221(a)”; and

17 (ii) by striking “1233” and inserting
18 “1237”; and

19 (B) in subsection (b), by striking
20 “1211(b)” and inserting “1221(b)”; and

21 (8) in section 1226, in each of subsections (a)
22 through (c), by striking “1211(a)” and inserting
23 “1221(a)”; and

24 (9) in section 1227—

1 (A) by striking “1211(a)” and inserting
2 “1221(a)”; and

3 (B) by striking “1214” and inserting
4 “1224”;

5 (10) in section 1228—

6 (A) in each of subsections (a) through (c),
7 by striking “1211(a)” each place such term ap-
8 pears and inserting “1221(a)”;

9 (B) in subsection (b), in each of para-
10 graphs (2)(A) and (3)(A), by striking
11 “1232(a)” and inserting “1239(a)”;

12 (C) in subsection (c)(2)—

13 (i) by striking “1232(b)(3)” and in-
14 serting “1239(b)(3)”;

15 (ii) by striking “1217” and inserting
16 “1227”;

17 (11) in section 1229(a), by striking “1211(a)”
18 each place such term appears and inserting
19 “1221(a)”;

20 (12) in section 1230(a), by striking “1211(a)”
21 each place such term appears and inserting
22 “1221(a)”;

23 (13) in section 1231—

1 (A) in each of subsections (a) and (b), by
2 striking “1211(a)” each place such term ap-
3 pears and inserting “1221(a)”; and

4 (B) in each of subsections (a) and (b), by
5 striking “1211(b)” and inserting “1221(b)”; and

6 (14) in section 1232, by striking “1211” and
7 inserting “1221”;

8 (15) in section 1236—

9 (A) in the matter preceding paragraph (1),
10 by striking “this title” and inserting “this
11 part”; and

12 (B) in paragraph (1), by striking “1213”
13 and inserting “1223”;

14 (16) in section 1237—

15 (A) in each of subsections (a) and (b), by
16 striking “1211” each place such term appears
17 and inserting “1221”;

18 (B) in subsection (b)—

19 (i) by striking “part B” and inserting
20 “subpart II”; and

21 (ii) by striking “1214(c)(1)” and in-
22 serting “1224(c)(1)”; and

23 (C) in subsection (c), by striking “1213”
24 and inserting “1223”; and

25 (17) in section 1239(c)(1)—

1 (A) by striking “1211(a)” and inserting
2 “1221(a)”;

3 (B) by striking “1218(a)(2)” and inserting
4 “1228(a)(2)”;

5 (C) by striking “part B” and inserting
6 “subpart II”.

7 **SEC. 1526. EFFECTIVE DATE.**

8 The amendments made by this part shall take effect
9 October 1, 1993, or upon the date of the enactment of
10 this Act, whichever occurs later.

11 **Subtitle G—State Flexibility in the**
12 **Medicaid Program: The Medical**
13 **Health Allowance Program**

14 **SEC. 1601. ESTABLISHMENT OF PROGRAM.**

15 (a) IN GENERAL.—Title XIX of the Social Security
16 Act (42 U.S.C. 1396 et seq.), as amended by section
17 13631(b) of the Omnibus Budget Reconciliation Act of
18 1993, is amended—

19 (1) by redesignating section 1931 as section
20 1932; and

21 (2) by inserting after section 1930 the following
22 new section:

23 “STATE HEALTH ALLOWANCE PROGRAMS

24 “SEC. 1931. (a) TREATMENT OF EXPENDITURES
25 UNDER HEALTH ALLOWANCE PROGRAMS AS MEDICAL
26 ASSISTANCE UNDER STATE PLAN.—

1 “(1) IN GENERAL.—Notwithstanding any other
2 provision of this title, for purposes of determining
3 the amount to be paid to a State under section
4 1903(a)(1) for quarters in any fiscal year, amounts
5 expended by an eligible State (as described in sub-
6 section (b)) during the fiscal year under a State
7 health allowance program (as described in subsection
8 (c)) shall be included in the total amount expended
9 during the fiscal year as medical assistance under
10 the State plan (except as provided under paragraphs
11 (2) and (3) and under subsection (d)(1)(C)).

12 “(2) FEDERAL PAYMENT RESTRICTED TO
13 ACUTE CARE SERVICES.—No amounts expended
14 under a State health allowance program that are at-
15 tributable to medical assistance described in para-
16 graphs (4), (14), (15), (23), or (24) of section
17 1905(a) shall be included in the total amount ex-
18 pended as medical assistance under the State plan.

19 “(3) LIMITATION.—In no case shall this sub-
20 section result in (A) the total Federal payments to
21 the State for the quarter under this title (including
22 payments attributable to this section and section
23 1923), exceeding (B) the total Federal payments
24 that the Secretary estimates would have been paid

1 under this title to the State for the quarter if the
2 State did not have a program under this section.

3 “(b) ELIGIBILITY OF STATE.—A State is eligible for
4 purposes of subsection (a) if the State submits (at such
5 time and in such form as the Secretary may require) an
6 application to the Secretary containing such information
7 and assurances as the Secretary may require, including
8 assurances that the State has adopted and is enforcing
9 standards regarding quality assurance for group health
10 plans participating in the State health allowance program,
11 including standards regarding—

12 “(1) uniform reporting requirements for such
13 plans relating to a minimum set of clinical data, pa-
14 tient satisfaction data, and other information that
15 may be used by individuals to compare the quality
16 of various plans; and

17 “(2) the establishment or designation of an en-
18 tity of the State government to collect the data de-
19 scribed in subparagraph (A) and to regularly report
20 such data to the Secretary.

21 “(c) STATE HEALTH ALLOWANCE PROGRAM DE-
22 SCRIBED.—

23 “(1) ENROLLMENT OF PARTICIPATING INDIVID-
24 UALS IN APPROVED GROUP HEALTH PLANS.—In this
25 section, a State health allowance program is a pro-

1 gram in effect in all the political subdivisions of the
2 State (except as provided in (c)) under which the
3 State makes payments to a group health plan (ap-
4 proved under paragraph (2)) which provides cov-
5 erage to the individual as an allowance towards the
6 costs of providing the individual with benefits under
7 the plan.

8 “(2) APPROVED PLANS DESCRIBED.—For pur-
9 poses of paragraph (1), a State shall approve group
10 health plans in accordance with such standards as
11 the State may establish, except that—

12 “(A) the State may not approve a plan for
13 a year unless the actuarial value of the benefits
14 provided by the plan (taking into account the
15 cost-sharing associated with the plan) for the
16 year—

17 “(i) with respect to the first year for
18 which the plan is approved for purposes of
19 this subsection, is not less than the actuar-
20 ial value of the medical assistance provided
21 under the State plan under this title for
22 the year (as determined by the Secretary
23 without regard to medical assistance de-
24 scribed in paragraphs (4), (14), (15), (23),
25 or (24) of section 1905(a)); and

1 “(ii) with respect to any subsequent
2 year, is not greater than the amount deter-
3 mined under this subparagraph for the
4 preceding year, increased or decreased by
5 the amount (expressed as a percentage) by
6 which the actuarial value of the medical
7 assistance described in clause (i) for the
8 year exceeds or is less than the actuarial
9 value of such medical assistance for the
10 preceding year;

11 “(B) at least one of the plans approved by
12 the State shall be a health maintenance organi-
13 zation or other plan under which payments are
14 otherwise made on a capitated basis for provid-
15 ing medical assistance to individuals enrolled in
16 the State plan under this title; and

17 “(C) in the case of an individual who is en-
18 titled to benefits under the State plan under
19 this title as of the first month during which the
20 State health allowance program is in effect, an
21 approved plan may not require the individual to
22 contribute a greater amount of cost-sharing
23 than the individual would have been required to
24 contribute under the State plan (except as may
25 be imposed on an individual described in sub-

1 paragraph (B) or subparagraph (C) of sub-
2 section (d)(1)).

3 “(3) WAIVER OF STATEWIDENESS REQUIRE-
4 MENT.—At the request of a State, the Secretary
5 may waive for a period not to exceed 3 years (sub-
6 ject to one 3-year extension) the requirement under
7 paragraph (1) that the State health allowance pro-
8 gram be in effect in all political subdivisions of the
9 State.

10 “(d) ELIGIBILITY OF INDIVIDUALS TO PARTICIPATE
11 IN ALLOWANCE PROGRAM.—

12 “(1) AUTOMATIC ELIGIBILITY OF MEDICAID
13 CATEGORICALLY ELIGIBLE INDIVIDUALS.—Subject
14 to subsection (e), any individual to whom the State
15 makes medical assistance available under the State
16 plan under this title pursuant to clause (i) of section
17 1902(a)(10)(A) shall be eligible to participate in the
18 State health allowance program.

19 “(2) MANDATORY ELIGIBILITY OF INDIVIDUALS
20 WITH INCOME UNDER THE POVERTY LEVEL.—

21 “(A) IN GENERAL.—Subject to subsection
22 (e) and subparagraph (B), an individual law-
23 fully residing in the State shall be eligible to
24 participate in the program if the income of the
25 individual’s family is equal to or less than 100

1 percent of the official poverty line (as defined
2 by the Office of Management and Budget, and
3 revised annually in accordance with section
4 673(2) of the Omnibus Budget Reconciliation
5 Act of 1991) applicable to a family of the size
6 involved.

7 “(B) EXCEPTION.—If the application of
8 subparagraph (A) would result in—

9 “(i) the total State expenditures for a
10 quarter under this title (including expendi-
11 tures attributable to this section and sec-
12 tion 1923), exceeding

13 “(ii) the total State expenditures that
14 the Secretary estimates would have been
15 made under this title for the quarter if the
16 State did not have a program under this
17 section,

18 then there shall be substituted for 100 percent
19 in subparagraph (A) such percent as would re-
20 sult in the amount described in clause (i) equal-
21 ing the amount described in clause (ii).

22 “(3) OPTIONAL ELIGIBILITY OF INDIVIDUALS
23 WITH INCOME UP TO 200 PERCENT OF POVERTY
24 LEVEL.—

1 “(A) IN GENERAL.—Subject to subsection
2 (e), a State operating a State health allowance
3 program under this section may make an indi-
4 vidual lawfully residing in the State eligible to
5 participate in the program if the income of the
6 individual’s family is greater than 100 percent
7 (but less than such percentage, not to exceed
8 200 percent, as the State may specify) of such
9 official poverty line.

10 “(B) CONTRIBUTION MAY BE REQUIRED.—
11 In the case of an individual who is participating
12 in the program under this paragraph, the pro-
13 gram may require such an individual to contrib-
14 ute all (or a portion) of the premiums and cost-
15 sharing of such a group health plan if the
16 amount of such contribution is determined in
17 accordance with a sliding scale based on the in-
18 dividual’s family income.

19 “(e) EXCLUSION AND USE OF RESOURCE STAND-
20 ARD.—

21 “(1) EXCLUSION OF ELDERLY MEDICARE-ELIGI-
22 BLE INDIVIDUALS.—No individual shall be eligible to
23 participate in the program if the individual is enti-
24 tled to benefits under title XVIII of the Social Secu-
25 rity Act pursuant to section 226 of such Act.

1 “(2) USE OF RESOURCE STANDARD.—A State
2 may require an individual to meet a resource stand-
3 ard as a condition of eligibility to participate in the
4 program only if the Secretary approves the State’s
5 use of such a standard.

6 “(f) CONSTRUCTION.—No provision of any Federal
7 law shall prevent a State from enrolling any employee or
8 other individual in accordance with this section. The pre-
9 vious sentence shall not be construed as permitting a State
10 to require the employer of an individual participating in
11 the program to contribute toward the individual’s pre-
12 mium required for such participation.

13 “(g) EVALUATIONS AND REPORTS.—

14 “(1) EVALUATIONS.—Not later than 3 years
15 after the date of the enactment of this section (and
16 at such subsequent intervals as the Secretary consid-
17 ers appropriate), the Secretary shall evaluate the ef-
18 fectiveness of the State health allowance programs
19 for which Federal financial participation is provided
20 under this section, and the impact of such programs
21 on increasing the number of individuals with health
22 insurance coverage in participating States and in
23 controlling the costs of health care in such States.

24 “(2) REPORTS.—Not later than 3 years after
25 the date of the enactment of this section (and at

1 such subsequent intervals as the Secretary considers
2 appropriate), the Secretary shall submit a report on
3 the program to Congress.”.

4 (b) ENSURING BUDGET NEUTRALITY THROUGH RE-
5 DUCTION IN DISPROPORTIONATE SHARE HOSPITAL PAY-
6 MENTS FOR PARTICIPATING STATES.—Section 1923 of
7 the Social Security Act (42 U.S.C. 1396r-4), as amended
8 by section 13621(b)(1) of the Omnibus Budget Reconcili-
9 ation Act of 1993, is amended by adding at the end the
10 following new subsection:

11 “(h) REDUCTION IN PAYMENT ADJUSTMENTS FOR
12 STATES WITH HEALTH ALLOWANCE PROGRAMS.—In the
13 case of a State operating a State health allowance pro-
14 gram under section 1931 in a fiscal year, the Secretary
15 shall reduce the total payment adjustments made under
16 this section for hospitals in the State for quarters in the
17 year by such amount as the Secretary determines to be
18 necessary to ensure that the total amount paid to the
19 State under section 1903(a)(1) for the year does not ex-
20 ceed the amount that would have been paid to the State
21 under such section for the year if the State did not operate
22 such a program.”.

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to calendar quarters beginning on
25 or after January 1, 1994.

1 **SEC. 1602. OPTIONAL USE OF PROGRAM TO OFFER COV-**
 2 **ERAGE TO SOME OR ALL STATE RESIDENTS.**

3 Section 1931 of the Social Security Act, as inserted
 4 by section 1601(a)(2), is amended—

5 (1) in subsection (c)(2)(A), in the matter before
 6 clause (i), by inserting “, except as provided in sub-
 7 section (d)(4)(B)(iii),” after “unless”, and

8 (2) by adding at the end of subsection (d) the
 9 following new paragraphs:

10 “(4) OPTIONAL ENROLLMENT OF OTHER INDIV-
 11 IDUALS.—

12 “(A) IN GENERAL.—Subject to subsection
 13 (e), a State operating a State health allowance
 14 program under this section may make any indi-
 15 vidual (or class of individuals) who is not de-
 16 scribed in paragraph (1), (2), or (3) and who
 17 is not offered coverage under an employer
 18 group health plan eligible to participate in the
 19 program.

20 “(B) SPECIAL RULES.—

21 “(i) CONTRIBUTION MAY BE RE-
 22 QUIRED.—In the case of an individual who
 23 is participating in the program under this
 24 paragraph, the program may require such
 25 an individual to contribute all (or a por-

tion) of the premiums and cost-sharing of such a group health plan.

“(ii) NO FEDERAL MATCHING PAYMENTS.—For purposes of payment to States under section 1903(a), no amounts expended by the State under the program during a fiscal year on behalf of an individual enrolled under subparagraph (A) may be included in the total amount expended during the fiscal year as medical assistance under the State plan.

“(iii) OPTIONAL USE OF STANDARD COVERAGE.—Notwithstanding subsection (c)(2)(A), with respect to individuals enrolled under subparagraph (A), such program may provide standard coverage (consistent with section 1102(c) of the Affordable Health Care Now Act of 1993) rather than the benefits of an actuarial value otherwise required under such subsection.

“(5) OFFERING OF COVERAGE THROUGH OTHER PROGRAMS.—Nothing in this section shall be construed as preventing a State which—

“(A) does not operate a State health allowance program under this section from assuring

that individuals in the State who are not offered coverage under an employer group health plan are offered coverage under a health plan, or

“(B) does operate such a program from assuring that individuals in the State who are not described in paragraph (1), (2), or (3) and who are not offered coverage under an employer group health plan are offered coverage under a health plan other than through such program.”.

Subtitle H—Medicaid Program Flexibility

SEC. 1701. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CON- TRACTING FOR COORDINATED CARE SERV- ICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(1) by striking all that precedes paragraph (4) and inserting the following:

“(m) COORDINATED CARE.—

“(1) PAYMENT CONDITIONED ON COMPLIANCE.—

“(A) GENERAL RULE.—No payment shall be made under this title to a State with respect

1 to expenditures incurred by it for payment to a
2 risk contracting entity or primary care case
3 management entity (as defined in subparagraph
4 (B)), or with respect to an undertaking de-
5 scribed in paragraph (6), unless the State and
6 the entity or undertaking meet the applicable
7 requirements of this subsection. For purposes
8 of determining whether payment may be made
9 under this section, the Secretary may reject a
10 State's determination of compliance with any
11 provision of this subsection.

12 “(B) GENERAL DEFINITIONS.—For pur-
13 poses of this title—

14 “(i) RISK CONTRACTING ENTITY.—
15 The term ‘risk contracting entity’ means
16 an entity that has a contract with the
17 State agency under which the entity—

18 “(I) provides or arranges for the
19 provision of health care items or serv-
20 ices to individuals eligible for medical
21 assistance under the State plan under
22 this title, and

23 “(II) is at risk (as defined in
24 clause (iv)) for part or all of the cost

1 of such items or services furnished to
2 such individuals.

3 “(ii) PRIMARY CARE CASE MANAGE-
4 MENT PROGRAM.—The term ‘primary care
5 case management program’ means a State
6 program under which individuals eligible
7 for medical assistance under the State plan
8 under this title are enrolled with primary
9 care case management entities, and are en-
10 titled to receive specified health care items
11 and services covered under such plan only
12 as arranged for and approved by such enti-
13 ties.

14 “(iii) AT RISK.—An entity is ‘at risk’,
15 for purposes of this subparagraph, if it has
16 a contract with the State agency under
17 which it is paid a fixed amount for provid-
18 ing or arranging for the provision of speci-
19 fied health care items or services to an in-
20 dividual eligible for medical assistance and
21 enrolled with the entity, regardless of
22 whether such items or services are fur-
23 nished to such individual, and is liable for
24 all or part of the cost of furnishing such
25 items or services, regardless of whether or

1 the extent to which such cost exceeds such
2 fixed payment.

3 “(iv) PRIMARY CARE CASE MANAGE-
4 MENT ENTITY.—The term ‘primary care
5 case management entity’ means a health
6 care provider (whether an individual or an
7 entity) that, under a State primary care
8 case management program meeting the re-
9 quirements of paragraph (7), has a con-
10 tract with the State agency under which
11 the entity arranges for or authorizes the
12 provision of health care items and services
13 to individuals eligible for medical assist-
14 ance under the State plan under this title,
15 but is not at risk (as defined in clause (iv))
16 for the cost of such items or services pro-
17 vided to such individuals.

18 “(2) GENERAL REQUIREMENTS FOR RISK CON-
19 TRACTING ENTITIES.—

20 “(A) FEDERAL OR STATE QUALIFICA-
21 TION.—Subject to paragraph (3), a risk con-
22 tracting entity meets the requirements of this
23 subsection only if it either—

24 “(i) is a qualified health maintenance
25 organization as defined in section 1310(d)

1 of the Public Health Service Act, as deter-
2 mined by the Secretary pursuant to section
3 1312 of that Act, or

4 “(ii) is an entity which the State
5 agency has determined—

6 “(I) affords, to individuals eligi-
7 ble for medical assistance under the
8 State plan and enrolled with the en-
9 tity, access to health care items and
10 services furnished by the entity, with-
11 in the area served by the entity, at
12 least equivalent to the access such in-
13 dividuals would have to such health
14 care items and services in such area if
15 not enrolled with the entity, and

16 “(II) has made adequate provi-
17 sion against the risk of insolvency,
18 and assures that individuals eligible
19 for medical assistance under this title
20 are not held liable for the entity’s
21 debts in case of the entity’s insol-
22 vency.

23 “(B) INTERNAL QUALITY ASSURANCE.—

24 Subject to paragraph (3), a risk contracting en-
25 tity meets the requirements of this subsection

1 only if it has in effect an internal quality assur-
2 ance program that meets the requirements of
3 paragraph (9).

4 “(C) CONTRACT WITH STATE AGENCY.—
5 Subject to paragraph (3), a risk contracting en-
6 tity meets the requirements of this subsection
7 only if the entity has a written contract with
8 the State agency that provides—

9 “(i) that the entity will comply with
10 all applicable provisions of this subsection;

11 “(ii) for a payment methodology based
12 on experience rating or another actuarially
13 sound methodology approved by the Sec-
14 retary, which guarantees (as demonstrated
15 by such models or formulas as the Sec-
16 retary may approve) that payments to the
17 entity under the contract shall not exceed
18 100 percent of expenditures that would
19 have been made by the State agency in the
20 absence of the contract;

21 “(iii) that the Secretary and the State
22 (or any person or organization designated
23 by either) shall have the right to audit and
24 inspect any books and records of the entity
25 (and of any subcontractor) that pertain—

1 “(I) to the ability of the entity to
2 bear the risk of potential financial
3 losses, or

4 “(II) to services performed or de-
5 terminations of amounts payable
6 under the contract;

7 “(iv) that in the entity’s enrollment,
8 reenrollment, or disenrollment of individ-
9 uals eligible for medical assistance under
10 this title and eligible to enroll, reenroll, or
11 disenroll with the entity pursuant to the
12 contract, the entity will not discriminate
13 among such individuals on the basis of
14 their health status or requirements for
15 health care services;

16 “(v)(I) that individuals eligible for
17 medical assistance under the State plan
18 who have enrolled with the entity are per-
19 mitted to terminate such enrollment with-
20 out cause as of the beginning of the first
21 calendar month following a full calendar
22 month after the request is made for such
23 termination (or at such times as required
24 pursuant to paragraph (8)), and

1 “(II) for notification of each such in-
2 dividual, at the time of the individual’s en-
3 rollment, of the right to terminate enroll-
4 ment;

5 “(vi) for reimbursement, either by the
6 entity or by the State agency, for medically
7 necessary services provided—

8 “(I) to an individual eligible for
9 medical assistance under the State
10 plan and enrolled with the entity, and

11 “(II) other than through the en-
12 tity because the services were imme-
13 diately required due to an unforeseen
14 illness, injury, or condition;

15 “(vii) for disclosure of information in
16 accordance with paragraph (4) and section
17 1124;

18 “(viii) in the case of an entity that
19 has entered into a contract with a Feder-
20 ally-qualified health center for the provi-
21 sion of services of such center—

22 “(I) that rates of prepayment
23 from the State are adjusted to reflect
24 fully the rates of payment specified in
25 section 1902(a)(13)(E), and

1 “(II) that, at the election of such
 2 center, payments made by the entity
 3 to such center for services described
 4 in section 1905(a)(2)(C) are made at
 5 the rates of payment specified in sec-
 6 tion 1902(a)(13)(E);

7 “(ix) that any physician incentive plan
 8 that the entity operates meets the require-
 9 ments of section 1876(i)(8);

10 “(x) for maintenance of sufficient pa-
 11 tient encounter data to identify the physi-
 12 cian who delivers services to patients; and

13 “(xi) that the entity complies with the
 14 requirement of section 1902(w) with re-
 15 spect to each enrollee.

16 “(3) EXCEPTIONS TO REQUIREMENTS FOR RISK
 17 CONTRACTING ENTITIES.—The requirements of
 18 paragraph (2) (other than subparagraph (C)(viii))
 19 do not apply to an entity that—

20 “(A)(i) received a grant of at least
 21 \$100,000 in the fiscal year ending June 30,
 22 1976, under section 329(d)(1)(A) or 330(d)(1)
 23 of the Public Health Service Act, and for the
 24 period beginning July 1, 1976, and ending on
 25 the expiration of the period for which payments

1 are to be made under this title, has been the re-
2 cipient of a grant under either such section;
3 and

4 “(ii) provides to its enrollees, on a prepaid
5 capitation or other risk basis, all of the services
6 described in paragraphs (1), (2), (3), (4)(C),
7 and (5) of section 1905(a) and, to the extent
8 required by section 1902(a)(10)(D) to be pro-
9 vided under the State plan, the services de-
10 scribed in section 1905(a)(7);

11 “(B) is a nonprofit primary health care en-
12 tity located in a rural area (as defined by the
13 Appalachian Regional Commission)—

14 “(i) which received in the fiscal year
15 ending June 30, 1976, at least \$100,000
16 (by grant, subgrant, or subcontract) under
17 the Appalachian Regional Development Act
18 of 1965), and

19 “(ii) for the period beginning July 1,
20 1976, and ending on the expiration of the
21 period for which payments are to be made
22 under this title either has been the recipi-
23 ent of a grant, subgrant, or subcontract
24 under such Act or has provided services
25 under a contract (initially entered into dur-

1 ing a year in which the entity was the re-
2 cipient of such a grant, subgrant, or sub-
3 contract) with a State agency under this
4 title on a prepaid capitation or other risk
5 basis; or

6 “(C) which has contracted with the State
7 agency for the provision of services (but not in-
8 cluding inpatient hospital services) to persons
9 eligible for medical assistance under this title
10 on a prepaid risk basis prior to 1970.”; and

11 (2) by adding after paragraph (6) the following
12 new paragraphs:

13 “(7) GENERAL REQUIREMENTS FOR PRIMARY
14 CARE CASE MANAGEMENT.—A State that elects in
15 its State plan under this title to implement a pri-
16 mary care case management program under this
17 subsection shall include in the plan methods for the
18 selection and monitoring of participating primary
19 care case management entities to ensure that—

20 “(A) the numbers, geographic locations,
21 hours of operation, and other relevant charac-
22 teristics of such entities are sufficient to afford
23 individuals eligible for medical assistance rea-
24 sonable access to and choice among such enti-
25 ties;

1 “(B) such entities and their professional
2 personnel are qualified to provide health care
3 case management services, through methods in-
4 cluding ongoing monitoring of compliance with
5 applicable requirements for licensing of health
6 care providers, providing training and certifi-
7 cation of primary care case managers, and pro-
8 viding information and technical assistance; and

9 “(C) such entities are making timely and
10 appropriate decisions with respect to enrollees’
11 need for health care items and services, and are
12 giving timely approval and referral to providers
13 of adequate quality where such items and serv-
14 ices are determined to be medically necessary.

15 “(8) STATE OPTIONS WITH RESPECT TO EN-
16 ROLLMENT AND DISENROLLMENT.—

17 “(A) MANDATORY ENROLLMENT OP-
18 TION.—A State plan may require an individual
19 eligible for medical assistance under the State
20 plan (other than a medicare qualified bene-
21 ficiary) to enroll with a risk contracting entity
22 or primary care case management entity, with-
23 out regard to the requirement of section
24 1902(a)(1) (concerning Statewideness), the re-
25 quirements of section 1902(a)(10)(B) (concern-

ing comparability of benefits), or the requirements of section 1902(a)(23) (concerning freedom of choice of provider), if the individual is permitted a choice—

“(i) between or among two or more risk contracting entities,

“(ii) between a risk contracting entity and a primary care case management entity, or

“(iii) between or among two or more primary care case management entities.

“(B)(i) RESTRICTIONS ON
DISENROLLMENT WITHOUT CAUSE.—A State plan may restrict the period in which individuals enrolled with a qualifying risk contracting entity (as defined in clause (ii)) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in clause (iii)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to

1 requests for termination of enrollment for
2 cause.

3 “(ii) For purposes of this subparagraph,
4 the term ‘qualifying risk contracting entity’
5 means a risk contracting entity that is—

6 “(I) a qualified health maintenance
7 organization as defined in section 1310(d)
8 of the Public Health Service Act;

9 “(II) an eligible organization with a
10 contract under section 1876;

11 “(III) an entity that is receiving (and
12 has received during the previous 2 years)
13 a grant of at least \$100,000 under section
14 329(d)(1)(A) or 330(d)(1) of the Public
15 Health Service Act;

16 “(IV) an entity that is receiving (and
17 has received during the previous 2 years)
18 at least \$100,000 (by grant, subgrant, or
19 subcontract) under the Appalachian Re-
20 gional Development Act of 1965;

21 “(V) a program pursuant to an under-
22 taking described in paragraph (6) in which
23 at least 25 percent of the membership en-
24 rolled on a prepaid basis are individuals
25 who (I) are not insured for benefits under

1 part B of title XVIII or eligible for medical
2 assistance under this title, and (II) (in the
3 case of such individuals whose prepay-
4 ments are made in whole or in part by any
5 government entity) had the opportunity at
6 the time of enrollment in the program to
7 elect other coverage of health care costs
8 that would have been paid in whole or in
9 part by any governmental entity; or

10 “(VI) an entity that, on the date of
11 enactment of this provision, had a contract
12 with the State agency under a waiver
13 under section 1115 or 1915(b) and was
14 not subject to a requirement under this
15 subsection to permit disenrollment without
16 cause.

17 “(iii) For purposes of this subparagraph,
18 the term ‘period of enrollment’ means—

19 “(I) a period not to exceed 6 months
20 in duration, or

21 “(II) a period not to exceed one year
22 in duration, in the case of a State that, on
23 the effective date of this subparagraph,
24 had in effect a waiver under section 1115
25 of requirements under this title under

1 which the State could establish a 1-year
2 minimum period of enrollment with risk
3 contracting entities.

4 “(C) REENROLLMENT OF INDIVIDUALS
5 WHO REGAIN ELIGIBILITY.—In the case of an
6 individual who—

7 “(i) in a month is eligible for medical
8 assistance under the State plan and en-
9 rolled with a risk contracting entity with a
10 contract under this subsection,

11 “(ii) in the next month (or next 2
12 months) is not eligible for such medical as-
13 sistance, but

14 “(iii) in the succeeding month is again
15 eligible for such benefits,

16 the State plan may enroll the individual for
17 that succeeding month with such entity, if the
18 entity continues to have a contract with the
19 State agency under this subsection.

20 “(9) REQUIREMENTS FOR INTERNAL QUALITY
21 ASSURANCE PROGRAMS.—The requirements for an
22 internal quality assurance program of a risk con-
23 tracting entity are that program is written and the
24 program—

1 “(A) specifies a systematic process includ-
2 ing ongoing monitoring, corrective action, and
3 other appropriate activities to achieve specified
4 and measurable goals and objectives for quality
5 of care, and including annual evaluation of the
6 program;

7 “(B) identifies the organizational units re-
8 sponsible for performing specific quality assur-
9 ance functions, and ensure that they are ac-
10 countable to the governing body of the entity
11 and that they have adequate supervision, staff,
12 and other necessary resources to perform these
13 functions effectively;

14 “(C) if any quality assistance functions are
15 delegated to other entities, ensures that the risk
16 contracting entity remains accountable for all
17 quality assurance functions, and has mecha-
18 nisms to ensure that all quality assurance ac-
19 tivities are carried out;

20 “(D) includes methods to ensure that phy-
21 sicians and other health care professionals
22 under contract with the entity are qualified to
23 perform the services they provide, and that
24 these qualifications are ensured through appro-

1 appropriate credentialing and recredentialing proce-
2 dures;

3 “(E) includes policies addressing enrollee
4 rights and responsibilities, including grievance
5 mechanisms and mechanisms to inform enroll-
6 ees about access to and use of services provided
7 by the entity;

8 “(F) provides for continuous monitoring of
9 the delivery of health care, including—

10 “(i) identification of clinical areas to
11 be monitored,

12 “(ii) use of quality indicators and
13 standards for assessing care delivered, in-
14 cluding availability and accessibility of
15 care,

16 “(iii) monitoring, through use of epi-
17 demiological data or chart review, the care
18 of individuals, as appropriate, and patterns
19 of care overall, and

20 “(iv) implementation of corrective ac-
21 tions; and

22 “(G) meets any other requirements pre-
23 scribed by the Secretary after consultation with
24 States.

1 “(10) INDEPENDENT REVIEW AND QUALITY AS-
2 SURANCE.—

3 “(A) STATE GRIEVANCE PROCEDURE.—A
4 State contracting with a risk contracting entity
5 or primary care case management entity under
6 this subsection shall provide for a grievance
7 procedure for enrollees of such entity with at
8 least the following elements:

9 “(i) A toll-free telephone number for
10 enrollee questions and grievances.

11 “(ii) A State-operated enrollee griev-
12 ance procedure.

13 “(iii) Periodic notification of enrollees
14 of their rights with respect to such entity
15 or program.

16 “(iv) Periodic sample reviews of griev-
17 ances registered with such entity or pro-
18 gram or with the State.

19 “(v) Periodic survey and analysis of
20 enrollee satisfaction with such entity or
21 program.

22 “(B) STATE MONITORING OF RISK CON-
23 TRACTING ENTITIES’ QUALITY ASSURANCE PRO-
24 GRAMS.—A State contracting with a risk con-
25 tracting entity under this subsection shall peri-

1 odically review such entity's quality assurance
2 program to ensure that it meets the require-
3 ments of paragraph (9).

4 “(C) EXTERNAL INDEPENDENT REVIEW
5 OF INTERNAL QUALITY ASSURANCE.—A State
6 contracting with a risk contracting entity under
7 this subsection shall provide for annual external
8 independent review (by a utilization control and
9 peer review organization with a contract under
10 section 1153, or another organization unaffili-
11 ated with the State government approved by the
12 Secretary) of such entity's internal quality as-
13 surance activities. Such independent review
14 shall include—

15 “(i) review of the entity's medical
16 care, through sampling of medical records
17 or other appropriate methods, for indica-
18 tions of inappropriate utilization and treat-
19 ment,

20 “(ii) review of enrollee inpatient and
21 ambulatory data, through sampling of
22 medical records or other appropriate meth-
23 ods, to determine quality trends,

24 “(iii) review of the entity's internal
25 quality assurance activities, and

1 “(iv) notification of the entity and the
2 State, and appropriate followup activities,
3 when the review under this subparagraph
4 indicates inappropriate care or treat-
5 ment.”.

6 (b) STATE OPTION TO GUARANTEE MEDICAID ELI-
7 GIBILITY.—Section 1902(e)(2) of such Act (42 U.S.C.
8 1396a(e)(2)) is amended—

9 (A) in subparagraph (A), by striking all
10 that precedes “(but for this paragraph)” and
11 inserting “In the case of an individual who is
12 enrolled—

13 “(i) with a risk contracting entity (as
14 defined in section 1903(m)(1)(B)(i)) re-
15 sponsible for the provision of inpatient hos-
16 pital services and any other service de-
17 scribed in paragraphs (2), (3), (4), (5),
18 and (7) of section 1905(a),

19 “(ii) with any risk contracting entity
20 (as so defined) in a State that, on the ef-
21 fective date of this provision, had in effect
22 a waiver under section 1115 of require-
23 ments under this title under which the
24 State could extend eligibility for medical
25 assistance for enrollees of such entity, or

1 “(iii) with an eligible organization
2 with a contract under section 1876 and
3 who would”, and

4 (B) in subparagraph (B), by striking “or-
5 ganization or” each place it appears.

6 (c) CONFORMING AMENDMENTS.—

7 (1) Section 1128(b)(6)(C)(i) of such Act (42
8 U.S.C. 1320a-7(b)(6)(C)(i)) is amended by striking
9 “health maintenance organization” and inserting
10 “risk contracting entity”.

11 (2) Section 1902(a)(25)(A) of such Act (42
12 U.S.C. 1396a(a)(25)(A)), as amended by section
13 13622(a)(1) of the Omnibus Budget Reconciliation
14 Act of 1993, is amended by striking “health mainte-
15 nance organizations” and inserting “risk contracting
16 entities”.

17 (3) Section 1902(a)(25)(H) of such Act (42
18 U.S.C. 1396a(a)(25)(H)), as added by section
19 13622(b)(3) of the Omnibus Budget Reconciliation
20 Act of 1993, is amended by striking “health mainte-
21 nance organization” and inserting “risk contracting
22 entity”.

23 (4) Section 1902(a)(30)(C) of such Act (42
24 U.S.C. 1396a(a)(30)(C)) is amended by striking all
25 that precedes “with the results” and inserting “pro-

1 vide for independent review and quality assurance of
2 entities with contracts under section 1903(m), in ac-
3 cordance with paragraph (10) of such section.”.

4 (5) Section 1902(a)(57) of such Act (42 U.S.C.
5 1396a(a)(57)) is amended by striking “or health
6 maintenance organization” and inserting “or risk
7 contracting entity”.

8 (6) Section 1902(a) of such Act (42 U.S.C.
9 1396a(a)), as amended by sections 13623(a),
10 13625(a), and 13631(a) of the Omnibus Budget
11 Reconciliation Act of 1993, is amended—

12 (A) by striking “and” at the end of para-
13 graph (61);

14 (B) by striking the period at the end of
15 paragraph (62) and inserting “; and”; and

16 (C) by adding at the end the following new
17 paragraph:

18 “(63) at State option, provide for a primary
19 care case management program in accordance with
20 section 1903(m)(7).”.

21 (7) Section 1902(p)(2) of such Act (42 U.S.C.
22 1396a(p)(2)) is amended by striking “health mainte-
23 nance organization” and inserting “risk contracting
24 entity”.

1 (8) Section 1902(w) of such Act (42 U.S.C.
2 1396a(w)) is amended—

3 (A) in paragraph (1), by striking “section
4 1903(m)(1)(A)” and inserting “section
5 1903(m)(2)(C)(xi)”, and

6 (B) in paragraph (2)(E), by striking
7 “health maintenance organization” and “the or-
8 ganization” and inserting “risk contracting en-
9 tity” and “the entity”, respectively.

10 (9) Section 1903(k) of such Act (42 U.S.C.
11 1396b(k)) is amended by striking “health mainte-
12 nance organization” and inserting “risk contracting
13 entity”.

14 (10) Section 1903(m)(4)(A) of such Act (42
15 U.S.C. 1396b(m)(4)(A)) is amended—

16 (A) in the first sentence, by striking “Each
17 health maintenance organization” and inserting
18 “Each risk contracting entity”,

19 (B) in the first sentence, by striking “the
20 organization” each place it appears and insert-
21 ing “the entity”, and

22 (C) in the second sentence, by striking “an
23 organization” and “the organization” and in-
24 serting “a risk contracting entity” and “the
25 risk contracting entity”, respectively.

1 (11) Section 1903(m)(4)(B) of such Act (42
2 U.S.C. 1396b(m)(4)(B)) is amended by striking “or-
3 organization” and inserting “risk contracting entity”.

4 (12) Section 1903(m)(5) of such Act (42
5 U.S.C. 1396b(m)(5)) is amended in paragraphs
6 (A)(iii) and (B)(ii) by striking “organization” and
7 inserting “entity”.

8 (13) Section 1903(o) (42 U.S.C. 1396b(o)), as
9 amended by section 13622(a)(2) of the Omnibus
10 Budget Reconciliation Act of 1993, is amended by
11 striking “health maintenance organization” and in-
12 serting “risk contracting entity”.

13 (14) Section 1903(w)(7)(A)(viii) of such Act
14 (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by
15 striking “health maintenance organizations (and
16 other organizations with contracts under section
17 1903(m))” and inserting “risk contracting entities
18 with contracts under section 1903(m)”.

19 (15) Section 1905(a) of such Act (42 U.S.C.
20 1396d(a)) is amended, in the matter preceding
21 clause (i), by inserting “(which may be on a prepaid
22 capitation or other risk basis)” after “payment” the
23 first place it appears.

24 (16) Section 1908(b) of such Act, as added by
25 section 13623(b) of the Omnibus Budget Reconcili-

1 ation Act of 1993, is amended by striking “health
2 maintenance organization” and inserting “risk con-
3 tracting entity”.

4 (17) Section 1916(b)(2)(D) of such Act (42
5 U.S.C. 1396o(b)(2)(D)) is amended by striking
6 “health maintenance organization” and inserting
7 “risk contracting entity”.

8 (18) Section 1925(b)(4)(D)(iv) of such Act (42
9 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended—

10 (A) in the heading, by striking “HMO” and
11 inserting “RISK CONTRACTING ENTITY”,

12 (B) by striking “health maintenance orga-
13 nization” and inserting “risk contracting en-
14 tity” each place it appears, and

15 (C) by striking “section 1903(m)(1)(A)”
16 and inserting “section 1903(m)(1)(B)(i)”.

17 (19) Paragraphs (1) and (2) of section 1926(a)
18 of such Act (42 U.S.C. 1396r-7(a)) are each amend-
19 ed by striking “health maintenance organizations”
20 and inserting “risk contracting entities”.

21 (20) Section 1927 of such Act (42 U.S.C.
22 1396s) is amended—

23 (A) in subsection (c)(1)(C)(i), as amended
24 by section 13602(a)(1) of the Omnibus Budget
25 Reconciliation Act of 1993, by striking “health

1 maintenance organization” and inserting “risk
2 contracting entity” , and

3 (B) in subsection (j)(1), by striking “***
4 Health Maintenance Organizations, including
5 those organizations” and inserting “risk con-
6 tracting entities”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section shall become effective with respect to calendar
9 quarters beginning on or after January 1, 1994.

10 **SEC. 1702. PERIOD OF CERTAIN WAIVERS.**

11 (a) IN GENERAL.—Section 1915(h) of the Social Se-
12 curity Act (42 U.S.C. 1396n(h)) is amended by striking
13 “No waiver” and all that follows through “unless the Sec-
14 retary” and inserting “A waiver under this section (other
15 than under subsection (c), (d), or (e)) shall be for an ini-
16 tial term of 3 years and, upon the request of a State, shall
17 be extended for additional 5 year periods unless the Sec-
18 retary”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) shall apply to waivers pursuant to applica-
21 tions which are approved, and with respect to continu-
22 ations of waivers for which requests are made, later than
23 30 days after the date of the enactment of this Act.

1 **TITLE II—HEALTH CARE COST**
2 **CONTAINMENT AND QUALITY**
3 **ENHANCEMENT**

4 **Subtitle A—Medical Malpractice**
5 **Liability Reform**

6 **PART 1—GENERAL PROVISIONS**

7 **SEC. 2001. FEDERAL REFORM OF MEDICAL MALPRACTICE**
8 **LIABILITY ACTIONS.**

9 (a) **APPLICABILITY.**—This subtitle shall apply with
10 respect to any medical malpractice liability claim and to
11 any medical malpractice liability action brought in any
12 State or Federal court, except that this subtitle shall not
13 apply to a claim or action for damages arising from a vac-
14 cine-related injury or death to the extent that title XXI
15 of the Public Health Service Act applies to the claim or
16 action.

17 (b) **PREEMPTION.**—The provisions of this subtitle
18 shall preempt any State law to the extent such law is in-
19 consistent with the limitations contained in such provi-
20 sions. The provisions of this subtitle shall not preempt any
21 State law that provides for defenses or places limitations
22 on a person's liability in addition to those contained in
23 this subtitle, places greater limitations on the amount of
24 attorneys' fees that can be collected, or otherwise imposes
25 greater restrictions than those provided in this subtitle.

1 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
2 OF LAW OR VENUE.—Nothing in subsection (b) shall be
3 construed to—

4 (1) waive or affect any defense of sovereign im-
5 munity asserted by any State under any provision of
6 law;

7 (2) waive or affect any defense of sovereign im-
8 munity asserted by the United States;

9 (3) affect the applicability of any provision of
10 the Foreign Sovereign Immunities Act of 1976;

11 (4) preempt State choice-of-law rules with re-
12 spect to claims brought by a foreign nation or a citi-
13 zen of a foreign nation; or

14 (5) affect the right of any court to transfer
15 venue or to apply the law of a foreign nation or to
16 dismiss a claim of a foreign nation or of a citizen
17 of a foreign nation on the ground of inconvenient
18 forum.

19 (d) FEDERAL COURT JURISDICTION NOT ESTAB-
20 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
21 this subtitle shall be construed to establish any jurisdiction
22 in the district courts of the United States over medical
23 malpractice liability actions on the basis of section 1331
24 or 1337 of title 28, United States Code.

1 **SEC. 2002. DEFINITIONS.**

2 As used in this subtitle:

3 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
4 TEM; ADR.—The term “alternative dispute resolu-
5 tion system” or “ADR” means a system established
6 under this subtitle that provides for the resolution of
7 medical malpractice liability claims in a manner
8 other than through medical malpractice liability ac-
9 tions.

10 (2) CLAIMANT.—The term “claimant” means
11 any person who alleges a medical malpractice liabil-
12 ity claim, and any person on whose behalf such a
13 claim is alleged, including the decedent in the case
14 of an action brought through or on behalf of an es-
15 tate.

16 (3) CLEAR AND CONVINCING EVIDENCE.—The
17 term “clear and convincing evidence” is that meas-
18 ure or degree of proof that will produce in the mind
19 of the trier of fact a firm belief or conviction as to
20 the truth of the allegations sought to be established,
21 except that such measure or degree of proof is more
22 than that required under preponderance of the evi-
23 dence, but less than that required for proof beyond
24 a reasonable doubt.

25 (4) ECONOMIC DAMAGES.—The term “economic
26 damages” means damages paid to compensate an in-

1 dividual for hospital and other medical expenses, lost
2 wages, lost employment, and other pecuniary losses.

3 (5) HEALTH CARE PROFESSIONAL.—The term
4 “health care professional” means any individual who
5 provides health care services in a State and who is
6 required by the laws or regulations of the State to
7 be licensed or certified by the State to provide such
8 services in the State.

9 (6) HEALTH CARE PROVIDER.—The term
10 “health care provider” means any organization or
11 institution that is engaged in the delivery of health
12 care services in a State and that is required by the
13 laws or regulations of the State to be licensed or cer-
14 tified by the State to engage in the delivery of such
15 services in the State.

16 (7) INJURY.—The term “injury” means any ill-
17 ness, disease, or other harm that is the subject of
18 a medical malpractice liability action or a medical
19 malpractice liability claim.

20 (8) MEDICAL MALPRACTICE LIABILITY AC-
21 TION.—The term “medical malpractice liability ac-
22 tion” means a civil action brought in a State or Fed-
23 eral court against a health care provider or health
24 care professional in which the plaintiff alleges a
25 medical malpractice liability claim, but does not in-

1 clude any action in which the plaintiff's sole allega-
2 tion is an allegation of an intentional tort.

3 (9) MEDICAL MALPRACTICE LIABILITY
4 CLAIM.—The term “medical malpractice liability
5 claim” means a claim in which the claimant alleges
6 that injury was caused by the provision of (or the
7 failure to provide) health care services or the use of
8 a medical product.

9 (10) MEDICAL PRODUCT.—

10 (A) IN GENERAL.—The term “medical
11 product” means, with respect to the allegation
12 of a claimant, a drug (as defined in section
13 201(g)(1) of the Federal Food, Drug, and Cos-
14 metic Act (21 U.S.C. 321(g)(1)) or a medical
15 device (as defined in section 201(h) of the Fed-
16 eral Food, Drug, and Cosmetic Act (21 U.S.C.
17 321(h)) if—

18 (i) such drug or device was subject to
19 premarket approval under section 505,
20 507, or 515 of the Federal Food, Drug,
21 and Cosmetic Act (21 U.S.C. 355, 357, or
22 360e) or section 351 of the Public Health
23 Service Act (42 U.S.C. 262) with respect
24 to the safety of the formulation or per-
25 formance of the aspect of such drug or de-

1 vice which is the subject of the claimant's
2 allegation or the adequacy of the packag-
3 ing or labeling of such drug or device, and
4 such drug or device is approved by the
5 Food and Drug Administration; or

6 (ii) the drug or device is generally rec-
7 ognized as safe and effective under regula-
8 tions issued by the Secretary of Health
9 and Human Services under section 201(p)
10 of the Federal Food, Drug, and Cosmetic
11 Act (21 U.S.C. 321(p)).

12 (B) EXCEPTION IN CASE OF MISREPRE-
13 SENTATION OR FRAUD.—Notwithstanding sub-
14 paragraph (A), the term “medical product”
15 shall not include any product described in such
16 subparagraph if the claimant shows that the
17 product is approved by the Food and Drug Ad-
18 ministration for marketing as a result of with-
19 held information, misrepresentation, or an ille-
20 gal payment by manufacturer of the product.

21 (11) NONECONOMIC DAMAGES.—The term
22 “noneconomic damages” means damages paid to
23 compensate an individual for physical and emotional
24 pain, suffering, inconvenience, physical impairment,
25 mental anguish, disfigurement, loss of enjoyment of

1 life, loss of consortium, and other nonpecuniary
2 losses, but does not include punitive damages.

3 (12) PUNITIVE DAMAGES; EXEMPLARY DAM-
4 AGES.—The terms “punitive damages” and “exem-
5 plary damages” mean compensation, in addition to
6 compensation for actual harm suffered, that is
7 awarded for the purpose of punishing a person for
8 conduct deemed to be malicious, wanton, willful, or
9 excessively reckless.

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

12 (14) STATE.—The term “State” means each of
13 the several States, the District of Columbia, the
14 Commonwealth of Puerto Rico, the Virgin Islands,
15 Guam, and American Samoa.

16 **SEC. 2003. EFFECTIVE DATE.**

17 (a) IN GENERAL.—Except as provided in subsection
18 (b) and section 2017(c), this subtitle shall apply with re-
19 spect to claims accruing or actions brought on or after
20 the expiration of the 3-year period that begins on the date
21 of the enactment of this Act.

22 (b) EXCEPTION FOR STATES REQUESTING EARLIER
23 IMPLEMENTATION OF REFORMS.—

24 (1) APPLICATION.—A State may submit an ap-
25 plication to the Secretary requesting the early imple-

1 mentation of this subtitle with respect to claims or
2 actions brought in the State.

3 (2) DECISION BY SECRETARY.—The Secretary
4 shall issue a response to a State’s application under
5 paragraph (1) not later than 90 days after receiving
6 the application. If the Secretary determines that the
7 State meets the requirements of this subtitle at the
8 time of submitting its application, the Secretary
9 shall approve the State’s application, and this sub-
10 title shall apply with respect to actions brought in
11 the State on or after the expiration of the 90-day
12 period that begins on the date the Secretary issues
13 the response. If the Secretary denies the State’s ap-
14 plication, the Secretary shall provide the State with
15 a written explanation of the grounds for the deci-
16 sion.

17 **PART 2—MEDICAL MALPRACTICE AND**
18 **PRODUCT LIABILITY REFORM**

19 **SEC. 2011. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**
20 **TION THROUGH ALTERNATIVE DISPUTE RES-**
21 **OLUTION.**

22 (a) IN GENERAL.—

23 (1) STATE CASES.—A medical malpractice li-
24 ability action may not be brought in any State court
25 during a calendar year unless the medical mal-

1 practice liability claim that is the subject of the ac-
2 tion has been initially resolved under an alternative
3 dispute resolution system certified for the year by
4 the Secretary under section 2032(a), or, in the case
5 of a State in which such a system is not in effect
6 for the year, under the alternative Federal system
7 established under section 2032(b).

8 (2) FEDERAL DIVERSITY ACTIONS.—A medical
9 malpractice liability action may not be brought in
10 any Federal court under section 1332 of title 28,
11 United States Code, during a calendar year unless
12 the medical malpractice liability claim that is the
13 subject of the action has been initially resolved
14 under the alternative dispute resolution system re-
15 ferred to in paragraph (1) that applied in the State
16 whose law applies in such action.

17 (3) CLAIMS AGAINST UNITED STATES.—

18 (A) ESTABLISHMENT OF PROCESS FOR
19 CLAIMS.—The Attorney General shall establish
20 an alternative dispute resolution process for the
21 resolution of tort claims consisting of medical
22 malpractice liability claims brought against the
23 United States under chapter 171 of title 28,
24 United States Code. Under such process, the
25 resolution of a claim shall occur after the com-

1 pletion of the administrative claim process ap-
2 plicable to the claim under section 2675 of such
3 title.

4 (B) REQUIREMENT FOR INITIAL RESOLU-
5 TION UNDER PROCESS.—A medical malpractice
6 liability action based on a medical malpractice
7 liability claim described in subparagraph (A)
8 may not be brought in any Federal court unless
9 the claim has been initially resolved under the
10 alternative dispute resolution process estab-
11 lished by the Attorney General under such sub-
12 paragraph.

13 (b) INITIAL RESOLUTION OF CLAIMS UNDER
14 ADR.—For purposes of subsection (a), an action is “ini-
15 tially resolved” under an alternative dispute resolution
16 system if—

17 (A) the ADR reaches a decision on wheth-
18 er the defendant is liable to the plaintiff for
19 damages; and

20 (B) if the ADR determines that the de-
21 fendant is liable, the ADR reaches a decision on
22 the amount of damages assessed against the de-
23 fendant.

24 (c) PROCEDURES FOR FILING ACTIONS.—

1 (1) NOTICE OF INTENT TO CONTEST DECI-
2 SION.—Not later than 60 days after a decision is is-
3 sued with respect to a medical malpractice liability
4 claim under an alternative dispute resolution system,
5 each party affected by the decision shall submit a
6 sealed statement to a court of competent jurisdiction
7 indicating whether or not the party intends to con-
8 test the decision.

9 (2) DEADLINE FOR FILING ACTION.—A medical
10 malpractice liability action may not be brought by a
11 party unless—

12 (A) the party has filed the notice of intent
13 required by paragraph (1); and

14 (B) the party files the action in a court of
15 competent jurisdiction not later than 90 days
16 after the decision resolving the medical mal-
17 practice liability claim that is the subject of the
18 action is issued under the applicable alternative
19 dispute resolution system.

20 (3) COURT OF COMPETENT JURISDICTION.—
21 For purposes of this subsection, the term “court of
22 competent jurisdiction” means—

23 (A) with respect to actions filed in a State
24 court, the appropriate State trial court; and

1 (B) with respect to actions filed in a Fed-
2 eral court, the appropriate United States dis-
3 trict court.

4 (d) LEGAL EFFECT OF UNCONTESTED ADR DECI-
5 SION.—The decision reached under an alternative dispute
6 resolution system shall, for purposes of enforcement by a
7 court of competent jurisdiction, have the same status in
8 the court as the verdict of a medical malpractice liability
9 action adjudicated in a State or Federal trial court. The
10 previous sentence shall not apply to a decision that is con-
11 tested by a party affected by the decision pursuant to sub-
12 section (c)(1).

13 **SEC. 2012. CALCULATION AND PAYMENT OF DAMAGES.**

14 (a) LIMITATION ON NONECONOMIC DAMAGES.—The
15 total amount of noneconomic damages that may be award-
16 ed to a claimant and the members of the claimant's family
17 for losses resulting from the injury which is the subject
18 of a medical malpractice liability action may not exceed
19 \$250,000, regardless of the number of parties against
20 whom the action is brought or the number of actions
21 brought with respect to the injury.

22 (b) TREATMENT OF PUNITIVE DAMAGES.—

23 (1) BASIS FOR RECOVERY.—Punitive or exem-
24 plary damages shall not be awarded in a medical
25 malpractice liability action unless the claimant es-

1 tablishes by clear and convincing evidence that the
2 injury suffered was the direct result of conduct
3 manifesting a malicious, wanton, willful, or exces-
4 sively reckless disregard of the safety of others.

5 (2) NO AWARD AGAINST MANUFACTURER OF
6 MEDICAL PRODUCT.—In the case of a medical mal-
7 practice liability action in which the plaintiff alleges
8 a claim against the manufacturer of a medical prod-
9 uct, no punitive or exemplary damages may be
10 awarded against such manufacturer.

11 (3) PAYMENTS TO STATE FOR MEDICAL QUAL-
12 ITY ASSURANCE ACTIVITIES.—

13 (A) IN GENERAL.—Any punitive or exem-
14 plary damages awarded in a medical mal-
15 practice liability action shall be paid to the
16 State in which the action is brought or, in a
17 case brought in Federal court, in the State in
18 which the health care services that caused the
19 injury that is the subject of the action were
20 provided.

21 (B) ACTIVITIES DESCRIBED.—A State
22 shall use amounts paid pursuant to subpara-
23 graph (A) to carry out activities to assure the
24 safety and quality of health care services pro-

1 vided in the State, including (but not limited
2 to)—

3 (i) licensing or certifying health care
4 professionals and health care providers in
5 the State;

6 (ii) operating alternative dispute reso-
7 lution systems;

8 (iii) carrying out public education pro-
9 grams relating to medical malpractice and
10 the availability of alternative dispute reso-
11 lution systems in the State; and

12 (iv) carrying out programs to reduce
13 malpractice-related costs for retired provid-
14 ers or other providers volunteering to pro-
15 vide services in medically underserved
16 areas.

17 (C) MAINTENANCE OF EFFORT.—A State
18 shall use any amounts paid pursuant to sub-
19 paragraph (A) to supplement and not to replace
20 amounts spent by the State for the activities
21 described in subparagraph (B).

22 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

23 (1) GENERAL RULE.—In any medical mal-
24 practice liability action in which the damages award-
25 ed for future economic loss exceeds \$100,000, a de-

1 defendant may not be required to pay such damages
 2 in a single, lump-sum payment, but shall be per-
 3 mitted to make such payments periodically based on
 4 when the damages are found likely to occur, as such
 5 payments are determined by the court.

6 (2) WAIVER.—A court may waive the applica-
 7 tion of paragraph (1) with respect to a defendant if
 8 the court determines that it is not in the best inter-
 9 ests of the plaintiff to receive payments for damages
 10 on such a periodic basis.

11 **SEC. 2013. TREATMENT OF ATTORNEY'S FEES AND OTHER**
 12 **COSTS.**

13 (a) LIMITATION ON AMOUNT OF CONTINGENCY
 14 FEES.—

15 (1) IN GENERAL.—An attorney who represents,
 16 on a contingency fee basis, a claimant in a medical
 17 malpractice liability claim may not charge, demand,
 18 receive, or collect for services rendered in connection
 19 with such claim in excess of the following amount re-
 20 covered by judgment or settlement under such claim:

21 (A) 25 percent of the first \$150,000 (or
 22 portion thereof) recovered, plus

23 (B) 10 percent of any amount in excess of
 24 \$150,000 recovered.

1 (2) CALCULATION OF PERIODIC PAYMENTS.—In
2 the event that a judgment or settlement includes
3 periodic or future payments of damages, the amount
4 recovered for purposes of computing the limitation
5 on the contingency fee under paragraph (1) shall be
6 based on the cost of the annuity or trust established
7 to make the payments. In any case in which an an-
8 nuity or trust is not established to make such pay-
9 ments, such amount shall be based on the present
10 value of the payments.

11 (b) REQUIRING PARTY CONTESTING ADR RULING
12 TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

13 (1) IN GENERAL.—The court in a medical mal-
14 practice liability action shall require the party that
15 (pursuant to section 2011(c)(1)) contested the ruling
16 of the alternative dispute resolution system with re-
17 spect to the medical malpractice liability claim that
18 is the subject of the action to pay to the opposing
19 party the costs incurred by the opposing party under
20 the action, including attorney's fees, fees paid to ex-
21 pert witnesses, and other litigation expenses (but not
22 including court costs, filing fees, or other expenses
23 paid directly by the party to the court, or any fees
24 or costs associated with the resolution of the claim

1 under the alternative dispute resolution system), but
2 only if—

3 (A) in the case of an action in which the
4 party that contested the ruling is the claimant,
5 the amount of damages awarded to the party
6 under the action does not exceed the amount of
7 damages awarded to the party under the ADR
8 system by at least 10 percent; and

9 (B) in the case of an action in which the
10 party that contested the ruling is the defendant,
11 the amount of damages assessed against the
12 party under the action is not at least 10 per-
13 cent less than the amount of damages assessed
14 under the ADR system.

15 (2) EXCEPTIONS.—Paragraph (1) shall not
16 apply if—

17 (A) the party contesting the ruling made
18 under the previous alternative dispute resolu-
19 tion system shows that—

20 (i) the ruling was procured by corrup-
21 tion, fraud, or undue means,

22 (ii) there was partiality or corruption
23 under the system,

1 (iii) there was other misconduct under
2 the system that materially prejudiced the
3 party's rights, or

4 (iv) the ruling was based on an error
5 of law;

6 (B) the party contesting the ruling made
7 under the alternative dispute resolution system
8 presents new evidence before the trier of fact
9 that was not available for presentation under
10 the ADR system;

11 (C) the medical malpractice liability action
12 raised a novel issue of law; or

13 (D) the court finds that the application of
14 such paragraph to a party would constitute an
15 undue hardship, and issues an order waiving or
16 modifying the application of such paragraph
17 that specifies the grounds for the court's deci-
18 sion.

19 (3) REQUIREMENT FOR PERFORMANCE
20 BOND.—The court in a medical malpractice liability
21 action shall require the party that (pursuant to sec-
22 tion 2011(c)(1)) contested the ruling of the alter-
23 native dispute resolution system with respect to the
24 medical malpractice liability claim that is the subject
25 of the action to post a performance bond (in such

1 amount and consisting of such funds and assets as
2 the court determines to be appropriate), except that
3 the court may waive the application of such require-
4 ment to a party if the court determines that the
5 posting of such a bond is not necessary to ensure
6 that the party shall meet the requirements of this
7 subsection to pay the opposing party the costs in-
8 curred by the opposing party under the action.

9 (4) LIMIT ON ATTORNEY'S FEES PAID.—Attor-
10 neys' fees that are required to be paid under para-
11 graph (1) by the contesting party shall not exceed
12 the amount of the attorneys' fees incurred by the
13 contesting party in the action. If the attorneys' fees
14 of the contesting party are based on a contingency
15 fee agreement, the amount of attorneys' fees for
16 purposes of the preceding sentence shall not exceed
17 the reasonable value of those services.

18 (5) RECORDS.—In order to receive attorneys'
19 fees under paragraph (1), counsel of record in the
20 medical malpractice liability action involved shall
21 maintain accurate, complete records of hours worked
22 on the action, regardless of the fee arrangement
23 with the client involved.

24 (c) CONTINGENCY FEE DEFINED.—As used in this
25 section, the term "contingency fee" means any fee for pro-

1 fessional legal services which is, in whole or in part, con-
2 tingent upon the recovery of any amount of damages,
3 whether through judgment or settlement.

4 **SEC. 2014. JOINT AND SEVERAL LIABILITY.**

5 Except as provided in subsection (b), a defendant
6 may be held severally but not jointly liable in a medical
7 malpractice action. A person found liable for damages in
8 any such action may be found liable, if at all, only for
9 those damages directly attributable to the person's propor-
10 tionate share of fault or responsibility for the injury, and
11 may not be found liable for damages attributable to the
12 proportionate share of fault or responsibility of any other
13 person (without regard to whether that person is a party
14 to the action) for the injury, including any person bringing
15 the action.

16 **SEC. 2015. STATUTE OF LIMITATIONS.**

17 A medical malpractice liability claim may not be
18 brought after the expiration of the 7-year period that be-
19 gins on the date the alleged injury that is the subject of
20 the claim occurred. If the commencement of such an ac-
21 tion is stayed or enjoined, the running of the statute of
22 limitations under this section shall be suspended for the
23 period of the stay or injunction.

1 **SEC. 2016. UNIFORM STANDARD FOR DETERMINING NEG-**
2 **LIGENCE.**

3 A defendant in a medical malpractice liability action
4 may not be found to have acted negligently unless the de-
5 fendant's conduct at the time of providing the health care
6 services that are the subject of the action was not reason-
7 able.

8 **SEC. 2017. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**
9 **SERVICES.**

10 (a) IMPOSITION OF HIGHER STANDARD OF PROOF.—
11 In the case of a medical malpractice liability claim relating
12 to services provided during labor or the delivery of a baby,
13 if the health care professional against whom the claim is
14 brought did not previously treat the individual alleged to
15 have been injured for the pregnancy, the trier of fact may
16 not find that the defendant committed malpractice and
17 may not assess damages against the health care profes-
18 sional unless the malpractice is proven by clear and con-
19 vincing evidence.

20 (b) APPLICABILITY TO GROUP PRACTICES OR
21 AGREEMENTS AMONG PROVIDERS.—For purposes of sub-
22 section (a), a health care professional shall be considered
23 to have previously treated an individual for a pregnancy
24 if the professional is a member of a group practice whose
25 members previously treated the individual for the preg-
26 nancy or is providing services to the individual during

1 labor or the delivery of a baby pursuant to an agreement
2 with another health care professional.

3 (c) EFFECTIVE DATE.—This section shall apply with
4 respect to claims accruing or actions brought on or after
5 the expiration of the 2-year period that begins on the date
6 of the enactment of this Act.

7 **PART 3—REQUIREMENTS FOR STATE AL-**
8 **TERNATIVE DISPUTE RESOLUTION**
9 **SYSTEMS (ADR)**

10 **SEC. 2031. BASIC REQUIREMENTS.**

11 (a) IN GENERAL.—A State’s alternative dispute reso-
12 lution system meets the requirements of this section if the
13 system—

14 (1) applies to all medical malpractice liability
15 claims under the jurisdiction of the courts of that
16 State;

17 (2) requires that a written opinion resolving the
18 dispute be issued not later than 6 months after the
19 date by which each party against whom the claim is
20 filed has received notice of the claim (other than in
21 exceptional cases for which a longer period is re-
22 quired for the issuance of such an opinion), and that
23 the opinion contain—

24 (A) findings of fact relating to the dispute,
25 and

1 (B) a description of the costs incurred in
2 resolving the dispute under the system (includ-
3 ing any fees paid to the individuals hearing and
4 resolving the claim), together with an appro-
5 priate assessment of the costs against any of
6 the parties;

7 (3) requires individuals who hear and resolve
8 claims under the system to meet such qualifications
9 as the State may require (in accordance with regula-
10 tions of the Secretary);

11 (4) is approved by the State or by local govern-
12 ments in the State;

13 (5) with respect to a State system that consists
14 of multiple dispute resolution procedures—

15 (A) permits the parties to a dispute to se-
16 lect the procedure to be used for the resolution
17 of the dispute under the system, and

18 (B) if the parties do not agree on the pro-
19 cedure to be used for the resolution of the dis-
20 pute, assigns a particular procedure to the par-
21 ties;

22 (6) provides for the transmittal to the State
23 agency responsible for monitoring or disciplining
24 health care professionals and health care providers
25 of any findings made under the system that such a

1 professional or provider committed malpractice, un-
2 less, during the 90-day period beginning on the date
3 the system resolves the claim against the profes-
4 sional or provider, the professional or provider
5 brings an action contesting the decision made under
6 the system; and

7 (7) provides for the regular transmittal to the
8 Administrator for Health Care Policy and Research
9 of information on disputes resolved under the sys-
10 tem, in a manner that assures that the identity of
11 the parties to a dispute shall not be revealed.

12 (b) APPLICATION OF MALPRACTICE LIABILITY
13 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—
14 The provisions of part 2 shall apply with respect to claims
15 brought under a State alternative dispute resolution sys-
16 tem or the alternative Federal system in the same manner
17 as such provisions apply with respect to medical mal-
18 practice liability actions brought in the State.

19 **SEC. 2032. CERTIFICATION OF STATE SYSTEMS; APPLICA-**
20 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

21 (a) CERTIFICATION.—

22 (1) IN GENERAL.—Not later than October 1 of
23 each year (beginning with 1994), the Secretary, in
24 consultation with the Attorney General, shall deter-
25 mine whether a State's alternative dispute resolution

1 system meets the requirements of this part for the
2 following calendar year.

3 (2) BASIS FOR CERTIFICATION.—The Secretary
4 shall certify a State’s alternative dispute resolution
5 system under this subsection for a calendar year if
6 the Secretary determines under paragraph (1) that
7 the system meets the requirements of section 2031.

8 (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-
9 TEM.—

10 (1) ESTABLISHMENT AND APPLICABILITY.—
11 Not later than October 1, 1994, the Secretary, in
12 consultation with the Attorney General, shall estab-
13 lish by rule an alternative Federal ADR system for
14 the resolution of medical malpractice liability claims
15 during a calendar year in States that do not have
16 in effect an alternative dispute resolution system
17 certified under subsection (a) for the year.

18 (2) REQUIREMENTS FOR SYSTEM.—Under the
19 alternative Federal ADR system established under
20 paragraph (1)—

21 (A) paragraphs (1), (2), (6), and (7) of
22 section 2031(a) shall apply to claims brought
23 under the system;

24 (B) if the system provides for the resolu-
25 tion of claims through arbitration, the claims

1 brought under the system shall be heard and
2 resolved by arbitrators appointed by the Sec-
3 retary in consultation with the Attorney Gen-
4 eral; and

5 (C) with respect to a State in which the
6 system is in effect, the Secretary may (at the
7 State's request) modify the system to take into
8 account the existence of dispute resolution pro-
9 cedures in the State that affect the resolution
10 of medical malpractice liability claims.

11 (3) TREATMENT OF STATES WITH ALTER-
12 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-
13 eral ADR system established under this subsection is
14 applied with respect to a State for a calendar year—

15 (A) the State shall reimburse the United
16 States (at such time and in such manner as the
17 Secretary may require) for the costs incurred
18 by the United States during the year as a result
19 of the application of the system with respect to
20 the State; and

21 (B) notwithstanding any other provision of
22 law, no funds may be paid to the State (or to
23 any unit of local government in the State) or to
24 any entity in the State pursuant to the Public
25 Health Service Act.

1 **SEC. 2033. REPORTS ON IMPLEMENTATION AND EFFEC-**
2 **TIVENESS OF ALTERNATIVE DISPUTE RESO-**
3 **LUTION SYSTEMS.**

4 (a) IN GENERAL.—Not later than 5 years after the
5 date of the enactment of this Act, the Secretary shall pre-
6 pare and submit to the Congress a report describing and
7 evaluating State alternative dispute resolution systems op-
8 erated pursuant to this part and the alternative Federal
9 system established under section 2032(b).

10 (b) CONTENTS OF REPORT.—The Secretary shall in-
11 clude in the report prepared and submitted under sub-
12 section (a)—

13 (1) information on—

14 (A) the effect of the alternative dispute
15 resolution systems on the cost of health care
16 within each State,

17 (B) the impact of such systems on the ac-
18 cess of individuals to health care within the
19 State, and

20 (C) the effect of such systems on the qual-
21 ity of health care provided within the State; and

22 (2) to the extent that such report does not pro-
23 vide information on no-fault systems operated by
24 States as alternative dispute resolution systems pur-
25 suant to this part, an analysis of the feasibility and
26 desirability of establishing a system under which

1 medical malpractice liability claims shall be resolved
2 on a no-fault basis.

3 **PART 4—OTHER PROVISIONS RELATING**
4 **TO MEDICAL MALPRACTICE LIABILITY**

5 **SEC. 2041. PERMITTING STATE PROFESSIONAL SOCIETIES**
6 **TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.**
7 **TIES.**

8 (a) **ROLE OF PROFESSIONAL SOCIETIES.**—Notwith-
9 standing any other provision of State or Federal law, a
10 State agency responsible for the conduct of disciplinary
11 actions for a type of health care practitioner may enter
12 into agreements with State or county professional societies
13 of such type of health care practitioner to permit such so-
14 cieties to participate in the licensing of such health care
15 practitioner, and to review any health care malpractice ac-
16 tion, health care malpractice claim or allegation, or other
17 information concerning the practice patterns of any such
18 health care practitioner. Any such agreement shall comply
19 with subsection (b).

20 (b) **REQUIREMENTS OF AGREEMENTS.**—Any agree-
21 ment entered into under subsection (a) for licensing activi-
22 ties or the review of any health care malpractice action,
23 health care malpractice claim or allegation, or other infor-
24 mation concerning the practice patterns of a health care
25 practitioner shall provide that—

1 (1) the health care professional society conducts
2 such activities or review as expeditiously as possible;

3 (2) after the completion of such review, such so-
4 ciety shall report its findings to the State agency
5 with which it entered into such agreement;

6 (3) the conduct of such activities or review and
7 the reporting of such findings be conducted in a
8 manner which assures the preservation of confiden-
9 tiality of health care information and of the review
10 process; and

11 (4) no individual affiliated with such society is
12 liable for any damages or injury directly caused by
13 the individual's actions in conducting such activities
14 or review.

15 (c) AGREEMENTS NOT MANDATORY.—Nothing in
16 this section may be construed to require a State to enter
17 into agreements with societies described in subsection (a)
18 to conduct the activities described in such subsection.

19 (d) EFFECTIVE DATE.—This section shall take effect
20 2 years after the date of the enactment of this Act.

21 **SEC. 2042. STUDY OF INCENTIVES TO ENCOURAGE VOL-**
22 **UNTARY SERVICE BY PHYSICIANS.**

23 (a) STUDY.—The Secretary shall conduct a study
24 analyzing the existence and effectiveness of incentives
25 adopted by State and local governments, insurers, medical

1 societies, and other entities to encourage physicians
2 (whether practicing or retired) to volunteer to provide
3 health care services in medically underserved areas.

4 (b) REPORTS.—(1) Not later than 1 year after the
5 date of the enactment of this Act, the Secretary shall sub-
6 mit an interim report to Congress on the study conducted
7 under subsection (a), together with the Secretary's rec-
8 ommendations for actions to increase the number of physi-
9 cians volunteering to provide health care services in medi-
10 cally underserved areas.

11 (2) Not later than 5 years after the date of the enact-
12 ment of this Act, the Secretary shall submit a final report
13 to the Congress on the study conducted under subsection
14 (a) (taking into account the effects of this subtitle on the
15 incidence and costs of medical malpractice), together with
16 the Secretary's recommendations for actions to increase
17 the number of physicians volunteering to provide health
18 care services in medically underserved areas.

19 **SEC. 2043. REQUIREMENTS FOR RISK MANAGEMENT PRO-**
20 **GRAMS.**

21 (a) REQUIREMENTS FOR PROVIDERS.—Each State
22 shall require each health care professional and health care
23 provider providing services in the State to participate in
24 a risk management program to prevent and provide early

1 warning of practices which may result in injuries to pa-
2 tients or which otherwise may endanger patient safety.

3 (b) REQUIREMENTS FOR INSURERS.—Each State
4 shall require each entity which provides health care profes-
5 sional or provider liability insurance to health care profes-
6 sionals and health care providers in the State to—

7 (1) establish risk management programs based
8 on data available to such entity or sanction pro-
9 grams of risk management for health care profes-
10 sionals and health care providers provided by other
11 entities; and

12 (2) require each such professional or provider,
13 as a condition of maintaining insurance, to partici-
14 pate in one program described in paragraph (1) at
15 least once in each 3-year period.

16 (c) EFFECTIVE DATE.—This section shall take effect
17 2 years after the date of the enactment of this Act.

18 **SEC. 2044. GRANTS FOR MEDICAL SAFETY PROMOTION.**

19 (a) RESEARCH ON MEDICAL INJURY PREVENTION
20 AND COMPENSATION.

21 (1) IN GENERAL.—The Secretary shall make
22 grants for the conduct of basic research in the pre-
23 vention of and compensation for injuries resulting
24 from health care professional or health care provider

1 malpractice, and research of the outcomes of health
2 care procedures.

3 (2) PREFERENCE FOR RESEARCH ON CERTAIN
4 ACTIVITIES.—In making grants under paragraph
5 (1), the Secretary shall give preference to applica-
6 tions for grants to conduct research on the behavior
7 of health care providers and health care profes-
8 sionals in carrying out their professional duties and
9 of other participants in systems for compensating in-
10 dividuals injured by medical malpractice, the effects
11 of financial and other incentives on such behavior,
12 the determinants of compensation system outcomes,
13 and the costs and benefits of alternative compensa-
14 tion policy options.

15 (3) APPLICATION.—The Secretary may not
16 make a grant under paragraph (1) unless an appli-
17 cant submits an application to the Secretary at such
18 time, in such form, in such manner, and containing
19 such information as the Secretary may require.

20 (b) GRANTS FOR LICENSING AND DISCIPLINARY AC-
21 TIVITIES.—

22 (1) IN GENERAL.—The Secretary shall make
23 grants to States to assist States in improving the
24 State's ability to license and discipline health care
25 professionals.

1 (2) USES FOR GRANTS.—A State may use a
2 grant awarded under subsection (a) to develop and
3 implement improved mechanisms for monitoring the
4 practices of health care professionals or for conduct-
5 ing disciplinary activities.

6 (3) TECHNICAL ASSISTANCE.—The Secretary
7 shall provide technical assistance to States receiving
8 grants under paragraph (1) to assist them in evalu-
9 ating their medical practice acts and procedures and
10 to encourage the use of efficient and effective early
11 warning systems and other mechanisms for detecting
12 practices which endanger patient safety and for dis-
13 ciplining health care professionals.

14 (4) APPLICATIONS.—The Secretary may not
15 make a grant under paragraph (1) unless the appli-
16 cant submits an application to the Secretary at such
17 time, in such form, in such manner, and containing
18 such information as the Secretary shall require.

19 (c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

20 (1) IN GENERAL.—The Secretary shall make
21 grants to States and to local governments, private
22 nonprofit organizations, and health professional
23 schools (as defined in paragraph (3)) for—

1 (A) educating the general public about the
2 appropriate use of health care and realistic ex-
3 pectations of medical intervention;

4 (B) educating the public about the re-
5 sources and role of health care professional li-
6 censing and disciplinary boards in investigating
7 claims of incompetence or health care mal-
8 practice; and

9 (C) developing programs of faculty train-
10 ing and curricula for educating health care pro-
11 fessionals in quality assurance, risk manage-
12 ment, and medical injury prevention.

13 (2) APPLICATIONS.—The Secretary may not
14 make a grant under paragraph (1) unless the appli-
15 cant submits an application to the Secretary at such
16 time, in such form, in such manner, and containing
17 such information as the Secretary shall require.

18 (3) HEALTH PROFESSIONAL SCHOOL DE-
19 FINED.—In paragraph (1), the term “health profes-
20 sional school” means a school of nursing (as defined
21 in section 853(2) of the Public Health Service Act)
22 or a school or program under section 799(1) of such
23 Act.

24 (d) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated not more than

1 \$15,000,000 for each of the first 5 fiscal years beginning
2 on or after the date of the enactment of this Act for grants
3 under this section.

4 **Subtitle B—Administrative Cost**
5 **Savings**

6 **PART 1—STANDARDIZATION OF CLAIMS**
7 **PROCESSING**

8 **SEC. 2101. ADOPTION OF DATA ELEMENTS, UNIFORM**
9 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**
10 **MISSION STANDARDS.**

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services (in this subtitle referred to as the “Sec-
13 retary”) shall adopt standards relating to each of the fol-
14 lowing:

15 (1) Data elements for use in paper and elec-
16 tronic claims processing under health benefit plans,
17 as well as for use in utilization review and manage-
18 ment of care (including data fields, formats, and
19 medical nomenclature, and including plan benefit
20 and insurance information).

21 (2) Uniform claims forms (including uniform
22 procedure and billing codes for uses with such forms
23 and including information on other health benefit
24 plans that may be liable for benefits).

1 (3) Uniform electronic transmission of the data
2 elements (for purposes of billing and utilization re-
3 view).

4 Standards under paragraph (3) relating to electronic
5 transmission of data elements for claims for services shall
6 supersede (to the extent specified in such standards) the
7 standards adopted under paragraph (2) relating to the
8 submission of paper claims for such services. Standards
9 under paragraph (3) shall include protections to assure
10 the confidentiality of patient-specific information and to
11 protect against the unauthorized use and disclosure of in-
12 formation.

13 (b) USE OF TASK FORCES.—In adopting standards
14 under this section—

15 (1) the Secretary shall take into account the
16 recommendations of current taskforces, including at
17 least the Workgroup on Electronic Data Inter-
18 change, National Uniform Billing Committee, the
19 Uniform Claim Task Force, and the Computer-based
20 Patient Record Institute;

21 (2) the Secretary shall consult with the Na-
22 tional Association of Insurance Commissioners (and,
23 with respect to standards under subsection (a)(3),
24 the American National Standards Institute); and

1 (3) the Secretary shall, to the maximum extent
2 practicable, seek to make the standards consistent
3 with any uniform clinical data sets which have been
4 adopted and are widely recognized.

5 (c) DEADLINES FOR PROMULGATION.—The Sec-
6 retary shall promulgate the standards under—

7 (1) subsection (a)(1) relating to claims process-
8 ing data, by not later than 12 months after the date
9 of the enactment of this Act;

10 (2) subsection (a)(2) (relating to uniform
11 claims forms) by not later than 12 months after the
12 date of the enactment of this Act; and

13 (3)(A) subsection (a)(3) relating to trans-
14 mission of information concerning hospital and phy-
15 sicians services, by not later than 24 months after
16 the date of the enactment of this Act, and

17 (B) subsection (a)(3) relating to transmission
18 of information on other services, by such later date
19 as the Secretary may determine it to be feasible.

20 (d) REPORT TO CONGRESS.—Not later than 3 years
21 after the date of the enactment of this Act, the Secretary
22 shall report to Congress recommendations regarding re-
23 structuring the medicare peer review quality assurance
24 program given the availability of hospital data in elec-
25 tronic form.

1 **SEC. 2102. APPLICATION OF STANDARDS.**

2 (a) IN GENERAL.—If the Secretary determines, at
3 the end of the 2-year period beginning on the date that
4 standards are adopted under section 2101 with respect to
5 classes of services, that a significant number of claims for
6 benefits for such services under health benefit plans are
7 not being submitted in accordance with such standards,
8 the Secretary may require, after notice in the Federal
9 Register of not less than 6 months, that all providers of
10 such services must submit claims to health benefit plans
11 in accordance with such standards. The Secretary may
12 waive the application of such a requirement in such cases
13 as the Secretary finds that the imposition of the require-
14 ment would not be economically practicable.

15 (b) SIGNIFICANT NUMBER.—The Secretary shall
16 make an affirmative determination described in subsection
17 (a) for a class of services only if the Secretary finds that
18 there would be a significant, measurable additional gain
19 in efficiencies in the health care system that would be ob-
20 tained by imposing the requirement described in such
21 paragraph with respect to such services.

22 (c) APPLICATION OF REQUIREMENT.—

23 (1) IN GENERAL.—If the Secretary imposes the
24 requirement under subsection (a)—

25 (A) in the case of a requirement that im-
26 poses the standards relating to electronic trans-

1 mission of claims for a class of services, each
2 health care provider that furnishes such services
3 for which benefits are payable under a health
4 benefit plan shall transmit electronically and di-
5 rectly to the plan on behalf of the beneficiary
6 involved a claim for such services in accordance
7 with such standards;

8 (B) any health benefit plan may reject any
9 claim subject to the standards adopted under
10 section 2101 but which is not submitted in ac-
11 cordance with such standards;

12 (C) it is unlawful for a health benefit plan
13 (i) to reject any such claim on the basis of the
14 form in which it is submitted if it is submitted
15 in accordance with such standards or (ii) to re-
16 quire, for the purpose of utilization review or as
17 a condition of providing benefits under the plan,
18 a provider to transmit medical data elements
19 that are inconsistent with the standards estab-
20 lished under section 2101(a)(1); and

21 (D) the Secretary may impose a civil
22 money penalty on any provider that knowingly
23 and repeatedly submits claims in violation of
24 such standards or on any health benefit plan
25 (other than a health benefit plan described in

1 paragraph (2)) that knowingly and repeatedly
2 rejects claims in violation of subparagraph (B),
3 in an amount not to exceed \$100 for each such
4 claim.

5 The provisions of section 1128A of the Social Secu-
6 rity Act (other than the first sentence of subsection
7 (a) and other than subsection (b)) shall apply to a
8 civil money penalty under subparagraph (D) in the
9 same manner as such provisions apply to a penalty
10 or proceeding under section 1128A(a) of such Act.

11 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
12 ULATION.—A plan described in this paragraph is a
13 health benefit plan—

14 (A) that is subject to regulation by a
15 State, and

16 (B) with respect to which the Secretary
17 finds that—

18 (i) the State provides for application
19 of the standards established under section
20 2101, and

21 (ii) the State regulatory program pro-
22 vides for the appropriate and effective en-
23 forcement of such standards.

24 (d) TREATMENT OF REJECTIONS.—If a plan rejects
25 a claim pursuant to subsection (c)(1), the plan shall per-

1 mit the person submitting the claim a reasonable oppor-
2 tunity to resubmit the claim on a form or in an electronic
3 manner that meets the requirements for acceptance of the
4 claim under such subsection.

5 **SEC. 2103. PERIODIC REVIEW AND REVISION OF**
6 **STANDARDS.**

7 (a) IN GENERAL.—The Secretary shall—

8 (1) provide for the ongoing receipt and review
9 of comments and suggestions for changes in the
10 standards adopted and promulgated under section
11 2101;

12 (2) establish a schedule for the periodic review
13 of such standards; and

14 (3) based upon such comments, suggestions,
15 and review, revise such standards and promulgate
16 such revisions.

17 (b) APPLICATION OF REVISED STANDARDS.—If the
18 Secretary under subsection (a) revises the standards de-
19 scribed in 2101, then, in the case of any claim for benefits
20 submitted under a health benefit plan more than the mini-
21 mum period (of not less than 6 months specified by the
22 Secretary) after the date the revision is promulgated
23 under subsection (a)(3), such standards shall apply under
24 section 2102 instead of the standards previously promul-
25 gated.

1 **SEC. 2104. HEALTH BENEFIT PLAN DEFINED.**

2 In this subtitle, the term “health benefit plan” has
3 the meaning given such term in section 112(6) and in-
4 cludes—

5 (1) the medicare program (under title XVIII of
6 the Social Security Act) and medicare supplemental
7 health insurance, and

8 (2) a State medicaid plan (approved under title
9 XIX of such Act).

10 **PART 2—ELECTRONIC MEDICAL DATA**
11 **STANDARDS**

12 **SEC. 2111. MEDICAL DATA STANDARDS FOR HOSPITALS**
13 **AND OTHER PROVIDERS.**

14 (a) PROMULGATION OF HOSPITAL DATA STAND-
15 ARDS.—

16 (1) IN GENERAL.—Between July 1, 1994, and
17 January 1, 1995, the Secretary shall promulgate
18 standards described in subsection (b) for hospitals
19 concerning electronic medical data.

20 (2) REVISION.—The Secretary may from time
21 to time revise the standards promulgated under this
22 subsection.

23 (b) CONTENTS OF DATA STANDARDS.—The stand-
24 ards promulgated under subsection (a) shall include at
25 least the following:

1 (1) A definition of a standard set of data ele-
2 ments for use by utilization and quality control peer
3 review organizations.

4 (2) A definition of the set of comprehensive
5 data elements, which set shall include for hospitals
6 the standard set of data elements defined under
7 paragraph (1).

8 (3) Standards for an electronic patient care in-
9 formation system with data obtained at the point of
10 care, including standards to protect against the un-
11 authorized use and disclosure of information.

12 (4) A specification of, and manner of presen-
13 tation of, the individual data elements of the sets
14 and system under this subsection.

15 (5) Standards concerning the transmission of
16 electronic medical data.

17 (6) Standards relating to confidentiality of pa-
18 tient-specific information.

19 The standards under this section shall be consistent with
20 standards for data elements established under section
21 2101.

22 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-
23 VIDERS.—

24 (1) IN GENERAL.—The Secretary may promul-
25 gate standards described in paragraph (2) concern-

1 ing electronic medical data for providers that are not
 2 hospitals. The Secretary may from time to time re-
 3 vise the standards promulgated under this sub-
 4 section.

5 (2) CONTENTS OF DATA STANDARDS.—The
 6 standards promulgated under paragraph (1) for non-
 7 hospital providers may include standards comparable
 8 to the standards described in paragraphs (2), (4),
 9 and (5) of subsection (b) for hospitals.

10 (d) CONSULTATION.—In promulgating and revising
 11 standards under this section, the Secretary shall—

12 (1) consult with the American National Stand-
 13 ards Institute, hospitals, with the advisory commis-
 14 sion established under section 2115, and with other
 15 affected providers, health benefit plans, and other
 16 interested parties, and

17 (2) take into consideration, in developing stand-
 18 ards under subsection (b)(1), the data set used by
 19 the utilization and quality control peer review pro-
 20 gram under part B of title XI of the Social Security
 21 Act.

22 **SEC. 2112. APPLICATION OF ELECTRONIC DATA STAND-**
 23 **ARDS TO CERTAIN HOSPITALS.**

24 (a) MEDICARE REQUIREMENT FOR SHARING OF
 25 HOSPITAL INFORMATION.—As of January 1, 1996, sub-

1 ject to paragraph (2), each hospital, as a requirement of
2 each participation agreement under section 1866 of the
3 Social Security Act, shall—

4 (1) maintain clinical data included in the set of
5 comprehensive data elements under section
6 2111(b)(2) in electronic form on all inpatients,

7 (2) upon request of the Secretary or of a utili-
8 zation and quality control peer review organization
9 (with which the Secretary has entered into a con-
10 tract under part B of title XI of such Act), transmit
11 electronically the data set, and

12 (3) upon request of the Secretary, or of a fiscal
13 intermediary or carrier, transmit electronically any
14 data (with respect to a claim) from such data set,
15 in accordance with the standards promulgated under sec-
16 tion 2111(a).

17 (b) WAIVER AUTHORITY.—Until January 1, 2000:

18 (1) The Secretary may waive the application of
19 the requirements of subsection (a) for a hospital
20 that is a small rural hospital, for such period as the
21 hospital demonstrates compliance with such require-
22 ments would constitute an undue financial hardship.

23 (2) The Secretary may waive the application of
24 the requirements of subsection (a) for a hospital
25 that is in the process of developing a system to pro-

1 vide the required data set and executes agreements
2 with its fiscal intermediary and its utilization and
3 quality control peer review organization that the hos-
4 pital will meet the requirements of subsection (a) by
5 a specified date (not later than January 1, 2000).

6 (3) The Secretary may waive the application of
7 the requirement of subsection (a)(1) for a hospital
8 that agrees to obtain from its records the data ele-
9 ments that are needed to meet the requirements of
10 paragraphs (2) and (3) of subsection (a) and agrees
11 to subject its data transfer process to a quality as-
12 surance program specified by the Secretary.

13 (c) APPLICATION TO HOSPITALS OF THE DEPART-
14 MENT OF VETERANS AFFAIRS.—

15 (1) IN GENERAL.—The Secretary of Veterans
16 Affairs shall provide that each hospital of the De-
17 partment of Veterans Affairs shall comply with the
18 requirements of subsection (a) in the same manner
19 as such requirements would apply to the hospital if
20 it were participating in the Medicare program.

21 (2) WAIVER.—Such Secretary may waive the
22 application of such requirements to a hospital in the
23 same manner as the Secretary of Health and
24 Human Services may waive under subsection (b) the
25 application of the requirements of subsection (a).

1 **SEC. 2113. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**
2 **CIES.**

3 (a) IN GENERAL.—Effective January 1, 2000, if a
4 provider is required under a Federal program to transmit
5 a data element that is subject to a presentation or trans-
6 mission standard (as defined in subsection (b)), the head
7 of the Federal agency responsible for such program (if not
8 otherwise authorized) is authorized to require the provider
9 to present and transmit the data element electronically in
10 accordance with such a standard.

11 (b) PRESENTATION OR TRANSMISSION STANDARD
12 DEFINED.—In subsection (a), the term “presentation or
13 transmission standard” means a standard, promulgated
14 under subsection (b) or (c) of section 2111, described in
15 paragraph (4) or (5) of section 2111(b).

16 **SEC. 2114. LIMITATION ON DATA REQUIREMENTS WHERE**
17 **STANDARDS IN EFFECT.**

18 (a) IN GENERAL.—If standards with respect to data
19 elements are promulgated under section 2111 with respect
20 to a class of provider, a health benefit plan may not re-
21 quire, for the purpose of utilization review or as a condi-
22 tion of providing benefits under the plan, that a provider
23 in the class—

24 (1) provide any data element not in the set of
25 comprehensive data elements specified under such
26 standards, or

1 (2) transmit or present any such data element
2 in a manner inconsistent with the applicable stand-
3 ards for such transmission or presentation.

4 (b) COMPLIANCE.—

5 (1) IN GENERAL.—The Secretary may impose a
6 civil money penalty on any health benefit plan (other
7 than a health benefit plan described in paragraph
8 (2)) that fails to comply with subsection (a) in an
9 amount not to exceed \$100 for each such failure.
10 The provisions of section 1128A of the Social Secu-
11 rity Act (other than the first sentence of subsection
12 (a) and other than subsection (b)) shall apply to a
13 civil money penalty under this paragraph in the
14 same manner as such provisions apply to a penalty
15 or proceeding under section 1128A(a) of such Act.

16 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
17 ULATION.—A plan described in this paragraph is a
18 health benefit plan that is subject to regulation by
19 a State, if the Secretary finds that—

20 (A) the State provides for application of
21 the requirement of subsection (a), and

22 (B) the State regulatory program provides
23 for the appropriate and effective enforcement of
24 such requirement with respect to such plans.

1 **SEC. 2115. ADVISORY COMMISSION.**

2 (a) IN GENERAL.—The Secretary shall establish an
3 advisory commission including hospital executives, hospital
4 data base managers, physicians, health services research-
5 ers, and technical experts in collection and use of data
6 and operation of data systems. Such commission shall in-
7 clude, as ex officio members, a representative of the Direc-
8 tor of the National Institutes of Health, the Administrator
9 for Health Care Policy and Research, the Secretary of
10 Veterans Affairs, and the Director of the Centers for Dis-
11 ease Control.

12 (b) FUNCTIONS.—The advisory commission shall
13 monitor and advise the Secretary concerning—

14 (1) the standards established under this part,
15 and

16 (2) operational concerns about the implementa-
17 tion of such standards under this part.

18 (c) STAFF.—From the amounts appropriated under
19 subsection (d), the Secretary shall provide sufficient staff
20 to assist the advisory commission in its activities under
21 this section.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated \$2,000,000 for each of
24 fiscal years 1994 through 1999 to carry out this section.

1 **PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION**

4 **SEC. 2121. STATE COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING.**

6 (a) PURPOSE.—In order to assure the availability of
7 comparative value information to purchasers of health
8 care in each State, the Secretary shall determine whether
9 each State is developing and implementing a health care
10 value information program that meets the criteria and
11 schedule set forth in subsection (b).

12 (b) CRITERIA AND SCHEDULE FOR STATE PROGRAMS.—The criteria and schedule for a State health care
13 value information program in this subsection shall be specified by the Secretary as follows:

16 (1) The State begins promptly after enactment
17 of this Act to develop (directly or through contractual or other arrangements with one or more States,
18 coalitions of health insurance purchasers, other entities, or any combination of such arrangements) information systems regarding comparative health values.
22

23 (2) The information contained in such systems
24 covers at least the average prices of common health
25 care services (as defined in subsection (d)) and

1 health insurance plans, and, where available, meas-
2 ures of the variability of these prices within a State
3 or other market areas.

4 (3) The information described in paragraph (2)
5 is made available within the State beginning not
6 later than one year after the date of the enactment
7 of this Act, and is revised as frequently as reason-
8 ably necessary, but at intervals of no greater than
9 one year.

10 (4) Not later than 6 years after the date of the
11 enactment of this Act the State has developed infor-
12 mation systems that provide comparative costs, qual-
13 ity, and outcomes data with respect to health insur-
14 ance plans and hospitals and made the information
15 broadly available within the relevant market areas.

16 Nothing in this section shall preclude a State from provid-
17 ing additional information, such as information on prices
18 and benefits of different health benefit plans, available.

19 (c) GRANTS TO STATES FOR THE DEVELOPMENT OF
20 STATE PROGRAMS.—

21 (1) GRANT AUTHORITY.—The Secretary may
22 make grants to each State to enable such State to
23 plan the development of its health care value infor-
24 mation program and, if necessary, to initiate the im-
25 plementation of such program. Each State seeking

1 such a grant shall submit an application therefore,
2 containing such information as the Secretary finds
3 necessary to assure that the State is likely to de-
4 velop and implement a program in accordance with
5 the criteria and schedule in subsection (b).

6 (2) OFFSET AUTHORITY.—If, at any time with-
7 in the 3-year period following the receipt by a State
8 of a grant under this subsection, the Secretary is re-
9 quired by section 2122 to implement a health care
10 information program in the State, the Secretary may
11 recover the amount of the grant under this sub-
12 section by offset against any other amount payable
13 to the State under the Social Security Act. The
14 amount of the offset shall be made available (from
15 the appropriation account with respect to which the
16 offset was taken) to the Secretary to carry out such
17 section.

18 (3) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated such sums
20 as are necessary to make grants under this sub-
21 section, to remain available until expended.

22 (d) COMMON HEALTH CARE SERVICES DEFINED.—
23 In this section, the term “common health care services”
24 includes such procedures as the Secretary may specify and

1 any additional health care services which a State may wish
2 to include in its comparative value information program.

3 (e) STATE DEFINED.—In this subtitle, the term
4 “State” includes the District of Columbia, Puerto Rico,
5 the Virgin Islands, Guam, and American Samoa.

6 **SEC. 2122. FEDERAL IMPLEMENTATION.**

7 (a) IN GENERAL.—If the Secretary finds, at any
8 time, that a State has failed to develop or to continue to
9 implement a health care value information program in ac-
10 cordance with the criteria and schedule in section 2121(b),
11 the Secretary shall take the actions necessary, directly or
12 through grants or contract, to implement a comparable
13 program in the State.

14 (b) FEES.—Fees may be charged by the Secretary
15 for the information materials provided pursuant to a pro-
16 gram under this section. Any amounts so collected shall
17 be deposited in the appropriation account from which the
18 Secretary’s costs of providing such materials were met,
19 and shall remain available for such purposes until ex-
20 pended.

21 **SEC. 2123. COMPARATIVE VALUE INFORMATION CONCERN-**
22 **ING FEDERAL PROGRAMS.**

23 (a) DEVELOPMENT.—The head of each Federal agen-
24 cy with responsibility for the provision of health insurance
25 or of health care services to individuals shall promptly de-

1 develop health care value information relating to each pro-
2 gram that such head administers and covering the same
3 types of data that a State program meeting the criteria
4 of section 2121(b) would provide.

5 (b) DISSEMINATION OF INFORMATION.—Such infor-
6 mation shall be made generally available to States and to
7 providers and consumers of health care services.

8 **SEC. 2124. DEVELOPMENT OF MODEL SYSTEMS.**

9 (a) IN GENERAL.—The Secretary shall, directly or
10 through grant or contract, develop model systems to facili-
11 tate—

12 (1) the gathering of data on health care cost,
13 quality, and outcome described in section
14 2121(b)(4), and

15 (2) analyzing such data in a manner that will
16 permit the valid comparison of such data among
17 providers and among health plans.

18 (b) EXPERIMENTATION.—The Secretary shall sup-
19 port experimentation with different approaches to achieve
20 the objectives of subsection (a) in the most cost effective
21 manner (relative to the accuracy and timeliness of the
22 data secured) and shall evaluate the various methods to
23 determine their relative success.

24 (c) STANDARDS.—When the Secretary considers it
25 appropriate, the Secretary may establish standards for the

1 collection and reporting of data on health care cost, qual-
 2 ity and outcomes in order to facilitate analysis and com-
 3 parisons among States and nationally.

4 (d) REPORT.—By not later than 3 years after the
 5 date of the enactment of this Act, the Secretary shall re-
 6 port to the Congress and the States on the models devel-
 7 oped, and experiments conducted, under this section.

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There
 9 are authorized to be appropriated such sums as are nec-
 10 essary for each fiscal year beginning with fiscal year 1994
 11 to enable the Secretary to carry out this section, including
 12 evaluation of the different approaches tested under sub-
 13 section (b) and their relative cost effectiveness.

14 **PART 4—ADDITIONAL STANDARDS AND**
 15 **REQUIREMENTS; RESEARCH AND**
 16 **DEMONSTRATIONS**

17 **SEC. 2131. STANDARDS RELATING TO USE OF MEDICARE**
 18 **AND MEDICAID MAGNETIZED HEALTH BENE-**
 19 **FIT CARDS; SECONDARY PAYOR DATA BANK.**

20 (a) MAGNETIZED IDENTIFICATION CARDS UNDER
 21 MEDICARE PROGRAM.—The Secretary shall adopt stand-
 22 ards relating to the design and use of magnetized medi-
 23 care identification cards in order to assist health care pro-
 24 viders providing medicare covered services to individuals—

1 (1) in determining whether individuals are eligi-
2 ble for benefits under the medicare program, and

3 (2) in billing the medicare program for such
4 services provided to eligible individuals.

5 Such cards shall be designed to be compatible with ma-
6 chines currently employed to transmit information on
7 credit cards. Such cards also shall be designed to be able
8 to be used with respect to the provision of benefits under
9 medicare supplemental policies.

10 (b) ADOPTION UNDER MEDICAID PLANS.—

11 (1) IN GENERAL.—The Secretary shall take
12 such steps as may be necessary to encourage and as-
13 sist States to design and use magnetized medicaid
14 identification cards that meet such standards, for
15 use under their medicaid plans.

16 (2) LIMITATION ON MMIS FUNDS.—In applying
17 section 1903(a)(3) of the Social Security Act, the
18 Secretary may determine that Federal financial par-
19 ticipation is not available under that section to a
20 State which has provided for a magnetized card sys-
21 tem that is inconsistent with the standards adopted
22 under subsection (a).

23 (c) MEDICARE AND MEDICAID SECONDARY PAYOR
24 DATA BANK.—The Secretary shall establish a medicare
25 and medicaid information system which is designed to pro-

1 vide information on those group health plans and other
2 health benefit plans that are primary payors to the medi-
3 care program and medicaid program under section
4 1862(b) or section 1905(a)(25) of the Social Security Act.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated, in equal proportions
7 from the Federal Hospital Insurance Trust Fund and
8 from the Federal Supplementary Medical Insurance Trust
9 Fund, a total of \$25,000,000 to carry out subsections (a)
10 and (c), including the issuance of magnetized cards to
11 medicare beneficiaries.

12 **SEC. 2132. PREEMPTION OF STATE QUILL PEN LAWS.**

13 (a) IN GENERAL.—Effective January 1, 1994, no ef-
14 fect shall be given to any provision of State law that re-
15 quires medical or health insurance records (including bill-
16 ing information) to be maintained in written, rather than
17 electronic form.

18 (b) SECRETARIAL AUTHORITY.—The Secretary of
19 Health and Human Services may issue regulations to
20 carry out subsection (a). Such regulations may provide for
21 such exceptions to subsection (a) as the Secretary deter-
22 mines to be necessary to prevent fraud and abuse, with
23 respect to controlled substances, and in such other cases
24 as the Secretary deems appropriate.

1 **SEC. 2133. USE OF STANDARD IDENTIFICATION NUMBERS.**

2 (a) IN GENERAL.—Effective January 1, 1995, each
3 health benefit plan shall—

4 (1) for each of its beneficiaries that has a social
5 security account number, use that number as the
6 personal identifier for claims processing and related
7 purposes, and

8 (2) for each provider that has a unique identi-
9 fier for purposes of title XVIII of the Social Security
10 Act and that furnishes health care items or services
11 to a beneficiary under the plan, use that identifier
12 as the identifier of that provider for claims process-
13 ing and related purposes.

14 (b) COMPLIANCE.—

15 (1) IN GENERAL.—The Secretary may impose a
16 civil money penalty on any health benefit plan (other
17 than a health benefit plan described in paragraph
18 (2)) that fails to comply with standards established
19 under subsection (a) in an amount not to exceed
20 \$100 for each such failure. The provisions of section
21 1128A of the Social Security Act (other than the
22 first sentence of subsection (a) and other than sub-
23 section (b)) shall apply to a civil money penalty
24 under this paragraph in the same manner as such
25 provisions apply to a penalty or proceeding under
26 section 1128A(a) of such Act.

1 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
 2 ULATION.—A plan described in this paragraph is a
 3 health benefit plan that is subject to regulation by
 4 a State, if the Secretary finds that—

5 (A) the State provides for application of
 6 the requirement of subsection (a), and

7 (B) the State regulatory program provides
 8 for the appropriate and effective enforcement of
 9 such requirement with respect to such plans.

10 **SEC. 2134. COORDINATION OF BENEFIT STANDARDS.**

11 (a) REVIEW OF COORDINATION OF BENEFIT PROB-
 12 LEMS.—Between July 1, 1994, and January 1, 1995, the
 13 Secretary shall determine whether problems relating to—

14 (1) the rules for determining the liability of
 15 health benefit plans when benefits are payable under
 16 two or more such plans, or

17 (2) the availability of information among such
 18 health benefit plans when benefits are so payable,
 19 cause significant administrative costs.

20 (b) CONTINGENT PROMULGATION OF STANDARDS.—

21 (1) IN GENERAL.—If the Secretary determines
 22 that such problems do cause significant administra-
 23 tive costs that could be significantly reduced through
 24 the implementation of standards, the Secretary shall
 25 promulgate standards concerning—

1 (A) the liability of health benefit plans
2 when benefits are payable under two or more
3 such plans, and

4 (B) the transfer among health benefit
5 plans of appropriate information (which may in-
6 clude standards for the use of unique identifi-
7 ers, and for the listing of all individuals covered
8 under a health benefit plan) in determining li-
9 ability in cases when benefits are payable under
10 two or more such plans.

11 (2) EFFECTIVE DATE.—The standards promul-
12 gated under paragraph (1) shall become effective on
13 a date specified by the Secretary, which date shall
14 be not earlier than one year after the date of pro-
15 mulgation of the standards.

16 (c) COMPLIANCE.—

17 (1) IN GENERAL.—The Secretary may impose a
18 civil money penalty on any health benefit plan (other
19 than a health benefit plan described in paragraph
20 (2)) that fails to comply with standards promulgated
21 under subsection (b) in an amount not to exceed
22 \$100 for each such failure. The provisions of section
23 1128A of the Social Security Act (other than the
24 first sentence of subsection (a) and other than sub-
25 section (b)) shall apply to a civil money penalty

1 under this paragraph in the same manner as such
2 provisions apply to a penalty or proceeding under
3 section 1128A(a) of such Act.

4 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
5 ULATION.—A plan described in this paragraph is a
6 health benefit plan that is subject to regulation by
7 a State, if the Secretary finds that—

8 (A) the State provides for application of
9 the standards established under subsection (b),
10 and

11 (B) the State regulatory program provides
12 for the appropriate and effective enforcement of
13 such standards with respect to such plans.

14 (d) REVISION OF STANDARDS.—If the Secretary es-
15 tablishes standards under subsection (b), the Secretary
16 may revise such standards from time to time and such
17 revised standards shall be applied under subsection (c) on
18 or after such date (not earlier than 6 months after the
19 date the revision is promulgated) as the Secretary shall
20 specify.

21 **SEC. 2135. RESEARCH AND DEMONSTRATIONS.**

22 (a) DEMONSTRATIONS AND RESEARCH ON MONITOR-
23 ING AND IMPROVING PATIENT CARE.—

24 (1) The Secretary shall provide grants to quali-
25 fied entities to demonstrate (and conduct research

1 concerning) the application of comprehensive infor-
2 mation systems—

3 (A) in continuously monitoring patient
4 care, and

5 (B) in improving patient care.

6 (2) To make grants under this subsection, there
7 are authorized to be appropriated from the Federal
8 Hospital Insurance Trust Fund \$10,000,000 for
9 each fiscal year (beginning with fiscal year 1994 and
10 ending with fiscal year 1998).

11 (b) COMMUNICATION LINKS.—

12 (1) The Secretary may make grants to at least
13 two, but not more than five, community organiza-
14 tions, or coalitions of health care providers, health
15 benefit plans, and purchasers, to establish and docu-
16 ment the efficacy of communication links between
17 the information systems of health benefit plans and
18 of health care providers.

19 (2) To make grants under this subsection, there
20 are authorized to be appropriated such sums as may
21 be necessary for fiscal year 1994, to remain avail-
22 able until expended.

23 (c) REGIONAL OR COMMUNITY BASED CLINICAL IN-
24 FORMATION SYSTEMS.—

1 (1) The Secretary may make grants to at least
2 two, but not more than five, public or private non-
3 profit entities for the development of regional or
4 community-based clinical information systems.

5 (2) To make grants under this subsection, there
6 are authorized to be appropriated such sums as may
7 be necessary for fiscal year 1994, to remain avail-
8 able until expended.

9 (d) AMBULATORY CARE DATA SETS.—

10 (1) The Secretary may make grants to public or
11 private non-profit entities to develop and test, for
12 electronic medical data generated by physicians and
13 other entities (other than hospitals) that provide
14 health care services—

15 (A) the definition of a comprehensive set of
16 data elements, and

17 (B) the specification of, and manner of
18 presentation of, the individual data elements of
19 the set under subparagraph (A).

20 (2) To make grants under this subsection, there
21 are authorized to be appropriated such sums as may
22 be necessary for fiscal year 1994, to remain avail-
23 able until expended.

1 **Subtitle C—Deduction for Cost of**
 2 **Catastrophic Health Plan; Medi-**
 3 **cal Savings Accounts**

4 **SEC. 2201. INDIVIDUALS ALLOWED DEDUCTION FROM**
 5 **GROSS INCOME FOR COST OF CATASTROPHIC**
 6 **HEALTH PLAN.**

7 (a) IN GENERAL.—Subsection (a) of section 62 of the
 8 Internal Revenue Code of 1986, as amended by title I,
 9 is amended by inserting after paragraph (16) the following
 10 new paragraph:

11 “(17) MEDICAL EXPENSES ATTRIBUTABLE TO
 12 CATASTROPHIC HEALTH PLAN COVERAGE.—

13 “(A) IN GENERAL.—The deduction allowed
 14 by section 213 to the extent attributable to cov-
 15 erage under a catastrophic health plan (as de-
 16 fined in section 220(c)(2)).

17 “(B) EXCEPTION.—Subparagraph (A)
 18 shall not apply to coverage of an individual who
 19 has coverage described in section
 20 220(c)(1)(B)(i).”.

21 (b) COORDINATION WITH DEDUCTION FOR OTHER
 22 MEDICAL EXPENSES.—Subsection (a) of section 213 of
 23 such Code is amended to read as follows:

24 “(a) ALLOWANCE OF DEDUCTION.—There shall be
 25 allowed as a deduction the expenses paid during the tax-

1 able year, not compensated by insurance or otherwise, for
 2 medical care of the taxpayer, his spouse, or a dependent
 3 (as defined in section 152) in an amount equal to the sum
 4 of—

5 “(1) the portion of such expenses attributable
 6 to coverage under a catastrophic health plan (as de-
 7 fined in section 220(c)(2)), and

8 “(2) the excess of such expenses (other than ex-
 9 penses described in paragraph (1)) over 7.5 percent
 10 of the adjusted gross income of the taxpayer.”

11 (c) EFFECTIVE DATE.—The amendments made by
 12 this section shall apply to taxable years beginning after
 13 December 31, 1993.

14 **SEC. 2202. MEDICAL SAVINGS ACCOUNTS.**

15 (a) IN GENERAL.—Part VII of subchapter B of chap-
 16 ter 1 of the Internal Revenue Code of 1986 (relating to
 17 additional itemized deductions for individuals) is amended
 18 by redesignating section 220 as section 221 and by insert-
 19 ing after section 219 the following new section:

20 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

21 “(a) DEDUCTION ALLOWED.—

22 “(1) IN GENERAL.—In the case of an eligible
 23 individual, there shall be allowed as a deduction the
 24 applicable percentage of the amounts paid in cash
 25 during the taxable year by or on behalf of such indi-

1 vidual to a medical savings account for the benefit
2 of such individual and (if any) such individual's
3 spouse and dependents if such spouse and depend-
4 ents are eligible individuals.

5 “(2) APPLICABLE PERCENTAGE.—For purposes
6 of paragraph (1), the term ‘applicable percentage’
7 means—

8 “(A) 25 percent for taxable years begin-
9 ning in 1994 or 1995,

10 “(B) 50 percent for taxable years begin-
11 ning in 1996 or 1997, and

12 “(C) 100 percent for taxable years begin-
13 ning after 1997.

14 “(b) LIMITATIONS.—

15 “(1) ONLY 1 ACCOUNT PER FAMILY.—Except as
16 provided in regulations prescribed by this Secretary,
17 no deduction shall be allowed under subsection (a)
18 for amounts paid to any medical savings account for
19 the benefit of an individual, such individual's spouse,
20 or any dependent of such individual or spouse if
21 such individual, spouse, or dependent is a beneficiary
22 of any other medical savings account.

23 “(2) DOLLAR LIMITATION.—The amount allow-
24 able as a deduction under subsection (a) for the tax-
25 able year shall not exceed the lesser of—

1 “(A) the lowest deductible under any cata-
 2 strophic health plan providing coverage to any
 3 beneficiary of the medical savings account, or

4 “(B)(i) \$2,500, or

5 “(ii) \$5,000 if the catastrophic health plan
 6 covering the taxpayer provides coverage for
 7 more than 1 individual.

8 A beneficiary of such account who has attained age
 9 65 before the close of the taxable year shall not be
 10 taken into account in determining the limitation
 11 under the preceding sentence.

12 “(c) DEFINITIONS.—For purposes of this section—

13 “(1) ELIGIBLE INDIVIDUAL.—

14 “(A) IN GENERAL.—The term ‘eligible in-
 15 dividual’ means any individual who is covered
 16 under a catastrophic health plan throughout the
 17 calendar year in which or with which the tax-
 18 able year ends.

19 “(B) LIMITATIONS.—Such term does not
 20 include—

21 “(i) an individual who is 65 years of
 22 age or older, unless the individual is cov-
 23 ered under a catastrophic health plan that
 24 is a primary plan (within the meaning of

1 section 1862(b)(2)(A) of the Social Secu-
2 rity Act); and

3 “(ii) an individual who has coverage
4 under a group health plan or health insur-
5 ance plan (other than a plan described in
6 1107(4)(B) of the Affordable Health Care
7 Now Act of 1993) that has either a de-
8 ductible that is less than the minimum de-
9 ductible required under a catastrophic
10 health plan (as defined in paragraph (2))
11 or has an actuarial value that is greater
12 than the value for MedAccess catastrophic
13 coverage (as provided in section 1102(d) of
14 such Act).

15 “(C) DEDUCTION NOT ALLOWED BEFORE
16 1999 TO INDIVIDUALS ELIGIBLE FOR EM-
17 PLOYER-SUBSIDIZED COVERAGE.—In the case
18 of any taxable year beginning before January 1,
19 1999, such term does not include an individ-
20 ual—

21 “(i) who is eligible to participate in
22 any subsidized health plan maintained by
23 an employer of such individual or the
24 spouse of such individual, or

1 “(ii) who is (or whose spouse is) a
2 member of a subsidized class of employees
3 of an employer.

4 The rules of subparagraphs (B) and (C) of sec-
5 tion 213(f)(3) shall apply for purposes of this
6 preceding sentence.

7 “(2) CATASTROPHIC HEALTH PLAN.—For pur-
8 poses of paragraph (1)—

9 “(A) IN GENERAL.—The term ‘cata-
10 strophic health plan’ means a health plan cover-
11 ing specified expenses incurred by an individual
12 for medical care for such individual and the
13 spouse and dependents (as defined in section
14 152) of such individual only to the extent such
15 expenses covered by the plan for any calendar
16 year exceed \$1,800 (\$3,600 if the catastrophic
17 health plan covering the taxpayer provides cov-
18 erage for more than 1 individual) or such high-
19 er amounts as may be specified by the plan.

20 “(B) COST-OF-LIVING ADJUSTMENT.—In
21 the case of any calendar year after 1994, each
22 dollar amount in subparagraph (A) shall be in-
23 creased by an amount equal to—

24 “(i) such dollar amount, multiplied by

1 “(ii) the cost-of-living adjustment de-
2 termined under section 1(f)(3) for such
3 calendar year.

4 If any increase under the preceding sentence is
5 not a multiple of \$50, such increase shall be
6 rounded to the nearest multiple of \$50.

7 “(d) MEDICAL SAVINGS ACCOUNTS.—For purposes
8 of this section—

9 “(1) MEDICAL SAVINGS ACCOUNT.—

10 “(A) IN GENERAL.—The term ‘medical
11 savings account’ means a trust created or orga-
12 nized in the United States exclusively for the
13 purpose of paying the medical expenses of the
14 beneficiaries of such trust, but only if the writ-
15 ten governing instrument creating the trust
16 meets the following requirements:

17 “(i) Except in the case of a rollover
18 contribution described in subsection (e)(4),
19 no contribution will be accepted unless it is
20 in cash, and contributions will not be ac-
21 cepted in excess of the amount allowed as
22 a deduction under this section for the tax-
23 able year (or would be allowed as such a
24 deduction but for subsection (c)(1)(C)).

1 “(ii) The trustee is a bank (as defined
2 in section 408(n)) or another person who
3 demonstrates to the satisfaction of the Sec-
4 retary that the manner in which such per-
5 son will administer the trust will be con-
6 sistent with the requirements of this sec-
7 tion.

8 “(iii) No part of the trust assets will
9 be invested in life insurance contracts.

10 “(iv) The assets of the trust will not
11 be commingled with other property except
12 in a common trust fund or common invest-
13 ment fund.

14 “(v) The interest of an individual in
15 the balance in his account is nonforfeit-
16 able.

17 “(vi) Under regulations prescribed by
18 the Secretary, rules similar to the rules of
19 section 401(a)(9) shall apply to the dis-
20 tribution of the entire interest of bene-
21 ficiaries of such trust.

22 “(B) TREATMENT OF COMPARABLE AC-
23 COUNTS HELD BY INSURANCE COMPANIES.—
24 For purposes of this section, an account held by
25 an insurance company in the United States

1 shall be treated as a medical savings account
2 (and such company shall be treated as a bank)
3 if—

4 “(i) such account is part of a health
5 insurance plan that includes a catastrophic
6 health plan (as defined in subsection
7 (c)(2)),

8 “(ii) such account is exclusively for
9 the purpose of paying the medical expenses
10 of the beneficiaries of such account who
11 are covered under such catastrophic health
12 plan, and

13 “(iii) the written instrument govern-
14 ing the account meets the requirements of
15 clauses (i), (v), and (vi) of subparagraph
16 (A).

17 “(2) MEDICAL EXPENSES.—

18 “(A) IN GENERAL.—The term ‘medical ex-
19 penses’ means, with respect to an individual,
20 amounts paid or incurred by such individual
21 for—

22 “(i) medical care (as defined in sec-
23 tion 213), or

24 “(ii) long-term care (as defined in
25 paragraph (3)),

1 for such individual, the spouse of such individ-
2 ual, and any dependent (as defined in section
3 152) of such individual, but only to the extent
4 such amounts are not compensated for by in-
5 surance or otherwise.

6 “(B) HEALTH PLAN COVERAGE MAY NOT
7 BE PURCHASED FROM ACCOUNT.—

8 “(i) IN GENERAL.—Such term shall
9 not include any amount paid for coverage
10 under a health plan.

11 “(ii) EXCEPTION.—Clause (i) shall
12 not apply—

13 “(I) in the case of coverage of an
14 individual under 65 years of age
15 under a catastrophic health plan or
16 under a long-term care insurance
17 plan, or

18 “(II) in the case of coverage of
19 an individual 65 years of age or older
20 under a medicare supplemental policy
21 or under a long-term care insurance
22 plan or for payment of premiums
23 under part A or part B of title XVIII
24 of the Social Security Act.

25 “(3) LONG-TERM CARE.—

1 “(A) IN GENERAL.—The term ‘long-term
2 care’ means diagnostic, preventive, therapeutic,
3 rehabilitative, maintenance, or personal care
4 services which are required by, and provided to,
5 a chronically ill individual, which have as their
6 primary purpose the direct provision of needed
7 assistance with 1 or more activities of daily liv-
8 ing (or the alleviation of the conditions neces-
9 sitating such assistance) that the individual is
10 certified under subparagraph (B) as being un-
11 able to perform, and which are provided in a
12 setting other than an acute care unit of a hos-
13 pital pursuant to a continuing plan of care pre-
14 scribed by a physician or registered professional
15 nurse. Such term does not include food or lodg-
16 ing provided in an institutional or other setting,
17 or basic living services associated with the
18 maintenance of a household or participation in
19 community life, such as case management,
20 transportation or legal services, or the perform-
21 ance of home maintenance or household chores.

22 “(B) CHRONICALLY ILL INDIVIDUAL.—The
23 term ‘chronically ill individual’ means an indi-
24 vidual who is certified by a physician or reg-
25 istered professional nurse as being unable to

1 perform at least 3 activities of daily living with-
2 out substantial assistance from another individ-
3 ual. For purposes of this paragraph, the term
4 ‘activities of daily living’ means bathing, dress-
5 ing, eating, toileting, transferring, and walking.

6 “(4) TIME WHEN CONTRIBUTIONS DEEMED
7 MADE.—A contribution shall be deemed to be made
8 on the last day of the preceding taxable year if the
9 contribution is made on account of such taxable year
10 and is made not later than the time prescribed by
11 law for filing the return for such taxable year (not
12 including extensions thereof).

13 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

14 “(1) IN GENERAL.—Any amount paid or dis-
15 tributed out of a medical savings account shall be in-
16 cluded in the gross income of the individual for
17 whose benefit such account was established unless
18 such amount is used exclusively to pay the medical
19 expenses of such individual.

20 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
21 FORE DUE DATE OF RETURN.—Paragraph (1) shall
22 not apply to the distribution of any contribution paid
23 during a taxable year to a medical savings account
24 to the extent that such contribution exceeds the

1 amount allowable as a deduction under subsection
2 (a) if—

3 “(A) such distribution is received by the
4 individual on or before the last day prescribed
5 by law (including extensions of time) for filing
6 such individual’s return for such taxable year,
7 and

8 “(B) such distribution is accompanied by
9 the amount of net income attributable to such
10 excess contribution.

11 Any net income described in subparagraph (B) shall
12 be included in the gross income of the individual for
13 the taxable year in which it is received.

14 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
15 FOR MEDICAL EXPENSES.—

16 “(A) IN GENERAL.—The tax imposed by
17 this chapter for any taxable year in which there
18 is a payment or distribution from a medical
19 savings account which is not used to pay the
20 medical expenses of the individual for whose
21 benefit the account was established shall be in-
22 creased by 10 percent of the amount of such
23 payment or distribution which is includible in
24 gross income under paragraph (1).

1 “(B) ACCOUNT BALANCE LIMITATION.—

2 If—

3 “(i) the tax imposed by this chapter is
4 required to be increased under subpara-
5 graph (A) by reason of a distribution, and

6 “(ii) after such distribution, the ag-
7 gregate balance of all medical savings ac-
8 counts established for the benefit of the in-
9 dividual, is less than the amount of the de-
10 ductible under the catastrophic health plan
11 covering such individual,
12 subparagraph (A) shall be applied by substitut-
13 ing ‘50 percent’ for ‘10 percent’.

14 “(4) ROLLOVERS.—Paragraph (1) shall not
15 apply to any amount paid or distributed out of a
16 medical savings account to the individual for whose
17 benefit the account is maintained if the entire
18 amount received (including money and any other
19 property) is paid into another medical savings ac-
20 count for the benefit of such individual not later
21 than the 60th day after the day on which he received
22 the payment or distribution.

23 “(5) PENALTY FOR MANDATORY DISTRIBU-
24 TIONS NOT MADE FROM ACCOUNT.—

1 “(A) IN GENERAL.—If during any taxable
2 year—

3 “(i) there is a payment of a manda-
4 tory distribution expense incurred by a
5 beneficiary of a medical savings account,
6 and

7 “(ii) the person making such payment
8 is not reimbursed for such payment with a
9 distribution from such account before the
10 60th day after such payment,

11 the taxpayer’s tax imposed by this chapter for
12 such taxable year shall be increased by 100 per-
13 cent of the excess of the amount of such pay-
14 ment over the amount of reimbursement made
15 before such 60th day.

16 “(B) MANDATORY DISTRIBUTION EX-
17 PENSE.—For purposes of subparagraph (A),
18 the term ‘mandatory distribution expense’
19 means—

20 “(i) any expense incurred which may
21 be counted towards a deductible, or for a
22 copayment or coinsurance, under the cata-
23 strophic health plan covering such bene-
24 ficiary, and

1 “(ii) in the case of a beneficiary who
2 has attained age 65, any expense for cov-
3 erage described in subsection
4 (d)(2)(B)(ii)(II) and any expense incurred
5 which may be counted toward a deductible,
6 or for a copayment or coinsurance, under
7 title XVIII of the Social Security Act.

8 “(f) TAX TREATMENT OF ACCOUNTS.—

9 “(1) EXEMPTION FROM TAX.—Any medical sav-
10 ings account is exempt from taxation under this sub-
11 title unless such account has ceased to be a medical
12 savings account by reason of paragraph (2) or (3).
13 Notwithstanding the preceding sentence, any such
14 account shall be subject to the taxes imposed by sec-
15 tion 511 (relating to imposition of tax on unrelated
16 business income of charitable, etc. organizations).

17 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-
18 GAGES IN PROHIBITED TRANSACTION.—

19 “(A) IN GENERAL.—If, during any taxable
20 year of the individual for whose benefit the
21 medical savings account was established, such
22 individual engages in any transaction prohibited
23 by section 4975 with respect to the account, the
24 account ceases to be a medical savings account
25 as of the first day of that taxable year.

1 “(B) ACCOUNT TREATED AS DISTRIBUTING
2 ALL ITS ASSETS.—In any case in which any ac-
3 count ceases to be a medical savings account by
4 reason of subparagraph (A) on the first day of
5 any taxable year, paragraph (1) of subsection
6 (e) shall be applied as if there were a distribu-
7 tion on such first day in an amount equal to
8 the fair market value (on such first day) of all
9 assets in the account (on such first day) and no
10 portion of such distribution were used to pay
11 medical expenses.

12 “(3) EFFECT OF PLEDGING ACCOUNT AS SECU-
13 RITY.—If, during any taxable year, the individual for
14 whose benefit a medical savings account was estab-
15 lished uses the account or any portion thereof as se-
16 curity for a loan, the portion so used is treated as
17 distributed to that individual and not used to pay
18 medical expenses.

19 “(g) CUSTODIAL ACCOUNTS.—For purposes of this
20 section, a custodial account shall be treated as a trust if—

21 “(1) the assets of such account are held by a
22 bank (as defined in section 408(n)) or another per-
23 son who demonstrates to the satisfaction of the Sec-
24 retary that the manner in which he will administer

1 the account will be consistent with the requirements
2 of this section, and

3 “(2) the custodial account would, except for the
4 fact that it is not a trust, constitute a medical sav-
5 ings account described in subsection (d).

6 For purposes of this title, in the case of a custodial ac-
7 count treated as a trust by reason of the preceding sen-
8 tence, the custodian of such account shall be treated as
9 the trustee thereof.

10 “(h) REPORTS.—The trustee of a medical savings ac-
11 count shall make such reports regarding such account to
12 the Secretary and to the individual for whose benefit the
13 account is maintained with respect to contributions, dis-
14 tributions, and such other matters as the Secretary may
15 require under regulations. The reports required by this
16 subsection shall be filed at such time and in such manner
17 and furnished to such individuals at such time and in such
18 manner as may be required by those regulations.”

19 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIV-
20 IDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
21 of section 62 of such Code is amended by inserting after
22 paragraph (17) the following new paragraph:

23 “(18) MEDICAL SAVINGS ACCOUNTS.—The de-
24 duction allowed by section 220.”

1 (c) DISTRIBUTIONS FROM MEDICAL SAVINGS AC-
2 COUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUC-
3 TION.—Section 213 of such Code is amended by adding
4 at the end thereof the following new subsection:

5 “(g) COORDINATION WITH MEDICAL SAVINGS AC-
6 COUNTS.—The amount otherwise taken into account
7 under subsection (a) as expenses paid for medical care
8 shall be reduced by the amount (if any) of the distribu-
9 tions from any medical savings account of the taxpayer
10 during the taxable year which is not includible in gross
11 income by reason of being used for medical care.”

12 (d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO
13 MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT
14 TAXES.—

15 (1) SOCIAL SECURITY TAXES.—

16 (A) Subsection (a) of section 3121 of such
17 Code is amended by striking “or” at the end of
18 paragraph (20), by striking the period at the
19 end of paragraph (21) and inserting “; or”, and
20 by inserting after paragraph (21) the following
21 new paragraph:

22 “(22) remuneration paid to or on behalf of
23 an employee if (and to the extent that) at the
24 time of payment of such remuneration it is rea-

1 sonable to believe that a corresponding deduc-
2 tion is allowable under section 220.”

3 (B) Subsection (a) of section 209 of the Social
4 Security Act is amended by striking “or” at the end
5 of paragraph (17), by striking the period at the end
6 of paragraph (18) and inserting “; or”, and by in-
7 serting after paragraph (18) the following new para-
8 graph:

9 “(19) remuneration paid to or on behalf of an
10 employee if (and to the extent that) at the time of
11 payment of such remuneration it is reasonable to be-
12 lieve that a corresponding deduction is allowable
13 under section 220 of the Internal Revenue Code of
14 1986.”

15 (2) RAILROAD RETIREMENT TAX.—Subsection
16 (e) of section 3231 of such Code is amended by add-
17 ing at the end thereof the following new paragraph:

18 “(10) EMPLOYER CONTRIBUTIONS TO MEDICAL
19 SAVINGS ACCOUNTS.—The term ‘compensation’ shall
20 not include any payment made to or on behalf of an
21 employee if (and to the extent that) at the time of
22 payment of such remuneration it is reasonable to be-
23 lieve that a corresponding deduction is allowable
24 under section 220.”

1 (3) UNEMPLOYMENT TAX.—Subsection (b) of
2 section 3306 of such Code is amended by striking
3 “or” at the end of paragraph (15), by striking the
4 period at the end of paragraph (16) and inserting “;
5 or”, and by inserting after paragraph (16) the fol-
6 lowing new paragraph:

7 “(17) remuneration paid to or on behalf of
8 an employee if (and to the extent that) at the
9 time of payment of such remuneration it is rea-
10 sonable to believe that a corresponding deduc-
11 tion is allowable under section 220.”

12 (4) WITHHOLDING TAX.—Subsection (a) of sec-
13 tion 3401 of such Code is amended by striking “or”
14 at the end of paragraph (19), by striking the period
15 at the end of paragraph (20) and inserting “; or”,
16 and by inserting after paragraph (20) the following
17 new paragraph:

18 “(21) remuneration paid to or on behalf of
19 an employee if (and to the extent that) at the
20 time of payment of such remuneration it is rea-
21 sonable to believe that a corresponding deduc-
22 tion is allowable under section 220.”

23 (e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
24 of such Code (relating to tax on excess contributions to
25 individual retirement accounts, certain section 403(b) con-

1 tracts, and certain individual retirement annuities) is
2 amended—

3 (1) by inserting “**MEDICAL SAVINGS AC-**
4 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
5 such section,

6 (2) by redesignating paragraph (2) of sub-
7 section (a) as paragraph (3) and by inserting after
8 paragraph (1) the following:

9 “(2) a medical savings account (within the
10 meaning of section 220(d)),”,

11 (3) by striking “or” at the end of paragraph
12 (1) of subsection (a), and

13 (4) by adding at the end thereof the following
14 new subsection:

15 “(d) **EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS**
16 **ACCOUNTS.**—For purposes of this section, in the case of
17 a medical savings account (within the meaning of section
18 220(d)), the term ‘excess contributions’ means the amount
19 by which the amount contributed for the taxable year to
20 the account exceeds the amount excludable from gross in-
21 come under section 220 for such taxable year. For pur-
22 poses of this subsection, any contribution which is distrib-
23 uted out of the medical savings account in a distribution
24 to which section 220(e)(2) applies shall be treated as an
25 amount not contributed.”

1 (f) TAX ON PROHIBITED TRANSACTIONS.—Section
2 4975 of such Code (relating to prohibited transactions)
3 is amended—

4 (1) by adding at the end of subsection (c) the
5 following new paragraph:

6 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
7 COUNTS.—An individual for whose benefit a medical
8 savings account (within the meaning of section
9 220(d)) is established shall be exempt from the tax
10 imposed by this section with respect to any trans-
11 action concerning such account (which would other-
12 wise be taxable under this section) if, with respect
13 to such transaction, the account ceases to be a medi-
14 cal savings account by reason of the application of
15 section 220(e)(2)(A) to such account.”, and

16 (2) by inserting “or a medical savings account
17 described in section 220(d)” in subsection (e)(1)
18 after “described in section 408(a)”.

19 (g) FAILURE TO PROVIDE REPORTS ON MEDICAL
20 SAVINGS ACCOUNTS.—Section 6693 of such Code (relat-
21 ing to failure to provide reports on individual retirement
22 account or annuities) is amended—

23 (1) by inserting “**OR ON MEDICAL SAVINGS**
24 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
25 such section, and

1 (2) by adding at the end of subsection (a) the
 2 following: “The person required by section 220(h) to
 3 file a report regarding a medical savings account at
 4 the time and in the manner required by such section
 5 shall pay a penalty of \$50 for each failure unless it
 6 is shown that such failure is due to reasonable
 7 cause.”

8 (h) CLERICAL AMENDMENTS.—

9 (1) The table of sections for part VII of sub-
 10 chapter B of chapter 1 of such Code is amended by
 11 striking the last item and inserting the following:

“Sec. 220. Medical savings accounts.
 “Sec. 221. Cross reference.”

12 (2) The table of sections for chapter 43 of such
 13 Code is amended by striking the item relating to sec-
 14 tion 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement
 accounts, medical savings accounts, certain 403(b)
 contracts, and certain individual retirement annu-
 ities.”

15 (3) The table of sections for subchapter B of
 16 chapter 68 of such Code is amended by inserting “or
 17 on medical savings accounts” after “annuities” in
 18 the item relating to section 6693.

19 (i) EFFECTIVE DATE.—The amendments made by
 20 this section shall apply to taxable years beginning after
 21 December 31, 1993.

1 **Subtitle D—Anti-Fraud**
2 **PART 1—CRIMINAL PROSECUTION OF**
3 **HEALTH CARE FRAUD**

4 **SEC. 2301. PENALTIES FOR HEALTH CARE FRAUD.**

5 (a) IN GENERAL.—Chapter 63 of title 18, United
6 States Code, is amended by adding at the end the follow-
7 ing:

8 **“§ 1347. Health care fraud**

9 “(a) OFFENSE.—Whoever, being a health care pro-
10 vider, knowingly engages in any scheme or artifice to de-
11 fraud any person in connection with the provision of
12 health care shall be fined under this title or imprisoned
13 not more than 5 years, or both.

14 “(b) DEFINITION.—In this section, the term ‘health
15 care provider’ means—

16 “(1) a physician, nurse, dentist, therapist, phar-
17 macist, or other professional provider of health care;
18 and

19 “(2) a hospital, health maintenance organiza-
20 tion, pharmacy, laboratory, clinic, or other health
21 care facility or a provider of medical services, medi-
22 cal devices, medical equipment, or other medical sup-
23 plies.

24 (b) CLERICAL AMENDMENT.—The table of sections
25 at the beginning of chapter 63 of title 18, United States

1 Code, is amended by adding at the end the following new
2 item:

“1347. Health care fraud.”.

3 **SEC. 2302. BROADENING APPLICATION OF MAIL FRAUD**
4 **STATUTE.**

5 Section 1341 of title 18, United States Code, is
6 amended—

7 (1) by inserting “or deposits or causes to be de-
8 posited any matter or thing whatever to be sent or
9 delivered by any private or commercial interstate
10 carrier,” after “Postal Service,”; and

11 (2) by inserting “or such carrier” after “causes
12 to be delivered by mail”.

13 **SEC. 2303. AUTHORIZATION OF APPROPRIATIONS.**

14 There are authorized to be appropriated for the pur-
15 poses of carrying out the purposes of this part and the
16 amendments made by this part—

17 (1) such sums as may be necessary for the Fed-
18 eral Bureau of Investigation to hire, equip, and train
19 no fewer than 225 special agents and support staff
20 to investigate health-care fraud cases;

21 (2) such sums as may be necessary to hire,
22 equip, and train no fewer than 50 assistant United
23 States Attorneys and support staff to prosecute
24 health-care fraud cases; and

1 (3) such sums as may be necessary to hire,
2 equip, and train no fewer than 25 investigators in
3 the Office of Inspector General, Department of
4 Health and Human Services, to be devoted exclu-
5 sively to health-care fraud cases.

6 **SEC. 2304. REWARDS FOR INFORMATION LEADING TO**
7 **PROSECUTION AND CONVICTION.**

8 Section 3059 of title 18, United States Code, is
9 amended by adding at the end the following new sub-
10 section:

11 “(c)(1) In special circumstances and in the Attorney
12 General’s sole discretion, the Attorney General may make
13 a payment of up to \$10,000 to a person who furnishes
14 information unknown to the Government relating to a pos-
15 sible prosecution under section 1101.

16 “(2) A person is not eligible for a payment under
17 paragraph (1) if—

18 “(A) the person is a current or former officer
19 or employee of a Federal or State government agen-
20 cy or instrumentality who furnishes information dis-
21 covered or gathered in the course of government em-
22 ployment;

23 “(B) the person knowingly participated in the
24 offense;

1 “(C) the information furnished by the person
2 consists of allegations or transactions that have been
3 disclosed to the public—

4 “(i) in a criminal, civil, or administrative
5 proceeding;

6 “(ii) in a congressional, administrative or
7 General Accounting Office report, hearing,
8 audit, or investigation; or

9 “(iii) by the news media, unless the person
10 is the original source of the information; or

11 “(D) when, in the judgment of the Attorney
12 General, it appears that a person whose illegal ac-
13 tivities are being prosecuted or investigated could
14 benefit from the award.

15 “(3) For the purposes of paragraph (2)(C)(iii), the
16 term ‘original source’ means a person who has direct and
17 independent knowledge of the information that is fur-
18 nished and has voluntarily provided the information to the
19 Government prior to disclosure by the news media.

20 “(4) Neither the failure of the Attorney General to
21 authorize a payment under paragraph (1) nor the amount
22 authorized shall be subject to judicial review.”.

1 **PART 2—COORDINATION OF HEALTH**
2 **CARE ANTI-FRAUD AND ABUSE ACTIVI-**
3 **TIES**

4 **SEC. 2311. ESTABLISHMENT OF ALL-PAYER ANTI-FRAUD**
5 **AND ABUSE PROGRAM.**

6 (a) IN GENERAL.—Not later than January 1, 1995,
7 the Secretary shall establish in the Office of the Inspector
8 General of the Department of Health and Human Services
9 a program—

10 (1) to coordinate Federal, State, and local law
11 enforcement programs to control fraud and abuse
12 with respect to the delivery of and payment for
13 health care in the United States,

14 (2) to conduct investigations, audits, evalua-
15 tions, and inspections relating to the delivery of and
16 payment for health care in the United States, and

17 (3) to facilitate the enforcement of the provi-
18 sions of sections 1128, 1128A, and 1128B of the
19 Social Security Act and other statutes applicable to
20 health care fraud and abuse.

21 (b) COORDINATION WITH LAW ENFORCEMENT
22 AGENCIES.—In carrying out the program established
23 under subsection (a), the Secretary shall consult with, and
24 arrange for the sharing of data and resources with the
25 Attorney General, State law enforcement agencies, State

1 medicaid fraud and abuse units, and State agencies re-
2 sponsible for the licensing and certification of health care
3 providers.

4 (c) COORDINATION WITH THIRD PARTY INSUR-
5 ERS.—In carrying out the program established under sub-
6 section (a), the Secretary shall consult with, and arrange
7 for the sharing of data with representatives of private
8 sponsors of health benefit plans and other providers of
9 health insurance.

10 (d) REGULATIONS.—

11 (1) IN GENERAL.—The Secretary shall by regu-
12 lation establish standards to carry out the program
13 under subsection (a).

14 (2) INFORMATION STANDARDS.—

15 (A) IN GENERAL.—Such standards shall
16 include standards relating to the furnishing of
17 information by health insurers (including self-
18 insured health benefit plans), providers, and
19 others to enable the Secretary to carry out the
20 program (including coordination with law en-
21 forcement agencies under subsection (b) and
22 third party insurers under subsection (c)).

23 (B) CONFIDENTIALITY.—Such standards
24 shall include procedures to assure that such in-
25 formation is provided and utilized in a manner

1 that protects the confidentiality of the informa-
2 tion and the privacy of individuals receiving
3 health care services.

4 (C) QUALIFIED IMMUNITY FOR PROVIDING
5 INFORMATION.—The provisions of section
6 1157(a) of the Social Security Act (relating to
7 limitation on liability) shall apply to a person
8 providing information to the Secretary under
9 the program under this section, with respect to
10 the Secretary's performance of duties under the
11 program, in the same manner as such section
12 applies to information provided to organizations
13 with a contract under part B of title XI of such
14 Act, with respect to the performance of such a
15 contract.

16 (e) ENSURING ACCESS TO DOCUMENTATION.—

17 (1) IN GENERAL.—The Inspector General of
18 the Department of Health and Human Services is
19 authorized to exercise the authority described in
20 paragraphs (4) and (5) of section 6 of the Inspector
21 General Act of 1978 (relating to subpoenas and ad-
22 ministration of oaths) with respect to the activities
23 under the all-payor fraud and abuse control program
24 established under this section to the same extent as
25 such Inspector General may exercise such authorities

1 to perform the functions assigned to such official by
2 such Act.

3 (2) FAILURE TO COMPLY AS GROUNDS FOR EX-
4 CLUSION FROM MEDICARE AND MEDICAID PRO-
5 GRAMS.—Section 1128(b) of the Social Security Act
6 (42 U.S.C. 1320a–7(b)) is amended by adding at
7 the end the following new paragraph:

8 “(15) FAILURE TO SUPPLY REQUESTED
9 INFORMATION TO THE INSPECTOR GENERAL.—
10 Any individual or entity that fails fully and ac-
11 curately to provide, upon request of the Inspec-
12 tor General of the Department of Health and
13 Human Services, records, documents, and other
14 information necessary for the purposes of carry-
15 ing out activities under the all-payor fraud and
16 abuse control program established under section
17 2311 of the Affordable Health Care Now Act of
18 1993.”.

19 **SEC. 2312. AUTHORIZATION OF ADDITIONAL APPROPRIA-**
20 **TIONS FOR INVESTIGATORS AND OTHER PER-**
21 **SONNEL.**

22 (a) IN GENERAL.—In addition to any other amounts
23 authorized to be appropriated to the Secretary of Health
24 and Human Services for health care anti-fraud and abuse
25 activities for a fiscal year, there are authorized to be ap-

1 appropriated additional amounts described in subsection (b)
2 to enable the Secretary to conduct investigations of allega-
3 tions of health care fraud and otherwise carry out the pro-
4 gram established under section 2311 in a fiscal year.

5 (b) AMOUNTS DESCRIBED.—The amounts referred to
6 in subsection (a) are as follows:

7 (1) For fiscal year 1995, \$100,000,000.

8 (2) For each of the fiscal years 1996 through
9 1998, such sums as may be necessary to assist the
10 Secretary in carrying out the program established
11 under section 2311 for such a fiscal year.

12 **SEC. 2313. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE**
13 **TRUST FUND.**

14 (a) ESTABLISHMENT.—

15 (1) IN GENERAL.—There is hereby created on
16 the books of the Treasury of the United States a
17 trust fund to be known as the “Anti-Fraud and
18 Abuse Trust Fund” (in this section referred to as
19 the “Trust Fund”). The Trust Fund shall consist of
20 such gifts and bequests as may be made as provided
21 in paragraph (2) and such amounts as may be de-
22 posited in, or appropriated to, such Trust Fund as
23 provided in this subtitle and section 1128A(f)(3) of
24 the Social Security Act.

1 (2) AUTHORIZATION TO ACCEPT GIFTS.—The
2 Managing Trustee of the Trust Fund is authorized
3 to accept on behalf of the United States money gifts
4 and bequests made unconditionally to the Trust
5 Fund, for the benefit of the Trust Fund, or any ac-
6 tivity financed through the Trust Fund.

7 (b) MANAGEMENT.—

8 (1) IN GENERAL.—The Trust Fund shall be
9 managed by the Secretary through a Managing
10 Trustee designated by the Secretary.

11 (2) INVESTMENT OF FUNDS.—It shall be the
12 duty of the Managing Trustee to invest such portion
13 of the Trust Fund as is not, in the trustee's judg-
14 ment, required to meet current withdrawals. Such
15 investments may be made only in interest-bearing
16 obligations of the United States or in obligations
17 guaranteed as to both principal and interest by the
18 United States. For such purpose such obligations
19 may be acquired on original issue at the issue price,
20 or by purchase of outstanding obligations at market
21 price. The purposes for which obligations of the
22 United States may be issued under chapter 31 of
23 title 31, United States Code, are hereby extended to
24 authorize the issuance at par of public-debt obliga-
25 tions for purchase by the Trust Fund. Such obliga-

1 tions issued for purchase by the Trust Fund shall
2 have maturities fixed with due regard for the needs
3 of the Trust Fund and shall bear interest at a rate
4 equal to the average market yield (computed by the
5 Managing Trustee on the basis of market quotations
6 as of the end of the calendar month next preceding
7 the date of such issue) on all marketable interest-
8 bearing obligations of the United States then form-
9 ing a part of the public debt which are not due or
10 callable until after the expiration of 4 years from the
11 end of such calendar month, except that where such
12 average is not a multiple of $\frac{1}{8}$ of 1 percent, the rate
13 of interest on such obligations shall be the multiple
14 of $\frac{1}{8}$ of 1 percent nearest such market yield. The
15 Managing Trustee may purchase other interest-bear-
16 ing obligations of the United States or obligations
17 guaranteed as to both principal and interest by the
18 United States, on original issue or at the market
19 price, only where the Trustee determines that the
20 purchase of such other obligations is in the public
21 interest.

22 (3) Any obligations acquired by the Trust Fund
23 (except public-debt obligations issued exclusively to
24 the Trust Fund) may be sold by the Managing
25 Trustee at the market price, and such public-debt

1 obligations may be redeemed at par plus accrued in-
2 terest.

3 (4) The interest on, and the proceeds from the
4 sale or redemption of, any obligations held in the
5 Trust Fund shall be credited to and form a part of
6 the Trust Fund.

7 (5) The receipts and disbursements of the Sec-
8 retary in the discharge of the functions of the Sec-
9 retary shall not be included in the totals of the
10 budget of the United States Government. For pur-
11 poses of part C of the Balanced Budget and Emer-
12 gency Deficit Control Act of 1985, the Secretary and
13 the Trust Fund shall be treated in the same manner
14 as the Federal Retirement Thrift Investment Board
15 and the Thrift Savings Fund, respectively. The
16 United States is not liable for any obligation or li-
17 ability incurred by the Trust Fund.

18 (c) USE OF FUNDS.—Amounts in the Trust Fund
19 shall be used to assist the Inspector General of the De-
20 partment of Health and Human Services in carrying out
21 the all-payor fraud and abuse control program established
22 under section 2311(a) in the fiscal year involved.

23 (d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD
24 AND ABUSE PENALTIES INTO TRUST FUND.—Section
25 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–

1 7a(f)(3)) is amended by striking “as miscellaneous re-
2 cepts of the Treasury of the United States” and inserting
3 “in the Anti-Fraud and Abuse Trust Fund established
4 under section 2313(a) of the Affordable Health Care Now
5 Act of 1993”.

6 (e) USE OF FEDERAL HEALTH ANTI-FRAUD AND
7 ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-
8 SHARING.—Section 1128A(f) of the Social Security Act
9 (42 U.S.C. 1320a–7a(f)) is amended in the matter preced-
10 ing paragraph (1) by striking “Secretary and disposed of
11 as follows:” and inserting the following: “Secretary. If the
12 person against whom such a penalty or assessment was
13 assessed collected a payment from an individual for pro-
14 viding to the individual the service that is the subject of
15 the penalty or assessment, the Secretary shall pay a por-
16 tion of the amount recovered to the individual in the na-
17 ture of restitution in an amount equal to the payment so
18 collected. The Secretary shall dispose of any remaining
19 amounts recovered under this section as follows:”.

20 **SEC. 2314. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**
21 **AND ABUSE SANCTIONS TO ALL FRAUD AND**
22 **ABUSE AGAINST ANY HEALTH BENEFIT PLAN.**

23 (a) CIVIL MONETARY PENALTIES.—Section 1128A
24 of the Social Security Act (42 U.S.C. 1320a–7a) is amend-
25 ed as follows:

1 (1) In subsection (a)(1), in the matter before
 2 subparagraph (A), by inserting “or of any health
 3 benefit plan,” after “subsection (i)(1)),”.

4 (2) In subsection (b)(1)(A), by inserting “or
 5 under a health benefit plan” after “title XIX”.

6 (3) In subsection (f)—

7 (A) by redesignating paragraph (3) as
 8 paragraph (4); and

9 (B) by inserting after paragraph (2) the
 10 following new paragraph:

11 “(3) With respect to amounts recovered arising
 12 out of a claim under a health benefit plan, the por-
 13 tion of such amounts as is determined to have been
 14 paid by the plan shall be repaid to the plan.”.

15 (4) In subsection (i)—

16 (A) in paragraph (2), by inserting “or
 17 under a health benefit plan” before the period
 18 at the end, and

19 (B) in paragraph (5), by inserting “or
 20 under a health benefit plan” after “or XX”.

21 (b) CRIMES.—

22 (1) SOCIAL SECURITY ACT.—Section 1128B of
 23 such Act (42 U.S.C. 1320a–7b) is amended as fol-
 24 lows:

1 (A) In the heading, by adding at the end
2 the following: “OR HEALTH BENEFIT PLANS”.

3 (B) In subsection (a)(1)—

4 (i) by striking “title XVIII or” and
5 inserting “title XVIII,”, and

6 (ii) by adding at the end the follow-
7 ing: “or a health benefit plan (as defined
8 in section 1128(i)),”.

9 (C) In subsection (a)(5), by striking “title
10 XVIII or a State health care program” and in-
11 serting “title XVIII, a State health care pro-
12 gram, or a health benefit plan”.

13 (D) In the second sentence of subsection
14 (a)—

15 (i) by inserting after “title XIX” the
16 following: “or a health benefit plan”, and

17 (ii) by inserting after “the State” the
18 following: “or the plan”.

19 (E) In subsection (b)(1), by striking “title
20 XVIII or a State health care program” each
21 place it appears and inserting “title XVIII, a
22 State health care program, or a health benefit
23 plan”.

24 (F) In subsection (b)(2), by striking “title
25 XVIII or a State health care program” each

1 place it appears and inserting “title XVIII, a
 2 State health care program, or a health benefit
 3 plan”.

4 (G) In subsection (b)(3), by striking “title
 5 XVIII or a State health care program” each
 6 place it appears in subparagraphs (A) and (C)
 7 and inserting “title XVIII, a State health care
 8 program, or a health benefit plan”.

9 (H) In subsection (d)(2)—

10 (i) by striking “title XIX,” and insert-
 11 ing “title XIX or under a health benefit
 12 plan,” and

13 (ii) by striking “State plan,” and in-
 14 serting “State plan or the health benefit
 15 plan,”.

16 (2) TREBLE DAMAGES FOR CRIMINAL SANC-
 17 TIONS.—Section 1128B of such Act (42 U.S.C.
 18 1320a–7b) is amended by adding at the end the fol-
 19 lowing new subsection:

20 “(f) In addition to the fines that may be imposed
 21 under subsection (a), (b), or (c), any individual found to
 22 have violated the provisions of any of such subsections
 23 may be subject to treble damages.”.

24 (3) IDENTIFICATION OF COMMUNITY SERVICE
 25 OPPORTUNITIES.—Section 1128B of such Act (42

1 U.S.C. 1320a–7b) is further amended by adding at
2 the end the following new subsection:

3 “(g) The Secretary shall—

4 “(1) in consultation with State and local health
5 care officials, identify opportunities for the satisfac-
6 tion of community service obligations that a court
7 may impose upon the conviction of an offense under
8 this section, and

9 “(2) make information concerning such oppor-
10 tunities available to Federal and State law enforce-
11 ment officers and State and local health care offi-
12 cials.”.

13 (c) HEALTH BENEFIT PLAN DEFINED.—Section
14 1128 of such Act (42 U.S.C. 1320a–7) is amended by re-
15 designating subsection (i) as subsection (j) and by insert-
16 ing after subsection (h) the following new subsection:

17 “(i) HEALTH BENEFIT PLAN DEFINED.—For pur-
18 poses of sections 1128A and 1128B, the term ‘health ben-
19 efit plan’ means a health benefit program other than the
20 medicare program, the medicaid program, or a State
21 health care program.”.

22 (d) CONFORMING AMENDMENT.—Section
23 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a–
24 7(b)(8)(B)(ii)) is amended by striking “1128A” and in-

1 serting “1128A (other than a penalty arising from a
2 health benefit plan, as defined in subsection (i))”.

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section shall take effect January 1, 1995.

5 **Subtitle E—Medicare Payment**
6 **Changes; Part B Premium Tax**
7 **for High-Income Individuals**

8 **PART 1—MEDICARE PAYMENT CHANGES**

9 **SEC. 2401. ELIMINATION OF MEMBERSHIP LIMITATION FOR**
10 **MEDICARE HMOS.**

11 (a) IN GENERAL.—Section 1876 of the Social Secu-
12 rity Act (42 U.S.C. 1395mm) is amended by striking sub-
13 section (f).

14 (b) CONFORMING AMENDMENTS.—Such section is
15 further amended—

16 (1) in subsection (c)(3)(A)(i), by striking “in
17 failure to meet the requirements of subsection (f) or
18 would result”, and

19 (2) in subsection (i)(1)(C), by striking “(e), and
20 (f)” and inserting “and (e)”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to contracts entered into on or
23 after the date of the enactment of this Act.

1 **SEC. 2402. EXPANSION AND REVISION OF MEDICARE SE-**
2 **LECT POLICIES.**

3 (a) PERMITTING MEDICARE SELECT POLICIES IN
4 ALL STATES.—

5 (1) IN GENERAL.—Subsection (c) of section
6 4358 of the Omnibus Budget Reconciliation Act of
7 1990 (hereafter referred to as “OBRA-1990”) is
8 hereby repealed.

9 (2) CONFORMING AMENDMENT.—Section 4358
10 of OBRA-1990 is amended by redesignating sub-
11 section (d) as subsection (c).

12 (b) REQUIREMENTS OF MEDICARE SELECT POLI-
13 CIES.—Section 1882(t)(1) of the Social Security Act (42
14 U.S.C. 1395ss(t)(1)) is amended to read as follows:

15 “(1)(A) If a medicare supplemental policy meets the
16 1991 NAIC Model Regulation or 1991 Federal Regulation
17 and otherwise complies with the requirements of this sec-
18 tion except that—

19 “(i) the benefits under such policy are re-
20 stricted to items and services furnished by certain
21 entities (or reduced benefits are provided when items
22 or services are furnished by other entities), and

23 “(ii) in the case of a policy described in sub-
24 paragraph (C)(i)—

1 “(I) the benefits under such policy are not
2 one of the groups or packages of benefits de-
3 scribed in subsection (p)(2)(A),

4 “(II) except for nominal copayments im-
5 posed for services covered under part B of this
6 title, such benefits include at least the core
7 group of basic benefits described in subsection
8 (p)(2)(B), and

9 “(III) an enrollee’s liability under such pol-
10 icy for physician’s services covered under part
11 B of this title is limited to the nominal
12 copayments described in subclause (II),

13 the policy shall nevertheless be treated as meeting those
14 standards if the policy meets the requirements of subpara-
15 graph (B).

16 “(B) A policy meets the requirements of this sub-
17 paragraph if—

18 “(i) full benefits are provided for items and
19 services furnished through a network of entities
20 which have entered into contracts or agreements
21 with the issuer of the policy,

22 “(ii) full benefits are provided for items and
23 services furnished by other entities if the services are
24 medically necessary and immediately required be-
25 cause of an unforeseen illness, injury, or condition

1 and it is not reasonable given the circumstances to
2 obtain the services through the network,

3 “(iii) the network offers sufficient access,

4 “(iv) the issuer of the policy has arrangements
5 for an ongoing quality assurance program for items
6 and services furnished through the network,

7 “(v)(I) the issuer of the policy provides to each
8 enrollee at the time of enrollment an explanation
9 of—

10 “(aa) the restrictions on payment under
11 the policy for services furnished other than by
12 or through the network,

13 “(bb) out of area coverage under the pol-
14 icy,

15 “(cc) the policy’s coverage of emergency
16 services and urgently needed care, and

17 “(dd) the availability of a policy through
18 the entity that meets the 1991 Model NAIC
19 Regulation or 1991 Federal Regulation without
20 regard to this subsection and the premium
21 charged for such policy, and

22 “(II) each enrollee prior to enrollment acknowl-
23 edges receipt of the explanation provided under
24 subclause (I), and

1 “(vi) the issuer of the policy makes available to
2 individuals, in addition to the policy described in this
3 subsection, any policy (otherwise offered by the is-
4 suer to individuals in the State) that meets the 1991
5 Model NAIC Regulation or 1991 Federal Regulation
6 and other requirements of this section without re-
7 gard to this subsection.

8 “(C) (i) A policy described in this subparagraph—

9 “(I) is offered by an eligible organization (as
10 defined in section 1876(b)),

11 “(II) is not a policy or plan providing benefits
12 pursuant to a contract under section 1876 or an ap-
13 proved demonstration project described in section
14 603(c) of the Social Security Amendments of 1983,
15 section 2355 of the Deficit Reduction Act of 1984,
16 or section 9412(b) of the Omnibus Budget Reconcili-
17 ation Act of 1986, and

18 “(III) provides benefits which, when combined
19 with benefits which are available under this title, are
20 substantially similar to benefits under policies of-
21 fered to individuals who are not entitled to benefits
22 under this title.

23 “(ii) In making a determination under subclause (III)
24 of clause (i) as to whether certain benefits are substan-
25 tially similar, there shall not be taken into account, except

1 in the case of preventive services, benefits provided under
2 policies offered to individuals who are not entitled to bene-
3 fits under this title which are in addition to the benefits
4 covered by this title and which are benefits an entity must
5 provide in order to meet the definition of an eligible orga-
6 nization under section 1876(b)(1).’’.

7 (c) RENEWABILITY OF MEDICARE SELECT POLI-
8 CIES.—Section 1882(q)(1) of the Social Security Act (42
9 U.S.C. 1395ss(q)(1)) is amended—

10 (1) by striking “(1) Each” and inserting
11 “(1)(A) Except as provided in subparagraph (B),
12 each”;

13 (2) by redesignating subparagraphs (A) and
14 (B) as clauses (i) and (ii), respectively; and

15 (3) by adding at the end the following new sub-
16 paragraph:

17 “(B)(i) Except as provided in clause (ii), in the
18 case of a policy that meets the requirements of sub-
19 section (t), an issuer may cancel or nonrenew such
20 policy with respect to an individual who leaves the
21 service area of such policy.

22 “(ii) If an individual described in clause (i)
23 moves to a geographic area where an issuer de-
24 scribed in clause (i), or where an affiliate of such is-
25 suer, is issuing medicare supplemental policies, such

1 individual must be permitted to enroll in any medi-
 2 care supplemental policy offered by such issuer or
 3 affiliate that provides benefits comparable to or less
 4 than the benefits provided in the policy being can-
 5 celed or nonrenewed. An individual whose coverage
 6 is canceled or nonrenewed under this subparagraph
 7 shall, as part of the notice of termination or
 8 nonrenewal, be notified of the right to enroll in other
 9 medicare supplemental policies offered by the issuer
 10 or its affiliates.

11 “(iii) For purposes of this subparagraph, the
 12 term ‘affiliate’ shall have the meaning given such
 13 term by the 1991 NAIC Model Regulation.”.

14 (d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of
 15 the Social Security Act (42 U.S.C. 1395ss(t)(2)) is
 16 amended—

17 (1) by striking “(2)” and inserting “(2)(A)”;

18 (2) by redesignating subparagraphs (A), (B),
 19 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-
 20 spectively;

21 (3) in clause (iv), as so redesignated—

22 (A) by striking “paragraph (1)(E)(i)” and
 23 inserting “paragraph (1)(B)(v)(I)”, and

24 (B) by striking “paragraph (1)(E)(ii)” and
 25 inserting “paragraph (1)(B)(v)(II)”;

1 (4) by striking “the previous sentence” and in-
2 serting “this subparagraph”; and

3 (5) by adding at the end the following new sub-
4 paragraph:

5 “(B) If the Secretary determines that an issuer of
6 a policy approved under paragraph (1) has made a mis-
7 representation to the Secretary or has provided the Sec-
8 retary with false information regarding such policy, the
9 issuer is subject to a civil money penalty in an amount
10 not to exceed \$100,000 for each such determination. The
11 provisions of section 1128A (other than the first sentence
12 of subsection (a) and other than subsection (b)) shall
13 apply to a civil money penalty under this subparagraph
14 in the same manner as such provisions apply to a penalty
15 or proceeding under section 1128A(a).”.

16 (e) EFFECTIVE DATES.—

17 (1) NAIC STANDARDS.—If, within 6 months
18 after the date of the enactment of this Act, the Na-
19 tional Association of Insurance Commissioners
20 (hereafter in this subsection referred to as the
21 “NAIC”) makes changes in the 1991 NAIC Model
22 Regulation (as defined in section 1882(p)(1)(A) of
23 the Social Security Act) to incorporate the additional
24 requirements imposed by the amendments made by
25 this section, section 1882(g)(2)(A) of such Act shall

1 be applied in each State, effective for policies issued
2 to policyholders on and after the date specified in
3 paragraph (3), as if the reference to the Model Reg-
4 ulation adopted on June 6, 1979, were a reference
5 to the 1991 NAIC Model Regulation (as so defined)
6 as changed under this paragraph (such changed
7 Regulation referred to in this subsection as the
8 “1994 NAIC Model Regulation”).

9 (2) SECRETARY STANDARDS.—If the NAIC
10 does not make changes in the 1991 NAIC Model
11 Regulation (as so defined) within the 6-month period
12 specified in paragraph (1), the Secretary of Health
13 and Human Services (in this subsection as the “Sec-
14 retary”) shall promulgate a regulation and section
15 1882(g)(2)(A) of the Social Security Act shall be ap-
16 plied in each State, effective for policies issued to
17 policyholders on and after the date specified in para-
18 graph (3), as if the reference to the Model Regula-
19 tion adopted in June 6, 1979, were a reference to
20 the 1991 NAIC Model Regulation (as so defined) as
21 changed by the Secretary under this paragraph
22 (such changed Regulation referred to in this sub-
23 section as the “1994 Federal Regulation”).

24 (3) DATE SPECIFIED.—

1 (A) IN GENERAL.—Subject to subpara-
2 graph (B), the date specified in this paragraph
3 for a State is the earlier of—

4 (i) the date the State adopts the 1994
5 NAIC Model Regulation or the 1994 Fed-
6 eral Regulation; or

7 (ii) 1 year after the date the NAIC or
8 the Secretary first adopts such regulations.

9 (B) ADDITIONAL LEGISLATIVE ACTION RE-
10 QUIRED.—In the case of a State which the Sec-
11 retary identifies, in consultation with the NAIC,
12 as—

13 (i) requiring State legislation (other
14 than legislation appropriating funds) in
15 order for medicare supplemental policies to
16 meet the 1994 NAIC Model Regulation or
17 the 1994 Federal Regulation, but

18 (ii) having a legislature which is not
19 scheduled to meet in 1995 in a legislative
20 session in which such legislation may be
21 considered,

22 the date specified in this paragraph is the first
23 day of the first calendar quarter beginning after
24 the close of the first legislative session of the
25 State legislature that begins on or after Janu-

1 ary 1, 1995. For purposes of the previous sen-
2 tence, in the case of a State that has a 2-year
3 legislative session, each year of such session
4 shall be deemed to be a separate regular session
5 of the State legislature.

6 **SEC. 2403. IMPROVED EFFICIENCY THROUGH CONSOLIDA-**
7 **TION OF ADMINISTRATION OF PARTS A AND**
8 **B.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services shall take such steps as may be necessary
11 to consolidate the administration (including processing
12 systems) of parts A and B of the medicare program (under
13 title XVIII of the Social Security Act) including over a
14 5-year period.

15 (b) COMBINATION OF INTERMEDIARY AND CARRIER
16 FUNCTIONS.—In taking such steps, the Secretary shall
17 contract with a single entity that combines the fiscal
18 intermediary and carrier functions in each area except
19 where the Secretary finds that special regional or national
20 contracts are appropriate.

21 (c) SUPERSEDING CONFLICTING REQUIREMENTS.—
22 The provisions of sections 1816 and 1842 of the Social
23 Security Act (including provider nominating provisions in
24 such section 1816) are superseded to the extent required
25 to carry out this section.

1 **PART 2—PART B PREMIUM TAX FOR HIGH-**
 2 **INCOME INDIVIDUALS**

3 **SEC. 2411. INCREASE IN MEDICARE PART B PREMIUM FOR**
 4 **INDIVIDUALS WITH HIGH INCOME.**

5 (a) IN GENERAL.—Subchapter A of chapter 1 of the
 6 Internal Revenue Code of 1986 is amended by adding at
 7 the end thereof the following new part:

8 **“PART VIII—MEDICARE PART B PREMIUMS FOR**
 9 **HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Medicare part B premium tax.

10 **“SEC. 59B. MEDICARE PART B PREMIUM TAX.**

11 “(a) IMPOSITION OF TAX.—In the case of an individ-
 12 ual to whom this section applies for the taxable year, there
 13 is hereby imposed (in addition to any other tax imposed
 14 by this subtitle) a tax for such taxable year equal to the
 15 aggregate of the Medicare part B premium taxes for each
 16 of the months during such year that such individual is
 17 covered by Medicare part B.

18 “(b) INDIVIDUALS TO WHOM SECTION APPLIES.—
 19 This section shall apply to any individual for any taxable
 20 year if—

21 “(1) such individual is covered under Medicare
 22 part B for any month during such year, and

23 “(2) the modified adjusted gross income of the
 24 taxpayer for such taxable year exceeds the threshold
 25 amount.

1 “(c) MEDICARE PART B PREMIUM TAX FOR
2 MONTH.—

3 “(1) IN GENERAL.—The Medicare part B pre-
4 mium tax for any month is $\frac{2}{3}$ the amount equal to
5 the excess of—

6 “(A) 150 percent of the monthly actuarial
7 rate for enrollees age 65 and over determined
8 for that calendar year under section 1839(b) of
9 the Social Security Act, over

10 “(B) the total monthly premium under sec-
11 tion 1839 of the Social Security Act (deter-
12 mined without regard to subsections (b) and (f)
13 of section 1839 of such Act).

14 “(2) PHASEIN OF TAX.—If the modified ad-
15 justed gross income of the taxpayer for any taxable
16 years exceeds the threshold amount by less than
17 \$50,000, the Medicare part B premium tax for any
18 month during such taxable year shall be an amount
19 which bears the same ratio to the amount deter-
20 mined under paragraph (1) (without regard to this
21 paragraph) as such excess bears to \$50,000. The
22 preceding sentence shall not apply to any individual
23 whose threshold amount is zero.

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

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

3 “(A) except as otherwise provided in this
4 paragraph, \$100,000,

5 “(B) \$125,000 in the case of a joint re-
6 turn, and

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

8 “(i) is married at the close of the tax-
9 able year but does not file a joint return
10 for such year, and

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

13 “(2) MODIFIED ADJUSTED GROSS INCOME.—
14 The term ‘modified adjusted gross income’ means
15 adjusted gross income—

16 “(A) determined without regard to sections
17 135, 911, 931, and 933, and

18 “(B) increased by the amount of interest
19 received or accrued by the taxpayer during the
20 taxable year which is exempt from tax.

21 “(3) MEDICARE PART B COVERAGE.—An indi-
22 vidual shall be treated as covered under Medicare
23 part B for any month if a premium is paid under
24 part B of title XVIII of the Social Security Act for

1 the coverage of the individual under such part for
2 the month.

3 “(4) MARRIED INDIVIDUAL.—The determina-
4 tion of whether an individual is married shall be
5 made in accordance with section 7703.”

6 (b) CLERICAL AMENDMENT.—The table of parts for
7 subchapter A of chapter 1 of such Code is amended by
8 adding at the end thereof the following new item:

“Part VIII. Medicare Part B Premiums For High-Income Individ-
uals.”

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to months after December 1993
11 in taxable years ending after December 31, 1993.

12 **Subtitle F—Removing Anti-Trust** 13 **Impediments**

14 **SEC. 2501. ESTABLISHMENT OF LIMITED EXEMPTION PRO-** 15 **GRAM FOR HEALTH CARE JOINT VENTURES.**

16 (a) ESTABLISHMENT.—

17 (1) IN GENERAL.—Not later than 6 months
18 after the date of the enactment of this Act, the At-
19 torney General, after consultation with the Secretary
20 of Health and Human Services and the Interagency
21 Advisory Committee on Competition, Antitrust Pol-
22 icy, and Health Care, shall promulgate specific
23 guidelines under which a health care joint venture
24 may submit an application requesting that the At-

1 torney General provide the entities participating in
2 the joint venture with an exemption under which
3 (notwithstanding any other provision of law)—

4 (A) monetary recovery on a claim under
5 the antitrust laws shall be limited to actual
6 damages if the claim results from conduct with-
7 in the scope of the joint venture that occurs
8 while the exemption is in effect; and

9 (B) the conduct of the entity in making or
10 performing a contract to carry out the joint
11 venture shall not be deemed illegal per se under
12 the antitrust laws but shall be judged on the
13 basis of its reasonableness, taking into account
14 all relevant factors affecting competition, in-
15 cluding (but not limited to) effects on competi-
16 tion in properly defined, relevant research, de-
17 velopment, product, process, and service mar-
18 kets (taking into consideration worldwide capac-
19 ity to the extent that it may be appropriate in
20 the circumstances).

21 (2) DEADLINE FOR RESPONSE.—The Attorney
22 General, after consultation with the Secretary and
23 the Advisory Committee, shall approve or disapprove
24 the application of a health care joint venture for an
25 exemption under this subsection not later than 30

1 days after the Attorney General receives the joint
2 venture's application.

3 (3) PROVIDING REASONS FOR DISAPPROVAL.—

4 If the Attorney General disapproves the application
5 of a health care joint venture for an exemption
6 under this subsection, the Attorney General shall
7 provide the joint venture with a statement explaining
8 the reasons for the Attorney General's disapproval.

9 (b) REQUIREMENTS FOR APPROVAL.—For purposes
10 of subsection (a), the Attorney General shall approve the
11 application of a health care joint venture for an exemption
12 under subsection (a) if an entity participating in the joint
13 venture submits to the Attorney General an application
14 not later than 30 days after the entity has entered into
15 a written agreement to participate in the joint venture (or
16 not later than 30 days after the date of the enactment
17 of this Act in the case of a joint venture in effect as of
18 such date) that contains the following information and as-
19 surances:

20 (1) The identities of the parties to the joint
21 venture.

22 (2) The nature, objectives, and planned activi-
23 ties of the joint venture.

24 (3) Assurances that the entities participating in
25 the joint venture shall notify the Attorney General

1 of any changes in the information described in para-
2 graphs (1) and (2) during the period for which the
3 exemption is in effect.

4 (c) REVOCATION OF EXEMPTION.—

5 (1) IN GENERAL.—The Attorney General, after
6 consultation with the Secretary, may revoke an ex-
7 emption provided to a health care joint venture
8 under this section if, at any time during which the
9 exemption is in effect, the Attorney General finds
10 that the joint venture no longer meets the applicable
11 requirements for approval under subsection (b), ex-
12 cept that the Attorney General may not revoke such
13 an exemption if the failure of the health care joint
14 venture to meet such requirements is merely tech-
15 nical in nature.

16 (2) TIMING.—The revocation of an exemption
17 under paragraph (1) shall apply only to conduct of
18 the health care joint venture occurring after the ex-
19 emption is no longer in effect.

20 (d) WITHDRAWAL OF APPLICATION.—Any party that
21 submits an application under this section may withdraw
22 such application at any time before the Attorney General's
23 response to the application.

1 (e) REQUIREMENTS RELATING TO NOTICE AND PUB-
2 LICATION OF EXEMPTIONS AND RELATED INFORMA-
3 TION.—

4 (1) PUBLICATION OF APPROVED APPLICATIONS
5 FOR EXEMPTIONS IN FEDERAL REGISTER.—

6 (A) IN GENERAL.—With respect to each
7 exemption for a health care joint venture pro-
8 vided under subsection (a), the Attorney Gen-
9 eral (acting jointly with the Secretary) shall—

10 (i) prepare a notice with respect to
11 the joint venture that identifies the parties
12 to the venture and that describes the
13 planned activities of the venture;

14 (ii) submit the notice to the entities
15 participating in the joint venture; and

16 (iii) after submitting the notice to
17 such entities (but not later than 30 days
18 after approving the application for the ex-
19 emption for the joint venture), publish the
20 notice in the Federal Register.

21 (B) EFFECT OF PUBLICATION.—An ex-
22 emption provided by the Attorney General
23 under subsection (a) shall take effect as of the
24 date of the publication in the Federal Register

1 of the notice with respect to the exemption pur-
2 suant to subparagraph (A).

3 (2) WAIVER OF DISCLOSURE REQUIREMENTS
4 FOR INFORMATION RELATING TO APPLICATIONS FOR
5 EXEMPTIONS.—

6 (A) IN GENERAL.—All information and
7 documentary material submitted as part of an
8 application of a health care joint venture for an
9 exemption under subsection (a), together with
10 any other information obtained by the Attorney
11 General, the Secretary, or the Advisory Com-
12 mittee in the course of any investigation, ad-
13 ministrative proceeding, or case with respect to
14 a potential violation of the antitrust laws by the
15 joint venture with respect to which the exemp-
16 tion applies, shall be exempt from disclosure
17 under section 552 of title 5, United States
18 Code, and shall not be made publicly available
19 by any agency of the United States to which
20 such section applies, except as relevant to a law
21 enforcement investigation or in a judicial or ad-
22 ministrative proceeding in which such informa-
23 tion and material is subject to any protective
24 order.

1 (B) EXCEPTION FOR INFORMATION IN-
2 CLUDED IN FEDERAL REGISTER NOTICE.—Sub-
3 paragraph (A) shall not apply with respect to
4 information contained in a notice published in
5 the Federal Register pursuant to paragraph
6 (1).

7 (3) USE OF INFORMATION TO SUPPORT OR AN-
8 SWER CLAIMS UNDER ANTITRUST LAWS.—

9 (A) IN GENERAL.—Except as provided in
10 subparagraph (B), the fact of disclosure of con-
11 duct under an application for an exemption
12 under subsection (a) and the fact of publication
13 of a notice in the Federal Register under para-
14 graph (1) shall be admissible into evidence in
15 any judicial or administrative proceeding for the
16 sole purpose of establishing that a person is en-
17 titled to the protections provided by an exemp-
18 tion granted under subsection (a).

19 (B) EFFECT OF REJECTED APPLICA-
20 TION.—If the Attorney General denies, in whole
21 or in part, an application for an exemption
22 under subsection (a), or revokes an exemption
23 under such section, neither the negative deter-
24 mination nor the statement of reasons therefor
25 shall be admissible into evidence in any admin-

1 istrative or judicial proceeding for the purpose
2 of supporting or answering any claim under the
3 antitrust laws.

4 **SEC. 2502. ISSUANCE OF HEALTH CARE CERTIFICATES OF**
5 **PUBLIC ADVANTAGE.**

6 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The
7 Attorney General, after consultation with the Secretary
8 and the Advisory Committee, shall issue in accordance
9 with this section a certificate of public advantage to each
10 eligible health care joint venture that complies with the
11 requirements in effect under this section on or after the
12 expiration of the 1-year period that begins on the date
13 of the enactment of this Act (without regard to whether
14 or not the Attorney General has promulgated regulations
15 to carry out this section by such date). Such venture, and
16 the parties to such venture, shall not be liable under any
17 of the antitrust laws for conduct described in such certifi-
18 cate and engaged in by such venture if such conduct oc-
19 curs while such certificate is in effect.

20 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF
21 CERTIFICATES.—

22 (1) STANDARDS TO BE MET.—The Attorney
23 General shall issue a certificate to an eligible health
24 care joint venture if the Attorney General finds
25 that—

1 (A) the benefits that are likely to result
2 from carrying out the venture outweigh the re-
3 duction in competition (if any) that is likely to
4 result from the venture, and

5 (B) such reduction in competition is rea-
6 sonably necessary to obtain such benefits.

7 (2) FACTORS TO BE CONSIDERED.—

8 (A) WEIGHING OF BENEFITS AGAINST RE-
9 Duction IN COMPETITION.—For purposes of
10 making the finding described in paragraph
11 (1)(A), the Attorney General shall consider
12 whether the venture is likely—

13 (i) to maintain or to increase the
14 quality of health care,

15 (ii) to increase access to health care,

16 (iii) to achieve cost efficiencies that
17 will be passed on to health care consumers,
18 such as economies of scale, reduced trans-
19 action costs, and reduced administrative
20 costs,

21 (iv) to preserve the operation of
22 health care facilities located in underserved
23 geographical areas,

24 (v) to improve utilization of health
25 care resources, and

1 (vi) to reduce inefficient health care
2 resource duplication.

3 (B) NECESSITY OF REDUCTION IN COM-
4 PETITION.—For purposes of making the finding
5 described in paragraph (1)(B), the Attorney
6 General shall consider—

7 (i) the ability of the providers of
8 health care services that are (or likely to
9 be) affected by the health care joint ven-
10 ture and the entities responsible for mak-
11 ing payments to such providers to nego-
12 tiate societally optimal payment and serv-
13 ice arrangements,

14 (ii) the effects of the health care joint
15 venture on premiums and other charges
16 imposed by the entities described in clause
17 (i), and

18 (iii) the availability of equally effi-
19 cient, less restrictive alternatives to achieve
20 the benefits that are intended to be
21 achieved by carrying out the venture.

22 (c) ESTABLISHMENT OF CRITERIA AND PROCE-
23 DURES.—Subject to subsections (d) and (e), not later than
24 1 year after the date of the enactment of this Act, the
25 Attorney General and the Secretary shall establish jointly

1 by rule the criteria and procedures applicable to the issu-
2 ance of certificates under subsection (a). The rules shall
3 specify the form and content of the application to be sub-
4 mitted to the Attorney General to request a certificate,
5 the information required to be submitted in support of
6 such application, the procedures applicable to denying and
7 to revoking a certificate, and the procedures applicable to
8 the administrative appeal (if such appeal is authorized by
9 rule) of the denial and the revocation of a certificate. Such
10 information may include the terms of the health care joint
11 venture (in the case of a venture in existence as of the
12 time of the application) and implementation plan for the
13 joint venture.

14 (d) ELIGIBLE HEALTH CARE JOINT VENTURE.—To
15 be an eligible health care joint venture for purposes of this
16 section, a health care joint venture shall submit to the At-
17 torney General an application that complies with the rules
18 in effect under subsection (c) and that includes—

19 (1) an agreement by the parties to the venture
20 that the venture will not foreclose competition by en-
21 tering into contracts that prevent health care provid-
22 ers from providing health care in competition with
23 the venture,

24 (2) an agreement that the venture will submit
25 to the Attorney General annually a report that de-

1 scribes the operations of the venture and informa-
2 tion regarding the impact of the venture on health
3 care and on competition in health care, and

4 (3) an agreement that the parties to the ven-
5 ture will notify the Attorney General and the Sec-
6 retary of the termination of the venture not later
7 than 30 days after such termination occurs.

8 (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—

9 Not later than 30 days after an eligible health care joint
10 venture submits to the Attorney General an application
11 that complies with the rules in effect under subsection (c)
12 and with subsection (d), the Attorney General shall issue
13 or deny the issuance of such certificate. If, before the expi-
14 ration of such 30-day period, the Attorney General fails
15 to issue or deny the issuance of such certificate, the Attor-
16 ney General shall be deemed to have issued such certifi-
17 cate.

18 (f) REVOCATION OF CERTIFICATE.—Whenever the
19 Attorney General finds that a health care joint venture
20 with respect to which a certificate is in effect does not
21 meet the standards specified in subsection (b), the Attor-
22 ney General shall revoke such certificate.

23 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

24 (1) DENIAL AND REVOCATION OF CERTIFI-
25 CATES.—If the Attorney General denies an applica-

1 tion for a certificate or revokes a certificate, the At-
2 torney General shall include in the notice of denial
3 or revocation a statement of the reasons relied upon
4 for the denial or revocation of such certificate.

5 (2) JUDICIAL REVIEW.—

6 (A) AFTER ADMINISTRATIVE PROCEED-
7 ING.—(i) If the Attorney General denies an ap-
8 plication submitted or revokes a certificate is-
9 sued under this section after an opportunity for
10 hearing on the record, then any party to the
11 health care joint venture involved may com-
12 mence a civil action, not later than 60 days
13 after receiving notice of the denial or revoca-
14 tion, in an appropriate district court of the
15 United States for review of the record of such
16 denial or revocation.

17 (ii) As part of the Attorney General's an-
18 swer, the Attorney General shall file in such
19 court a certified copy of the record on which
20 such denial or revocation is based. The findings
21 of fact of the Attorney General may be set aside
22 only if found to be unsupported by substantial
23 evidence in such record taken as a whole.

24 (B) DENIAL OR REVOCATION WITHOUT AD-
25 MINISTRATIVE PROCEEDING.—If the Attorney

1 General denies an application submitted or re-
2 vokes a certificate issued under this section
3 without an opportunity for hearing on the
4 record, then any party to the health care joint
5 venture involved may commence a civil action,
6 not later than 60 days after receiving notice of
7 the denial or revocation, in an appropriate dis-
8 trict court of the United States for de novo re-
9 view of such denial or revocation.

10 (h) EXEMPTION.—A person shall not be liable under
11 any of the antitrust laws for conduct necessary—

12 (1) to prepare, agree to prepare, or attempt to
13 agree to prepare an application to request a certifi-
14 cate under this section, or

15 (2) to attempt to enter into any health care
16 joint venture with respect to which such a certificate
17 is in effect.

18 **SEC. 2503. INTERAGENCY ADVISORY COMMITTEE ON COM-**
19 **PETITION, ANTITRUST POLICY, AND HEALTH**
20 **CARE.**

21 (a) ESTABLISHMENT.—There is hereby established
22 the Interagency Advisory Committee on Competition,
23 Antitrust Policy, and Health Care. The Advisory Commit-
24 tee shall be composed of—

1 (1) the Secretary of Health and Human Serv-
2 ices (or the designee of the Secretary);

3 (2) the Attorney General (or the designee of the
4 Attorney General);

5 (3) the Director of the Office of Management
6 and Budget (or the designee of the Director); and

7 (4) a representative of the Federal Trade Com-
8 mission.

9 (b) DUTIES.—The duties of the Advisory Committee
10 are—

11 (1) to discuss and evaluate competition and
12 antitrust policy, and their implications with respect
13 to the performance of health care markets;

14 (2) to analyze the effectiveness of health care
15 joint ventures receiving exemptions under the pro-
16 gram established under section 2501(a) or certifi-
17 cates under section 2502 in reducing the costs of
18 and expanding access to the health care services that
19 are the subject of such ventures; and

20 (3) to make such recommendations to Congress
21 not later than 2 years after the date of the enact-
22 ment of this Act (and at such subsequent periods as
23 the Advisory Committee considers appropriate) re-
24 garding modifications to the program established
25 under section 2501(a) or to section 2502 as the Ad-

1 visory Committee considers appropriate, including
2 modifications relating to the costs to health care
3 providers of obtaining an exemption for a joint ven-
4 ture under such program.

5 **SEC. 2504. DEFINITIONS.**

6 For purposes of this subtitle:

7 (1) The term “Advisory Committee” means the
8 Interagency Advisory Committee on Competition,
9 Antitrust Policy, and Health Care established under
10 section 2503.

11 (2) The term “antitrust laws”—

12 (A) has the meaning given it in subsection
13 (a) of the first section of the Clayton Act (15
14 U.S.C. 12(a)), except that such term includes
15 section 5 of the Federal Trade Commission Act
16 (15 U.S.C. 45) to the extent such section ap-
17 plies to unfair methods of competition; and

18 (B) includes any State law similar to the
19 laws referred to in subparagraph (A).

20 (3) The term “certificate” means a certificate
21 of public advantage authorized to be issued under
22 section 2502(a).

23 (4) The term “health care joint venture” means
24 an agreement (whether existing or proposed) be-
25 tween 2 or more providers of health care services

1 that is entered into solely for the purpose of sharing
2 in the provision of health care services and that in-
3 volves substantial integration or financial risk-shar-
4 ing between the parties, but does not include the ex-
5 changing of information, the entering into of any
6 agreement, or the engagement in any other conduct
7 that is not reasonably required to carry out such
8 agreement.

9 (5) The term “health care services” includes
10 services related to the delivery or administration of
11 health care services.

12 (6) The term “liable” means liable for any civil
13 or criminal violation of the antitrust laws.

14 (7) The term “provider of health care services”
15 means any individual or entity that is engaged in the
16 delivery of health care services in a State and that
17 is required by State law or regulation to be licensed
18 or certified by the State to engage in the delivery of
19 such services in the State.

20 (8) The term “Secretary” means the Secretary
21 of Health and Human Services.

1 **Subtitle G—Encouraging Enforce-**
2 **ment Activities of Medical Self-**
3 **Regulatory Entities**

4 **PART 1—APPLICATION OF THE CLAYTON**
5 **ACT TO MEDICAL SELF-REGULATORY**
6 **ENTITIES**

7 **SEC. 2601. ANTITRUST EXEMPTION FOR MEDICAL SELF-**
8 **REGULATORY ENTITIES.**

9 (a) IN GENERAL.—(1) Except as provided in para-
10 graph (2), no damages, interest on damages, cost of suit,
11 or attorney’s fee may be recovered under section 4, 4A,
12 or 4C of the Clayton Act (15 U.S.C. 15, 15a, 15c), or
13 under any State law similar to such section, from any
14 medical self-regulatory entity (including its members, offi-
15 cers, employees, consultants, and volunteers or committees
16 thereof) as a result of engaging in standard setting or en-
17 forcement activities that are—

18 (A) designed to promote the quality of health
19 care provided to patients, and

20 (B) not conducted for purposes of financial
21 gain.

22 (2) Paragraph (1) shall not prohibit the recovery of
23 actual damages, interest on damages, the cost of suit, or
24 a reasonable attorney’s fee under section 4 or 4A of the
25 Clayton Act (15 U.S.C. 15, 15a), or under any State law

1 similar to such section, by a State or the United States
2 from a medical self-regulatory entity (including its mem-
3 bers, officers, employees, consultants, and volunteers or
4 committees thereof) for injury sustained as a result of en-
5 gaging in the conduct described in such paragraph.

6 (b) FEES.—In any action under section 4, 4C, or 16
7 of the Clayton Act (15 U.S.C. 15, 15c, 26), or under a
8 similar State law, brought against any medical self-regu-
9 latory entity (including its members, officers, employees,
10 consultants, and volunteers or committees thereof) as a
11 result of engaging in conduct described in subsection
12 (a)(1), the court shall award the cost of suit, including
13 a reasonable attorney’s fee, to a substantially prevailing
14 defendant.

15 **SEC. 2602. DEFINITIONS.**

16 For purposes of this subtitle:

17 (1) The term “medical self-regulatory entity”
18 means a medical society or association, a specialty
19 board, a recognized accrediting agency, or a hospital
20 medical staff.

21 (2) The term “standard setting and enforce-
22 ment activities” means—

23 (A) accreditation of health care practition-
24 ers, health care providers, medical education in-
25 stitutions, or medical education programs,

1 (B) technology assessment and risk man-
2 agement activities,

3 (C) the development and implementation of
4 practice guidelines or practice parameters, or

5 (D) official peer review proceedings under-
6 taken by a hospital medical staff (or committee
7 thereof) or a medical society or association for
8 purposes of evaluating the quality of health care
9 provided by a medical professional.

10 **PART 2—CONSULTATION BY FEDERAL**
11 **AGENCIES**

12 **SEC. 2611. CONSULTATION WITH MEDICAL SELF-REGU-**
13 **LATORY ENTITIES RESPECTING MEDICAL**
14 **PROFESSIONAL GUIDELINES AND STAND-**
15 **ARDS.**

16 Any Federal agency engaged in the establishment of
17 medical professional standards shall consult with appro-
18 priate medical societies or associations, specialty boards,
19 or recognized accrediting agencies, if available, in carrying
20 out medical professional standard setting and guidelines
21 or standards relating to the practice of medicine.

1 **Subtitle H—Prefunding Govern-**
2 **ment Health Benefits for Cer-**
3 **tain Annuitants**

4 **SEC. 2701. REQUIREMENT THAT CERTAIN AGENCIES**
5 **PREFUND GOVERNMENT HEALTH BENEFITS**
6 **CONTRIBUTIONS FOR THEIR ANNUITANTS.**

7 (a) DEFINITIONS.—For the purpose of this section—

8 (1) the term “agency” means any agency or
9 other instrumentality within the executive branch of
10 the Government, the receipts and disbursements of
11 which are not generally included in the totals of the
12 budget of the United States Government submitted
13 by the President;

14 (2) the term “health benefits plan” means, with
15 respect to an agency, a health benefits plan, estab-
16 lished by or under Federal law, in which employees
17 or annuitants of such agency may participate;

18 (3) the term “health-benefits coverage” means
19 coverage under a health benefits plan”;

20 (4) an individual shall be considered to be an
21 “annuitant of an agency” if such individual is enti-
22 tled to an annuity, under a retirement system estab-
23 lished by or under Federal law, by virtue of—

24 (A) such individual’s service with, and sep-
25 aration from, such agency; or

1 (B) being the survivor of an annuitant
2 under subparagraph (A) or of an individual who
3 died while employed by such agency; and

4 (5) the term “Office” means the Office of Per-
5 sonnel Management.

6 (b) PREFUNDING REQUIREMENT.—

7 (1) IN GENERAL.—Effective as of October 1,
8 1994, each agency (or February 1, 1995, in the case
9 of the agency with the greatest number of employ-
10 ees, as determined by the Office) shall be required
11 to prepay the Government contributions which are
12 or will be required in connection with providing
13 health-benefits coverage for annuitants of such agen-
14 cy.

15 (2) REGULATIONS.—The Office shall prescribe
16 such regulations as may be necessary to carry out
17 this section. The regulations shall be designed to en-
18 sure at least the following:

19 (A) Amounts paid by each agency shall be
20 sufficient to cover the amounts which would
21 otherwise be payable by such agency (on a
22 “pay-as-you-go” basis), on or after the applica-
23 ble effective date under paragraph (1), on be-
24 half of—

1 (i) individuals who are annuitants of
2 the agency as of such effective date; and

3 (ii) individuals who are employed by
4 the agency as of such effective date, or
5 who become employed by the agency after
6 such effective date, after such individuals
7 have become annuitants of the agency (in-
8 cluding their survivors).

9 (B)(i) For purposes of determining any
10 amounts payable by an agency—

11 (I) this section shall be treated as if
12 it had taken effect at the beginning of the
13 20-year period which ends on the effective
14 date applicable under paragraph (1) with
15 respect to such agency; and

16 (II) in addition to any amounts pay-
17 able under subparagraph (A), each agency
18 shall also be responsible for paying any
19 amounts for which it would have been re-
20 sponsible, with respect to the 20-year pe-
21 riod described in subclause (I), in connec-
22 tion with any individuals who are annu-
23 itants or employees of the agency as of the
24 applicable effective date under paragraph
25 (1).

1 (ii) Any amounts payable under this sub-
 2 paragraph for periods preceding the applicable
 3 effective date under paragraph (1) shall be pay-
 4 able in equal installments over the 20-year pe-
 5 riod beginning on such effective date.

6 (c) FASB STANDARDS.—Regulations under sub-
 7 section (b) shall be in conformance with the provisions of
 8 standard 106 of the Financial Accounting Standards
 9 Board, issued in December 1990.

10 (d) CLARIFICATION.—Nothing in this section shall be
 11 considered to permit or require duplicative payments on
 12 behalf of any individuals.

13 (e) DRAFT LEGISLATION.—The Office shall prepare
 14 and submit to Congress any draft legislation which may
 15 be necessary in order to carry out this section.

16 **Subtitle I—Miscellaneous** 17 **Provisions**

18 **SEC. 2801. INCREASE IN MINIMUM AGE REQUIRED IN**
 19 **ORDER TO BE ELIGIBLE FOR AN IMMEDIATE**
 20 **CIVIL SERVICE ANNUITY.**

21 (a) CIVIL SERVICE RETIREMENT SYSTEM.—

22 (1) WITH 30 YEARS OF SERVICE.—Section
 23 8336(a) of title 5, United States Code, is amended
 24 to read as follows:

1 “(a)(1) An employee who is separated from the serv-
2 ice after attaining the minimum retirement age under
3 paragraph (2) and completing 30 years of service is enti-
4 tled to an annuity.

5 “(2) The minimum retirement age under this para-
6 graph is—

7 “(A) for an individual whose date of birth is be-
8 fore January 1, 1939, 55 years of age; and

9 “(B) for an individual whose date of birth is
10 after December 31, 1938, and before January 1,
11 1942, 58 years of age.

12 “(3) The preceding provisions of this subsection shall
13 not apply with respect to any individual whose date of
14 birth is after December 31, 1941.”.

15 (2) WITH 20 YEARS OF SERVICE.—Section
16 8336(b) of title 5, United States Code, is amended
17 to read as follows:

18 “(b)(1) An employee who is separated from the serv-
19 ice after attaining the minimum retirement age under
20 paragraph (2) and completing 20 years of service is enti-
21 tled to an annuity.

22 “(2) The minimum retirement age under this para-
23 graph is, for an individual whose date of birth is before
24 January 1, 1935, 60 years of age.

1 “(3) The preceding provisions of this subsection shall
2 not apply with respect to any individual whose date of
3 birth is after December 31, 1934.”.

4 (3) MEMBERS OF CONGRESS.—Section 8336(g)
5 of title 5, United States Code, is amended—

6 (A) by redesignating paragraphs (1) and
7 (2) as subparagraphs (A) and (B), respectively,
8 and by striking “(g)” and inserting “(g)(1)”;

9 (B) in the first sentence by striking “be-
10 coming 60 years of age” and inserting “satisfy-
11 ing the requirements of paragraph (2)”;

12 (C) in the second sentence by striking “be-
13 coming 55 years of age (but before becoming 60
14 years of age)” and inserting “satisfying the re-
15 quirements of paragraph (3)”;

16 (D) by adding at the end the following:

17 “(2) A Member shall be considered to satisfy the re-
18 quirements of this paragraph if such Member has attained
19 the minimum retirement age which would apply to such
20 Member under section 8336(b), except that such require-
21 ments shall not be considered satisfied by any Member de-
22 scribed in section 8336(b)(3).

23 “(3) A Member shall be considered to satisfy the re-
24 quirements of this paragraph if such Member—

1 “(A) has attained the minimum retirement age
2 which would apply to such Member under section
3 8336(a), but

4 “(B) has not attained the minimum retirement
5 age which would apply to such Member under sec-
6 tion 8336(b),

7 except that such requirements shall not be considered sat-
8 isfied by any Member described in section 8336(b)(3).”.

9 (b) FEDERAL EMPLOYEES’ RETIREMENT SYSTEM.—

10 (1) WITH 20 YEARS OF SERVICE.—Section
11 8412(b) of title 5, United States Code, is amended
12 to read as follows:

13 “(b)(1) An employee or Member who is separated
14 from the service after attaining the minimum retirement
15 age under paragraph (2) and completing 20 years of serv-
16 ice is entitled to an annuity.

17 “(2) The minimum retirement age under this para-
18 graph is, for an individual whose date of birth is before
19 January 1, 1935, 60 years of age.

20 “(3) The preceding provisions of this subsection shall
21 not apply with respect to any individual whose date of
22 birth is after December 31, 1934.”.

23 (2) WITH 30 YEARS OF SERVICE.—Section
24 8412(h) of title 5, United States Code, is amended
25 to read as follows:

1 “(h)(1) The applicable minimum retirement age
2 under this subsection is—

3 “(A) for an individual whose date of birth is be-
4 fore January 1, 1939, 55 years of age; and

5 “(B) for an individual whose date of birth is
6 after December 31, 1938, and before January 1,
7 1948, 58 years of age.

8 “(2) Nothing in paragraph (1) shall be considered to
9 apply with respect to any individual whose date of birth
10 is after December 31, 1947.”.

11 (c) CONFORMING AMENDMENT.—Section
12 8442(c)(2)(B)(i)(I) of title 5, United States Code, is
13 amended by striking “age 60” and inserting “the mini-
14 mum retirement age under section 8412(b)”.

15 (d) CONFORMANCE OF THE RETIREMENT SYSTEMS
16 RELATING TO THE FOREIGN SERVICE AND THE CENTRAL
17 INTELLIGENCE AGENCY.—

18 (1) FOREIGN SERVICE.—The President shall, in
19 accordance with applicable provisions of section 827
20 of the Foreign Service Act of 1980 (22 U.S.C.
21 4067), provide that the Foreign Service Retirement
22 and Disability System and the Foreign Service Pen-
23 sion System are conformed to reflect the amend-
24 ments made by this section.

1 (2) CENTRAL INTELLIGENCE AGENCY.—The
 2 President shall, using the authority available to him
 3 under section 292 of the Central Intelligence Agency
 4 Retirement Act, as set forth in section 802 of the
 5 CIARDS Technical Corrections Act of 1992 (Public
 6 Law 102–496; 106 Stat. 3241), provide that the
 7 Central Intelligence Agency Retirement and Disabil-
 8 ity System shall be conformed to reflect the amend-
 9 ments made by this section.

10 (e) EFFECTIVE DATE.—This section and the amend-
 11 ments made by this section shall take effect on January
 12 1, 1994, and shall apply with respect to annuities based
 13 on the service of any individual separating on or after that
 14 date.

15 **TITLE III—LONG-TERM CARE**
 16 **Subtitle A—Tax Treatment of Long-**
 17 **term Care Insurance**

18 **SEC. 3001. TREATMENT OF LONG-TERM CARE INSURANCE**
 19 **OR PLANS.**

20 (a) GENERAL RULE.—Subpart E of part I of sub-
 21 chapter L of chapter 1 of the Internal Revenue Code of
 22 1986 is amended by inserting after section 818 the follow-
 23 ing new section:

1 **“SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE**
2 **OR PLANS.**

3 “(a) GENERAL RULE.—For purposes of this part, a
4 long-term care insurance contract shall be treated as an
5 accident or health insurance contract.

6 “(b) LONG-TERM CARE INSURANCE CONTRACT.—

7 “(1) IN GENERAL.—For purposes of this part,
8 the term ‘long-term care insurance contract’ means
9 any insurance contract issued if—

10 “(A) the only insurance protection pro-
11 vided under such contract is coverage of quali-
12 fied long-term care services and benefits inci-
13 dental to such coverage,

14 “(B) the maximum benefit under the pol-
15 icy for expenses incurred for any day does not
16 exceed \$200,

17 “(C) such contract does not cover expenses
18 incurred for services or items to the extent that
19 such expenses are reimbursable under title
20 XVIII of the Social Security Act or would be so
21 reimbursable but for the application of a de-
22 ductible or coinsurance amount,

23 “(D) such contract is guaranteed renew-
24 able,

25 “(E) such contract does not have any cash
26 surrender value, and

1 “(F) all refunds of premiums, and all pol-
2 icyholder dividends or similar amounts, under
3 such contract are to be applied as a reduction
4 in future premiums or to increase future bene-
5 fits.

6 “(2) SPECIAL RULES.—

7 “(A) PER DIEM, ETC. PAYMENTS PER-
8 MITTED.—A contract shall not fail to be treated
9 as described in paragraph (1)(A) by reason of
10 payments being made on a per diem or other
11 periodic basis without regard to the expenses
12 incurred during the period to which the pay-
13 ments relate.

14 “(B) CONTRACT MAY COVER MEDICARE
15 REIMBURSABLE EXPENSES WHERE MEDICARE
16 IS SECONDARY PAYOR.—Paragraph (1)(C) shall
17 not apply to expenses which are reimbursable
18 under title XVIII of the Social Security Act
19 only as a secondary payor.

20 “(C) REFUNDS OF PREMIUMS.—Paragraph
21 (1)(F) shall not apply to any refund of pre-
22 miums on surrender or cancellation of the con-
23 tract.

24 “(c) QUALIFIED LONG-TERM CARE SERVICES.—For
25 purposes of this section—

1 “(1) IN GENERAL.—The term ‘qualified long-
2 term care services’ means necessary diagnostic, pre-
3 ventive, therapeutic, and rehabilitative services, and
4 maintenance or personal care services, which—

5 “(A) are required by a chronically ill indi-
6 vidual in a qualified facility, and

7 “(B) are provided pursuant to a plan of
8 care prescribed by a licensed health care practi-
9 tioner.

10 “(2) CHRONICALLY ILL INDIVIDUAL.—

11 “(A) IN GENERAL.—The term ‘chronically
12 ill individual’ means any individual who has
13 been certified by a licensed health care practi-
14 tioner as—

15 “(i) (I) being unable to perform (with-
16 out substantial assistance from another in-
17 dividual) at least 2 activities of daily living
18 (as defined in subparagraph (B)) for a pe-
19 riod of at least 90 days due to a loss of
20 functional capacity, or

21 “(II) having a level of disability simi-
22 lar (as determined by the Secretary in con-
23 sultation with the Secretary of Health and
24 Human Services) to the level of disability
25 described in subclause (I), or

1 “(ii) having a similar level of disabil-
2 ity due to cognitive impairment.

3 “(B) ACTIVITIES OF DAILY LIVING.—For
4 purposes of subparagraph (A), each of the fol-
5 lowing is an activity of daily living:

6 “(i) MOBILITY.—The process of walk-
7 ing or wheeling on a level surface which
8 may include the use of an assistive device
9 such as a cane, walker, wheelchair, or
10 brace.

11 “(ii) DRESSING.—The overall complex
12 behavior of getting clothes from closets
13 and drawers and then getting dressed.

14 “(iii) TOILETING.—The act of going
15 to the toilet room for bowel and bladder
16 function, transferring on and off the toilet,
17 cleaning after elimination, and arranging
18 clothes or the ability to voluntarily control
19 bowel and bladder function, or in the event
20 of incontinence, the ability to maintain a
21 reasonable level of personal hygiene.

22 “(iv) TRANSFER.—The process of get-
23 ting in and out of bed or in and out of a
24 chair or wheelchair.

1 “(v) EATING.—The process of getting
2 food from a plate or its equivalent into the
3 mouth.

4 “(3) QUALIFIED FACILITY.—The term ‘quali-
5 fied facility’ means—

6 “(A) a nursing, rehabilitative, hospice, or
7 adult day care facility (including a hospital, re-
8 tirement home, nursing home, skilled nursing
9 facility, intermediate care facility, or similar in-
10 stitution)—

11 “(i) which is licensed under State law,
12 or

13 “(ii) which is a certified facility for
14 purposes of title XVIII or XIX of the So-
15 cial Security Act, or

16 “(B) an individual’s home if a licensed
17 health care practitioner certifies that without
18 home care the individual would have to be cared
19 for in a facility described in subparagraph (A).

20 “(4) MAINTENANCE OR PERSONAL CARE SERV-
21 ICES.—The term ‘maintenance or personal care serv-
22 ices’ means any care the primary purpose of which
23 is to provide needed assistance with any of the ac-
24 tivities of daily living described in paragraph (2)(B).

1 “(5) LICENSED HEALTH CARE PRACTI-
2 TIONER.—The term ‘licensed health care practi-
3 tioner’ means any physician (as defined in section
4 1861(r) of the Social Security Act) and any reg-
5 istered professional nurse, licensed social worker, or
6 other individual who meets such requirements as
7 may be prescribed by the Secretary.

8 “(d) CONTINUATION COVERAGE EXCISE TAX NOT
9 TO APPLY.—This section shall not apply in determining
10 whether section 4980B (relating to failure to satisfy con-
11 tinuation coverage requirements of group health plans) ap-
12 plies.

13 “(e) INFLATION ADJUSTMENT OF \$200 BENEFIT
14 LIMIT.—

15 “(1) IN GENERAL.—In the case of a calendar
16 year after 1994, the \$200 amount contained in sub-
17 section (b)(1)(B) shall be increased for such cal-
18 endar year by the medical care cost adjustment for
19 such calendar year. If any increase determined
20 under the preceding sentence is not a multiple of
21 \$10, such increase shall be rounded to the nearest
22 multiple of \$10.

23 “(2) MEDICAL CARE COST ADJUSTMENT.—For
24 purposes of paragraph (1), the medical care cost ad-

1 justment for any calendar year is the percentage (if
2 any) by which—

3 “(A) the medical care component of the
4 Consumer Price Index (as defined in section
5 1(f)(5)) for August of the preceding calendar
6 year, exceeds

7 “(B) such component for August of 1993.”

8 (b) CLERICAL AMENDMENT.—The table of sections
9 for such subpart E is amended by inserting after the item
10 relating to section 818 the following new item:

 “Sec. 818A. Treatment of long-term care insurance or plans.”

11 **SEC. 3002. EXCLUSION FOR BENEFITS PROVIDED UNDER**
12 **LONG-TERM CARE INSURANCE; INCLUSION**
13 **OF EMPLOYER-PROVIDED COVERAGE.**

14 (a) IN GENERAL.—Subsection (a) of section 104 of
15 the Internal Revenue Code of 1986 (relating to compensa-
16 tion for injuries or sickness) is amended by striking “and”
17 at the end of paragraph (4), by striking the period at the
18 end of paragraph (5) and inserting “, and”, and by insert-
19 ing after paragraph (4) the following new paragraph:

20 “(6) benefits under a long-term care insurance
21 contract (as defined in section 818A(b)).”

22 (b) INCLUSION OF EMPLOYER-PROVIDED COV-
23 ERAGE.—Section 106 of such Code (relating to contribu-
24 tions by employer to accident and health plans) is amend-
25 ed by adding at the end thereof the following sentence:

1 “The preceding sentence shall not apply to any plan pro-
2 viding coverage for long-term care services.”

3 **SEC. 3003. QUALIFIED LONG-TERM SERVICES TREATED AS**
4 **MEDICAL CARE.**

5 (a) GENERAL RULE.—Paragraph (1) of section
6 213(d) of the Internal Revenue Code of 1986 (defining
7 medical care) is amended by striking “or” at the end of
8 subparagraph (B), by redesignating subparagraph (C) as
9 subparagraph (D), and by inserting after subparagraph
10 (B) the following new subparagraph:

11 “(C) for qualified long-term care services
12 (as defined in section 818A(c)), or”.

13 (b) DEDUCTION FOR LONG-TERM CARE EXPENSES
14 FOR PARENT OR GRANDPARENT.—Section 213 of such
15 Code (relating to deduction for medical expenses) is
16 amended by adding at the end the following new sub-
17 section:

18 “(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE
19 EXPENSES.—For purposes of subsection (a), the term ‘de-
20 pendent’ shall include any parent or grandparent of the
21 taxpayer for whom the taxpayer has expenses for long-
22 term care services described in section 818A(c), but only
23 to the extent of such expenses.”

24 (c) TECHNICAL AMENDMENTS.—

1 (1) Subparagraph (D) of section 213(d)(1) of
 2 such Code (as redesignated by subsection (a)) is
 3 amended by striking “subparagraphs (A) and (B)”
 4 and inserting “subparagraphs (A), (B), and (C)”.

5 (2)(A) Paragraph (1) of section 213(d) of such
 6 Code is amended by adding at the end thereof the
 7 following new flush sentence:
 8 “‘In the case of a long-term care insurance contract
 9 (as defined in section 818A), only eligible long-term
 10 care premiums (as defined in paragraph (10)) shall
 11 be taken into account under subparagraph (D).’”

12 (B) Subsection (d) of section 213 is amended
 13 by adding at the end the following new paragraph:

14 “(10) ELIGIBLE LONG-TERM CARE PRE-
 15 MIUMS.—

16 “(A) IN GENERAL.—For purposes of this
 17 section, the term ‘eligible long-term care pre-
 18 miums’ means the amount paid during a tax-
 19 able year for any long-term care insurance con-
 20 tract (as defined in section 818A) covering an
 21 individual, to the extent such amount does not
 22 exceed the limitation determined under the fol-
 23 lowing table:

“In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	\$200
More than 40 but not more than 50	375

More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

1 “(B) INDEXING.—

2 “(i) IN GENERAL.—In the case of any
3 taxable year beginning in a calendar year
4 after 1993, each dollar amount contained
5 in paragraph (1) shall be increased by the
6 medical care cost adjustment of such
7 amount for such calendar year. If any in-
8 crease determined under the preceding sen-
9 tence is not a multiple of \$10, such in-
10 crease shall be rounded to the nearest mul-
11 tiple of \$10.

12 “(ii) MEDICAL CARE COST ADJUST-
13 MENT.—For purposes of clause (i), the
14 medical care cost adjustment for any cal-
15 endar year is the percentage (if any) by
16 which—

17 “(I) the medical care component
18 of the Consumer Price Index (as de-
19 fined in section 1(f)(5)) for August of
20 the preceding calendar year, exceeds

21 “(II) such component for August
22 of 1991.”

23 (3) Paragraph (6) of section 213(d) of such
24 Code is amended—

1 (A) by striking “subparagraphs (A) and
2 (B)” and inserting “subparagraphs (A), (B),
3 and (C)”, and

4 (B) by striking “paragraph (1)(C)” in sub-
5 paragraph (A) and inserting “paragraph
6 (1)(D)”.

7 (4) Paragraph (7) of section 213(d) of such
8 Code is amended by striking “subparagraphs (A)
9 and (B)” and inserting “subparagraphs (A), (B),
10 and (C)”.

11 **SEC. 3004. CERTAIN EXCHANGES OF LIFE INSURANCE CON-**
12 **TRACTS FOR LONG-TERM CARE INSURANCE**
13 **CONTRACTS NOT TAXABLE.**

14 Subsection (a) of section 1035 of the Internal Reve-
15 nue Code of 1986 (relating to certain exchanges of insur-
16 ance contracts) is amended by striking the period at the
17 end of paragraph (3) and inserting “; or”, and by adding
18 at the end thereof the following new paragraph:

19 “(4) a contract of life insurance or an endow-
20 ment or annuity contract for a long-term care insur-
21 ance contract (as defined in section 818A).”

1 **SEC. 3005. EXCLUSION FROM GROSS INCOME FOR**
2 **AMOUNTS WITHDRAWN FROM INDIVIDUAL**
3 **RETIREMENT PLANS OR 401(k) PLANS FOR**
4 **LONG-TERM CARE INSURANCE.**

5 (a) IN GENERAL.—Part III of subchapter B of chap-
6 ter 1 of the Internal Revenue Code of 1986 (relating to
7 items specifically excluded from gross income) is amended
8 by redesignating section 137 as section 138 and by insert-
9 ing after section 136 the following new section:

10 **“SEC. 137. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT**
11 **ACCOUNTS AND SECTION 401(k) PLANS FOR**
12 **LONG-TERM CARE INSURANCE.**

13 “(a) GENERAL RULE.—The amount includible in the
14 gross income of an individual for the taxable year by rea-
15 son of qualified distributions during such taxable year
16 shall not exceed the excess of—

17 “(1) the amount which would (but for this sec-
18 tion) be so includible by reason of such distributions,
19 over

20 “(2) the aggregate premiums paid by such indi-
21 vidual during such taxable year for any long-term
22 care insurance contract (as defined in section 818A)
23 for the benefit of such individual or the spouse of
24 such individual.

25 “(b) QUALIFIED DISTRIBUTION.—For purposes of
26 this section, the term ‘qualified distribution’ means any

1 distribution to an individual from an individual retirement
2 account or a section 401(k) plan if such individual has
3 attained age 59½ on or before the date of the distribution
4 (and, in the case of a distribution used to pay premiums
5 for the benefit of the spouse of such individual, such
6 spouse has attained age 59½ on or before the date of the
7 distribution).

8 “(c) DEFINITIONS.—For purposes of this section—

9 “(1) INDIVIDUAL RETIREMENT ACCOUNT.—The
10 term ‘individual retirement account’ has the mean-
11 ing given such term by section 408(a).

12 “(2) SECTION 401(k) PLAN.—The term ‘section
13 401(k) plan’ means any employer plan which meets
14 the requirements of section 401(a) and which in-
15 cludes a qualified cash or deferred arrangement (as
16 defined in section 401(k)).

17 “(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

18 “(1) WITHDRAWALS CANNOT EXCEED ELEC-
19 TIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR
20 DEFERRED ARRANGEMENT.—This section shall not
21 apply to any distribution from a section 401(k) plan
22 to the extent the aggregate amount of such distribu-
23 tions for the use described in subsection (a) exceeds
24 the aggregate employer contributions made pursuant
25 to the employee’s election under section 401(k)(2).

1 “(2) WITHDRAWALS NOT TO CAUSE DISQUALI-
 2 FICATION.—A plan shall not be treated as failing to
 3 satisfy the requirements of section 401, and an ar-
 4 rangement shall not be treated as failing to be a
 5 qualified cash or deferred arrangement (as defined
 6 in section 401(k)(2)), merely because under the plan
 7 or arrangement distributions are permitted which
 8 are excludable from gross income by reason of this
 9 section.”

10 (b) CONFORMING AMENDMENTS.—

11 (1) Section 401(k) of such Code is amended by
 12 adding at the end the following new paragraph:

13 “(11) CROSS REFERENCE.—

**“For provision permitting tax-free withdrawals
 for payment of long-term care premiums, see section
 137.”**

14 (2) Section 408(d) of such Code is amended by
 15 adding at the end the following new paragraph:

16 “(8) CROSS REFERENCE.—

**“For provision permitting tax-free withdrawals
 from individual retirement accounts for payment of
 long-term care premiums, see section 137.”**

17 (3) The table of sections for such part III is
 18 amended by striking the last item and inserting the
 19 following new items:

 “Sec. 137. Distributions from individual retirement accounts and
 section 401(k) plans for long-term care insurance.
 “Sec. 138. Cross references to other Acts.”

1 **SEC. 3006. TAX TREATMENT OF ACCELERATED DEATH BEN-**
 2 **EFITS UNDER LIFE INSURANCE CONTRACTS.**

3 Section 101 of the Internal Revenue Code of 1986
 4 (relating to certain death benefits) is amended by adding
 5 at the end thereof the following new subsection:

6 “(g) TREATMENT OF CERTAIN ACCELERATED
 7 DEATH BENEFITS.—

8 “(1) IN GENERAL.—For purposes of this sec-
 9 tion, any amount paid or advanced to an individual
 10 under a life insurance contract on the life of an in-
 11 sured—

12 “(A) who is a terminally ill individual, or

13 “(B) who is a chronically ill individual (as
 14 defined in section 818A(c)(2)) who is confined
 15 to a qualified facility (as defined in section
 16 818A(c)(3)(A)),

17 shall be treated as an amount paid by reason of the
 18 death of such insured.

19 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
 20 poses of this subsection, the term ‘terminally ill indi-
 21 vidual’ means an individual who has been certified
 22 by a physician as having an illness or physical condi-
 23 tion which can reasonably be expected to result in
 24 death in 12 months or less.

1 “(3) PHYSICIAN.—For purposes of this sub-
 2 section, the term ‘physician’ has the meaning given
 3 to such term by section 213(d)(4).”

4 **SEC. 3007. EFFECTIVE DATE.**

5 The amendments made by this subtitle shall apply to
 6 taxable years beginning after December 31, 1994.

7 **Subtitle B—Protection of Assets**
 8 **Under Medicaid Through Use of**
 9 **Qualified Long-term Care Insur-**
 10 **ance**

11 **SEC. 3101. PROTECTION OF ASSETS THROUGH USE OF**
 12 **QUALIFIED LONG-TERM CARE INSURANCE.**

13 (a) IN GENERAL.—Title XIX of the Social Security
 14 Act, as amended by section 1601(a), is amended—

15 (1) by redesignating section 1932 as section
 16 1933; and

17 (2) by inserting after section 1931 the following
 18 new section:

19 “SPECIAL RULES FOR ASSET DISREGARD IN THE CASE OF
 20 QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

21 “SEC. 1932. (a) IN GENERAL.—Each State plan
 22 under this title, as a condition for the receipt of payment
 23 under section 1903(a) with respect to long-term care serv-
 24 ices (as defined in subsection (c)(1)), shall provide that
 25 in determining the eligibility of an individual for medical
 26 assistance under the plan with respect to such services

1 there shall be disregarded some or all of the individual's
 2 assets which are attributable (as determined under sub-
 3 section (c)(2)) to coverage under a qualified long-term
 4 care insurance contract (as defined in subsection (b)).

5 “(b) QUALIFIED LONG-TERM CARE INSURANCE
 6 CONTRACT DEFINED.—In this section, the term ‘qualified
 7 long-term care insurance contract’ means, with respect to
 8 a State, a long-term care insurance contract (as defined
 9 in section 818A(b) of the Internal Revenue Code of 1986)
 10 which—

11 “(1) provides such protection against the costs
 12 of receiving long-term care services as the State may
 13 require by law;

14 “(2) provides that benefits under the contract
 15 shall be paid without regard to eligibility for medical
 16 assistance under this title; and

17 “(3) meets such other requirements (such as re-
 18 quirements relating to premiums, disclosure, mini-
 19 mum benefits, rights of conversion, and standards
 20 for claims processing) as the State may determine to
 21 be appropriate.

22 “(c) OTHER DEFINITIONS.—In this section:

23 “(1) LONG-TERM CARE SERVICES.—The term
 24 ‘long-term care services’ means nursing facility serv-
 25 ices, home health care services, and home and com-

1 munity-based services, and includes such other simi-
2 lar items and services described in section 1905(a)
3 as a State may specify.

4 “(2) ATTRIBUTION RULES.—An individual’s as-
5 sets are considered to be ‘attributable’ to a qualified
6 long-term care insurance contract to the extent spec-
7 ified under the State plan. Such a plan shall provide
8 for at least one of the following:

9 “(A) All assets are considered attributable
10 if the insurance contract provides coverage for
11 at least a specified period of coverage (of not
12 less than 3 years and of not more than 6 years)
13 for long-term care services.

14 “(B) An amount of assets, up to the dollar
15 limitation on benefits for long-term care serv-
16 ices under the contract, is considered attrib-
17 utable to the contract.”.

18 (b) CONFORMING AMENDMENT.—Section
19 1902(a)(17)(A) of such Act (42 U.S.C. 1396a(a)(17)(A))
20 is amended by inserting “and section 1932” after “objec-
21 tives of this title”.

22 (c) EFFECTIVE DATE.—

23 (1) IN GENERAL.—The amendments made by
24 this section shall apply (except as provided under
25 paragraph (2)) to payments to States under title

1 XIX of the Social Security Act for calendar quarters
2 beginning on or after one year after the date of the
3 enactment of this Act, without regard to whether
4 regulations to implement such amendment are pro-
5 mulgated by such date.

6 (2) DELAY PERMITTED IF STATE LEGISLATION
7 REQUIRED.—In the case of a State plan for medical
8 assistance under title XIX of the Social Security Act
9 which the Secretary of Health and Human Services
10 determines requires State legislation (other than leg-
11 islation authorizing or appropriating funds) in order
12 for the plan to meet the additional requirements im-
13 posed by the amendments made by this section, the
14 State plan shall not be regarded as failing to comply
15 with the requirements of such title solely on the
16 basis of its failure to meet these additional require-
17 ments before the first day of the first calendar quar-
18 ter beginning after the close of the first regular ses-
19 sion of the State legislature that begins after the
20 date of the enactment of this Act. For purposes of
21 the previous sentence, in the case of a State that has
22 a 2-year legislative session, each year of such session
23 shall be deemed to be a separate regular session of
24 the State legislature.

Subtitle C—Studies

**SEC. 3201. FEASIBILITY OF ENCOURAGING HEALTH CARE
PROVIDERS TO DONATE SERVICES TO HOME-
BOUND PATIENTS.**

The Comptroller General of the United States shall conduct a study on the feasibility of encouraging health care providers to donate their services to homebound patients. Such study shall include an examination of the effects of qualifying such services as a charitable contribution.

**SEC. 3202. FEASIBILITY OF TAX CREDIT FOR HEADS OF
HOUSEHOLDS WHO CARE FOR ELDERLY FAM-
ILY MEMBERS IN THEIR HOMES.**

The Comptroller General of the United States shall conduct a study on the feasibility of providing heads of households who care for elderly family members in their homes with a tax credit. Such study shall estimate the cost of such a tax credit which would apply to expenses incurred in the custodial care of such an elderly family member to the extent such expenses exceed 5 percent of adjusted gross income.

**SEC. 3203. CASE MANAGEMENT OF CURRENT LONG-TERM
CARE BENEFITS.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the feasibility

1 of encouraging or requiring the use of a single designated
 2 public or nonprofit agency (such as an area agency on
 3 aging) to coordinate, through case management, the provi-
 4 sion of long-term care benefits under current Federal,
 5 State, and local programs in a geographic area.

6 (b) REPORT.—The Secretary shall submit to Con-
 7 gress a report on the study conducted under subsection
 8 (a) by not later than 1 year after the date of the enact-
 9 ment of this Act. Such report shall include such rec-
 10 ommendations regarding changes in legislation to encour-
 11 age or require the use (described in subsection (a)) of an
 12 agency to coordinate long-term care benefits as may be
 13 appropriate.

14 **Subtitle D—Volunteer Service** 15 **Credit Demonstration Projects**

16 **SEC. 3301. AMENDMENT TO THE OLDER AMERICANS ACT** 17 **OF 1965.**

18 (a) IN GENERAL.—Part B of title IV of the Older
 19 Americans Act of 1965 (42 U.S.C. 3034–3035r) is amend-
 20 ed by adding at the end the following:

21 **“SEC. 429K. VOLUNTEER SERVICE CREDIT DEMONSTRA-** 22 **TION PROJECTS.**

23 “(a) REQUIREMENTS.—The Commissioner shall—

24 “(1) establish and operate (directly, or through
 25 the State agency on aging or one or more area agen-

1 cies on aging) a volunteer service credit demonstra-
2 tion project in all or part of each State;

3 “(2) establish criteria for selecting individuals
4 to whom volunteer services will be provided under
5 volunteer service credit demonstration projects oper-
6 ated under paragraph (1);

7 “(3) recruit and train (directly or through State
8 agencies on aging or area agencies on aging) individ-
9 uals who volunteer to provide services through such
10 projects;

11 “(4) establish a minimum standard for each
12 service to be provided by volunteers through such
13 projects;

14 “(5) monitor services provided by volunteers
15 through such projects to ensure that standards es-
16 tablished under paragraph (4) are met; and

17 “(6) maintain (directly or through State agen-
18 cies on aging or area agencies on aging) with respect
19 to each individual who provides services through a
20 volunteer service credit demonstration project oper-
21 ated under paragraph (1) a separately identifiable
22 account showing the number of hours such individ-
23 ual provided such services.

24 “(b) DEFINITION.—For purposes of subsection (a),
25 the term ‘volunteer service credit demonstration project’

1 means a demonstration project through which homemaker
 2 services, respite care for families, adult day care, and edu-
 3 cational, transportation, and home-delivery services are
 4 provided by—

5 “(1) volunteer older individuals for the benefit
 6 of older individuals or low-income children; or

7 “(2) volunteer individuals of any age for the
 8 benefit of older individuals;

9 in return for the the receipt of similar services under any
 10 such demonstration project (that is established under this
 11 section) at a time at which such volunteers are older indi-
 12 viduals in need of such services.”.

13 (b) EFFECTIVE DATE.—The amendment made by
 14 subsection (a) shall take effect October 1, 1994.

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